Northern Inyo County Local Hospital District

Board of Directors Regular Meeting

Wednesday July 17 2013; 5:30pm

Board Room
Birch Street Annex
2957 Birch Street, Bishop, CA

THIS SHEET

INTENTIONALLY

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CALL TO ORDER

The meeting was called to order at 5:33 p.m. by John Ungersma, M.D., President. Doctor Ungersma read the mission statement of Northern Inyo Hospital to those present.

PRESENT

John Ungersma, M.D. President
M.C. Hubbard, Vice President
Denise Hayden, Secretary
D. Scott Clark, M.D., Treasurer
Peter Watercott, Member

ALSO PRESENT

John Halfen, Administrator
Robbin Cromer-Tyler, M.D., Chief of Staff
Douglas Buchanan, District Legal Counsel
Sandy Blumberg, Executive Assistant

OPPORTUNITY FOR PUBLIC COMMENT

Doctor Ungersma asked if any members of the public wished to comment on any items listed on the agenda for this meeting, or on any items of interest. No comments were heard.

CONSENT AGENDA

The proposed consent agenda for this meeting contained the following items:

1. Approval of the minutes of the May 15, 2013 regular meeting (*action item*).
2. Approval of the minutes of the May 2, 2013 special meeting (*action item*).
3. Security report for April 2013 (*information item*).
4. Financial and Statistical Reports for the month of April 2013; John Halfen (*action item*).
5. Ratification of Private Practice Physician Income Guarantee Agreement with Matthew Wise, M.D. (*action item*).
6. Ratification of Relocation Expense Agreement with Matthew Wise, M.D. (*action item*).
7. Approval of annual Appropriations Limit (*action item*).

It was moved by Peter Watercott, seconded by D. Scott Clark, M.D. and passed to approve the proposed consent agenda as presented, with the exception of agenda item 7 which will be presented at the July regular meeting of the District Board.

ADMINISTRATOR'S REPORT

Mr. Halfen reported that OB/Gyn Matthew Wise, M.D. has joined the practice of Lara Jeanine Arndal, M.D., and is working approximately 20 days per month. Orthopedist Richard Meredick, M.D. is still expected to relocate to this area and practice at Northern Inyo Hospital (NIH), and at this time he is waiting to receive his California license. Administration also continues to negotiate with two potential internal medicine candidates who are considering joining the practice of Doctors Kamei, Hathaway, and Englesby.

PHYSICIAN RECRUITING UPDATE

CMS SURVEY RESPONSE

Mr. Halfen provided an update on the recent Centers for Medicare and Medicaid (CMS) follow-up survey, stating that the hospital's response has been accepted by CMS and our deemed status has been reinstated. The surveyors who came for the follow-up survey were extremely cooperative and clearly felt that NIH's deemed status should remain intact.

LETTER OF INTENT, CAL FIRST

Mr. Halfen also called attention to a letter of intent with California First National Bank, which would potentially provide the District with a $1,000,000 revolving line of credit at a remarkably low interest rate.

EMPLOYEES OF THE MONTH

Mr. Halfen additionally stated that he will begin providing information on a monthly basis regarding employees who are designated as "Employees of the Month" for Northern Inyo Hospital. The Employee of the Month for May was Phlebotomist Shawn Williams; and the Employee of the Month for June, 2013 was Maintenance Employee Robert Ralston.

ALPHA FUND RATES

Mr. Halfen also called attention to a notice received from Alpha Fund, the Hospital's Worker's Compensation Insurance carrier, informing us of our rates effective as of July 1, 2013. Our Worker's Comp rates have increased for the 2nd year in a row; however the increase for the next fiscal year will be less than the industry median, at 5.6%. In light of the fact that nationwide many employers are facing increases of up to 15%, the hospital's increase can be seen as being fairly modest.

CHIEF OF STAFF REPORT

POLICY AND PROCEDURE APPROVALS

Chief of Staff Robbin Cromer-Tyler, M.D. reported following careful review and consideration by the appropriate committees, the Medical Executive Committee recommends approval of the following hospital wide policies and procedures:

1. *Emergency Department Narcotic Prescription Guidelines*
2. *Prescribing Pain Medication in the Emergency Department*
3. *Professional Conduct, Prohibition of Disruptive or Discriminatory Behavior (Revised)*
4. *Practitioner Complaint resolution Process (Revised)*
5. *Pre-Application Process for Initial Applicant*

Following review of the information provided it was moved by Denise Hayden, seconded by M.C. Hubbard, and passed to approve all 5 policies and procedures as presented.

PHYSICIAN PRIVILEGING AND CREDENTIALING

Doctor Cromer-Tyler also stated following careful review and consideration the Medical Executive Committee recommends the appointments and privileging of the following physicians:

1. Catherine Leja, M.D., Family Practice (*Provisional Active Staff)*
2. Matthew Wise M.D., OB/Gyn (*Provisional Active Staff)*
3. Mohammad Kanakriyeh, M.D., Pediatric Cardiology (*Provisional Consulting Staff)*

It was moved by Mr. Watercott, seconded by Ms. Hayden, and passed to

approve all three physician appointments and privileging as requested.

MEDICAL STAFF ELECTION RESULTS

Doctor Cromer-Tyler additionally stated the results of the Medical Staff Elections for the 7/1/13 through 6/30/14 year are as follows:

- Chief of Staff, Taema Weiss, M.D.
- Vice Chief of Staff, Thomas Boo, M.D.
- Immediate Past Chief of Staff, Robbin Cromer-Tyler M.D.
- Chief of Surgery, Curtis Schweizer, M.D.
- Chief of Emergency Medicine, Jennie Walker M.D.
- Chief of Intensive Care, Nickoline Hathaway, M.D.
- Chief of Pediatrics, Charlotte Helvie, M.D.
- Member at Large, Stacey Brown M.D.

It was moved by Ms. Hayden, seconded by Ms. Hubbard, and passed to approve the slate of Medical Staff officers for the upcoming year as presented.

STAFF RESIGNATION

Doctor Cromer-Tyler additionally stated that Doctor John Meher M.D. has voluntarily resigned from the Northern Inyo Hospital Medical Staff. It was moved by Ms. Hayden, seconded by Ms. Hubbard, and passed to accept the resignation of Dr. Meher as requested.

NEW BUSINESS

2013/2014 PRELIMINARY BUDGET

Mr. Halfen called attention to the 2013/2014 Fiscal Year preliminary operating budget, explaining that it is 'preliminary' because we are still attempting to trim expenses for the upcoming year. The proposed budget includes the following elements:

1. A general rate increase of 6.5% effective 7/1/13
2. A Cost of Living Adjustment (COLA) for employees, with a 1% increase becoming effective as of the first pay period of July 2013; followed by another .7% increase effective as of the first pay period in January 2014, if financial performance allows
3. An across-the-board increase of 12% for all medical premiums, and the installation of a $130 per year premium for a single hospital employee, for basic coverage
4. A 10% across-the-board increase to Cafeteria food prices, rounded up to the nearest 5 cents
5. Installation of an employee discount of 50% of the co-insurance and/or co-pay after the 20% District discount for hospital services rendered only by NIH

Mr. Halfen additionally noted that many other healthcare facilities are initiating 8 to 12 percent rate increases, so in light of that fact the proposed 6.5% increase is fairly low. He also stated that employee wages, salaries, and benefits remain high; however it is important to stay in line with industry standards in this area. Depreciation expense for the upcoming year is also higher following the completion of the new hospital building, and debt service payments are a relatively new aspect of our budget. Mr. Halfen also pointed out that the preliminary budget predicts

an expected bottom line net income of 1.9 million for the next fiscal year. Following review of the information provided it was moved by Ms. Hubbard, seconded by Doctor Clark and passed to approve the preliminary 2013/2014 operating budget as presented, with Ms. Hayden and Mr. Watercott abstaining from the vote.

POLICY REVISION, IDENTIFICATION BADGES

Human Resources Director Georgan Stottlemyre called attention to a revision to the NIH Personnel Policy which removes the allowance for an administrative fee being charged for lost or forgotten employee ID badges. Ms. Stottlemyre explained that research on this subject has revealed that legally the hospital is not allowed to charge a fee for replacement employee badges. It was moved by Ms. Hayden, seconded by Ms. Hubbard, and passed to approve the revision to the NIH Personnel Policy as requested.

ACTUARIAL VALUATION AS OF JANUARY 1, 2013

Mr. Halfen called attention to the Actuarial Valuation of the Hospital District Retirement Plan as of January 1, 2013, prepared by Milliman Incorporated. The report reveals that the District's Plan remains very healthy at this time; however Milliman recommends that we increase funding in the upcoming year by 5.75%. Following review of the information provided it was moved by Ms. Hubbard, seconded by Doctor Clark and passed to approve the Milliman Actuarial Valuation as presented, with Ms. Hayden and Mr. Watercott abstaining from the vote.

ULTRASOUND MACHINE PURCHASE

Radiology Director Patty Dickson called attention to a proposal to purchase a GE Logic E9 Ultrasound machine for the Radiology Department, stating that both of the machines that are currently in use are over 11 years old and past their useful life according to the manufacturer. NIH Radiologists and Ultrasound Techs have undergone a thorough evaluation of ultrasound machines currently on the market, and they recommend purchase the GE Logic E9 machine. The new machine will be used for abdominal and vascular studies, obstetric exams, etc., and Ms. Dickson noted that the volume of our ultrasound exams is definitely on the increase. Following review of the information provided, it was moved by Doctor Clark, seconded by Ms. Hubbard and passed to approve the purchase of the GE Logic E9 Ultrasound machine as requested.

PHYSICIAN AGREEMENT WITH A. DOUGLAS WILL M.D.

Mr. Halfen called attention to a proposed Private Practice Physician Income Guarantee and Practice Management Agreement with Albert Douglas Will, M.D.. Mr. Halfen explained that the proposed agreement differs from other physician agreements in that Dr. Will shares office space with Dr. Mark Robinson, so some of his compensation figures will be unique due to the fact that it is less expensive for the Hospital to manage his practice. Following review of the information provided it was moved by Doctor Clark, seconded by Mr. Watercott and passed to approve the Private Practice Physician Income Guarantee and Practice Management Agreement with Doctor Will as requested.

APPROVAL OF QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN

Mr. Halfen also called attention to the hospital's revised Quality Assessment and Performance Improvement (QAPI) Plan as revised by Executive Consultants with B.E. Smith Inc. in order to bring us into better compliance with Joint Commission and State of California standards. The Hospital continues in its efforts to continually improve performance in all areas of patient care, and per Joint Commission recommendations Board approval of our QAPI plan is suggested. Following review of the information provided it was moved by Mr. Watercott, seconded by Ms. Hubbard and passed to approve the proposed Quality Assurance Performance Improvement Plan as presented.

PPAC COMMITTEE UPDATE

Personnel Payroll Advisory Committee (PPAC) representative and NIH Surgery Tech Nita Eddy was present to update the Board on the progress the PPAC Committee has made toward coming to an agreement with management on revising the hospital's Family and Medical Leave (FML) policy. Ms. Eddy stated that she was not present to give an official report, however she wished to update the Board on the Committee's progress as she had previously promised to do. The PPAC Committee has been meeting on a weekly basis and has made great progress toward agreeing with management on a revision of the policy. Ms. Eddy additionally stated that once the policy is revised it will be important to educate hospital staff on the specifics of their allowed leave, because very few employees fully understand the existing policies. The PPAC Committee hopes to present their suggestions for revision of the policy at the July regular meeting of the District Board, and the experience working with management has been very positive overall. The Board thanked Ms. Eddy for providing an update, and Mr. Watercott suggested that an employee training regarding established leave policies might be recorded and made available to all hospital employees for viewing on the intranet.

CEO SEARCH COMMITTEE

Don Whiteside with HFS Consultants was present to update the Board on the effort to find a new Chief Executive Officer (CEO) to replace John Halfen by July of 2014. Mr. Whiteside recommends that the Board establish a CEO Search Advisory Committee to assist in the early stages of the process by narrowing the field of potential CEO candidates to the most desirable group appropriate for Board consideration. The proposed Committee is made up of: two members of the District Board; five hospital employees and managers; two Medical Staff members, and one member of the general public; as follows:

- John Ungersma, M.D., District Board President
- M.C. Hubbard, District Board Vice President
- Robbin Cromer-Tyler, M.D., general surgeon and current Chief of Medical Staff
- Stacey Brown, M.D.; Rural Health Clinic Medical Director and hospitalist
- Lori Plakos, Dental Hygienist and former District Board candidate

- Georgan Stottlemyre, NIH Human Resources Director
- Dan Webster, NIH Maintenance Director
- Nita Eddy, PPAC Representative and NIH Surgery Tech
- Sandy Blumberg, NIH Administration Executive Assistant

Mr. Whiteside emphasized that this group will function as an advisory committee only, which will assist in selecting candidates who are appropriate for consideration by the District Board. The responsibility of selecting the successful candidate will rest entirely on the Board of Directors. Following discussion of this topic it was moved by Mr. Watercott, seconded by Ms. Hayden, and passed to approve the appointment of the CEO Selection Advisory Committee, with Doctor Clark registering a "no" vote. Mr. Whiteside additionally distributed a document he has developed for potential CEO candidates, which includes a description of our organization; a description of the position and opportunity; goals and objectives for the successful candidate; and required qualifications. Mr. Whiteside invited the Board to maintain open communication with him on the subject of the selection process, and to provide any input they wish regarding improving the draft document. He additionally stated that he believes is will take no more than 6 months to select a successful CEO candidate.

BOARD MEMBER REPORTS

Doctor Ungersma asked if any members of the Board of Directors wished to report on any items of interest. He then reported that he recently attended the Association of California Healthcare Districts (ACHD) annual meeting that was held in San Diego, and he felt that in particular the speaker from Beta Healthcare was extremely informative.

OPPORTUNITY FOR PUBLIC COMMENT

Doctor Ungersma again asked if any members of the public wished to comment on any items of interest, or on any items listed on the agenda for this meeting. Mr. Halfen introduced Barry Mathis with HIS Pros, who will function as a "fractional Chief Information Officer (CIO)" for the Hospital, and will provide oversight for the Information Technology Department on a consulting basis. Mr. Mathis has extensive experience working on a wide variety of Hospital Information Systems.

CLOSED SESSION

At 7:02p.m. Doctor Ungersma reported the meeting would adjourn to closed session to allow the Board of Directors to:

A. Hear reports on the hospital quality assurance activities, and hear a report from the Medical Staff Executive Committee (Section 32155 of the Health and Safety Code, and Government Code Section 54962).
B. Confer with legal counsel regarding pending litigation based on stop notice FILED BY Strocal, Inc. (Government code Section 910 et seq., 54956.9).
C. Confer with legal counsel regarding significant exposure of litigation (Subdivision (b) of Government Code Section 54956.9). One potential case.

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 8:03 p.m. the meeting returned to open session. Doctor Clark made a motion that the Hospital District make an offer of $200,000 to purchase the former Hospice Building located at 151 Pioneer Lane in Bishop, California. The motion was seconded by M.C. Hubbard and passed to approve. Doctor Ungersma then reported that the Board took no other reportable action.
OPPORTUNITY FOR PUBLIC COMMENT	Doctor Ungersma again asked if any members of the public wished to address the Board of Directors on any items of interest. No comments were heard.
ADJOURNMENT	The meeting was adjourned at 8:05 p.m..

John Ungersma, M.D., President

Attest: Denise Hayden, Secretary

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NORTHERN INYO HOSPITAL

SECURITY REPORT

MAY 2013

FACILITY SECURITY

Access security during this period revealed seven exterior doors found unsecure during those times when doors were to be secured. No interior doors were found unsecure during this period. Old Building roof access was found open twice this month.

Keys were located in Hospital vehicles twice this month. One other vehicle was found unlocked.

ALARMS

On May 2nd, a HUGS Alarm activated as the result of a loose tag.

On May 4th, an RHC Entry Alarm was activated. It was determined to be employee error.

On May 17th, two HUGS Alarms were activated, both as a result of a loose tag.

HUMAN SECURITY

On May 3rd, Security Staff assisted Bishop Police and Child Protective Services with the service of a warrant requiring the surrender of a newborn to Child Protective Services Staff.

On May 19th, Security was called to the ED for a combative, patient with head injuries.

On May 26th, Security Staff stood by in the ED for a suspected 5150 patient, until the arrival of Inyo County Mental Health Staff.

On May 26th, Security assisted ED Staff and Inyo County Sheriff's Personnel with an uncooperative Mental Health patient.

On May 27th, Security Staff assisted ED Staff and the California Highway Patrol with a DUI Crash Victim that was uncooperative.

Security Staff provided Law Enforcement assistance on 19 occasions this month. 11 of these assists were for Lab BAC's.

Security stood by with 4 suspected 5150's this month.

Security Staff provided 42 patient assists this month.

EOC REPORTING INFORMATION

FIRE DOORS / OPEN OR PROPPED

0

TRESPASSING

0

VANDALISM

0

DISORDERLY CONDUCT

By Patient

3

By Others

0

SUSPICIOUS PERSON / VEHICLE ACTION

0

PERTSONAL PROPERTY DAMAGE / LOSS

0

HOSPITAL PROPERTY DAMAGE / LOSS

0

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NORTHERN INYO HOSPITAL
STATEMENT OF OPERATIONS
for period ending May 31, 2013

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Ancillary	535,763	580,728	(44,965)	6,091,444	6,275,602	(184,158)
Routine	2,249,129	1,921,142	327,987	23,995,681	20,760,720	3,234,961
Total Inpatient Service Revenue	2,784,892	2,501,870	283,022	30,087,125	27,036,322	3,050,803
Outpatient Service Revenue	5,509,433	5,710,301	(200,868)	61,422,086	61,708,061	(285,975)
Gross Patient Service Revenue	8,294,325	8,212,171	82,154	91,509,211	88,744,383	2,764,828
Less Deductions from Revenue						
Patient Service Revenue Deductions	230,565	178,677	51,888	2,173,769	1,930,864	242,905
Contractual Adjustments	3,393,750	3,025,793	367,957	35,411,949	32,698,091	2,713,858
Prior Period Adjustments	(1,058,808)	(157,464)	(901,344)	(4,559,312)	(1,701,626)	(2,857,686)
Total Deductions from Patient Service Revenue	2,565,507	3,047,006	(481,499)	33,026,407	32,927,329	99,078
Net Patient Service Revenue	5,728,818	5,165,165	563,653	58,482,805	55,817,054	2,665,751
Other revenue	24,550	27,782	(3,232)	718,226	300,214	418,012
Transfers from Restricted Funds for Operating Exp	102,014	98,467	3,547	1,122,149	1,064,077	58,072
Total Other Revenue	126,564	126,249	315	1,840,374	1,364,291	476,083
Expenses:						
Salaries and Wages	1,802,319	1,799,842	2,477	19,360,342	19,449,892	(89,550)
Employee Benefits	1,154,189	1,119,159	35,030	13,138,982	12,094,126	1,044,856
Professional Fees	678,468	499,061	179,407	5,900,496	5,393,093	507,403
Supplies	508,213	526,582	(18,369)	5,369,022	5,690,460	(321,438)
Purchased Services**	926,284	237,467	688,817	3,599,649	2,566,157	1,033,492
Depreciation	162,004	322,518	(160,514)	2,570,981	3,485,273	(914,292)
Interest Expense	189,199	180,906	8,293	2,167,415	1,954,950	212,465
Bad Debts	109,659	203,071	(93,412)	2,484,919	2,194,476	290,443
Other Expense	331,362	246,663	84,699	3,228,501	2,665,565	562,936
Total Expenses	5,861,697	5,135,269	726,428	57,820,308	55,493,992	2,326,316
Operating Income (Loss)	(6,315)	156,145	(162,460)	2,502,871	1,687,353	815,518
Other Income:						
District Tax Receipts	42,397	44,530	(2,133)	466,364	481,209	(14,845)
Partnership Investment Incomce		3,822	(3,822)	0	41,303	(41,303)
Grants and Other Contributions						
Unrestricted		21,233	(21,233)	160,511	229,453	(68,942)
Interest Income	5,350	7,252	(1,902)	94,803	78,372	16,431
Other Non-Operating Income	5,366	3,144	2,222	104,758	33,977	70,781
Net Medical Office Activity	(289,422)	(84,931)	(204,491)	(2,417,238)	(917,796)	(1,499,442)
340B Net Activity	66,453	47,254	19,199	549,065	510,649	38,416
Non-Operating Income/Loss	(169,857)	42,304	(212,161)	(1,041,736)	457,167	(1,498,903)
Net Income/Loss	(176,171)	198,449	(374,620)	1,461,135	2,144,520	(683,385)
Extraordinary Items*						
Total Extraordinary Items	11,459	10,881	578	425,220	117,585	307,635
Net Income/Loss Including Extraordinary Items	(187,631)	187,568	(375,199)	1,035,915	2,026,935	(991,020)

*Extraordinary Items are 1998 Revenue Bond Cost of Issurance and Bond Insurance for redeemed Bond Issue

**Purchased Services includes the Building Project Closeout Purchased Services for Turner Logistics related to Procurement and Relocation. Equipment Procurement; $487,516, Relocation Assistance; $146,414

	Target	May-13	Apr-13
Current Ratio	>1.5-2.0	3.05	2.88
Quick Ratio	>1.33-1.5	2.45	2.34
Days Cash on Hand	>75	105.61	106.75

Northern Inyo Hospital
Balance Sheet
Period Ending May 31, 2013

Current Assets:	
Cash and Equivaliants	65,005
Short-Term Investments	8,395,172
Assets Limited as to Use	0
Plant Replacement and Expansion Fund	2
Other Investments	1,178,290
Patient Receivable	37,578,276
Less: Allowances	(27,555,653)
Other Receivables	413,686
Inventories	3,373,947
Prepaid Expenses	973,761
Total Current Assets	**24,422,487**
Internally Designated for Capital Acquistions	951,548
Special Purpose Assets	710,932
Revenue Bonds Held by a Trustee	2,921,019
Less Amounts Required to Meet Current Obligations	0
Assets Limited as to use	**4,583,498**
Long Term Investments	100,000
Property & equipment, net Accumulated Depreciation	89,657,876
Unamortized Bond Costs	726,964
Total Assets	**119,490,825**
Liabilities and Net Assets	
Current Liabilities:	
Current Maturities of Long-Term Debt	(5,123)
Accounts Payable	877,425
Accured Salaries, Wages & Benefits	4,245,611
Accrued Interest and Sales Tax	599,678
Deferred Income	42,397
Due to 3rd Party Payors	1,900,000
Due to Specific Purpose Funds	350,759
Total Current Liabilites	**8,010,748**
Long Term Debt, Net of Current Maturities	55,349,059
Bond Premium	1,418,222
Total Long Term Debt	**56,767,280**
Net Assets	
Unrestricted Net Assets	54,001,865
Tempororily Restricted	710,932
Net Income	
Total Net Assets	**54,712,797**
Total Liabilities and Net Assets	**119,490,825**

Investments as of 5/31/2013

No.	Purchase Date	Maturity Date	Institution	Broker	Rate	Principal Invested
1	02-May-13	01-Jun-13	LAIF (Walker Fund)	Northern Inyo Hospital	0.25%	$ 321,871.51
2	03-May-13	01-Jun-13	Local Agency Investment Fund	Northern Inyo Hospital	0.25%	$ 5,500,886.67
3	02-May-13	01-Jun-13	Multi-Bank Securities	Multi-Bank Service	0.01%	$ 2,572,414.07
				Short Term Investments		$ 8,395,172.25
4	20-May-10	20-May-15	First Republic Bank-Div of BOFA FNC	Financial Northeaster Corp.	3.10%	$ 100,000.00
				Long Term Investments		$ 100,000.00
				Total Investments		$ 8,495,172.25

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending JUNE 30, 2013
As of May 31, 2013

MONTH APPROVED BY BOARD	DESCRIPTION OF APPROVED CAPITAL EXPENDITURES		AMOUNT
FY 2011-12	Transport Monitor for PACU to be purchased by NIH Auxillary Donation		15,000 *
	Additional Coppper and Fiberoptic Cable		29,884
	Paragon Physician Documentation Module		137,254
	Ultrasound Machine		165,694 *
	AMOUNT APPROVED BY THE BOARD IN THE PRIOR FISCAL YEARS TO BE EXPENDED IN THE CURRENT FISCAL YEAR		347,832
FY 2012-13	Breast Ultrasound	GE Capital Lease	200,000
	Digital Radiography Upgrade to Radiology Room 2		108,000 *
	Zimmer Orthopedic Power Equipment		44,115
	Invivo HD 8ch Foot/Ankle Coil for MRI		41,600 *
	Magnitude Outdoor Walk-in Freezer		52,550
	Paragon Rules Engine/Meaningful Use Stage 2 QeM	Plus annual fees	60,360
	Centricity Upgrade and Practice Management Purchase	Rural Health Clinic	30,762
	Centricity EMR and Practice Management	Medical Office Practices	204,118
	AMOUNT APPROVED BY THE BOARD IN THE CURRENT FISCAL YEAR TO BE EXPENDED IN THE CURRENT FISCAL YEAR		741,505

Amount Approved by the Board in Prior Fiscal Years to be Expended in the Current Fiscal Year	347,832
Amount Approved by the Board in the Current Fiscal Year to be Expended in the Current Fiscal Year	741,505
Year-to-Date Board-Approved Amount to be Expended	1,089,337
Year-to-Date Administrator-Approved Amount	1,237,523 *
Actually Expended in Current Fiscal Year	149,600 *

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending JUNE 30, 2013
As of May 31, 2013

MONTH APPROVED BY BOARD	DESCRIPTION OF APPROVED CAPITAL EXPENDITURES	AMOUNT
	Year-to-Date Completed Building Project Expenditures	0 *
	TOTAL FUNDS APPROVED TO BE EXPENDED	2,476,460
	Total-to-Date Spent on Incomplete Board Approved Expenditures	0

Reconciling Totals:

Actually Capitalized in the Current Fiscal Year Total-to-Date		
Plus: Lease Payments from a Previous Period		
Less: Lease Payments Due in the Future		1,387,123
Less: Funds Expended in a Previous Period		0
Plus: Other Approved Expenditures		0
		0
ACTUAL FUNDS APPROVED IN THE CURRENT FISCAL YEAR TOTAL-TO-DATE		1,089,337
		2,476,460

Donations by Auxiliary	For 2012 Asset receive 2013	
Donations by Hospice of the Owens Valley		
+Tobacco Funds Used for Purchase		60,000
		0
		0
		0
*Completed Purchase		60,000

(Note: The budgeted amount for capital expenditures for all priority requests for the fiscal year ending June 30, 2013, is $943,036 coming from existing hospital funds.)

**Completed in prior fiscal year

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending JUNE 30, 2013
As of May 31, 2013

Administrator-Approved Item(s)	Department	Amount	Month Total	Grand Total
Restoration of Cupola for Healing Garden	GROUNDS	2,980		
Interface Setup for HIS System	PARAGON POST-GOLIVE	11,901		
*Approved by Board in 2012-project closed				
Horizon and Paragon Implemenation Servic	PARAGON POST-GOLIVE	799,330		
*Approved by Board in 2012-project closed				
Kronos Open Enrollment Module	KRONOS POST-GOLIVE	10,575		
*Approved by Board in 2012-project closed				
SCHLAGE PIM 400-486 ACCESS AND LOCKSE	MAINTENANCE	8,785		
VENDING FOOD MACHINE	COMMUNITY RELATIONS	1,404		
CANON IR ADVANCE 5051	RURAL HEALTH CLINIC	10,773		
Signage for Imaging Center	RADIOLOGY	1,580		
MONTH ENDING MAY 31, 2013			847,328	**1,237,523**

Northern Inyo Hospital
PLANT EXPANSION AND REPLACEMENT BUILDING PROJECTS
Fiscal Year Ending JUNE 30, 2013
As of May 31, 2013
(Completed and Occupied or Installed)

Item	Amount	Grand Total
New Hospital Building Equipment	3,388,198	
Signage for New Hospital Building	36,968	
Board Room Sidewalk	3,450	
Utilities Prep work for new Building	11,883	
Utilities-Drainage for new Building	12,155	
Finish Landscaping Including Walkways	153,810	
2013 New Hospital Construction	61,212,228	
Interior Design Consultant	68,459	
New Hospital Construction Building Services Equipment	8,539	
Medical Gases Construction for new Building	287,937	
Secondary DMARC for new hospital phone system	9,230	
Utilities Work for new Hospital Building	48,055	
MONTH ENDING MAY 31, 2013	**65,240,913**	**65,268,659**

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
CSPD	1	Dispenser, Medication, Auxiliary	Omnicell, Inc	OmniRx Auxiliary G3	NIH	$ -
CSPD	1	Dispenser, Medication, Host (Main)	Omnicell, Inc	OmniRx Color Touch G3	NIH	$ -
ICU	1	Dispenser, Medication, Lock Module	Omnicell, Inc	FlexLock	NIH	$ -
OB	1	Dispenser, Medication, Lock Module	Omnicell, Inc	FlexLock	NIH	$ -
PACU	1	Dispenser, Medication, Lock Module	Omnicell, Inc	FlexLock	NIH	$ -
						$ -
SURGERY	1	Anesthesia Machine, General	Draeger Medical, Inc	Narkomed 6400 (Full Config)	$ 44,490.00	$ 44,490.00
LAB IN PT HOSPITAL	1	Arm, Wheelchair Draw Station	Bobrick Washroom Equipment, Inc.	B-298x24	$ 95.68	$ 95.68
OB	1	Bed, Birthing	Hill-Rom - Bed & Stretcher Group	Affinity 4 [AF400]	$ 13,366.40	$ 13,366.40
OB	1	Bed, Birthing	Hill-Rom - Bed & Stretcher Group	Affinity 4 [AF400]	$ 13,366.40	$ 13,366.40
OB	1	Bed, Birthing	Hill-Rom - Bed & Stretcher Group	Affinity 4 [AF400]	$ 13,366.40	$ 13,366.40
	1	Bed, Birthing	Hill-Rom - Bed & Stretcher Group	Affinity 4 [AF400]	$ 13,366.40	$ 13,366.40
MED SURG	1	Bed, Electric	Hill-Rom - Bed & Stretcher Group	Versacare VC230	$ 6,237.49	$ 6,237.49
MED SURG	1	Bed, Electric	Hill-Rom - Bed & Stretcher Group	Versacare VC230	$ 6,237.49	$ 6,237.49
MED SURG	1	Bed, Electric	Hill-Rom - Bed & Stretcher Group	Versacare VC230	$ 6,237.49	$ 6,237.49
MED SURG	1	Bed, Electric	Hill-Rom - Bed & Stretcher Group	Versacare VC230	$ 6,237.49	$ 6,237.49
MED SURG	1	Bed, Electric	Hill-Rom - Bed & Stretcher Group	Versacare VC230	$ 6,237.49	$ 6,237.49
MED SURG	1	Bed, Electric, Bariatric	Hill-Rom - Bed & Stretcher Group	Excel Care ES EC355	$ 29,622.40	$ 29,622.40

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
EMERGENCY	1	Boom, Single with Single Light	Skytron	EC2F-CPS/ST29 with LED55	$ 34,507.10	$ 34,507.10
SURGERY	1	Bracket, Monitor, Wall, Flat Panel	Peerless Industries, Inc.	R1-011-32	$ 170.00	$ 170.00
SURGERY	1	Bracket, Monitor, Wall, Flat Panel	Peerless Industries, Inc.	R1-011-32	$ 170.00	$ 170.00
SURGERY	1	Bracket, Monitor, Wall, Flat Panel	Peerless Industries, Inc.	R1-011-32	$ 170.00	$ 170.00
SURGERY	1	Cabinet, OR Console, Supply	Skytron	SS2304-C (Freestanding)	$ 3,361.88	$ 3,361.88
SURGERY	1	Cabinet, OR Console, Supply	Skytron	SS2304-C (Freestanding)	$ 3,361.88	$ 3,361.88
SURGERY	1	Cabinet, OR Console, Supply	Skytron	SS2304-C (Freestanding)	$ 3,361.88	$ 3,361.88
SURGERY	1	Cabinet, OR Console, Supply	Skytron	SS2304-C (Freestanding)	$ 3,361.88	$ 3,361.88
SURGERY	1	Cabinet, OR Console, Supply	Skytron	SS2304-C (Freestanding)	$ 3,361.88	$ 3,361.88
SURGERY	1	Cabinet, OR Console, Supply	Skytron	SS2304-C (Freestanding)	$ 3,361.88	$ 3,361.88
SURGERY	1	Cabinet, OR Console, Supply	Skytron	SS2304-C (Freestanding)	$ 3,361.88	$ 3,361.88
SURGERY	1	Cabinet, OR Console, Supply	Skytron	SS2304-C (Freestanding)	$ 3,361.88	$ 3,361.88
SURGERY	1	Cabinet, OR Console, Supply	Skytron	SS2304-C (Freestanding)	$ 3,361.88	$ 3,361.88
SURGERY	1	Cabinet, Storage, Clinical, Endoscope	InnerSpace - Datel	3800VA (8 scopes)	$ 2,735.77	$ 2,735.77
EMERGENCY	1	Cabinet, Warming, Dual, Freestanding	STERIS Corporation	18 Glass Door [DJ05]	$ 7,822.29	$ 7,822.29
ICU	1	Cabinet, Warming, Dual, Freestanding	STERIS Corporation	18 Glass Door [DJ05]	$ 7,822.29	$ 7,822.29
MED SURG	1	Cabinet, Warming, Dual, Freestanding	STERIS Corporation	18 Glass Door [DJ05]	$ 7,822.29	$ 7,822.29
PACU	1	Cabinet, Warming, Dual, Freestanding	STERIS Corporation	18 Glass Door [DJ05]	$ 7,822.29	$ 7,822.29

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
SURGERY	1	Cabinet, Warming, Dual, Freestanding	STERIS Corporation	18 Glass Door [DJ05]	$ 7,822.29	$ 7,822.29
SURGERY	1	Cabinet, Warming, Dual, Freestanding	STERIS Corporation	18 Glass Door [DJ05]	$ 7,822.29	$ 7,822.29
OB	1	Cabinet, Warming, Injection, Freestanding	Enthermics	"EC770L w/ Warm Watch	$ 8,305.00	$ 8,305.00
OB	1	Cabinet, Warming, Single, Counter	STERIS Corporation	24 Glass Door [DJ06]	$ 5,235.97	$ 5,235.97
SURGERY	1	Camera System, O.R., In-Light	Skytron	Stellar TV-II (ST23/ST29)	$ 6,000.00	$ 6,000.00
SURGERY	1	Carrier, Chair, Scrub Sink	STERIS Corporation	Double Bay [CE00]	$ 208.00	$ 208.00
SURGERY	1	Carrier, Chair, Scrub Sink	STERIS Corporation	Triple Bay [CE00]	$ 256.79	$ 256.79
EMERGENCY	1	Cart / Truck, Soiled Utility	Rubbermaid Commercial Products	4708 Cube Truck w/4609 lid (8 cu.ft., Black)	$ 710.50	$ 710.50
EMERGENCY	2	Cart / Truck, Soiled Utility	Rubbermaid Commercial Products	4608 Cube Truck (8 cu.ft., Black)	$ 425.00	$ 850.00
ICU	1	Cart / Truck, Soiled Utility	Rubbermaid Commercial Products	4708 Cube Truck w/4609 lid (8 cu.ft., Black)	$ 710.50	$ 710.50
ICU	1	Cart / Truck, Soiled Utility	Rubbermaid Commercial Products	4608 Cube Truck (8 cu.ft., Black)	$ 425.00	$ 425.00
OB	1	Cart / Truck, Soiled Utility	Rubbermaid Commercial Products	4708 Cube Truck w/4609 lid (8 cu.ft., Black)	$ 710.50	$ 710.50
OB	1	Cart / Truck, Soiled Utility	Rubbermaid Commercial Products	4608 Cube Truck (8 cu.ft., Black)	$ 425.00	$ 425.00
PACU	1	Cart / Truck, Soiled Utility	Rubbermaid Commercial Products	4708 Cube Truck w/4609 lid (8 cu.ft., Black)	$ 710.50	$ 710.50
PACU	2	Cart / Truck, Soiled Utility	Rubbermaid Commercial Products	4608 Cube Truck (8 cu.ft., Black)	$ 425.00	$ 850.00
SURGERY	1	Cart, Anesthesia, 6-drawer	Armstrong Medical Industries, Inc.	PKL-HG-30/ PSP-1B	$ 2,265.85	$ 2,265.85

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
OB	1	Cart, Case, LDRP	Hill-Rom - Room & Furniture	Contemporary Perinatal Case Cart	$ 2,150.00	$ 2,150.00
OB	1	Cart, Case, LDRP	Hill-Rom - Room & Furniture	Contemporary Perinatal Case Cart	$ 2,150.00	$ 2,150.00
CSPD	1	Cart, Case, Vertical (40 in or taller)	Blickman Inc.	Ultra Space Saver CCC5	$ 2,753.19	$ 2,753.19
CSPD	1	Cart, Case, Vertical (40 in or taller)	Blickman Inc.	Ultra Space Saver CCC5	$ 2,753.19	$ 2,753.19
CSPD	1	Cart, Case, Vertical (40 in or taller)	Blickman Inc.	Ultra Space Saver CCC5	$ 2,753.19	$ 2,753.19
CSPD	1	Cart, Case, Vertical (40 in or taller)	Blickman Inc.	Ultra Space Saver CCC5	$ 2,753.19	$ 2,753.19
CSPD	1	Cart, Case, Vertical (40 in or taller)	Blickman Inc.	Ultra Space Saver CCC5	$ 2,753.19	$ 2,753.19
CSPD	1	Cart, Case, Vertical (40 in or taller)	Blickman Inc.	Ultra Space Saver CCC5	$ 2,753.19	$ 2,753.19
OB	1	Cart, Equipment, Monitor	Hill-Rom - Room & Furniture	Contemporary P15117	$ 2,475.00	$ 2,475.00
OB	1	Cart, Equipment, Monitor	Hill-Rom - Room & Furniture	Contemporary P15117	$ 2,475.00	$ 2,475.00
OB	1	Cart, Equipment, Monitor	Hill-Rom - Room & Furniture	Contemporary P15117	$ 2,475.00	$ 2,475.00
OB	1	Cart, Equipment, Monitor	Hill-Rom - Room & Furniture	Contemporary P15117	$ 2,475.00	$ 2,475.00
EMERGENCY	1	Cart, Procedure, General	Armstrong Medical Industries, Inc.	5-dr Mini Bedside Bge/Bge (Auto-lock)	$ 1,055.00	$ 1,055.00
EMERGENCY	1	Cart, Procedure, General	Armstrong Medical Industries, Inc.	5-dr Mini Bedside Bge/Bge (Auto-lock)	$ 1,055.00	$ 1,055.00
EMERGENCY	1	Cart, Procedure, General	Armstrong Medical Industries, Inc.	5-dr Mini Bedside Bge/Bge (Auto-lock)	$ 1,055.00	$ 1,055.00

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
EMERGENCY	1	Cart, Procedure, General	Armstrong Medical Industries, Inc.	5-dr Mini Bedside Bge/Bge (Auto-lock)	$ 1,055.00	$ 1,055.00
EMERGENCY	1	Cart, Procedure, General	Armstrong Medical Industries, Inc.	5-dr Mini Bedside Bge/Bge (Auto-lock)	$ 1,055.00	$ 1,055.00
EMERGENCY	1	Cart, Procedure, General	Armstrong Medical Industries, Inc.	5-dr Mini Bedside Bge/Bge (Auto-lock)	$ 1,055.00	$ 1,055.00
EMERGENCY	1	Cart, Procedure, General	Armstrong Medical Industries, Inc.	5-dr Mini Bedside Bge/Bge (Auto-lock)	$ 1,055.00	$ 1,055.00
EMERGENCY	1	Cart, Procedure, Latex-free	Armstrong Medical Industries, Inc.	A-SMART AN-6	$ 1,140.00	$ 1,140.00
EMERGENCY	1	Cart, Procedure, Resuscitation	Armstrong Medical Industries, Inc.	6-dr Standard Red/RedAR-6/AP 2	$ 1,105.00	$ 1,105.00
PACU	1	Cart, Procedure, Resuscitation	Armstrong Medical Industries, Inc.	6-dr Standard Red/RedAR-6/AP 2	$ 1,105.00	$ 1,105.00
EMERGENCY	1	Cart, Supply, Chrome, 48 inch	LogiQuip LLC	746MD-6 (24 X 48)	$ 624.50	$ 624.50
EMERGENCY	1	Cart, Supply, Chrome, 60 inch	LogiQuip LLC	EXCHANGE CART, 21 X 60 X 66	$ 466.50	$ 466.50
LAB IN PT HOSPITAL	1	Cart, Supply, Chrome, 60 inch	LogiQuip LLC	EXCHANGE CART, 21 X 60 X 66	$ 466.50	$ 466.50
EMERGENCY	1	Cart, Supply, Chrome, 72 inch	LogiQuip LLC	749M	$ 403.00	$ 403.00
ICU	2	Cart, Supply, Chrome, 72 inch	LogiQuip LLC	749M	$ 403.00	$ 806.00

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
ICU	1	Cart, Supply, Chrome, 72 inch	LogiQuip LLC	749M	$ 403.00	$ 403.00
MED SURG	2	Cart, Supply, Chrome, 72 inch	LogiQuip LLC	749M	$ 403.00	$ 806.00
SURGERY	1	Cart, Supply, Suture	LogiQuip LLC	SL424 Single Sided	$ 286.50	$ 286.50
SURGERY	1	Cart, Supply, Suture	LogiQuip LLC	SL424 Single Sided	$ 286.50	$ 286.50
SURGERY	1	Cart, Supply, Suture	LogiQuip LLC	SL424 Single Sided	$ 286.50	$ 286.50
LAB IN PT HOSPITAL	1	Cart, Utility, Stainless	LogiQuip LLC	3052 Enclosed	$ 779.50	$ 779.50
LAB IN PT HOSPITAL	1	Cart, Utility, Stainless	LogiQuip LLC	3052 Enclosed	$ 779.50	$ 779.50
LAB IN PT HOSPITAL	1	Cart, Utility, Stainless	LogiQuip LLC	3052 Enclosed	$ 779.50	$ 779.50
MED SURG	1	Cart, Utility, Stainless	LogiQuip LLC	3052 Enclosed	$ 779.50	$ 779.50
CSPD	1	Cart, Washer/Sterilizer, Transfer	STERIS Corporation	Universal Transfer Cart-Height Adjustable	$ 2,516.00	$ 2,516.00
CSPD	1	Cart, Washer/Sterilizer, Transfer	STERIS Corporation	Universal Transfer Cart-Height Adjustable	$ 2,516.00	$ 2,516.00
CSPD	1	Cart, Washer/Sterilizer, Transfer	STERIS Corporation	Universal Transfer Cart-Height Adjustable	$ 2,516.00	$ 2,516.00
CSPD	1	Cart, Washer/Sterilizer, Transfer	STERIS Corporation	Universal Transfer Cart-Height Adjustable	$ 2,516.00	$ 2,516.00
LAB IN PT HOSPITAL	1	Chair, Clinical, Blood Draw	Custom Comfort Medtek	1201-L Std Height (Molded)	$ 686.95	$ 686.95
LAB IN PT HOSPITAL	1	Chair, Clinical, Blood Draw	Custom Comfort Medtek	1201-L Std Height (Molded)	$ 686.95	$ 686.95
LAB IN PT HOSPITAL	1	Chair, Clinical, Blood Draw	Custom Comfort Medtek	1201-L Std Height (Molded)	$ 686.95	$ 686.95

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
OB	1	Computer Info System, Data Mgt, Obstetric	Philips Healthcare - Monitoring Systems	OB TraceVue	$ 41,458.00	$ 41,458.00
LAB IN PT HOSPITAL	1	Cryostat	Fisher Health Care	HM 525	$ 20,500.00	$ 20,500.00
SURGERY	1	Electrosurgical Unit, Bipolar	Conmed Corporation	System 5000	$ 11,381.28	$ 11,381.28
EMERGENCY	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
EMERGENCY	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
EMERGENCY	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
EMERGENCY	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
EMERGENCY	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
EMERGENCY	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
EMERGENCY	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
EMERGENCY	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
ICU	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
ICU	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
ICU	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
ICU	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
ICU	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
ICU	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
ICU	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
ICU	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
ICU	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
MED SURG	1	Hamper, Linen	Centurion Medical Products	CX107 Large-Trash/Linen	$ 112.00	$ 112.00
OB	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
SURGERY	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
SURGERY	1	Hamper, Linen	Centurion Medical Products	CX102 Large	$ 112.00	$ 112.00
EMERGENCY	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
EMERGENCY	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
EMERGENCY	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
EMERGENCY	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
EMERGENCY	2	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 2,089.64
EMERGENCY	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
EMERGENCY	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
ICU	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7012 (Dual) w/Bed Docker	$ 2,949.33	$ 2,949.33
ICU	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7012 (Dual) w/Bed Docker	$ 2,949.33	$ 2,949.33
ICU	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7012 (Dual) w/Bed Docker	$ 2,949.33	$ 2,949.33
ICU	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7012 (Dual) w/Bed Docker	$ 2,949.33	$ 2,949.33

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
MED SURG	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
MED SURG	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
MED SURG	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
MED SURG	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
MED SURG	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
MED SURG	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
MED SURG	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
MED SURG	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
MED SURG	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
MED SURG	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
MED SURG	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
MED SURG	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
MED SURG	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
MED SURG	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
MED SURG	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
MED SURG	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
OB	2	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 2,089.64
OB	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
OB	2	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 2,089.64
OB	2	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 2,089.64
OB	2	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 2,089.64
OB	2	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 2,089.64
PACU	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
PACU	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
PACU	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
PACU	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
PACU	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
PACU	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
PACU	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
PACU	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
PACU	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
PACU	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
PACU	1	Headwall, Flatwall, Recessed	Modular Services Co	Profile 7011	$ 1,044.82	$ 1,044.82
NURSING DPTS	1	HL7 Interface	Philips Healthcare - Monitoring Systems	Various	$ 61,688.30	$ 61,688.30
NURSING DPTS	1	HL7 Interface Installation	Philips Healthcare - Monitoring Systems	Various	$ 24,746.24	$ 24,746.24
EMERGENCY	1	Ice Machine, Dispenser, Nugget, Countertop	Follett Corporation	25CI400W	$ 3,975.90	$ 3,975.90

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
EMERGENCY	1	Ice Machine, Dispenser, Nugget, Countertop	Follett Corporation	25CI400W	$ 3,975.90	$ 3,975.90
ICU	1	Ice Machine, Dispenser, Nugget, Countertop	Follett Corporation	25CI400W	$ 3,975.90	$ 3,975.90
PACU	1	Ice Machine, Dispenser, Nugget, Countertop	Follett Corporation	25CI400W	$ 3,975.90	$ 3,975.90
EMERGENCY	1	Immobilizer, Infant / Child, Radiographic	Octostop	Universal Octopaque Kit	NIH	$ -
OB	1	Incubator, Infant, General	Draeger Medical - Air Shields Div.	C450QT Isolette	$ 14,123.01	$ 14,123.01
OB	1	Incubator, Infant, General	Draeger Medical - Air Shields Div.	C450QT Isolette	$ 14,123.01	$ 14,123.01
SURGERY	1	Insufflator, CO2	Karl Storz Endoscopy - America, Inc.	SCB CO2 20L Endoflator Unit	$ 6,500.00	$ 6,500.00
SURGERY	1	Insufflator, CO2	Karl Storz Endoscopy - America, Inc.	SCB CO2 20L Endoflator Unit	$ 6,500.00	$ 6,500.00
SURGERY	1	Light Controller, Stellar Series	Skytron	B9-410-02	$ 2,445.00	$ 2,445.00
SURGERY	1	Light Controller, Stellar Series	Skytron	B9-410-02	$ 2,445.00	$ 2,445.00
SURGERY	1	Light Controller, Stellar Series	Skytron	B9-410-02	$ 2,445.00	$ 2,445.00
SURGERY	1	Light Source, Xenon	Integra Luxtec	9300XSP (Single Turret)	$ 7,400.00	$ 7,400.00
SURGERY	1	Light Source, Xenon	Integra Luxtec	9300XSP (Single Turret)	$ 7,400.00	$ 7,400.00
OB	1	Light, Exam/Procedure, Dual, Ceiling, Recessed	Skytron	Argos II	$ 6,316.25	$ 6,316.25
OB	1	Light, Exam/Procedure, Dual, Ceiling, Recessed	Skytron	Argos II	$ 6,316.25	$ 6,316.25
OB	1	Light, Exam/Procedure, Dual, Ceiling, Recessed	Skytron	Argos II	$ 6,316.25	$ 6,316.25
OB	1	Light, Exam/Procedure, Dual, Ceiling, Recessed	Skytron	Argos II	$ 6,316.25	$ 6,316.25
EMERGENCY	1	Light, Exam/Procedure, Single, Ceiling	Skytron	Stellar ST9	$ 3,097.00	$ 3,097.00

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
EMERGENCY	1	Light, Exam/Procedure, Single, Ceiling	Skytron	Stellar ST9	$ 3,097.00	$ 3,097.00
EMERGENCY	1	Light, Exam/Procedure, Single, Ceiling	Skytron	Stellar ST9	$ 3,097.00	$ 3,097.00
EMERGENCY	1	Light, Exam/Procedure, Single, Ceiling	Skytron	Stellar ST9	$ 3,097.00	$ 3,097.00
EMERGENCY	1	Light, Exam/Procedure, Single, Ceiling	Skytron	Stellar ST9	$ 3,097.00	$ 3,097.00
EMERGENCY	1	Light, Exam/Procedure, Single, Ceiling	Skytron	Stellar ST9	$ 3,097.00	$ 3,097.00
ICU	2	Light, Exam/Procedure, Single, Floor	Skytron	Stellar ST19S	$ 11,410.00	$ 22,820.00
PACU	1	Light, Exam/Procedure, Single, Floor	Skytron	Stellar ST9S	$ 2,119.00	$ 2,119.00
OB	1	Light, Exam/Procedure, Single, Wall	Skytron	Stellar ST9W	$ 2,445.00	$ 2,445.00
OB	1	Light, Phototherapy, Infant, Mobile	Draeger Medical - Air Shields Div.	Photo-Therapy 4000 w/ stand on casters	$ 1,965.60	$ 1,965.60
OB	1	Light, Phototherapy, Infant, Mobile	Draeger Medical - Air Shields Div.	Photo-Therapy 4000 w/ stand on casters	$ 1,965.60	$ 1,965.60
		Light, Surgical, Dual, Ceiling, w/Monitor Arm & Anes.. Boom	Skytron	ECT2FVB/2AFC1/A UR7TV5 Anesthesia/Surg		
SURGERY	1	Light, Surgical, Dual, Ceiling, w/Monitor Arm & Anes.. Boom	Skytron	ECT2FVB/2AFC1/A UR7TV5 Anesthesia/Surg	$ 69,308.16	$ 69,308.16
SURGERY	1	Light, Surgical, Dual, Ceiling, w/Monitor Arm & Anes.. Boom	Skytron	ECT2FVB/2AFC1/A UR55TV Anesthesia/Surg		$ -
		Light, Surgical, Dual, Ceiling, w/Monitor Arm & Anes.. Boom	Skytron	ECT2FVB/2AFC1/A UR55TV Anesthesia/Surg		

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
SURGERY	1	Light, Surgical, Dual, Ceiling, w/Monitor Arm & Anes.. Boom	Skytron	ECT2FVB/2AFC1/A UR55TV Anesthesia/Surg	$ 55,616.16	$ 55,616.16
SURGERY	1	Light, Surgical, Dual, Ceiling, w/Monitor Arm & Anes.. Boom	Skytron	ECT2FVB/2AFC1/A UR55TV Anesthesia/Surg	$ 55,616.16	$ 55,616.16
SURGERY	1	Light, Surgical, Single, Ceiling, w/Monitor Arm & Equip. Boom	Skytron	ECT2FPS/2AFC1/A UR5	$ 47,380.59	$ 47,380.59
SURGERY	1	Light, Surgical, Single, Ceiling, w/Monitor Arm & Equip. Boom	Skytron	ECT2FPS/2AFC1/A UR5	$ 47,380.59	$ 47,380.59
SURGERY	1	Light, Surgical, Single, Ceiling, w/Monitor Arm & Equip. Boom	Skytron	ECT2FPS/2AFC1/A UR5	$ 47,380.59	$ 47,380.59
EMERGENCY	1	Light, Surgical, Single, Floor	STERIS Corporation	Harmony 500	$ 5,724.18	$ 5,724.18
EMERGENCY	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
EMERGENCY	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
EMERGENCY	2	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 1,604.40
EMERGENCY	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
EMERGENCY	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
EMERGENCY	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
EMERGENCY	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
MED SURG	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
MED SURG	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
MED SURG	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
MED SURG	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
MED SURG	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
MED SURG	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
MED SURG	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
MED SURG	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
MED SURG	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
MED SURG	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
MED SURG	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
MED SURG	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
MED SURG	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
MED SURG	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
MED SURG	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
MED SURG	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
OB	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
OB	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
OB	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
OB	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
OB	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
PACU	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
PACU	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
PACU	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
PACU	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
PACU	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
PACU	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
PACU	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
PACU	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
PACU	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
PACU	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
PACU	1	Locator, Bed, Wall	Modular Services Co	Bed Docker BD600	$ 802.20	$ 802.20
EMERGENCY	1	Monitor Mount, Wall	GCX Corporation	WC-0002-05	$ -	$ -
EMERGENCY	1	Monitor Mount, Wall	GCX Corporation	WC-0002-05	$ -	$ -
EMERGENCY	1	Monitor Mount, Wall	GCX Corporation	WC-0002-05	$ -	$ -
EMERGENCY	1	Monitor Mount, Wall	GCX Corporation	WC-0002-05	$ -	$ -
EMERGENCY	1	Monitor Mount, Wall	GCX Corporation	WC-0002-05	$ -	$ -
PACU	1	Monitor Mount, Wall	GCX Corporation	WC-0002-05	$ -	$ -
PACU	1	Monitor Mount, Wall	GCX Corporation	WC-0002-05	$ -	$ -
PACU	1	Monitor Mount, Wall	GCX Corporation	WC-0002-05	$ -	$ -

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
PACU	1	Monitor Mount, Wall	GCX Corporation	WC-0002-05	$ -	$ -
PACU	1	Monitor Mount, Wall	GCX Corporation	WC-0002-05	$ -	$ -
PACU	1	Monitor Mount, Wall	GCX Corporation	WC-0002-05	$ -	$ -
PACU	1	Monitor Mount, Wall	GCX Corporation	WC-0002-05	$ -	$ -
EMERGENCY	1	Monitor, 8-bed Central Station	Philips Healthcare - Monitoring Systems	M3155B/A08	$ 93,788.32	$ 93,788.32
PACU	1	Monitor, 8-bed Central Station	Philips Healthcare - Monitoring Systems	M3155B/A08	$ 93,788.32	$ 93,788.32
ICU	1	Monitor, Central Station, 12 Patient	Philips Healthcare - Monitoring Systems	IntelliVue	$ 17,216.32	$ 17,216.32
MED SURG	1	Monitor, Central Station, Patient	Philips Healthcare - Monitoring Systems	IntelliVue	$ 17,216.32	$ 17,216.32
OB	1	Monitor, O.B., Intrapartum, Maternal/Fetal	Philips Healthcare - Monitoring Systems	Avalon FM50	$ 13,984.24	$ 13,984.24
OB	1	Monitor, O.B., Intrapartum, Maternal/Fetal	Philips Healthcare - Monitoring Systems	Avalon FM50	$ 13,984.24	$ 13,984.24
OB	1	Monitor, O.B., Intrapartum, Maternal/Fetal	Philips Healthcare - Monitoring Systems	Avalon FM50	$ 12,961.15	$ 12,961.15
OB	1	Monitor, O.B., Intrapartum, Maternal/Fetal	Philips Healthcare - Monitoring Systems	Avalon FM50	$ 12,961.15	$ 12,961.15
ICU	1	Monitor, Physiologic	Philips Healthcare - Monitoring Systems	IntelliVue MP30	$ 7,896.53	$ 7,896.53
OB	1	Monitor, Physiologic	Philips Healthcare - Monitoring Systems	Intellivue MP5 (4 wave w/stand)	$ 7,745.93	$ 7,745.93
SURGERY	1	Monitor, Physiologic, Bedside	GE monitoring	pdm		
SURGERY	1	Monitor, Physiologic, Bedside	GE monitoring	pdm		
SURGERY	1	Monitor, Physiologic, Bedside	GE monitoring	pdm		
SURGERY	1	Monitor, Physiologic, Bedside	GE monitoring	pdm		

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
SURGERY	1	Monitor, Physiologic, Bedside	GE monitoring	Transport Pro		
SURGERY	1	Monitor, Physiologic, Bedside	GE monitoring	Carescape B650-1	$ -	$ -
SURGERY	1	Monitor, Physiologic, Bedside	GE monitoring	Carescape B650-1	$ -	$ -
SURGERY	1	Monitor, Physiologic, Bedside	GE monitoring	Carescape B650-1	$ 80,045.71	$ 80,045.71
EMERGENCY	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP30	$ 9,080.81	$ 9,080.81
EMERGENCY	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP30	$ 9,080.81	$ 9,080.81
EMERGENCY	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP30	$ 9,080.81	$ 9,080.81
EMERGENCY	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP30	$ 9,080.81	$ 9,080.81
EMERGENCY	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP50	$ 7,858.06	$ 7,858.06
EMERGENCY	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP50	$ 7,858.06	$ 7,858.06
EMERGENCY	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP30	$ 7,858.06	$ 7,858.06
EMERGENCY	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	Intellivue MP5 (4 wave)	$ 10,106.58	$ 10,106.58
ICU	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP50	$ 10,069.51	$ 10,069.51
ICU	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP50	$ 10,069.51	$ 10,069.51
ICU	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP50	$ 10,069.51	$ 10,069.51
ICU	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP50	$ 10,069.51	$ 10,069.51
OB	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	Intellivue MP5 (4 wave)	$ 10,106.58	$ 10,106.58
PACU	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP50	$ 14,968.00	$ 14,968.00

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
PACU	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP50	$ 14,968.00	$ 14,968.00
PACU	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP50	$ 14,968.00	$ 14,968.00
PACU	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP50	$ 14,968.00	$ 14,968.00
PACU	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP50	$ 14,968.00	$ 14,968.00
PACU	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP50	$ 14,968.00	$ 14,968.00
PACU	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP50	$ 14,968.00	$ 14,968.00
PACU	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP50	$ 14,968.00	$ 14,968.00
PACU	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP50	$ 14,968.00	$ 14,968.00
PACU	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP50	$ 14,968.00	$ 14,968.00
PACU	1	Monitor, Physiologic, Portable	Philips Healthcare - Monitoring Systems	IntelliVue MP50	$ 14,968.00	$ 14,968.00
MED SURG	4	Monitor, Physiologic, Transport	Philips Healthcare - Monitoring Systems	Suresigns C1 (NIBP, SpO2, Temp)	$ 2,561.41	$ 10,245.64
SURGERY	1	Monitor, Video, 26 - 32 inch, Medical Grade	Skytron	GDM HD Z3 26	$ 6,762.00	$ 6,762.00
SURGERY	1	Monitor, Video, 26 - 32 inch, Medical Grade	Skytron	GDM HD Z3 26	$ 6,762.00	$ 6,762.00
SURGERY	1	Monitor, Video, 26 - 32 inch, Medical Grade	Skytron	GDM HD Z3 26	$ 6,762.00	$ 6,762.00
SURGERY	1	Monitor, Video, 26 - 32 inch, Medical Grade	Skytron	GDM HD Z3 26	$ 6,762.00	$ 6,762.00
SURGERY	1	Monitor, Video, 26 - 32 inch, Medical Grade	Skytron	GDM HD Z3 26	$ 6,762.00	$ 6,762.00
SURGERY	1	Monitor, Video, 26 - 32 inch, Medical Grade	Skytron	GDM HD Z3 26	$ 6,762.00	$ 6,762.00
SURGERY	1	Monitor, Video, 40 - 42 inch, Medical Grade	Skytron	GDM HD z3 42	$ 9,016.00	$ 9,016.00

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
SURGERY	1	Monitor, Video, 40 - 42 inch, Medical Grade	Skytron	GDM HD z3 42	$ 9,016.00	$ 9,016.00
SURGERY	1	Monitor, Video, 40 - 42 inch, Medical Grade	Skytron	GDM HD z3 42	$ 9,016.00	$ 9,016.00
EMERGENCY	1	Oto/Ophthalmoscope Set, Wall Mount	Welch Allyn, Inc. - Med Division	76710-72M	$ 699.00	$ 699.00
EMERGENCY	1	Oto/Ophthalmoscope Set, Wall Mount	Welch Allyn, Inc. - Med Division	76710-72M	$ 699.00	$ 699.00
EMERGENCY	1	Oto/Ophthalmoscope Set, Wall Mount	Welch Allyn, Inc. - Med Division	76710-72M	$ 699.00	$ 699.00
EMERGENCY	1	Oto/Ophthalmoscope Set, Wall Mount	Welch Allyn, Inc. - Med Division	76710-72M	$ 699.00	$ 699.00
EMERGENCY	1	Oto/Ophthalmoscope Set, Wall Mount	Welch Allyn, Inc. - Med Division	76710-72M	$ 699.00	$ 699.00
EMERGENCY	1	Oto/Ophthalmoscope Set, Wall Mount	Welch Allyn, Inc. - Med Division	76710-72M	$ 699.00	$ 699.00
EMERGENCY	1	Oto/Ophthalmoscope Set, Wall Mount	Welch Allyn, Inc. - Med Division	76710-72M	$ 699.00	$ 699.00
EMERGENCY	1	PACS, Monitor, 2 Panel, Desktop	Barco Medical Imaging	Coronis 3MP (Portrait)	$ 14,312.00	$ 14,312.00
PACU	1	Pump, Suction/Aspirator, General, Portable	Allied Healthcare Products - Gomco Division	4005	$ 886.00	$ 886.00
CSPD	1	Rack, Multi-Function	STERIS Corporation	FD75600	$ 800.00	$ 800.00
CSPD	1	Rack, Multi-Function	STERIS Corporation	FD75500	$ 2,078.51	$ 2,078.51
CSPD	1	Rack, Sterile Wrap, Mobile	LogiQuip LLC	WC60	$ 555.00	$ 555.00
Sterile Processing	1	Refrigerator	GE Appliances	GMR06AAZAWW		
LAB IN PT HOSPITAL	1	Refrigerator, Blood Bank	Helmer, Inc.	iB105	$ 3,974.70	$ 3,974.70
EMERGENCY	2	Refrigerator, Domestic with Freezer	GE Appliances	GTR12HBXRWW	$ 408.00	$ 816.00
EMERGENCY	1	Refrigerator, Domestic with Freezer	GE Appliances	GTR12HBXRWW	$ 408.00	$ 408.00

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
EMERGENCY	1	Refrigerator, Domestic with Freezer	GE Appliances	GTR12HBXRWW	$ 408.00	$ 408.00
ICU	2	Refrigerator, Domestic with Freezer	GE Appliances	GTR12HBXRWW	$ 408.00	$ 816.00
MED SURG	1	Refrigerator, Domestic with Freezer	GE Appliances	GTR12HBXRWW	$ 408.00	$ 408.00
OB	1	Refrigerator, Domestic with Freezer	GE Appliances	GTR12HBXRWW	$ 408.00	$ 408.00
SURGERY	1	Refrigerator, Domestic with Freezer	GE Appliances	GTR12HBXRWW	$ 408.00	$ 408.00
EMERGENCY	1	Refrigerator, Undercounter	Summit Appliance	FF28L	$ 530.00	$ 530.00
ICU	1	Refrigerator, Undercounter	Summit Appliance	FF28L	$ 530.00	$ 530.00
ICU	1	Refrigerator, Undercounter	Summit Appliance	FF28L	$ 530.00	$ 530.00
OB	1	Refrigerator, Undercounter	Summit Appliance	FF28L	$ 530.00	$ 530.00
OB	2	Refrigerator, Undercounter	Summit Appliance	FF28L	$ 530.00	$ 1,060.00
OB	1	Refrigerator, Undercounter	Summit Appliance	FF28L	$ 530.00	$ 530.00
pacu	1	Refrigerator, Undercounter	Summit Appliance	FF28L	$ 530.00	$ 530.00
PACU	1	Refrigerator, Undercounter	Summit Appliance	FF28L	$ 530.00	$ 530.00
SURGERY	1	Refrigerator, Undercounter	Summit Appliance	FF28L	$ 530.00	$ 530.00
EMERGENCY	1	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 295.00
EMERGENCY	1	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 295.00
EMERGENCY	1	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 295.00
EMERGENCY	1	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 295.00

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
EMERGENCY	1	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 295.00
EMERGENCY	1	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 295.00
EMERGENCY	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
EMERGENCY	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
EMERGENCY	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
EMERGENCY	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
MED SURG	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
MED SURG	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
MED SURG	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
MED SURG	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
MED SURG	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
MED SURG	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
MED SURG	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
MED SURG	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
MED SURG	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
MED SURG	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
MED SURG	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
MED SURG	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
MED SURG	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
MED SURG	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
MED SURG	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
MED SURG	2	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 590.00
PACU	1	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 295.00
PACU	1	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 295.00
PACU	1	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 295.00
PACU	1	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 295.00
PACU	1	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 295.00
PACU	1	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 295.00
PACU	1	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 295.00
PACU	1	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 295.00
SURGERY	3	Regulator, Suction, Intermittent/Continuous	Allied Healthcare Products - Chemetron	Vacutron 22-15-1208	$ 295.00	$ 885.00
OB	1	Scale, Clinical, Adult, Digital, Floor	Detecto Scale-Div.Cardinal Scale Mfg	6855 Bariatric	$ 1,703.00	$ 1,703.00
MED SURG	1	Scale, Clinical, Infant, Mobile	Natus Medical - Olympic	Smart Scale Rapid-Weigh Model 65	$ 3,998.61	$ 3,998.61
CSPD	1	Scope Cleaner	STERIS Corporation	System 1 E	$ 21,200.61	$ 21,200.61
CSPD	1	Scope Cleaner	STERIS Corporation	System 1 E	$ 21,200.61	$ 21,200.61
LAB IN PT HOSPITAL	1	Shaker, Lab, Test Tube	Thermo Fisher Scientific	LabQuake 415110 (Clip Bar)	$ -	$ -

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
CSPD	1	Shelving, Movable, High Density	LogiQuip LLC	Mechanical Asst. Track System; Floor Mounted	$ 46,683.49	$ 46,683.49
EMERGENCY	3	Shelving, Wire, Chrome, 60	LogiQuip LLC	748 (60x24)	$ 372.50	$ 1,117.50
ICU	1	Shelving, Wire, Chrome, 60	LogiQuip LLC	748 (60x24)	$ 372.50	$ 372.50
MED SURG	2	Shelving, Wire, Chrome, 60	LogiQuip LLC	748 (60x24)	$ 372.50	$ 745.00
PACU	1	Shelving, Wire, Chrome, 60	LogiQuip LLC	748 (60x24)	$ 372.50	$ 372.50
PACU	2	Shelving, Wire, Chrome, 60	LogiQuip LLC	748 (60x24)	$ 372.50	$ 745.00
SURGERY	5	Shelving, Wire, Chrome, 60	LogiQuip LLC	748 (60x24)	$ 372.50	$ 1,862.50
SURGERY	1	Sink, Scrub, 2-Bay, Stainless Steel	STERIS Corporation	Flexmatic w/o Timer [CE12]	$ 7,260.00	$ 7,260.00
SURGERY	1	Sink, Scrub, 3-Bay, Stainless Steel	STERIS Corporation	Flexmatic w/o timer [CE12]	$ 9,825.88	$ 9,825.88
EMERGENCY	1	Slit Lamp	Leica Microsystems Inc.	XCEL 400	$ 4,995.00	$ 4,995.00
SURGERY	1	Stand, Basin, Double	Blickman Inc.	7808SS Snyder	$ 446.99	$ 446.99
SURGERY	1	Stand, Basin, Double	Blickman Inc.	7808SS Snyder	$ 446.99	$ 446.99
SURGERY	2	Stand, Basin, Single	Blickman Inc.	7807SS Baker	$ 276.84	$ 553.68
EMERGENCY	1	Stand, Equipment, Monitor	Philips Healthcare - Monitoring Systems	M3910A (A3 Roll Stand)	$ -	$ -
MED SURG	5	Stand, Equipment, Monitor	Philips Healthcare - Monitoring Systems	M3910A (A3 Roll Stand)	$ 238.25	$ 1,191.25
PACU	1	Stand, Equipment, Monitor	Philips Healthcare - Monitoring Systems	M3910A (A3 Roll Stand)	$ -	$ -
PACU	1	Stand, Equipment, Monitor	Philips Healthcare - Monitoring Systems	M3910A (A3 Roll Stand)	$ -	$ -

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
PACU	1	Stand, Equipment, Monitor	Philips Healthcare - Monitoring Systems	M3910A (A3 Roll Stand)	$ -	$ -
PACU	1	Stand, Equipment, Monitor	Philips Healthcare - Monitoring Systems	M3910A (A3 Roll Stand)	$ -	$ -
EMERGENCY	2	Stand, IV, Stainless Steel	Blickman Inc.	7794SS-4	$ 261.06	$ 522.12
EMERGENCY	2	Stand, IV, Stainless Steel	Blickman Inc.	7794SS-4	$ 261.06	$ 522.12
EMERGENCY	2	Stand, IV, Stainless Steel	Blickman Inc.	7794SS-4	$ 261.06	$ 522.12
EMERGENCY	2	Stand, IV, Stainless Steel	Blickman Inc.	7794SS-4	$ 261.06	$ 522.12
EMERGENCY	2	Stand, IV, Stainless Steel	Blickman Inc.	7794SS-4	$ 261.06	$ 522.12
ICU	3	Stand, IV, Stainless Steel	Blickman Inc.	7794SS-4	$ 261.06	$ 783.18
ICU	3	Stand, IV, Stainless Steel	Blickman Inc.	7794SS-4	$ 261.06	$ 783.18
ICU	3	Stand, IV, Stainless Steel	Blickman Inc.	7794SS-4	$ 261.06	$ 783.18
ICU	3	Stand, IV, Stainless Steel	Blickman Inc.	7794SS-4	$ 261.06	$ 783.18
ICU	2	Stand, IV, Stainless Steel	Blickman Inc.	7794SS-4	$ 261.06	$ 522.12
OB	2	Stand, IV, Stainless Steel	Blickman Inc.	7794SS-4	$ 261.06	$ 522.12
SURGERY	3	Stand, IV, Stainless Steel	Blickman Inc.	7794SS-4	$ 261.06	$ 783.18
EMERGENCY	1	Stand, Mayo, Foot-Operated	Blickman Inc.	7769SS (Richmond Model)	$ 610.97	$ 610.97
EMERGENCY	1	Stand, Mayo, Foot-Operated	Blickman Inc.	7769SS (Richmond Model)	$ 610.97	$ 610.97
EMERGENCY	1	Stand, Mayo, Foot-Operated	Blickman Inc.	7769SS (Richmond Model)	$ 610.97	$ 610.97

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
EMERGENCY	1	Stand, Mayo, Foot-Operated	Blickman Inc.	7769SS (Richmond Model)	$ 610.97	$ 610.97
SURGERY	2	Stand, Mayo, Foot-Operated	Blickman Inc.	7769SS (Richmond Model)	$ 610.97	$ 1,221.94
SURGERY	1	Sterilizer, Endoscope	STERIS Corporation	System 1E	$ 20,350.00	$ 20,350.00
CSPD	1	Sterilizer, Hydrogen Peroxide	STERIS Corporation	Amsco V-Pro 1 (Cabinet)	$ 113,628.23	$ 113,628.23
SURGERY	1	Sterilizer, Steam (Electric), Cabinet	STERIS Corporation	Amsco Century V-116 16"x16"x26" Prevacuum Steam	$ 47,473.01	$ 47,473.01
SURGERY	1	Sterilizer, Steam (Electric), Cabinet	STERIS Corporation	Amsco Century V-116 16"x16"x26" Prevacuum Steam	$ 47,473.01	$ 47,473.01
CSPD	1	Sterilizer, Steam, Cabinet	STERIS Corporation	Century Prevac 26x37x48 1dr (RH hinge) 480V	$ 93,508.95	$ 93,508.95
CSPD	1	Sterilizer, Steam, Cabinet	STERIS Corporation	Century Prevac 26x37x48 1dr (RH hinge) 480V	$ 93,508.95	$ 93,508.95
SURGERY	2	Stool, Exam, Cushion-Seat	Blickman Inc.	1210BLK	$ 147.80	$ 295.60
EMERGENCY	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
EMERGENCY	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
EMERGENCY	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
EMERGENCY	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
EMERGENCY	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
EMERGENCY	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
EMERGENCY	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
EMERGENCY	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
PACU	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
PACU	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
PACU	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
PACU	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
PACU	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
PACU	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
PACU	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
PACU	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
PACU	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
PACU	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
PACU	1	Stool, Exam, Steel Seat	Blickman Inc.	7745SS (Clifton)	$ 286.84	$ 286.84
EMERGENCY	1	Stool, Step, Stackable	Phelan Manufacturing Corporation	5058-1 Add-A-Unit	NIH	$ -
EMERGENCY	1	Stool, Step, Stackable	Phelan Manufacturing Corporation	5058-1 Add-A-Unit	NIH	$ -
EMERGENCY	1	Stool, Step, Stackable	Phelan Manufacturing Corporation	5058-1 Add-A-Unit	NIH	$ -
EMERGENCY	4	Stool, Step, Stackable	Phelan Manufacturing Corporation	5058-1 Add-A-Unit	NIH	$ -
EMERGENCY	1	Stool, Step, Stackable	Phelan Manufacturing Corporation	5058-1 Add-A-Unit	NIH	$ -
EMERGENCY	1	Stool, Step, Stackable	Phelan Manufacturing Corporation	5058-1 Add-A-Unit	NIH	$ -

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
EMERGENCY	1	Stool, Step, Stackable	Phelan Manufacturing Corporation	5058-1 Add-A-Unit	NIH	$ -
EMERGENCY	1	Stool, Step, Stackable	Phelan Manufacturing Corporation	5058-1 Add-A-Unit	NIH	$ -
EMERGENCY	1	Stool, Step, Stackable	Phelan Manufacturing Corporation	5058-1 Add-A-Unit	NIH	$ -
SURGERY	4	Stool, Step, Stackable	Phelan Manufacturing Corporation	5058-1 Add-A-Unit	NIH	$ -
SURGERY	1	Stool, Surgeon	Reliance Medical Products	548 (Standard)	$ 376.74	$ 376.74
EMERGENCY	1	Stretcher, Procedure, OB/GYN	Stryker Medical	Gynnie	$ 4,797.54	$ 4,797.54
OB	1	Stretcher, Procedure, OB/GYN	Stryker Medical	Gynnie		
OB	1	Stretcher, Procedure, OB/GYN	Stryker Medical	Gynnie	$ 4,797.54	$ 4,797.54
EMERGENCY	1	Stretcher, Transport	Stryker Medical	M-Series w/5th Wheel SM104 (26" Litter)	$ 3,605.58	$ 3,605.58
EMERGENCY	1	Stretcher, Transport	Stryker Medical	M-Series w/5th Wheel SM104 (26" Litter)	$ 3,605.58	$ 3,605.58
EMERGENCY	1	Stretcher, Transport	Stryker Medical	M-Series w/5th Wheel SM104 (26" Litter)	$ 3,605.58	$ 3,605.58
EMERGENCY	1	Stretcher, Transport	Stryker Medical	M-Series w/5th Wheel SM104 (26" Litter)	$ 3,605.58	$ 3,605.58
LAB IN PT HOSPITAL	1	Stretcher, Transport	Stryker Medical	Transport 737 (26" Litter)	$ 2,612.48	$ 2,612.48
OB	1	Stretcher, Transport	Stryker Medical	Transport 737 (26" Litter)	$ 2,612.48	$ 2,612.48
ICU	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75
ICU	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
ICU	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75
ICU	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75
OB	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75
OB	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75
OB	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75
OB	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75
PACU	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75
PACU	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75
PACU	2	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 913.50
PACU	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75
PACU	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75
PACU	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75
PACU	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75
PACU	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75
PACU	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75
PACU	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75
PACU	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75
PACU	1	Table, Overbed, General	Hill-Rom - Room & Furniture	PatientMate Jr OBT220	$ 456.75	$ 456.75

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
SURGERY	1	Table, Surgical, Major	Skytron	EZ Slide 3501B	$ 37,327.00	$ 37,327.00
SURGERY	1	Table, Utility, General Purpose	Blickman Inc.	7850SS Ferguson	$ 558.22	$ 558.22
CSPD	1	Table, Work, Adjustable Height	STERIS Corporation	Ergostat Deluxe (Manual)	$ 3,951.63	$ 3,951.63
CSPD	1	Table, Work, Stainless, 60 inch	LogiQuip LLC	MTS 101 (60 x 30 w/ Shelf)	$ -	$ -
CSPD	1	Table, Work, Stainless, 60 inch	Blickman Inc.	CSTD6830S1	$ 1,619.36	$ 1,619.36
CSPD	1	Table, Work, Stainless, 96 inch	STERIS Corporation	96x44 [CG80-008-000]	$ 3,269.66	$ 3,269.66
CSPD	1	Table, Work, Stainless, 96 inch	STERIS Corporation	96x44 [CG80-008-000]	$ 3,269.66	$ 3,269.66
NURSING DPTS	1	Telemetry Access Points	Philips Healthcare - Monitoring Systems	Various	$ 46,498.82	$ 46,498.82
MED SURG	1	Telemetry, Receiver Mainframe/Server	Philips Healthcare - Monitoring Systems	Viridia	$ 69,295.37	$ 69,295.37
ICU	1	Telemetry, Traditional Band, 5-8 Channels	Philips Healthcare - Monitoring Systems	Viridia 8 channel	$ 51,828.70	$ 51,828.70
OB	1	Telemetry, Transmitter, Fetal	Philips Healthcare - Monitoring Systems	Series 50T	$ 1,611.69	$ 1,611.69
OB	1	Telemetry, Transmitter, Fetal	Philips Healthcare - Monitoring Systems	Series 50T	$ 1,611.69	$ 1,611.69
OB	1	Telemetry, Transmitter, Fetal	Philips Healthcare - Monitoring Systems	Series 50T	$ 1,611.69	$ 1,611.69
OB	1	Telemetry, Transmitter, Fetal	Philips Healthcare - Monitoring Systems	Series 50T	$ 1,611.69	$ 1,611.69
OB	1	Telemetry, Wireless, Fetal/Maternal	Philips Healthcare - Monitoring Systems	Avalon CTS	$ 72,746.56	$ 72,746.56
ICU	1	Thermometer, Tympanic, Digital	Welch Allyn, Inc. - Med Division	Braun ThermoScan Pro 4000 w/stand		
ICU	1	Thermometer, Tympanic, Digital	Welch Allyn, Inc. - Med Division	Braun ThermoScan Pro 4000 w/stand		
ICU	1	Total Care ICU BED	Hill-Rom - Bed & Stretcher Group	TotalCare	$ 13,366.40	$ 13,366.40

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
CSPD	1	Ultrasonic Cleaner, Rinser	Medisafe America	Sonic Irrigator SA (Semi Auto)	$ 31,928.00	$ 31,928.00
SURGERY	1	Video/ Data Communication System	Skytron	GDM	$ 140,945.28	$ 140,945.28
SURGERY	1	Video/ Data Communication System	Skytron	GDM	$ 134,543.28	$ 134,543.28
SURGERY	1	Video/ Data Communication System	Skytron	GDM	$ 140,945.28	$ 140,945.28
EMERGENCY	1	Viewbox, 2 Panel, Surface	Maxant Technologies Inc.	Techline 400 Series TS402	$ 570.00	$ 570.00
SURGERY	1	Viewbox, 4 Panel, Recessed	Maxant Technologies Inc.	Techline 400 Series TR404	$ 1,105.00	$ 1,105.00
SURGERY	1	Viewbox, 4 Panel, Recessed	Maxant Technologies Inc.	Techline 400 Series TR404	$ 1,105.00	$ 1,105.00
SURGERY	1	Viewbox, 4 Panel, Recessed	Maxant Technologies Inc.	Techline 400 Series TR404	$ 1,105.00	$ 1,105.00
SURGERY	1	Warmer, Fluid/ Blood, Portable	Smiths Medical - Level 1 Inc.	H-1100 NormoFlo	$ 3,745.00	$ 3,745.00
SURGERY	1	Warmer, Fluid/ Blood, Portable	Smiths Medical - Level 1 Inc.	H-1100 NormoFlo	$ 3,745.00	$ 3,745.00
OB	1	Warmer, Infant, Freestanding	Draeger Medical - Air Shields Div.	Birthing Room Warmer	$ 11,556.32	$ 11,556.32
OB	1	Warmer, Infant, Freestanding	Draeger Medical - Air Shields Div.	Birthing Room Warmer	$ 11,556.32	$ 11,556.32
CSPD	1	Washer / Disinfector, Steam	STERIS Corporation	Reliance Vision Single Chamber (480V, 2-Dr)	$ 89,149.32	$ 89,149.32
CSPD	1	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	6144 Red (12 gal)	$ 115.00	$ 115.00
EMERGENCY	1	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	6144 Red (12 gal)	$ 115.00	$ 115.00
EMERGENCY	1	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	6144 Red (12 gal)	$ 115.00	$ 115.00
ICU	1	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	6144 Red (12 gal)	$ 115.00	$ 115.00

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
ICU	1	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	6144 Red (12 gal)	$ 115.00	$ 115.00
MED SURG	1	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	6144 Red (12 gal)	$ 115.00	$ 115.00
OB	2	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	6144 Red (12 gal)	$ 115.00	$ 230.00
OB	1	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	6144 Red (12 gal)	$ 115.00	$ 115.00
OB	1	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	6144 Red (12 gal)	$ 115.00	$ 115.00
OB	1	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	6144 Red (12 gal)	$ 115.00	$ 115.00
OB	1	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	6144 Red (12 gal)	$ 115.00	$ 115.00
OB	1	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	6144 Red (12 gal)	$ 115.00	$ 115.00
OB	1	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	6144 Red (12 gal)	$ 115.00	$ 115.00
OB	1	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	6144 Red (12 gal)	$ 115.00	$ 115.00
OB	1	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	6144 Red (12 gal)	$ 115.00	$ 115.00
PACU	1	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	6144 Red (12 gal)	$ 115.00	$ 115.00
ICU	1	Waste Can, Step-On	Rubbermaid Commercial Products	6143 (8 gal)	$ 96.00	$ 96.00
MED SURG	1	Waste Can, Step-On	Rubbermaid Commercial Products	6143 (8 gal)	$ 96.00	$ 96.00
SURGERY	1	Waste Disposal System, Surgical Fluid Collection	Stryker Instruments Corporation	Neptune Gold Rover 700-1	$ 16,901.40	$ 16,901.40

Department	Qty	Description	Manufacturer	Model	Cost/Unit	Total Cost/Room *
SURGERY	1	Waste Disposal System, Surgical Fluid Collection	Stryker Instruments Corporation	Neptune Gold Rover 700-1	$ 16,901.40	$ 16,901.40
SURGERY	1	Waste Disposal System, Surgical Fluid Collection	Stryker Instruments Corporation	Neptune Gold Rover 700-1	$ 16,901.40	$ 16,901.40
CSPD	1	Waste Disposal System, Surgical Fluid Disposal	Stryker Instruments Corporation	Neptune Detergent Docking Station	$ 13,524.35	$ 13,524.35
SURGERY	1	Workstation Cart	STERIS Corporation	A1965	$ 2,516.00	$ 2,516.00
SURGERY	1	Workstation Cart	STERIS Corporation	A1965	$ 2,516.00	$ 2,516.00
SURGERY	1	Workstation, Nurse Documentation	Skytron	SORIC-72	$ 20,171.25	$ 20,171.25
SURGERY	1	Workstation, Nurse Documentation	Skytron	SORIC-72	$ 20,171.25	$ 20,171.25
SURGERY	1	Workstation, Nurse Documentation	Skytron	SORIC-72	$ 20,171.25	$ 20,171.25

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RESOLUTION NO. ____
OF THE
NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT
BOARD OF DIRECTORS

WHEREAS, the Northern Inyo County Local Hospital District is required to establish an annual appropriations limit in accordance with Article XIIIB of the California Constitution; and

WHEREAS, using data provided by the State of California Department of Finance, on May, 2013, the Board of Directors of Northern Inyo Hospital established an appropriations limit of $508,760.41 for the July 1, 2012 to June 30, 2013 fiscal year; and

WHEREAS, using the attached data provided by the State of California Department of Finance, an appropriations limit of $535,724.71 has been calculated for the July 1, 2013 to June 30, 2014 fiscal year.

NOW, THEREFORE, BE IT RESOLVED by this Board of Directors of Northern Inyo County Local Hospital District, meeting in regular session this 17th day of July, 2013 that an appropriations limit of $535,724.71 be established for the Northern Inyo County Local Hospital District for the 2013-2014 fiscal year; and

BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting.

_____
John Ungersma, M.D., President

Attest: _____
Denise Hayden, Secretary

APPROPRIATIONS LIMIT CALCULATIONS
FISCAL YEAR 2014

Per capita change multiplied by the population change yields a calculation factor.

For the district this is:

1.0512 X 1.0018 = 1.053

1.053 x $508,760.41=$535,524.71

New Limit is $535,724.71

DEPARTMENT OF FINANCE
OFFICE OF THE DIRECTOR

EDMUND G. BROWN JR. • GOVERNOR
STATE CAPITOL ■ ROOM 1145 ■ SACRAMENTO CA ■ 95814-4998 ■ WWW.DOF.CA.GOV

May 2013

Dear Fiscal Officer:

Subject: Price and Population Information

Appropriations Limit
The California Revenue and Taxation Code, section 2227, mandates the Department of Finance to transmit an estimate of the percentage change in population to local governments. Each local jurisdiction must use their percentage change in population factor for January 1, 2013, in conjunction with a change in the cost of living, or price factor, to calculate their appropriations limit for fiscal year 2013-14. Attachment A provides the change in California's per capita personal income and an example for utilizing the price factor and population percentage change factor to calculate the 2013-14 appropriations limit. Attachment B provides city and unincorporated county population percentage change. Attachment C provides population percentage change for counties and their summed incorporated areas. The population percentage change data excludes federal and state institutionalized populations and military populations.

Population Percent Change for Special Districts
Some special districts must establish an annual appropriations limit. Consult the Revenue and Taxation Code section 2228 for further information regarding the appropriations limit. Article XIII B, section 9(C), of the State Constitution exempts certain special districts from the appropriations limit calculation mandate. The Code and the California Constitution can be accessed at the following website: http://leginfo.legislature.ca.gov/faces/codes.xhtml.

Special districts required by law to calculate their appropriations limit must present the calculation as part of their annual audit. Any questions special districts have on this issue should be referred to their respective county for clarification, or to their legal representation, or to the law itself. No state agency reviews the local appropriations limits.

Population Certification
The population certification program applies only to cities and counties. Revenue and Taxation Code section 11005.6 mandates Finance to automatically certify any population estimate that exceeds the current certified population with the State Controller's Office. **Finance will certify the higher estimate to the State Controller by June 1, 2013.**

Please Note: Prior year's city population estimates may be revised.

If you have any questions regarding this data, please contact the Demographic Research Unit at (916) 323-4086.

ANA J. MATOSANTOS
Director
By:

MICHAEL COHEN
Chief Deputy Director

Attachment

May 2013

Attachment A

A. **Price Factor**: Article XIII B specifies that local jurisdictions select their cost of living factor to compute their appropriation limit by a vote of their governing body. The cost of living factor provided here is per capita personal income. If the percentage change in per capita personal income is selected, the percentage change to be used in setting the fiscal year 2013-14 appropriation limit is:

Per Capita Personal Income

Fiscal Year (FY)	Percentage change over prior year
2013-14	5.12

B. Following is an example using sample population change and the change in California per capita personal income as growth factors in computing a 2013-14 appropriation limit.

2013-14:

Per Capita Cost of Living Change = 5.12 percent
Population Change = 0.79 percent

Per Capita Cost of Living converted to a ratio: $\frac{5.12 + 100}{100} = 1.0512$

Population converted to a ratio: .18 $\frac{0.79 + 100}{100} = 1.0079$ 1.0018

Calculation of factor for FY 2013-14: 1.0018

1.0512 x 1.0079 = 1.0595 1.053

Attachment B
Annual Percent Change in Population Minus Exclusions*
January 1, 2012 to January 1, 2013 and Total Population, January 1, 2013

County City	Percent Change 2012-2013	--- Population Minus Exclusions --- 1-1-12	 1-1-13	Total Population 1-1-2013
Inyo				
Bishop	0.03	3,876	3,877	3,877
Unincorporated	0.22	14,555	14,587	14,696
County Total	0.18	18,431	18,464	18,573

595

0 • C

1 • 0512 ×
1 • 0018 =
1 • 05309216 *

508 , 760 • 41 ×
1 • 053 =
535 , 724 • 71173 *

0 • C

*Exclusions include residents on federal military installations and group quarters residents in state mental institutions, state and federal correctional institutions and veteran homes.

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PERSONNEL/PAYROLL ADVISORY COMMITTEE (PPAC) GUIDELINES

OF

NORTHERN INYO HOSPITAL

Adopted: November 17, 1993
Amended: May 17, 1995
Amended: September 23, 2009
Amended: July 17, 2013

NORTHERN INYO HOSPITAL
PERSONNEL/PAYROLL ADVISORY COMMITTEE GUIDELINES

Introduction

Since 1985 there has existed at Northern Inyo Hospital a Fringe Benefit Advisory Committee. The role of this Committee has been to make recommendations to the Hospital Board of Directors concerning the employees' fringe benefits package and personnel policies. In September 1993 a petition, signed by hospital employees, was submitted to the Hospital Administrator requesting that the Fringe Benefit Advisory Committee be discontinued, and a new committee be formed. These guidelines outline the mission, composition, and functions of the new committee.

Name

The name of this Committee is the Northern Inyo Hospital Personnel/Payroll Advisory Committee.

Mission

The mission of the Committee is to provide the Northern Inyo Hospital Administrator and Board of Directors with written recommendations regarding the Northern Inyo Hospital Personnel Policies, Payroll Policies and Guidelines, and the fringe benefit package offered by the Hospital to its employees.

Composition

The Committee shall be composed of eleven Northern Inyo Hospital employees. Included in this total shall be:

- The Human Resources Manager, who shall serve as Chairperson of the Committee and who shall be entitled to vote only when it is necessary to break a tie vote of the Committee and may present agenda items.
- The Controller, appointed by position, non-voting, may present agenda items.
- The Hospital Administrator, appointed by position, non-voting, may present agenda items.
- The Employee Advocate, appointed by position, non-voting, may present agenda items.

The remaining seven voting Committee members who may present agenda items shall be selected as follows:

- One manager elected by secret ballot by managers. Managers appear on the Northern Inyo Hospital Organization Chart – refer to current copy.
- Two non-management employees from nursing services elected by secret ballot by non-management employees from nursing services. Please see appendix with list of areas included in nursing services.
- One non-management employee from ancillary services elected by secret ballot by non-management employees from ancillary services. Please see appendix with list of areas included in ancillary services.
- One non-management employee from support services elected by secret ballot by non-management employees from support services. Please see appendix with list of areas included in support services.
- One non-management employee from administrative services elected by secret ballot by non-management employees from administrative services. Please see appendix with list of areas included in administrative services.
- One non-management employee from non-hospital-based employees elected by secret ballot by non-management employees from non-hospital-based employees. Please see appendix with list of areas included in non-hospital-based employees.

Nominations

In November of each year the Committee will invite nominations for employees to be elected to the Committee. Managers may nominate another manager, non-management employees from nursing services may nominate another non-~~managment~~management employee from nursing services, etc. Nominations shall be submitted in writing to the Committee Chairperson, who shall ensure that the names of those nominated appear on the election ballots as candidates.

Elections and Terms

Elections shall be held by secret ballot in December of each year.

To be elected to the Committee, an employee must receive a majority of votes cast. If there are more than two candidates for a Committee seat, and no candidate receives a majority of votes cast, then there shall be a runoff election between the two candidates receiving the most votes.

If only one candidate is nominated for a Committee seat, no election will be necessary and that candidate shall be considered to be the elected member.

Those elected to the Committee shall serve two-year terms starting on the first day of January of the following year. So that the terms may be staggered, the members representing management, one of the two nursing services, support services, and non-hospital-based employees will be elected in odd years and start in even years while members representing one of the two nursing services, ancillary services, and administrative services will be elected in even years and start in odd years.

In case of a vacancy on the Committee, the Committee will invite nominations, and a special secret ballot election shall be held to elect a person to serve the remainder of the vacant term.

Meetings

The Committee shall meet on an as needed basis, and not less than four times a year. Meetings shall be scheduled by the Committee Chairperson. Special meetings shall be called upon written request signed by at least five members of the Committee and submitted to the Committee Chairperson or as determined at a previous meeting. Committee members are paid their regular wages by the Hospital for time spent in Committee meetings.

All meetings of the Committee are open to any interested persons. When employees are invited to attend a Committee meeting by the Committee Chairperson, time spent by the invited employees at the Committee meeting will be paid by the hospital.

Attendance Requirements

Unless excused for good cause by the remaining members of the Committee, any elected Committee member who is absent from ~~three~~ fifty percent (50%) or more meetings during a twelve month period will be removed from the Committee, and a vacancy will be declared. In the case of such a vacancy, the Committee will invite nominations, and a special secret ballot election shall be held to elect a person to serve the remainder of the vacant term. To be excused, Committee members must make their request to the Committee Chairperson prior to the meeting or as soon as practicable.

Meeting Agenda

Voting and non-voting members may submit agenda items on the PPAC Agenda Item Submission form or present unscheduled discussion items and announcements. Agenda items must be submitted ~~two weeks before a scheduled meeting~~at least three

days prior to the required agenda posting date to allow time for the agenda to be prepared and posted as required.

The agenda for each Committee meeting shall be written, and posted in the Northern Inyo Hospital dining room for at least ~~one week~~three days prior to the time of each Committee meeting. An Everyone On Email (Business Only) email will also be sent out with the agenda attached at least ~~one week~~three days prior to the time of each Committee meeting.

Meeting Minutes

Minutes of each meeting shall be written by a non-Committee member secretary. ~~A draft of the minutes of each meeting shall be distributed in an Everyone On Email (Business Only) email as well as posted in the Northern Inyo Hospital dining room for at least one week, in a timely manner.~~ Approved minutes of each Committee meeting shall be distributed in an Everyone On Email (Business Only) email as well as posted in the Northern Inyo Hospital dining room for at least one week, in a timely manner.

Order of Business

The order of business at Committee meetings shall include:

1. Call to Order
2. Approval of Previous Meeting Minutes
3. Unfinished Business
4. New Business
5. Unscheduled discussion items and announcements
6. Adjournment

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CalFirst
California First National Bank
Commercial Finance Division

June 27, 2013

Mr. John Halfen
CEO/CFO
Northern Inyo County Local Hospital District
150 Pioneer Lane
Bishop, CA 93514

RE: LEASE AGREEMENT ORDER NO. ML-00240
LEASE SCHEDULE NO. 01

Dear Mr. Halfen:

This letter shall serve as your formal notification that the above-referenced transaction has been approved by California First National Bank ("CFNB"), through September 25, 2013. The approved Property cost is $1,000,000.00. All Property shall be subject to CFNB's review and approval and shall consist of new Technology equipment, software, soft costs, pharmacy equipment and radiology equipment and accessories.

The approval of this transaction is conditioned upon there being no material adverse change in the financial condition of the Lessee and receipt of all documentation required and approved by CFNB's legal counsel. Lessee agrees to provide annual CPA prepared audited financial statements with an unqualified opinion as soon as possible but in any event no later than 150 days after Lessee's fiscal year-end.

Lessee will be responsible for all standard documentation fees including, but not limited to UCC filing fees, lien search fees, applicable Stamp Tax fees, Equipment Inspection fees and e-Waste fees that CalFirst may incur. In the event of a Change in Control and Ownership as set forth on the Lease Agreement and/or with the relocation of Property as set forth on the Lease Schedule, Lessee will be charged any associated Documentation and UCC/Lien Search fees.

The Lease has been approved with CFNB's understanding that the Property will be installed and accepted from June 2013 through April 2014, and that advance payments to the supplier(s) of the Property will be required from time to time during the installation period. The Lessee understands that a daily pro-rata rental fee will be due to CFNB based upon these advance payments during this installation period as stated in the "Request For Payment To Supplier(s) in Advance of The Agreement Authorization Date" document.

With written notice, CFNB may extend the credit approval at its sole discretion. The specific terms of the Agreement are outlined on the enclosed Lease Agreement Order No. ML-00240, Lease Schedule No. 01 and on the other subsidiary documents enclosed and to follow.

Enclosed please find the following items for your review and execution:

- Lease Agreement Order No. ML-00240;
- Certificate of Incumbency and Authority for John Halfen, CEO/CFO
  (This document requires the signature of **another** officer of the corporation and the corporate seal);
- Lease Schedule No. 01;
- Request for Payment to Supplier(s) in Advance of Agreement Authorization Date;
- Casualty Schedule;
- Insurance Requirements Form; and
- Financial Statement Rider.

In addition, please make the following arrangements at your earliest convenience:

1) Please have your insurance company forward the required Insurance Certificate(s) to the attention of Amber Arambul. The Certificate(s) should reflect both liability and personal property damage as specified on the enclosed Insurance Requirements Form.

2) Please have the applicable supplier(s) forward invoices reflecting the following relationship:

SOLD TO:	**SHIP TO:**
California First National Bank 18201 Von Karman Avenue, 8th Floor Irvine, CA 92612 Attention: Amber Arambul	Northern Inyo County Local Hospital District (as directed by Lessee)

Please ask your supplier(s) to include serial numbers and installation dates on the invoice(s).

3) Please provide your Federal Identification Number with your return package.

4) Please forward a copy of your Tax Exemption Certificate with your return package.

5) Please include a check in the amount of $3,290.00 for the balance of the deposit.

If you have any questions, do not hesitate to call me at (949) 255-0500, Ext. 308. Please indicate your acceptance of the terms and conditions outlined herein by executing this letter in the space provided. This approval shall expire within five (5) days from the date hereof unless countersigned by you prior to the end of business on July 5, 2013. Once executed, please fax this letter to my attention at (949) 255-0501 or email to jbartells@calfirst.com, with the original to follow via overnight mail along with the other documents attached hereto. Thank you for choosing CFNB as your leasing source.

Sincerely,

California First National Bank

Janet Bartells
Assistant Vice President

JB/cag
Enclosures

Agreed and acknowledged on this _____ day of _____, 2013.

Northern Inyo County Local Hospital District

By: _____

Name: John Halfen

Title: CEO/CFO

Federal ID No.: _____

CalFirst
California First National Bank
Commercial Finance Division

LEASE AGREEMENT

18201 Von Karman Avenue, 8th Floor, Irvine, California 92612
Phone 800-496-4640 949-255-0500 Fax 949-255-0501 www.CalFirst.com

ORDER NO. ML-00240

LESSEE				
Northern Inyo County Local Hospital District				
STREET	CITY	STATE	COUNTY	ZIP
150 Pioneer Lane	Bishop	CA	Inyo	93514

1. AGREEMENT/LEASE: California First National Bank ("Lessor") agrees to lease to Lessee the hardware, software, equipment and all related capitalized costs (capitalized costs are those costs that are necessary to put the hardware, software and equipment into full productive use by Lessee), or other costs or expenditures made by Lessor (collectively, the "Property") subject to the terms set forth herein and on each Schedule(s) that the parties may from time to time enter into with respect to this Agreement. Each Schedule identified as being a part of this Agreement incorporates the terms of this Agreement and constitutes a separate Lease Agreement and is referred to herein as the "Lease". The Lease is in force and is binding upon Lessee and Lessor upon signed acceptance by Lessor.

2. UNIFORM COMMERCIAL CODE ACKNOWLEDGMENT: Lessee acknowledges that it has received and approved any written "Supply Contract" covering the Property purchased from each Supplier for lease and Lessor has informed or advised Lessee, either previously or by this Lease, of the following: (i) the identity of the Supplier; (ii) that Lessee may have rights under the Supply Contract; and (iii) that Lessee may contact the Supplier for a description of any such rights. This Lease is a "Finance Lease". (The terms "Finance Lease", "Supply Contract" and "Supplier" as used in this Lease have the meanings only as ascribed to them under Division 10 of the California Uniform Commercial Code and have no effect on any tax or accounting treatment of the Lease). This provision survives termination and/or expiration of the Lease.

3. NO WARRANTIES: LESSOR IS NOT THE SUPPLIER, MANUFACTURER, DEVELOPER, PUBLISHER, DISTRIBUTOR, OR LICENSOR (COLLECTIVELY, "SUPPLIER") OF THE PROPERTY AND MAKES NO EXPRESS OR IMPLIED WARRANTY OR REPRESENTATION AS TO FITNESS, QUALITY, DESIGN, CONDITION, CAPACITY, SUITABILITY, VALUE, MERCHANTABILITY, OR PERFORMANCE OF THE PROPERTY OR THE MATERIAL OR WORKMANSHIP THEREOF OR AGAINST INTERFERENCE BY LICENSORS OR OTHER THIRD PARTIES, IT BEING AGREED THAT THE PROPERTY IS LEASED "AS IS" AND THAT ALL SUCH RISKS ARE TO BE BORNE BY LESSEE. Lessee has selected the Property and represents to Lessor that all the Property is suitable for Lessee's purposes. Lessor assigns to Lessee during the term of the Lease any warranty rights it may have received from the Supplier as a result of Lessor's purchase of the Property. If Lessee has any claims regarding the Property or any other matter arising from Lessee's relationship with the Supplier, Lessee must make them against the Supplier. This provision survives termination and/or expiration of the Lease.

4. AUTHORIZATION DATE AND PAYMENT OBLIGATIONS: A Schedule commences and rent is due beginning on the date that Lessee certifies in writing to Lessor that all of the Property has been received and accepted by Lessee as installed, tested and ready for use, and Lessee authorizes Lessor in writing to disburse payment to the Supplier ("Authorization Date"). Unless and until Lessee provides such written authorization, Lessor will not disburse payment to Suppliers. The Term of each Schedule is reflected on the Schedule and begins on the first day of the calendar quarter following the Authorization Date. A calendar quarter commences on the first day of January, April, July and October. Lessee has the right to use the Property at the specific locations shown on the Schedule throughout the duration of this Lease in accordance with the provisions of this Lease. Rents shall be paid directly to Lessor unless otherwise instructed by Lessor. The rent payable is shown on the Schedule(s). The monthly rent is due to Lessor, in advance, for each month or portion of a month beginning on the Authorization Date and continuing for each month that this Lease is in effect. Rent for portions of a month are based on a daily rental equal to one-thirtieth of the monthly rent. **ALL RENTS SHALL BE PAID WITHOUT NOTICE OR DEMAND AND WITHOUT ABATEMENT, DEDUCTION OR SETOFF OF ANY AMOUNT WHATSOEVER. THE OPERATION AND USE OF THE PROPERTY IS SOLELY AT THE RISK OF LESSEE AND THE OBLIGATION OF LESSEE TO PAY RENT UNDER THE LEASE SHALL BE ABSOLUTE AND UNCONDITIONAL. TO THE EXTENT PERMITTED BY APPLICABLE LAW, LESSEE HEREBY WAIVES THE FOLLOWING RIGHTS AND REMEDIES CONFERRED UPON LESSEE BY LAW: (I) RIGHT TO CANCEL OR TERMINATE THIS LEASE PRIOR TO EXPIRATION OF THE APPLICABLE TERM, (II) RIGHT TO REJECT THE PROPERTY, (III) RIGHT TO REVOKE ACCEPTANCE OF THE PROPERTY, (IV) RIGHT TO RECOVER DAMAGES FROM LESSOR FOR ANY BREACH OF WARRANTY, AND (V) RIGHT TO RECOVER ANY CONSEQUENTIAL DAMAGES WHATSOEVER. LESSEE SHALL PROVIDE TO LESSOR WRITTEN NOTICE OF LESSEE'S ELECTION OF ONE OF THE OPTIONS SET FORTH IN SECTION G. OF THE SCHEDULE AT LEAST ONE HUNDRED EIGHTY (180) DAYS PRIOR TO THE EXPIRATION OF THE TERM. IF LESSEE DOES NOT GIVE SUCH NOTICE, THEN THE TERM SHALL EXTEND FOR A MINIMUM PERIOD OF NINETY (90) DAYS AND SHALL CONTINUE UNTIL NINETY (90) DAYS AFTER LESSEE PROVIDES WRITTEN NOTICE TO LESSOR OF LESSEE'S ELECTION OF ONE OF THE OPTIONS SET FORTH IN SECTION G. OF THE SCHEDULE ("EXTENSION TERM").**

THIS LEASE AGREEMENT AND THE APPLICABLE SCHEDULE(S) CONTAIN THE ENTIRE AGREEMENT BETWEEN LESSOR AND LESSEE WITH RESPECT TO THE SUBJECT MATTER HEREOF. THE LEASE CAN ONLY BE MODIFIED IN WRITING, WITH SUCH MODIFICATIONS SIGNED BY A PERSON AUTHORIZED TO SIGN AGREEMENTS ON BEHALF OF LESSEE AND BY AN AUTHORIZED SIGNER OF LESSOR. NO ORAL OR OTHER WRITTEN AGREEMENTS, REPRESENTATIONS OR PROMISES SHALL BE RELIED UPON BY, OR BE BINDING ON, THE PARTIES UNLESS MADE A PART OF THIS LEASE BY A WRITTEN MODIFICATION SIGNED BY AN AUTHORIZED SIGNER OF LESSEE AND LESSOR.

LESSEE: _____ (Signature)

CALIFORNIA FIRST NATIONAL BANK _____ (Signature)

This Lease is subject to acceptance by Lessor's Finance Committee. **By signing below, the signer certifies that he or she has read this Lease Agreement, INCLUDING THE REVERSE SIDE, has had an opportunity to discuss its terms with Lessor, and is authorized to sign on behalf of Lessee.** Until this Lease has been signed by an authorized signer of Lessor, it will constitute a firm offer by Lessee.

	Lessee/Offeror		**LESSOR**
OFFER:	**Northern Inyo County Local Hospital District**	**ACCEPTANCE:**	**California First National Bank**
Signature:	_____	Signature:	_____
Name:	John Halfen	Name:	Irene Tanihara
Title:	CEO/CFO	Title:	Vice President & Group Manager
Date:	_____	Date:	_____

CERTIFICATE OF INCUMBENCY AND AUTHORITY

I, X _____ , do hereby certify that I am the
(OFFICER OTHER THAN SIGNATORY)

qualified and acting X _____ of
(OTHER OFFICER'S TITLE)

Northern Inyo County Local Hospital District, a California Corporation, with its

chief executive office located in Bishop, California.

On behalf of this corporation, I represent and warrant the following: (i) that as of the date of Lease Agreement Order No. ML-00240 ("the Lease"), the person(s) whose name, title, and signature appears below is authorized to execute, on behalf of this corporation, documents and instruments in conjunction with the Lease of personal property (the "Property") from California First National Bank ("Lessor"); (ii) the execution and delivery of such documents and instruments, and performance of the terms thereof, are not prohibited, or in any manner restricted, by the terms of this corporation's Certificate of Incorporation, its By-Laws, or any loan agreement, indenture, or contract to which this corporation is a party; (iii) this corporation is duly organized and validly existing in good standing under the laws of the above-referenced state of its incorporation, is duly qualified to do business in each jurisdiction where the Property is, or will be, located, has full corporate power and authority to hold Property and to enter into and perform its obligations under the Lease; (iv) all information provided by this corporation to Lessor including, without limitation, the corporation's legal name, organizational structure, state of incorporation/formation and location of its chief executive office is true and correct; and (v) in order to be enforceable by or against Lessee, all of its rights and obligations under the Lease shall be set forth in writing and signed by both authorized signer of this corporation and an authorized officer of Lessor.

NAME	TITLE	SIGNATURE
John Halfen	CEO/CFO	

IN WITNESS WHEREOF, I have set my hand and affixed the seal of said corporation on this X 7-3-13
day of X _____ , 20 13 .

X _____
(SIGNATURE OF "OTHER OFFICER")

PLEASE AFFIX CORPORATE SEAL HERE

CalFirst
California First National Bank
Commercial Finance Division

18201 Von Karman Avenue, 8th Floor, Irvine, California 92612
Phone 800-496-4640 949-255-0500 Fax 949-255-0501 www.CalFirst.com

LEASE SCHEDULE

NO. 01

LESSEE				CONTACT
Northern Inyo County Local Hospital District				John Halfen
STREET				PHONE NO.
150 Pioneer Lane				(760) 873-2838
CITY	STATE	COUNTY	ZIP	FACSIMILE NO.
Bishop	CA	Inyo	93514	(760) 872-5802

A. This Schedule is issued with respect to the Lease Agreement Order No. ML-00240 dated _____ (the "Agreement"). All of the terms of the Agreement are incorporated into this Schedule as if fully reflected on the Schedule. The terms of this Schedule and the Agreement combine to form an individual Lease with an independent Term.

B. Any Deposit under this Schedule shall be returned to Lessee (without interest thereon) if Lessor does not accept this Schedule. Unless otherwise specified herein, upon acceptance of this Lease by Lessor any such Deposit shall be security for Lessee's obligations under the Lease, and provided that all other outstanding payment obligations have been fully satisfied, such Deposit shall be applied to the rent due in the last month(s) of the Term.

C. Term (months) : Sixty (60)

D. Deposit : $18,290.00

E. Monthly Rent : $18,290.00

F. Property : TOTAL PROPERTY COST: $1,000,000.00

PROPERTY TO CONSIST OF VARIOUS TECHNOLOGY EQUIPMENT, SOFTWARE, SOFT COSTS, PHARMACY AND RADIOLOGY EQUIPMENT AS MORE FULLY DESCRIBED ON EXHIBIT "A" TO RELATED DOCUMENTS AT A LATER DATE.

THE MONTHLY LEASE RATE FACTOR OF 0.01829 MAY BE ADJUSTED UPWARD BY (.0000046) FOR EVERY ONE (01) BASIS POINT ADJUSTMENT IN THE CORRESPONDING AVERAGE YIELD OF EQUALLY MATURING INTEREST RATE SWAPS. THE FINAL MONTHLY LEASE RATE FACTOR SHALL BE FIXED AT THE AUTHORIZATION DATE AND SHALL REMAIN CONSTANT THROUGHOUT THE TERM OF THE LEASE. THE INITIAL INDEX RATE SHALL BE 1.06%.

INTEREST SWAP RATES ARE PUBLISHED DAILY IN THE FEDERAL RESERVE STATISTICAL RELEASE H-15, WHICH CAN BE FOUND AT: www.federalreserve.gov/releases/h15/update

G. AT THE EXPIRATION OF THE TERM AND AFTER THE FINAL RENTAL PAYMENT HAS BEEN PAID BY LESSEE, PLUS ALL ACCRUED BUT UNPAID LATE CHARGES, INTEREST, TAXES, PENALTIES AND/OR ANY OTHER SUMS DUE AND OWING UNDER THE LEASE, AND NO EVENT OF DEFAULT, AS THE SAME IS MORE FULLY DESCRIBED IN THE AGREEMENT HAS OCCURRED OR IS CONTINUING, ONE FINAL PAYMENT OF ONE U.S. DOLLAR ($1.00) SHALL BECOME DUE, OWING AND PAYABLE BY LESSEE TO LESSOR, FOR WHICH LESSOR WILL PASS ITS TITLE IN THE PROPERTY TO THE LESSEE. THE NOTICE OF ELECTION REQUIREMENT SET FORTH IN SECTION 4 OF THE AGREEMENT DOES NOT APPLY TO THIS SCHEDULE.

THE INDIVIDUAL SIGNING BELOW CERTIFIES THAT HE OR SHE HAS READ THIS SCHEDULE (INCLUDING THE TERMS ON THE REVERSE SIDE HEREOF) AND THE LEASE AGREEMENT, AND IS AUTHORIZED TO SIGN THIS SCHEDULE ON BEHALF OF LESSEE.

THIS SCHEDULE ALONG WITH THE AGREEMENT CONTAIN THE ENTIRE AGREEMENT BETWEEN LESSOR AND LESSEE WITH RESPECT TO THE SUBJECT MATTER HEREOF. THIS AGREEMENT CAN ONLY BE MODIFIED IN WRITING, WITH SUCH MODIFICATIONS SIGNED BY A PERSON AUTHORIZED TO SIGN AGREEMENTS ON BEHALF OF LESSEE AND BY AN AUTHORIZED SIGNER OF LESSOR. NO ORAL OR OTHER WRITTEN AGREEMENTS, REPRESENTATIONS OR PROMISES SHALL BE RELIED UPON OR BE BINDING ON THE PARTIES UNLESS MADE A PART OF THIS LEASE BY A WRITTEN MODIFICATION SIGNED BY AN AUTHORIZED SIGNER OF BOTH LESSEE AND LESSOR.

	LESSEE/OFFEROR		LESSOR
OFFER:	**Northern Inyo County Local Hospital District**	**ACCEPTANCE:**	**California First National Bank**
Signature:		Signature:	
Name:	John Halfen	Name:	Irene Tanihara
Title:	CEO/CFO	Title:	Vice President & Group Manager
Date:	7-3-13	Date:	

CalFirst
California First National Bank
Commercial Finance Division

June 27, 2013

Northern Inyo County Local Hospital District
150 Pioneer Lane
Bishop, CA 93514

[RE:] **REQUEST FOR PAYMENT TO SUPPLIER(S) IN ADVANCE OF THE AGREEMENT AUTHORIZATION DATE**

Ladies/Gentlemen:

Reference is made to that Lease Agreement No. ML-00240 dated _____ by and between Northern Inyo County Local Hospital District as Lessee, and California First National Bank, (the "Agreement") and to Lease Schedule No. 01 (the "Schedule") and all related subsidiary documents under the Agreement and Schedule (collectively, the "Lease"). Notwithstanding anything to the contrary contained therein, and to the limited extent hereof, this Letter Agreement amends and supersedes the Lease and is hereby incorporated by reference herein.

California First National Bank ("Lessor") has received a request from Northern Inyo County Local Hospital District ("Lessee") to advance funds to supplier(s) for certain items of Property (including amounts for deposits and/or progress payments) prior to Lessee's certification in writing to Lessor, that all of the Property has been received and accepted by Lessee as installed, tested and ready for use. As adequate and valuable consideration for Lessor advancing funds to supplier(s) on behalf of Lessee prior to Lessee's written certification of receipt and acceptance of all of the subject Property, Lessee agrees to make the following terms and conditions mutually binding under the Lease:

Lessee will pay to Lessor a daily pro-rata rental fee from the date each item of Property is installed, tested and ready for use (or a deposit and/or progress payment is made) through the "Authorization Date". The Authorization Date as further defined in Section 4. AUTHORIZATION DATE AND PAYMENT OBLIGATIONS of the Agreement, shall be the date that the final item of Property is certified in writing to Lessor to be received and accepted by Lessee as installed, tested and ready for use by Lessee. If Lessor has advanced funds either as a deposit or a progress payment on items of Property not yet installed, tested and ready for use, the daily pro-rata rental fee will be calculated from the date of Lessor's disbursement. The daily pro-rata rental fee will be calculated as follows: (0.01829 X (the cost of each item of installed Property + amount of progress payments and deposits made)/30). This rental fee will be billed monthly. Lessor will not be required to fund on any items of Property not installed, tested and ready for use by Lessee on or before 09/25/13 (the "Funding Cut-Off Date"). If all of the Property to be included in the above-referenced Lease is not certified in writing to Lessor to be installed, tested and ready for use by Lessee on or before the Funding Cut-Off Date, or if Lessee is in violation of any terms of the Lease, or if in the sole opinion of Lessor there has been a deterioration in the credit worthiness of Lessee, Lessor may, at its sole option, pursue one of the following alternatives: (a) Lessor may commence the Lease

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MEMBER FDIC
Phone 800-496-4640 • Fax 949-255-0501 • www.CalFirst.com

(using the Funding Cut-Off Date or the date Lessor determines that there is a deterioration in the credit worthiness of Lessee, as the Authorization Date) based on the portion of the Property which has been certified by Lessee to be installed, tested and ready for use and paid for by Lessor, and demand that Lessee pay to Lessor an amount equal to that which Lessor has paid to supplier(s) on behalf of Lessee for items of Property not yet installed, tested and ready for use, plus all pro-rata rental fees, taxes, late fees, and other charges which are due and owing; (b) Lessor may, at its sole and absolute discretion, extend the allowed Installation Period and establish a new Funding Cut-Off Date; or (c) Lessor may demand that Lessee pay to Lessor a total amount equal to that which Lessor has paid to supplier(s) on behalf of Lessee, plus all pro-rata rental fees, taxes, late fees, and other charges which are due and owing under the terms of the above-referenced Lease. Should such a demand be made by Lessor, Lessee hereby unconditionally agrees to reimburse said funds to Lessor in full within ten business days of said demand, and Lessor, upon receipt of such payment in full, shall release Lessee from further payment obligations under the Lease. If Lessee fails to fully reimburse said funds to Lessor within ten business days of such demand, in addition to any other amounts that are due and owing, or become due and owing, to Lessor pursuant to the Lease (including this Letter Agreement), pro-rata rental fees and late fees shall continue to accrue and be due and owing to Lessor up to the date upon which Lessor receives full reimbursement of the amount required by (c), above. Lessee shall provide Lessor with updated financial information as periodically requested by Lessor. Irrespective of this Letter Agreement, all other terms and conditions including, without limitation, all payment obligations by Lessee under the Lease shall remain absolute and unconditional without regard in any manner whatsoever to the pro-rata rental obligations and/or pro-rata rental period set forth herein. The pro-rata rentals under this Letter Agreement do not apply to, or offset rentals due from the Authorization Date forward, as defined in the Agreement. The certification in writing to Lessor that all items of Property have been received and accepted by Lessee as installed, tested and ready for use is not a pre-condition to Lessee's performance of any of its obligations under the Lease, including all rental and other payment obligations.

The Lease is hereby duly amended to incorporate the foregoing revisions. Please acknowledge your acceptance of the same by your authorized signature below and return the original of this Letter Agreement to Lessor within five days of the date hereof, retaining the enclosed copy for your records.

LESSEE:	
Northern Inyo County Local Hospital District	**California First National Bank**
BY: _____	BY: _____
NAME: John Halfen	NAME: Irene Tanihara
TITLE: CEO/CFO	TITLE: Vice President & Group Manager
DATE: _____	DATE: _____

Casualty Schedule attached to and made a part of Lease Schedule No. 01 which is part of Lease Agreement Order No. ML-00240 dated _____ by and between Northern Inyo County Local Hospital District, as Lessee and California First National Bank ("Lessor")

Casualty Occurrence through the end of each month of the term, or if extended, the extension term.

MONTH	STIPULATED VALUE (% OF ORIGINAL PURCHASE PRICE)	MONTH	STIPULATED VALUE (% OF ORIGINAL PURCHASE PRICE)
1	110	32	64
2	105	33	62
3	105	34	59
4	102	35	56
5	102	36	54
6	102	37	52
7	102	38	50
8	102	39	48
9	102	40	46
10	101	41	44
11	101	42	42
12	101	43	40
13	100	44	38
14	100	45	36
15	100	46	34
16	98	47	32
17	96	48	30
18	94	49	28
19	92	50	26
20	90	51	24
21	87	52	22
22	84	53	19
23	82	54	17
24	80	55	15
25	78	56	13
26	76	57	11
27	74	58	10
28	72	59	10
29	70	60	10
30	68		
31	66		

Lessor and Lessee acknowledge and agree that, in the event of a Casualty Occurrence, Lessor's damages would be difficult to determine and, therefore, the above Stipulated Values represent the parties' reasonable and considered attempt to approximate such Casualty Occurrence damages.

Lessee:
Northern Inyo County Local Hospital District

By: _____

Name: John Halfen

Title: CEO/CFO

Date: _____

Lessor:
California First National Bank

By: _____

Name: Irene Tanihara

Title: Vice President & Group Manager

Date: _____

CALIFORNIA FIRST NATIONAL BANK
INSURANCE REQUIREMENTS

RE: **Northern Inyo County Local Hospital District**
Lease Agreement Order No. ML-00240, Lease Schedule No. 01

The above referenced Lease Agreement specifies that Northern Inyo County Local Hospital District ("Lessee") is required to secure insurance coverage for all items of Property. Said coverage shall include public liability, property damage liability, theft, fire, vandalism, malicious mischief, and all other risks. If applicable, please also include automobile liability and comprehensive and collision coverage. If Lessee fails to obtain such coverage, California First National Bank may place coverage at the Lessee's expense. A 30-day notice of cancellation is also a minimum requirement. California First National Bank is, however, not obligated to acquire such insurance, and any loss incurred during the period of non-coverage shall be borne by the Lessee.

LESSEE INSURANCE INFORMATION
(To be completed by Lessee)

Agent's Name: _____ Insurance Company: _____

Agent's Address: _____ Policy No.: _____

_____ Expiration Date: _____

Agent's Phone No: _____ Amt. of Coverage: _____

Agent's Fax No: _____

PLEASE ISSUE A CERTIFICATE OF INSURANCE TO:

California First National Bank
18201 Von Karman Avenue, 8th Floor
Irvine, CA 92612
Attn: Amber Arambul

CERTIFICATE CONTENTS: Must reference all risk coverage. The Property description must be referenced on the Insurance Certificate, as well as the Lease Agreement Order Number. California First National Bank is to be named as ***ADDITIONAL INSURED*** and ***LOSS PAYEE.***

Lessee hereby confirms that the above referenced policy information is true and correct. If the above referenced policy is not in compliance with the requirements of the Lease Agreement, Lessee authorizes California First National Bank to order said coverage (at Lessee's expense) from the above referenced agent.

LESSEE: **Northern Inyo County Local Hospital District**

BY: _____

NAME: John Halfen

TITLE: CEO/CFO

DATE: _____

FINANCIAL STATEMENT
CORPORATION, PARTNERSHIP, OR INDIVIDUAL PROPRIETORSHIP

NAME: Northern Inyo County Local Hospital District

BUSINESS: _____

ADDRESS: 150 Pioneer Lane

STATEMENT DATE: As reflected on each statement

CITY & STATE: Bishop, California

To: CALIFORNIA FIRST NATIONAL BANK

The undersigned, on behalf of the above named, for the purpose of procuring and establishing credit from time to time with you and to induce you to permit the undersigned to become indebted to you on leases, notes, endorsements, guarantees, overdrafts or otherwise, agrees to furnish financial statements that are true and correct statements of the financial condition of the undersigned on the date of the financial statement, and agrees to notify you immediately of the extent and character of any material change in said financial condition, and also agrees that if the undersigned, or any endorser or guarantor of any of the obligations of the undersigned, at any time fails in business or becomes insolvent, or commits an act of bankruptcy, or if any deposit account of the undersigned with you, or any other property of the undersigned held by you be attempted to be obtained or held by Writ of Execution, Garnishment Attachment of other legal process, or if any of the representations in the attached statement prove to be untrue, or if the undersigned fails to notify you of any material change as above agreed, then and in such case, at your option , all of obligations of the undersigned to you, or held by you, shall immediately become due and payable, without demand or notice. In such event, any sum or sums of money in your possession belonging or owing to the undersigned or in which the undersigned may have an interest, whether on deposit or otherwise, may be taken by you to apply on such obligation, to the full extent thereof if necessary. The undersigned does further agree that any spaces in the attached statement under "Liabilities" or "Contingent Liabilities", which have been or may be left blank; shall be construed by you the same as though the word "none" were written in each of such spaces. All current and future statements provided by subject entity shall also be construed by you to be a continuing statement of the condition of the undersigned, and a new original statement of all assets and liabilities upon each and every transaction in and by which the undersigned hereafter becomes indebted to you, until the undersigned advises in writing to the contrary.

I solemnly declare and certify that any financial statements and schedules provided to you currently and in the future will give a true and complete account of the condition of this business on the day stated on the statement, and further, I solemnly declare and certify that all copies of Federal Income Tax Returns provided to you currently and in the future are true, accurate, and complete copies of the original documents filed with Internal Revenue Service for the tax year indicated on the tax return.

(Signature) _____ Date: 7-3-13

Typed Name & Title: John Halfen / CEO/CFO

Note: **If you have ever failed in business attach a complete explanation and state basis of settlement with creditors.**

THIS SHEET

INTENTIONALLY

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Communicating Protected Health Information Via Electronic Mail (Email)**	
Scope:	Department: **HOSPITAL WIDE**
Source: Compliance Officer	Effective Date:

PURPOSE: To describe the procedures governing an individual's use of a Northern Inyo Hospital (NIH) electronic mail (email) system. It also defines the steps that must be taken by NIH patients who wish to engage in email with an NIH workforce member.

POLICY: NIH does not permit the email of unencrypted Protected Health Information (PHI).

PROCEDURE:

1. **Communicating PHI via Email**
   Email of unencrypted PHI is not permitted

2. **Communicating PHI via Email Internally**
   Email of PHI will be permitted at NIH if the following safeguards are implemented.

   a. NIH shall use the following safeguards when communicating PHI in or attached to an email message:
      (1) Email communications containing PHI about NIH patients will be transmitted only on NIH email system and **cannot be forwarded to an email account outside NIH.**
      (2) PHI should not be transmitted in the subject line of the email message. This includes the name of the patient or a medical record number.
      (3) If a message or an attachment to the message contains PHI, the subject line of the email message will reflect that the message contains PHI.
      (4) The Email message will include the following confidentiality notice:
      "This electronic message is intended for the use of the named recipient and may contain confidential and/or privileged information. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of the contents of this message is strictly prohibited. If you have received this message in error or are not the named recipient, please notify us immediately by contacting the sender at the electronic mail address noted above with a copy to hipaa.compliance@nih.org and destroy this message".

      Note: This confidentiality notice can be added to the signature block of your email signature if you currently use an automated signature.

      (5) If a document that contains PHI is attached to the message, the User should verify before transmitting the email message that he/she has attached the proper attachment.
      (6) Before transmitting the email message, Users should double-check the message and any attachments to verify that no unintended information is included.
      (7) Users who communicate PHI via email will comply with all other NIH policies and procedures including, but not limited to, the Minimum Necessary Policy.

   b. Any user who is unsure whether an email message or attachment contains PHI should contact his/her supervisor or the HIPAA Privacy Officer before initiating the email communication.

Title: **Communicating Protected Health Information Via Electronic Mail (Email)**	
Scope:	Department: **HOSPITAL WIDE**
Source: Compliance Officer	Effective Date:

3. **Communicating PHI with Patients**
   a. Patients have the right to request that NIH communicate with them via email.
   b. If a patient requests email communications containing their PHI, the individual receiving the request must obtain a completed **Patient Request for Email Communication** form from the patient AND provide the patient with the **Important Information About Provider/Patient Email** form prior to processing the patient's request

      Both forms are available as an attachment to this policy and on the NIH Intranet. The forms are located under Forms>HIPAA.

   c. NIH workforce members reserve the right to deny a patient's request to communicate with him/her via email.
   d. All completed Request for Communications forms will be maintained by the office/department processing the patient's request for a minimum of six (6) years. Approved Requests are valid regardless of the time period as long is maintained or the signed form is scanned into the patient's electronic medical record.
   e. An approved Request for Email Communication will be effective for only the health care provider identified on the Request. The patient must complete a separate Request for each health care provider with whom he/she wants to communicate via email, and must revoke each Request to discontinue email communications.

4. **Communicating PHI via Email Externally**
   a. PHI shall not be sent to email systems located outside of NIH , hereby defined as 'external destinations', unencrypted.
   b. All email that contains PHI sent to external destinations shall be encrypted prior to delivery, in a manner adherent to NIH Information Technology (I.T.) Department requirements. (See "Steps to Encrypt PHI Email" attached to this policy).
   c. All automatic forwarding, redirection, or other automated delivery or pickup of NIH email, to external destinations is explicitly prohibited.

5. **Ownership of Electronic Mail**
   a. The email systems at NIH belong to Northern Inyo Hospital.
   b. NIH reserves the right to override individual passwords and access the email system at any time for valid business purposes such as PHI security investigations.

I have received, read and understand this policy and understand that I will only Communicate PHI via Email as it pertains to my job description at NIH and with prior approval as an NIH workforce member authorized to communicate PHI via email.

_____ _____

Employee Signature Date

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Communicating Protected Health Information Via Electronic Mail (Email)**	
Scope:	Department: **HOSPITAL WIDE**
Source: Compliance Officer	Effective Date:

APPLICABILITY: **NIH WORKFORCE**

RESPONSIBILITY: HIPAA Privacy Officer, Information Security Officer

Committee Approval	**Date**

Responsibility for review and maintenance: HIPAA Privacy Officer, Information Security Officer
Developed: July 2013
Revised:
Reviewed:

Important Information About Patient Email

As a patient at Northern Inyo Hospital, you may request we communicate with you by electronic mail (email). This Fact Sheet will inform you about the risks of communicating with your health care provider or program via email and how Northern Inyo Hospital will use and disclose provider/patient email.

PLEASE READ THIS INFORMATION CAREFULLY

Email communications are two-way communications. However, responses and replies to emails sent to or received by either you or your health care provider may be hours or days apart. This means that there could be a delay in receiving treatment for an acute condition.

If you have an urgent or an emergency situation, you should not rely solely on provider/patient email to request assistance or to describe the urgent or emergency situation. Instead, you should act as though provider/patient email is not available to you – and seek assistance by means consistent with your needs.

Email messages on your computer, your laptop, and/or your phone have inherent privacy risks – especially when your email access is provided through your employer or when access to your email messages is not password protected.

Unencrypted email provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the Post Office.

Email messages may be inadvertently missed. To minimize risk, Northern Inyo Hospital requires you respond appropriately to a test email message before we will allow health information to be communicated via email. You can also help minimize this risk by using only the email address that you are provided at the successful conclusion of the testing period to communicate with your providers.

Email is sent at the touch of a button. Once sent, an email message cannot be recalled or cancelled. Errors in transmission, regardless of the sender's caution, can occur.

In order to forward or to process and respond to your email, individuals at Northern Inyo Hospital other than your health care provider may read your email message. Your email message is not a private communication between you and your treating provider.

Neither you nor the person reading your email can see the facial expressions or gestures or hear the voice of the sender. Emails can be misinterpreted.

At your health care provider's discretion, your email messages and any and all responses to them may become part of your medical record.

Effective Date: April 18, 2013

Patient Request for Email Communications

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Email Address: _____

Communications over the Internet and / or using the email system may not be encrypted and may not be secure. There is no assurance of confidentiality when communicating via email. To request that this provider communicate with you via email you must complete this form and return it to your provider.

Please be advised that:

1. **This request applies only to the healthcare provider that you indicate below. If you would like to request to communicate via email with another health care provider, you must complete a separate request for that office.**
2. Northern Inyo Hospital will not communicate health information that is specially protected under state and federal law (e.g., HIV/AIDS, substance abuse, mental health information) via email. Labs will be only released if a completed "Authorization to Release Lab Results to Patients" is on file.
3. Your request will not be effective until you receive and respond appropriately to a test email message.

Please select the question you want to use (by checking one of the boxes below) for your test email and provide your answer.

- ○ My mother's maiden name: _____
- ○ My middle name: _____
- ○ The street number of my residence: _____

I understand and agree to the following:

- I certify the email address provided on this request is accurate, and that I accept full responsibility for messages sent to or from this address.
- I have received a copy of the IMPORTANT INFORMATION ABOUT PATIENT EMAIL form, and I have read and understand it.
- I understand and acknowledge that communications over the Internet and/or using the email system may not be encrypted and may not be secure; that there is no assurance of confidentiality of information when communicated this way.
- I understand that all email communications in which I engage may be forwarded to other providers for purposes of providing treatment to me.

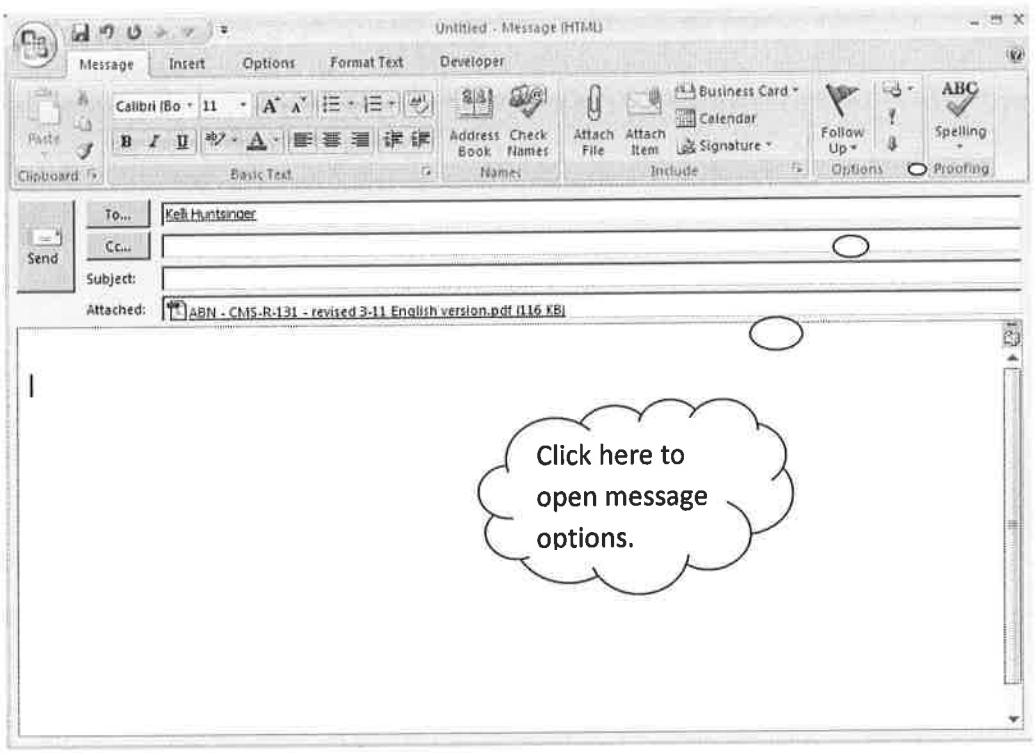
_____ _____

Signature of patient or personal representative Date

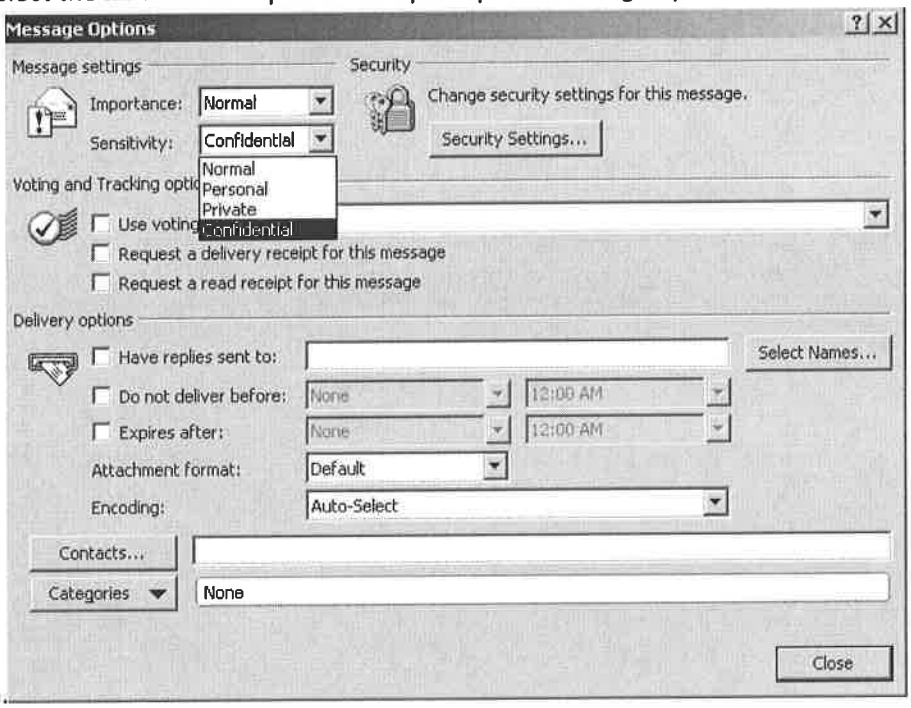
_____ _____

If personal representative, authority to act on behalf of patient Name of Physician

To send an encrypted email, enter the person you are emailing the records to and attach the documents to the email.



Next select the next to "Options" to open up the message options



screen.

Click on the sensitivity tab and select confidential. This will encrypt your email. Close the Message Options box and send email.

NORTHERN INYO HOSPITAL
MEDICAL RECORDS
POLICY AND PROCEDURE

Title: **Minimum Necessary Access, Use and Disclosure of Protected Health Information (PHI)**	
Scope:	Department: **Medical Records**
Source: Medical Records Director	Effective Date:

PURPOSE: To provide guidance with the identification of the Northern Inyo Hospital (NIH) workforce members that need access to PHI to perform their job. Only the information needed to deliver the healthcare service required shall be used for that business service.

POLICY: When using or disclosing Protected Health Information (PHI), or when requesting PHI, Northern Inyo Hospital will make reasonable efforts to limit the PHI used, disclosed, or requested, to the minimum necessary.

PROCEDURES:

1. **When the Minimum Necessary Standard Does Not Apply**
   The use and disclosure of patient PHI minimum necessary standard does not apply in the following circumstances:
   a. The PHI is for use by or a disclosure to a healthcare provider for treatment purposes;
   b. The disclosure is to the patient or the patient's legally authorized representative;
   c. The disclosure is pursuant to a valid authorization, in which case, the disclosure will be limited to the PHI specified on the authorization;
   d. The disclosure is to the California Department of Public Health; or
   e. The disclosure is required by law. (See "HIPAA/Disclosures of Protected Health Information Required by Law" policy)

2. **Accessibility by Workforce Members to PHI**
   Each Department is responsible for identifying those individuals in the Department who need access to PHI in order to carry out their duties and the PHI or types of PHI to which access is needed.
   a. Each Department is responsible for identifying any conditions that would have an impact on a workforce members' ability to access and/or disclose the PHI is authorized to access.
   b. Each Department is responsible for making reasonable efforts to limit the access to PHI that is necessary to carry out the job duties, functions and/or responsibilities.
   c. Questions about PHI and its access by workforce members of NIH should be directed to the HIPAA Privacy Officer.

3. **Requests for PHI**
   Each Department is responsible for reviewing *requests for PHI from internal and/or external sources* to determine whether the request is one to which the Minimum Necessary Standard applies.

a. If the request is made by another health care provider in order to obtain PHI necessary to treat the patient, the Minimum Necessary Standard **does not** apply, and the PHI that is requested will be released as quickly as possible.
b. If the request is not made for purposes of providing treatment to the patient, but it is also a type of request to which the Minimum Necessary Standard does not apply, the Department will release the PHI in accordance with the policies of NIH.
c. If the request is not made for purposes of providing treatment to the patient, and it is a type of request to which the Minimum Necessary Standard applies, the Department will:
    i. Evaluate to determine that the request includes a statement of purpose and release only the minimum amount of information necessary to meet the purpose of the request; or
    ii. If the request does not include a statement of purpose, contact the requestor to obtain the purpose for the request, document the contact, and take appropriate action.

d. If the request for PHI is one that occurs on a routine or recurring basis, the Department is responsible for reviewing the request to determine if the Minimum Necessary Standard applies. Routine or recurring requests should be reviewed to determine whether the Minimum Necessary Standard applies only the first time received and after each time the request is modified.

e. Northern Inyo Hospital will request only the minimum amount of PHI necessary to accomplish the purpose for which the request is made.
    i. Any questions about how to limit a request for PHI to request for only the minimum amount necessary should be directed to the HIPAA Privacy Officer.
    ii. The HIPAA Privacy Officer is responsible for conducting audits on an "as needed" basis to confirm NIH is in compliance with the Minimum Necessary Policy.

f. Northern Inyo Hospital will rely on requests for PHI as requesting only that PHI that is minimally necessary to meet the purpose o the request if:
    i. The request is from a public official and the public official represents that the information requested is the minimum necessary for the state purpose(s); or
    ii. The information is requested by another covered entity (health care provider, health care clearinghouse, or health plan); or

iii. The information is requested by an employee or a business associate of NIH and the individual represents that the information requested is the minimum necessary for the state purpose(s).

4. **Responses to Requests for PHI**
   If a request for PHI is reviewed to determine whether the Minimum Necessary Standard applies to it, but it is then forwarded to another workforce member at NIH for processing, the individual forwarding the request is responsible for advising the individual who will respond to the request whether the Minimum Necessary Standard applies.
   a. The person who responds to a request for PHI to which the Minimum Necessary Standard applies is responsible to determine that the PHI disclosed is limited to the minimum amount of information necessary to meet the stated purpose of the request.

Committee Approval	**Date**

Responsibility for review and maintenance: Departments, HIPAA Privacy Officer
Developed: July 2013
Revised:
Reviewed:

NORTHERN INYO HOSPITAL
MEDICAL RECORDS
POLICY AND PROCEDURE

Title: **Using and Disclosing Protected Health Information for Treatment, Payment and Health Care Operations**	
Scope:	Department: **Medical Records**
Source: Medical Records Director	Effective Date:

PURPOSE: To describe how Northern Inyo Hospital (NIH) will protect the privacy of its patient's Protected Health Information (PHI) while allowing workforce members to use and disclose PHI for treatment, payment, or health care operations.

POLICY: In accordance with city, state, and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Northern Inyo Hospital (NIH) will protect patient records and other information that may reveal a patient's identity when using or disclosing such information for purposes of treatment, payment, or health care operations.

PROCEDURES:

1. **Protecting the privacy and confidentiality of patients' PHI**
    a. In accordance with city, state, and federal laws and regulations, including HIPAA, Northern Inyo Hospital will:
        i. Appropriately use, manage, control, disclose, and release PHI; and
        ii. Comply with the terms of the requirement of the Notice of Privacy Practices.

    b. Employees are provided with HIPAA privacy training at employment that provides detailed information required to protect a patient's right to privacy.

    c. NIH will provide training for its workforce members on how to use, manage, control, disclose and release patients' PHI.

    d. Workforce members and affiliates of NIH will continue to comply with existing city, state, and federal laws and regulations that govern confidentiality of patient PHI, including certain specially protected categories of PHI such as HIV/AIDS information, substance abuse and treatment records, and mental health records.

2. **Using and disclosing PHI**
    NIH will use and disclose a patient's PHI in accordance with city, state, and federal laws and regulations, including HIPAA, and primarily for purposes of:
    Treatment:
        a. NIH may use a patient's PHI to provide him/her with treatment or services.

b. A patient's PHI may be shared by different Departments of NIH as long as each Department sharing the PHI is providing or has, in the past, provided services and treatment.
c. NIH may disclose a patient's PHI to its physicians, other health care professionals, and other NIH personnel who are involved in the patient's care.
d. NIH may disclose a patient's PHI to people outside NIH who are involved in the patient's care.

Payment:

a. NIH may use and disclose a patient's PHI to bill and collect for the treatment and services provided to the patient.
b. NIH may disclose a patient's PHI to the patient's health plan to obtain prior approval for treatment and/or to determine whether the patient's plan will cover the treatment.
c. NIH may disclose a patient's PHI to other health care providers to facilitate the other health care providers' billing and collection efforts and as permitted by law.

Health Care Operations:

a. NIH may use and disclose a patient's PHI for purposes of its own operations.
b. NIH may combine PHI about many patients to decide what additional services should be offered, what services are not needed and whether certain new treatments are effective.
c. NIH may combine the PHI in its possession with PHI from other health care providers in order to compare its performance with other like providers and to make improvements in the care and services offered.
d. NIH may disclose a patients PHI to its physicians, other health care professionals, and other NIH personnel for educational purposes.
e. NIH may disclose a patient's PHI to other health care organizations by law.

3. **Questions**
Questions about using or disclosing PHO or about the Notice of Privacy Practices should be directed to the workforce members' supervisor or the HIPAA Privacy Officer.

NORTHERN INYO HOSPITAL
MEDICAL RECORDS
POLICY AND PROCEDURE

Title: **Using and Disclosing Protected Health Information for Treatment, Payment and Health Care Operations**	
Scope:	Department: **Medical Records**
Source: Medical Records Director	Effective Date:

Committee Approval	**Date**

Responsibility for review and maintenance: Departments, HIPAA Privacy Officer
Developed: July 2013
Revised:
Reviewed:

NORTHERN INYO HOSPITAL
MEDICAL RECORDS
POLICY AND PROCEDURE

Title: **Disclosures of Protected Health Information Over The Telephone**	
Scope:	Department: **Medical Records**
Source: Medical Records Director	Effective Date:

PURPOSE: In certain instances, using the telephone to communicate with a patient or to respond to requests for a patient's PHI is necessary or more convenient for the patient than communicating via mail or requiring the patient come to Northern Inyo Hospital (NIH) in person. However, the individual's identity cannot be verified with absolute certainty if communications are conducted solely via the telephone.

POLICY: Describes the procedures to confirm the identity of the individual to whom they disclose PHI to over the telephone to limit the possibility of unauthorized disclosures.

PROCEDURES:

1. **Workforce Members Should Attempt to Limit, to the Extent Practicable, PHI Communicated Over the Telephone**
2. **Requests From or Disclosures to a Caller Stating He/She Is a Patient**
   If a caller states he/she is a patient and he/she is requesting PHI about himself/herself, the workforce member will provide the PHI when they have confirmed the caller is the patient.
   a. The workforce member will, prior to disclosing PHI, ask specific questions that could only be answered by the patient. For example, the patient's date of birth, address, father's name, or mother's name.
   b. If the workforce member knows the patient and the patient's voice, and recognizes the voice on the telephone as being that of the patient, the verification is not required.
   c. The workforce member may elect to place a return call to the patient using the telephone number documented in the patient's record rather than immediately disclosing the patient's PHI to a caller initiating the telephone conversation.

3. **Request From or Disclosures to a Caller Who Is Not the Patient**
   If the caller states he/she is an immediate family member (i.e. father, mother, child, or sibling) of the patient, the workforce member will refer to the patient's record for documentation to determine what information may be provided to this individual.
   a. If the caller states he/she is a friend, relative, or acquaintance of the patient or if the caller is unrelated to the patient (i.e. the patient's employer, law enforcement, a reporter etc.) the workforce member will:
      i. Not disclose PHI without the patient's permission; or
      ii. Provide only directory information about the patient. Directory information is defined as:
         1. The patient's name

Title: **Disclosures of Protected Health Information Over The Telephone**	
Scope:	Department: **Medical Records**
Source: Medical Records Director	Effective Date:

2. The patient's location
3. The patient's condition described in general terms that do not communicate specific PHI about the patient (i.e., "good", "stable", "critical", etc)

4. **Calls to a Patient's Home**
   Workforce members may not leave messages regarding treatments, diagnostic or testing information on a patient's answering machine. Individuals leaving appointment reminders may only provide the name of the provider, the office phone number or the location.

5. **Documenting Disclosures Made Over the Telephone**
   If PHI is disclosed to a caller, the workforce member will document the disclosure: the disclosure should be documented in the medical record.

6. **Questions**
   Questions about disclosure of a patient's PHI over the telephone should be directed to the workforce members' supervisor or the HIPAA Privacy Officer.

Committee Approval	**Date**

Responsibility for review and maintenance: Departments, HIPAA Privacy Officer
Developed: July 2013
Revised:
Reviewed:

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STATEMENTS REGARDING PHOTOGRAPHY INCLUDED IN THE COA (CONDITIONS OF ADMISSIONS):

PHOTOGRAPHY OF PATIENT: It is understood and agreed that hospital personnel, or persons contracted by the hospital, may photograph the patient, or the patient's newborn for identification, diagnosis, or treatment of medical or surgical conditions, education and training, or security purposes.

PHOTOGRAPHY BY VISITORS AND PATIENTS: In order to protect confidential patient information and the rights of privacy of hospital staff, patient and visitor use of recording devices such as cameras (including cell phone cameras), video recorders, audio recorders or any other type of equipment used to capture or record images and/or sound is prohibited on the Northern Inyo Hospital premises with the exception of the labor, delivery and obstetrics area. (See below)

Labor, Delivery & Obstetrics: It is the policy of Northern Inyo Hospital's Obstetrics Department to provide family-centered care, recognizing the desire of parents to celebrate and share the birth process while aligning with the concepts outlined in the Northern Inyo Hospital photography policy. Our policy during labor and delivery is as follows:

- Family photography is only permitted in the Labor/Delivery Rooms (not in hallways, to protect the privacy of others)
- Photography and videotaping of medical and surgical procedures is not allowed
- Videotaping of the birth is not allowed
- After delivery and stabilization of the newborn is complete, photographs/videotaping of the newborn may be taken by family members, with the consent of the mother. Staff must affirm that stabilization is complete prior to photography/videotaping of the newborn by family members
- After delivery and stabilization is complete, photographs/videotaping may be taken of the mother by family members, with consent of the mother. Staff must affirm that delivery care has been completed prior to photography/videotaping of the mother by family members
- Photography/videotaping of hospital staff is not allowed without permission

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NORTHERN INYO HOSPITAL UXILIARY
YEAR END REPORT
JUNE 2012 TO MAY 2013

RECEIPTS	
Gifts	$8,152.25
Snacks	1,884.20
Membership Dues	537.04
Fines	26.15
Uniforms	33.20
Boutique Tickets	5,041.00
Boutique Sales	4,739.65
Albright Vending	528.75
Devon's Flowers Commission	100.00
Stamps (resale)	225.65
Art Donation	56.25
Money From Safe Deposit Box	40.00
Yard Sale	700.05
State Tax Refund	10.00
Christmas Lunch	480.00
Boutique Start Up Money	160.00
Hall Sale	955.20
50/50	2,590.00
Mother's Day Lunch	1,460.00
ABUS Donation	500.00
Silent Auction	733.20
Bank Interest	18.63
TOTAL RECEIPTS	$28,971.22

JUNE 2012 TO MAY 2013

BANK BALANCES AS OF MAY 31, 2013	
EL DORADO CHECKING ACCOUNT	$10,518.65
EL DORADO SAVINGS ACCOUNT	6,344.56
CHASE C.D.	32,662.13
BALANCE ON ACCOUNT	$49,525.34

Submitted by Sharon Moore Treasurer

DISBURSEMENTS

Gift Vendors	$4,043.56
Snacks	1,199.17
Workshop Supplies	327.78
Gift Shop Supplies	330.38
Postage Newsletter	275.70
Postage Correspondence	36.80
Postage Treasurer	12.90
Postage Resale (gift shop)	272.00
Postage (mailing boutique tickets)	19.50
Boutique Tickets (printing of)	271.53
Boutique Expenses (including $1500.prize money)	1,720.32
Boutique start up money	160.00
Church Hall (for Boutique)	250.00
Membership Pins	46.35
John Cocherell CPA	626.75
Board of Equalization (sales taxes)	1,000.78
Franchise Tax Board	10.00
Historian	26.82
Installation Lunch	22.45
Treasurer Supplies	35.01
Treasurer checks	52.94
Charitable Trust Registry	25.00
Newsletter Supplies	192.18
Christmas Lunch	630.67
Flowers	24.00
Yard Sale (ad paper)	13.00
NIHA (Ultrasound equipment, emergency room)	20,000.00
Hospital Equipment (ABUS Machine)	40,000.00
50/50 (including $1295.00 prize money)	1,324.67
TOTAL DISBURSEMENTS	$72,950.26

JUNE 2012 TO MAY 2013

SUBMITTED BY SHARON MOORE TREASURER

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SUMMARY SHEET
For
DOCUMENT SIGNATURE

Today's Date: July 5, 2013

Date Needed by: when possible, hopefully not later than 6/30/14

Who is Requesting: Rick Johnson as Health Officer

Who needs to sign: Gary Myers, John Halfen, Lee Barron

Title of Document: "Eastern Sierra Hospital Mutual Aid Network" MOU

Brief Description of Document: All 3 hospitals in the Eastern Sierra are recipients of funds through our Hospital Preparedness Program grants from the federal government. As part of the grants, a Healthcare Coalition is a requirement, which includes hospitals as well as other healthcare system providers. As demonstration of participation in the coalition, the federal government wants MOU's between coalition members, not only addressing intent to participate, but outlining the operational areas which would be involved in responding to an emergency/disaster.

This proposed document outlines the voluntary (not legally binding) intent to provide mutual aid when an emergency/disaster exceeds the response capability of a given facility. The terms are only activated when there is a federal, state, or local declaration of an emergency or health emergency by the government officials with authority to do so. Locally, that is the Board of Supervisors, the County Sheriff, or the Health Officer.

There are 5 sections:

- Organizational Structure and Communications – outlines how the hospital will organize itself in order to integrate seamlessly with government response structures, consistent with the Hospital Incident Command System (HICS).
- Patient Movement, Distribution, and Evacuation – outlines operational aspects of the movement of patients from one facility to another, both for assisting and accepting facilities
- Equipment and Supplies – outlines principles of sharing of "stuff"
- Personnel – outlines principles of the sharing of staff
- Financial and Legal – outlines the legal and financial aspects of mutual aid

This document was created by me, after review of numerous other documents from other California counties, Washoe County Health District, Preparedness and Catastrophic Event Response (PACER) consortium out of the Johns Hopkins Center for Law and the Public's Health, National Association of City and County Health Officials (NACCHO) Advanced Practice Center (APC), Disaster Medicine and Public health Preparedness, Vol. 5, #1, 2011.

Proposed Language (4/24/13) for:

"EASTERN SIERRA HOSPITAL MUTUAL AID NETWORK"

("EASTERN SIERRA H-MAN")

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding (MOU) is made and entered into as of this ___ day of ____ in the year _____, by and between Mammoth Hospital (MH), Northern Inyo Hospital (NIH), and Southern Inyo Hospital (SIH).

Each of these hospitals is a party to this MOU and collectively they constitute the "Eastern Sierra Hospital Mutual Aid Network" (Eastern Sierra H-MAN) for the purposes of this MOU.

This Eastern Sierra H-MAN MOU is a voluntary agreement among said hospitals for the purpose of providing medical mutual aid at the time of a declared emergency.

This MOU is not and shall not be construed as a legally binding contract, but rather signifies the belief and commitment of the undersigned hospitals that in the event of an emergency, regardless of cause, which exceeds the effective response capability of a hospital(s), the medical needs of the community will be best met if the undersigned hospitals make their "best effort" to collaborate, to coordinate their response efforts, and to provide mutual aid through the procedures set forth herein, in order to optimize the utilization of available resources.

Nothing in this MOU is intended to create any relationship among the hospitals other than that of independent entities agreeing with each other solely for the purposes set forth in this MOU.

This document addresses the relationships between and among hospitals and is intended to augment, not replace, each facility's disaster plan. The MOU also provides the framework for hospitals to coordinate their actions with other primary members of the Mono County and Inyo County Healthcare Coalitions (MCHCC and ICHCC), to include the Inyo and Mono County Medical and Health Operational Area Coordinator (MHOAC) Programs, the appropriate jurisdictional emergency management personnel and structure, and the Inland Counties Emergency Medical Agency (ICEMA), during planning and response.

An emergency declaration (e.g., federal, state, or local declaration of an emergency or health emergency by the government officials with authority to so declare – President, Governor, Board of Supervisors, County Sheriff, local Health Officer) activates the terms of this MOU. The MOU does not govern the exchange of resources among the parties in non-emergency situations, but may be used to guide resource allocations during training exercises as agreed to by the parties.

Each hospital shall have full and absolute discretion to determine the extent, if any, to which it wishes to provide resources to assist another hospital under this MOU. Accordingly, no hospital shall be required to provide medical supplies, equipment, services, personnel, or bed capacity to another hospital, either during an emergency, or at any other time, regardless of available capacity or other conditions at the affected or assisting hospital. For purposes of this MOU, the emergency may be an external or internal event for one or more hospitals, and is

subject to the affected hospital's emergency operations plan being implemented. The terms of this MOU are to be integrated into and coordinated with each hospital's emergency operations plan.

The term of this MOU shall be effective from (Date), through (Date) (5 years?). A hospital may at any time terminate its participation in this MOU by providing sixty (60) days written notice to the Chief Executive Officer (CEO) at each of the other participating hospitals. The term of this MOU shall automatically be renewed for 5 year periods upon the terms and conditions then in effect, unless a party gives the other parties written notice of its intention not to renew, which notice shall be given no less than thirty (30) days prior to the expiration date of the then current term.

All amendments and modifications to this MOU must be formally agreed to in writing by the parties and signed by all the parties.

Disaster management personnel from MH, NIH, SIH, Mono and Inyo MHOAC Programs, and ICEMA shall conduct development of operational procedures, forms, and other tools to operationalize this MOU, which will be included as "Appendices" to the main document. Updates to these procedures, forms, and tools do not require revision of this MOU.

Now, therefore, in order to provide for continuation of care of patients of hospitals within the Eastern Sierra, the parties hereby mutually agree to make a reasonable effort to abide by the following:

Section 1: Organizational Structure and Communications

Section 2: Patient Movement, Distribution, and Evacuation

Section 3: Equipment and Supplies

Section 4: Personnel

Section 5: Financial and Legal

Appendix A: Definitions

Section 1: Organizational Structure and Communications

Parties shall integrate Hospital Incident Command System (HICS) and National Incident Management System (NIMS) principles into their emergency operations plans including NIMS Implementation Activities for Hospital and Healthcare Systems established by the NIMS Integration Center. <http://www.fema.gov/pdf/emergency/nims/imp_hos.pdf>

This shall include:

- Parties shall have established a command hierarchy which facilitates communications between hospitals, government officials, and their communities.
- Parties shall comply to the maximum extent possible with NIMS requirements for healthcare facilities concerning baseline credentialing, certification, training, and education. Party administrators and healthcare workers likely to assume a supervisory or leadership position during a government declared state of emergency shall complete prescribed NIMS compliance courses.
- Parties agree to participate in training and exercises related to all-hazards, including hospital evacuation. This includes exercise planning, execution, hotwash and debriefing, After-Action Reports (AAR), and Improvement Plans (IP).
- Parties agree to actively participate in all debriefings and after action reports and improvement planning following any declared emergency and activation of this MOU.
- Each party agrees to identify a designated representative to meet and communicate with other parties prior to a government-declared state of emergency and to ensure compliance with NIMS requirements. The names and contact information for the designated representatives and alternate(s) will be shared and included in an appendix. These individuals will be responsible for determining the distribution of information within their own internal organization.
- Prior to an event, hospitals will designate persons, positions, and redundant interoperable contact information, to be used by external agencies (e.g., MHOAC, ICEMA, other hospitals) when attempting to establish a communications channel into the facility (e.g., Nurse Supervisor, Registered Nurse on Duty, Administrator on call, etc.) during an emergency. A designated representative must be available to act at all times. This information will be shared only with other parties to this MOU, and updated at least annually and sooner as necessary.
- A communications plan must be designed and established by each party to enable efficient communication during declared emergencies when prevailing modes of communication may be unavailable or compromised. The plan must specify a process for utilizing alternate communication modes (e.g., satellite phone, radio, etc.). Implementation and maintenance of such plans should be regularly tested in periodic exercises with the other parties and partners.

Activation of any elements of this MOU will occur through procedures as outlined in applicable communications plans, such as the Inyo County Intelligence/Information Sharing and Dissemination Plan, the Mono County Health Department Operations Plan (DOP), each county's Emergency Operations Plan, each hospital's emergency operations plan, and the California Public Health and Medical Emergency Operations Plan (EOM).

Hospitals will notify the MHOAC for all unusual occurrences or emergencies (internal or external), as they become aware. Hospitals will provide the MHOAC with the requested information in the Mono or Inyo County Operational Area (OA) Med/Health Situation Report (Sit Rep), which includes HAvBED information (e.g., bed availability, and hospital capacity/status).

During a response, hospitals will coordinate efforts to respond primarily via their liaison officers, public information officers (PIO's), and Hospital Incident Commanders, once they have activated their emergency operations plan and opened a Hospital Command Center (HCC). Redundant interoperable communications systems will be utilized for sharing intelligence and information between HCC's, the MHOAC, and ICEMA.

Hospitals agree to participate in a Joint Information Center (JIC), coordinated by the local emergency management agency (OES, CAO, or designee), during a disaster that will allow their appointed PIO and community relations personnel to communicate with each other and release accurate, consistent, and timely community and media educational/advisory messages to the public and the media. Each hospital should designate a PIO who will be the hospital liaison with the JIC.

The Hospital Incident Commander of the evacuating hospital should already be in contact with the MHOAC when a hospital evacuation decision is made, or as soon as feasible in a level 1 evacuation (see Section 2 for definition of "level 1"). Once a decision to evacuate has been made, the MHOAC should be in contact with the jurisdictional authorities to declare a local emergency.

The MHOAC will:

- perform statutory functions out of the Medical/Health Branch of the Operations Section of the operational area EOC
- notify all other healthcare coalition partners and stakeholders (to include local emergency management (OES, CAO, or designee), ICEMA, Region 6, the California Department of Public Health (CDPH), the California Emergency Medical Services Authority (EMSA), and the California Emergency Management Agency (CalEMA)), of the activation of this MOU, and provide situation reporting both horizontally and vertically to all parties, partners, and stakeholders.
- function as the channel (single source shopping) for all requests for resources (medical, non-medical, equipment, supplies, personnel, subject matter expertise, etc.) from the parties, once normal supply channels have been or are expected to be exhausted or overwhelmed
- enlist the jurisdictional local health department in the assessment of any public health impacts
- be responsible for maintenance and update of all appendices

Parties shall provide mutual assistance as set forth in this MOU to the maximum extent possible. Decisions about providing mutual assistance pursuant to this MOU shall be made by:

- objectively assessing whether and which resources can be feasibly shared and the degree to which patients can be safely transferred or received;

- clearly conveying capacity for mutual assistance to other parties; and
- striving to ensure transparency, honesty, and fairness in all phases of mutual assistance.

After an emergency declaration is made, the affected hospital's designated representative may initially request personnel or resources from the assisting hospital's designated representative verbally, and be followed with written verification within 24 hours if feasible. All requests for resources must be directed to the designated representative who is authorized to agree to provide requested resources. This request must be confirmed in writing within 24 hours, or as soon as possible, and must employ NIMS data-types where possible. Parties shall confirm receipt of verbal or written requests for mutual assistance and provide responses within 24 hours when possible.

The affected hospital shall set forth in the written request to the assisting hospital the following:

- the type and number of requested personnel and resources;
- an estimate of how quickly personnel and resources are needed;
- the location where the personnel should report or the resources should be delivered; and
- an estimate of how long the personnel or resources will be needed.

Parties shall participate in a medical and health Multi-Agency Coordination System (MACS) with the public and private sectors and nongovernmental organizations as requested and appropriate and necessary. The MACS will be facilitated by the Medical/Health Operational Area Coordinator (MHOAC). Hospitals, when requested by the MHOAC, will designate an individual(s) to be part of a Multi-Agency Coordination (MAC) Group, which would serve as an advisory group to the MHOAC when critical decisions need to be made, such as the allocation and prioritization of scarce resources when multiple requests have been made.

Section 2: Patient Movement/Distribution/Evacuation

Definitions:

- Level 1 – Immediate evacuation requires the immediate, prompt departure of patients from a hospital due to life-threatening conditions. Such an evacuation may require the affected hospital to move patients to an external holding area in the parking lot or other outside or sheltered locations before being moved to an assisting hospital. Critical care patients should be moved directly to the assisting hospital. It may not be practical to pull medical records to go with the patients, and medical records may have to follow as soon as possible at a later time.

- Level 2 – An urgent evacuation allows for a quick, but orderly hospital departure. Such an evacuation allows time for patient dispersion from the affected hospital directly to assisting hospitals. It may result from non- life threatening environmental conditions which allows for orderly gathering of transportation and staffing resources before patient are moved out of the affected hospital. Patients may be moved to one or more internal staging areas (e.g., ambulatory versus wheelchair versus gurney) allowing for the staging of appropriate transportation resources in order to expedite patient movement and egress. There should be time to ensure that the patient's records are sent with the patient.

The critical consideration that Level 1 versus Level 2 evacuations affects is the decision regarding which patients to evacuate first. Patients with critical care needs require more time and resources to evacuate. Their place in the evacuation process may change depending on whether the evacuation is urgent or immediate. In an immediate evacuation, the priority will be to get as many patients out as possible, so the first priority might be the easiest to evacuate – ambulatory patients, those with the least equipment and who need the least amount of assistance from staff. In this scenario, patients with special needs would be the last to be evacuated. In an urgent evacuation when there is time to move patients, the critical care patient would be the first to move as there is time to accommodate equipment and patient care considerations.

The parties, through a designated liaison representative, will use the OA Sit Rep to report to the MHOAC the hospital's bed capacity, its capabilities, and its ability to receive patients. The MHOAC will update this information with each hospital at the beginning of each operational period and more frequently as indicated during an evolving event.

If an emergency affects one or more of the hospitals resulting in partial or complete facility evacuation, upon request of the affected hospital(s), the other hospital(s) agree to confer with the MHOAC and the affected hospital(s) to determine the extent to which the hospital(s) are willing to participate in the distribution of patients from the affected hospital(s) to assisting hospitals.

Transfer of patients shall be considered in terms of "resourced beds." The designated representatives of the parties shall monitor the availability and make transfer requests in terms of specific types of resourced beds Classifications of resourced beds, depending on the capacities of the parties, will be identified according to categories in the Healthcare Facility to Op Area Sit Rep.

Parties will use the patient evacuation tracking form provided by the MHOAC.

Parties shall comply with all preexisting government public health surveillance and reporting requirements to the maximum extent possible.

A Field Treatment Site (FTS) (a/k/a casualty collection site), or an Alternate Care Site (ACS) may be required in the event an emergency overwhelms area hospitals' capacity and capabilities. The MHOAC will coordinate administration, staffing, and site operations for Mono and Inyo County. The parties may be asked to contribute volunteer staff to a FTS or an ACS on an urgent basis, subject to availability.

Emergency Departments (EDs) at assisting hospitals will NOT be used as receiving sites for patient transfers. The ED will need to continue to focus on the emergency healthcare needs of the community.

Parties will identify external holding areas close to their location to provide temporary shelter if an immediate evacuation is required (Level 1), and internal staging areas for patients for an urgent evacuation (Level 2).

Non-ambulance transport methods for non-critical patients may be used if needed. It is assumed that the primary modes of non-ambulance transportation will come from vendors that have been pre-identified and listed as resource assets within the jurisdictional Emergency Operations Plan (EOP).

Unless there is a federal declaration, there is no deviation from EMTALA compliance.

Transfer and tracking of patients will be in accordance with HIPAA regulations. The parties recognize the importance of maintaining the privacy of patient identifiable health data to the maximum extent possible consistent with national or regional health information privacy protections without compromising the provision of critical healthcare services during a government-declared state of emergency. Although these protections may be modified or waived during a government-declared state of emergency, parties shall agree on a procedure for securely sharing identifiable health data concerning transferred patients.

Affected hospital:

- The affected hospital's administration or other authority having jurisdiction (e.g., fire department, OSHPD) declares the hospital unsafe and unstable, requiring a full or partial evacuation. Hospital's decision to evacuate should be determined based on pre-developed evacuation criteria.
- The affected hospital carries out measures to decrease patient census (as time allows) including: review all elective surgical procedures, early discharges and discharges of patients to home, or transfer to a skilled nursing facility (SNF).
- Prior to the transfer of patients, the affected facility must have utilized its internal surge plan, capacity, and capability in an attempt to keep patients within its facility in order to minimize disruption of patient care and business continuity.
- The affected hospital must determine that prior to being screened, the patient cannot receive adequate healthcare services at its facility because of circumstances arising from the emergency and that the potential harm to the patient from the transfer does not outweigh the potential harm from staying at the affected hospital due to the state of healthcare services at the affected hospital.
- The affected hospital must seek patient consent to the transfer unless such consent is impossible due to the exigencies of the emergency or the inability of the patient or a surrogate to consent due to legal incapacity, incompetence, or unavailability of the healthcare surrogate.
- The affected hospital must make all reasonable efforts to either directly notify the patient, the patient's healthcare surrogate, or next of kin of the transfer including the time of transfer and the location of the assisting hospital, or share patient lists to enable these persons to locate transferred patients.

- The affected hospital must designate a single person as the Hospital Planning Technical Specialist. This individual will work with the medical and nursing staff and coordinate with the MHOAC to determine the most appropriate destination, staff, equipment, and method of transport. The MHOAC must rely on the medical triage completed by the hospital and utilize hospital personnel to coordinate appropriate treatment, personnel, equipment, and methods of transport.
- The request for transfer of patients by an affected hospital can initially be made verbally to the MHOAC and/or potential assisting hospital(s). The initial verbal request, however, must be followed up with a written communication as soon as possible, which may be facilitated by the MHOAC. The affected hospital, to the extent possible, will identify to the MHOAC and the assisting hospital:
    - The number of patients needing to be transferred
    - The general nature of their illness/injury/condition
    - Any type of specialized services required
    - Patient medications, and/or specialized equipment needed
- The affected hospital will ensure that appropriate transportation to the assisting hospital is provided to ensure patient safety to the maximum extent possible given the exigencies of the emergency. The affected hospital is responsible for arranging transportation of patients from the assisting hospital back to the affected facility when feasible. The affected hospital will pay the transportation cost and seek reimbursement by billing third party payers or the patient.
- The affected hospital will help the assisting hospital in obtaining proper consents for care.
- The affected hospital will send with each patient at the time of transfer (or as soon thereafter as possible) all of the patient's personal effects, and any information relevant thereto. In the event that personal effects cannot be sent with an alert and competent patient, the affected hospital may elect to secure such personal effects until the emergency is over. The affected hospital will remain responsible for such items until receipt thereof is acknowledged by the assisting hospital.
- The affected hospital, to the extent possible in an emergency situation and in accordance with governing state and federal law, is responsible for providing the assisting hospital with:
    - The patient's medical records
    - Insurance information
    - Any other patient information necessary for the care of the patient
    - Patient's medications
    - Any specialized equipment necessary for the care of the patient
- The affected hospital is responsible for tracking the destination of all patients transferred out (patient evacuation tracking sheet) if time allows and during an urgent evacuation is responsible for notification of each patient's physician and family of pending relocation, if time allows.
- If time does not allow for pulling medical records, at a minimum, the affected hospital will ensure that the medication administration record accompanies the patient.
- The affected hospital, whenever possible, sends appropriate physician and/or nursing personnel to accompany patients to the assisting hospital.
- The affected hospital designates appropriate administration, nursing supervisory staff, and pharmacy staff to coordinate care with the assisting hospital.
- The medical/nursing staff/patient ratio during transport will be determined as reasonably safe for care by the affected hospital's designated medical staff and the transportation supervisor/coordinator.
- The affected hospital maintains responsibility for patients until accepted by an assisting hospital.

- Traditional triage tags will not be used. The affected hospital will track patients using the name and hospital number from the patients existing armband and write this information on the Patient Tracking Form. Triage tags will only be used if individuals do not have such an identifying armband.
- The affected hospital assumes responsibility for all costs of transportation of patients to external staging areas or assisting hospitals
- The affected hospital ensures that the vacated premises are secure (e.g., medications, radioactive devices, etc.) and that no one is left behind after the evacuation.
- The affected hospital ensures that appropriate notifications are carried out (e.g., OSHPD, Licensing and Certification, fire department, law enforcement, MHOAC), in coordination and with the assistance of the MHOAC.
- The affected hospital agrees to readmit patients when services are restored at the affected hospital.

Assisting hospitals will:

- carry out measures to decrease patient census including: review all elective surgical procedures, early discharge and discharge of appropriate patient to home, or transfer to a skilled nursing facility (SNF).
- determine ability to accommodate influx of patients, and communicate this status and any changes to the MHOAC.
- make preparation for receiving patients, including calling in additional staff and implementing their emergency credentialing policy.
- obtain additional equipment and supplies needed to provide care.
- maintain communication with the affected hospital (if feasible) and the MHOAC.
- continue patient tracking within its hospital when patients are received. Send the Patient Tracking Form (e.g., Fax) to the MHOAC, and back to the affected hospital if feasible, in order to allow the affected facility to send more medical records (if feasible) and to complete their internal patient tracking process.
- notify families/responsible party and attending physician upon receipt of patients.
- designate the admitting service, the admitting physician for each patient, and, if requested, will provide at least temporary courtesy privileges to the patient's original attending physician per the assisting hospital's policy and procedure. (Emergency privileges for physicians and other healthcare providers will be granted in accordance with any applicable standards of JCAHO, the Licensing and Certification Division (L and C) of the California Department of Public Health (CDPH), and the California Department of Health Care Services (DHCS).
- be responsible for the safety of staff from the affected hospital working within its building, and for the safekeeping and continued operability of medical equipment that is sent from the affected hospital.
- Assume responsibility of evacuated patients when received.
- Notify L and C about their change in status or if they have exceeded licensed bed capacities.
- return all patients and equipment to the hospital of origin unless other arrangements have been made (e.g., the affected hospital is not able to be reoccupied for a long duration of time), upon notification that the affected hospital is able to be reoccupied.
- discharge patients in accordance with its standard procedures.

Section 3: Equipment and Supplies

In the event that needed items (supplies, equipment, pharmaceuticals) are available at one of the undersigned hospitals and lacking at another, the undersigned hospital with available supplies will share supplies to help ensure that patients in the Eastern Sierra area receive necessary treatment during a disaster.

Parties shall use an inventory system to track resources that may be available during a government-declared state of emergency, including any resources stored off premises. The inventory list shall be accessible to the designated representative during a government-declared state of emergency.

To enhance emergency preparedness, parties shall follow the national typing protocol as prescribed by NIMS to describe available resources using category, kind, components, metrics, and type data, when available.

Parties shall acquire equipment that will perform in accordance with minimum standards as prescribed by NIMS so that equipment is interoperable with similar equipment used by other parties in the HMAN and other hospitals.

Requests initially can be made verbally but must be followed up with a written request as soon as practical.

During a disaster, the affected hospital will accept and honor the assisting hospital's standard requisition forms. Documentation should detail the items involved in the transaction, condition of the material prior to the loan or transfer (if applicable), and the party responsible for the material.

The affected hospital will have supervisory control /direction over the borrowed medical supplies, pharmaceuticals, or equipment, once they are delivered to the affected hospital.

Any physical resources may be shared between parties including pharmaceuticals, medical equipment, non-medical equipment, and basic supplies. Parties shall continuously monitor the availability of physical resources for potential transfer during a government-declared state of emergency, and share this information with the MHOAC.

The sharing of equipment and/or supplies will occur in cooperation between the Incident Commanders at the involved hospitals, with the MHOAC functioning in a coordinating role.

In the event of scarcity of resources (e.g., resource need greater than the sum of all available resources, the MHOAC may convene a MAC Group to prioritize the allocation of scarce resources.

The assisting hospital may recall its personnel and resources from an affected hospital through a formal request for recall. Recall requests may be made by the assisting hospital at any time in its discretion. Affected hospitals shall honor the assisting hospital's request for recall at the earliest opportunity possible without significantly and irreversibly harming existing patients, and must immediately begin to arrange for the acquisition of comparable personnel or resources from other parties, agencies, or facilities.

Section 4: Personnel

In the event of a disaster when patient care staff can be made available at one of the undersigned hospitals and are needed at another, the hospital with available staff will share staff to ensure that available hospital beds in the Eastern Sierra are adequately staffed during a disaster.

The sharing of personnel will occur in cooperation between the Incident Commanders at the involved hospitals, with the MHOAC in a coordinating role.

The following personnel may be transferred between parties subject to limitations set forth below:

- Employees: Assisting hospitals may allow or encourage the voluntary transfer of employees to an affected hospital under the terms of this MOU. No employee may be ordered to transfer to an affected hospital if the employee is not willing to be transferred. Each party shall maintain a list of current employees who may be willing to transfer to an affected hospital during an emergency.
- Contractors: Parties may allow the transfer of contractors to an affected hospital. All transferred contractors provide their services to the affected hospital voluntarily. Whenever possible, contractors with a prior or existing relationship with the affected hospital should be transferred first.
- In-State VHPs. Volunteer registration systems across the nation, including California's DHV program, Medical Reserve Corps programs, and hospital-specific registries facilitate rapid deployment of vetted VHPs to meet surge capacity needs in hospitals. Whenever the use and deployment of VHPs through such registries can be accomplished without compromising the provision of healthcare services to patients, parties shall do so before requesting employees or contractors from other parties.
- Inter-state VHPs. Under the Emergency Management Assistance Compact (EMAC), VHPs who hold out-of-state licenses may be deployed during an emergency.

The request for the "transfer" of personnel can initially be made verbally followed by written documentation of the request as soon as practical. Requests will be made in a standardized format. A request and documented response will occur prior to the arrival of personnel at the affected hospital. A hospital is not obligated under this MOU to provide the requested personnel if the hospital does not have the available personnel, or if the personnel are unwilling to provide the services under this MOU. The affected hospital will identify to the assisting hospital the following:

- The type and number of requested personnel
- An estimate of how quickly the request is needed
- The location of where they are to report (including contact person and information)
- an estimate of the duration of time that requested personnel would be needed

The "transferred" personnel will be required to present their identification badge from their employer hospital at the affected hospital's check-in site as designated by the affected hospital's Command Center. The affected hospital will be responsible for the following:

- Providing a contact person at the check-in site to receive the "transferred" personnel
- Providing adequate identification (e.g., "visiting personnel" badge, to the "transferred" personnel
- Provide food, housing, and/or transportation for "transferred" personnel asked to work for extended periods or for multiple shifts. Including the costs for these services

- Within 90 days following receipt of invoice, reimburse the assisting hospital for the actual salaries and benefits of such personnel
- Provide and coordinate any necessary demobilization procedures and post event stress debriefing

The affected hospital will have supervisory direction over the assisting hospital's staff once they are received by the affected hospital. The affected hospital shall clarify the relevant procedures concerning authorization, scope of practice, and supervision for transferred personnel that arrive at the affected hospital pursuant to the terms of this MOU. The requesting hospital shall clarify the prescribing powers of transferred personnel to ensure consistency with California prescription laws.

All facilities will have in place emergency credentialing plans that will permit credentialing of personnel who may wish to volunteer their professional services during an emergency.

The affected hospital will be responsible for providing a mechanism for granting emergency privileges for physicians, and other licensed healthcare providers to provide services at the affected hospital. Joint Commission Standard 1.25 requires the volunteer practitioners must at a minimum present a valid government ID and at least one of the following:

- Current hospital picture ID
- A current license or certification
- Primary source verification
- Identification from a DMAT, MRC, or DHV
- Identification by a current organization member who possesses personal knowledge regarding the practitioner's qualifications

Liability, malpractice, and disability claims, attorneys' fees and other incurred costs are the responsibility of the affected hospital. An extension of liability coverage will be provided by the affected hospital, to the extent permitted by federal law, insofar as the loaned personnel are operating within their scope of practice.

The assisting hospital shall ensure that the records of all transferred healthcare workers comply with requirements applicable to the assisting hospital, including licensure and accreditation requirements for healthcare professionals. To the maximum extent possible, the assisting hospital shall provide the affected hospital with copies of deployed healthcare professionals' credentialing documents to facilitate the granting of emergency staff privileges.

Resident physicians, students, or healthcare workers who are not fully-trained shall only be transferred with the agreement of the affected hospital, which shall closely supervise their activities.

Nothing contained herein is intended to permit practitioners who have not been granted privileges to practice within a particular hospital the right to practice therein without first having obtained clinical privileges from the hospital in accordance with its customary procedures. Each hospital, however, agrees to work cooperatively to ensure the patient care is not unduly interrupted, and will work to coordinate care between their respective medical staffs, or to grant temporary privileges to practitioners pursuant to its standard procedures.

The assisting hospital may recall its personnel and resources from an affected hospital through a formal request for recall. Recall requests may be made by the assisting hospital at any time in its discretion. Affected hospitals shall honor the assisting hospital's request for recall at the earliest opportunity possible

without significantly and irreversibly harming existing patients, and must immediately begin to arrange for the acquisition of comparable personnel or resources from other parties, agencies, or facilities.

Section 5: Financial and Legal

The affected hospital will assume legal responsibility for the professional services of the personnel, supplies, pharmaceuticals, and/or equipment from the assisting hospital during the time the personnel, equipment, pharmaceuticals, and/or supplies are at the affected hospital. The affected hospital will reimburse the assisting hospital, to the extent permitted by federal law, for all of the affected hospital's costs determined by the assisting hospital's regular rate. Costs include all use, breakage, damage, replacement, and return costs of borrowed materials, for personnel injuries that result in disability, loss of salary, and reasonable expenses, and for reasonable costs of defending any liability claims, except where the assisting hospital has not provided preventive maintenance or proper repair of loaned equipment which resulted in patient injury. The assisting hospital shall also be reimbursed for services rendered, including salaries of the transferred personnel at their normal pay rate as if those personnel were being paid by the assisting hospital. Reimbursement shall be for actual costs, but shall not include ancillary expenses, such as administrative costs or loss of revenues. Reimbursement will be made within 90 days following receipt of the invoice.

Hospitals accepting patients assume the legal and financial responsibility for transferred patients upon arrival into their facility. Upon admission, the assisting hospital is responsible for liability claims originating from the time the patient is admitted to the assisting hospital. Reimbursement for care should be negotiated with each hospital's insurer under the conditions for admissions without pre-certification requirements in the events of emergencies.

Parties shall maintain and demonstrate their existing professional liability, property, workers' compensation, or other insurance coverage and affirm their intention to retain such coverage at all times as a party to this MOU.

All reasonable and eligible costs associated with the activation and implementation of provisions of this MOU in a declared emergency will be submitted for consideration and reimbursement through established State and Federal disaster assistance/reimbursement.

The affected hospital shall hold harmless the assisting hospital for acts of negligence or omissions on the part of the assisting hospital in their good faith response for assistance during an emergency. The assisting hospital, however, is responsible for appropriate credentialing of personnel and for the safety and integrity of the equipment and supplies provided for use at the affected hospital.

An emergency declaration changes the legal environment in diverse and numerous ways that may impact the operation of this MOU. An emergency declaration may:

- Suspend laws and regulations applicable to hospitals, including those that regulate the provision of healthcare services by healthcare workers;
- Require hospital compliance with local, state, regional, and national emergency management agency directives and regional response efforts;
- Initiate temporary licensure reciprocity through which healthcare professionals licensed in one jurisdiction are allowed to practice in another jurisdiction, often pursuant to various requirements such as advance volunteer registration or affiliation with an entity that deploys VHPs;
- Provide enhanced liability protections to healthcare workers or VHPs for services that they render in responding to the emergency;
- Extend workers compensation benefits to VHPs who would not otherwise qualify as covered employees;

- Change the applicable standards of care;
- Provide enhanced government emergency and disaster relief funding for ongoing response activities and reimbursement for rendered emergency and disaster services; and
- Provide increased and expedited access to public entitlement programs, including through the waiver of enrollment requirements for Medicaid and Medicare.

Parties shall actively follow directives from federal, state, and local emergency management agencies and accommodate these agencies in their efforts to oversee or direct the use of property or allocate health resources across impacted areas during an emergency.

EMTALA can impact the provision of healthcare services at hospitals, including medical triage, by requiring hospitals to screen and stabilize individuals requesting emergency treatment and prohibiting inappropriate transfer of patients. Under certain circumstances during declared emergencies, federal officials can suspend some of the requirements under EMTALA. If an EMTALA waiver is issued which covers one or more parties to this MOU, such parties shall immediately assess capacity to accept transferred patients and provide additional screening and stabilization services. As well, other parties shall be informed as soon as possible of:

- the inception of the party's disaster protocol and the duration of the waiver's coverage;
- any plans to suspend or modify patient screening and stabilization procedures; and
- intended or expected needs regarding the transfer of existing patients, pursuant to the section on patient movement/distribution/evacuation.

During an emergency, potential liability can be a major concern for hospitals and healthcare workers. While exposure to liability cannot be fully eradicated, it can be significantly minimized through the clear expression of the expectations of the parties. The parties recognize the following principles concerning liability:

- Changing standards of care. Emergency declarations may lead to alterations or changes in the standard of care that healthcare workers are obligated to adhere to in the treatment of patients. These changing standards of care may impact potential claims of liability to the extent that they provide varying expectations of the duties healthcare workers or hospitals owe to patients in the provision of personnel or resources.
- Use of VHPs. Parties may minimize their potential exposure to liability and workers' compensation costs relating to personnel by utilizing registered VHPs. VHPs may be legally protected from liability claims and entitled to governmental coverage for workers' compensation benefits and costs during declared emergencies (subject to specific laws). Use of VHPs may also decrease the need for the transfer of employees and contractors whose acts may not be similarly protected from liability or entitled to workers' compensation coverage via government.
- Employees. An affected hospital may normally be responsible for all liability claims, disability claims, litigation costs, and other foreseeable costs incurred by transferred employees involving third parties except in instances arising from gross, willful, or wanton misconduct of the transferred employee. Transferred employees shall not be principally liable to an affected hospital, including through indemnity actions, for their actions taken in good faith.
- Contractors. The affected hospital also shall be responsible for all liability claims, malpractice claims, disability claims, attorneys' fees and other foreseeable costs incurred by transferred contractors except in instances arising from gross, willful, or wanton misconduct of the transferred contractor. A contractor who agrees to be transferred shall not be contractually liable

for failing to fully discharge the terms of employment at the assisting hospital provided that the assisting hospital agrees in writing to the transfer.

- Assisting hospitals: Vicarious liability. An assisting hospital shall not be held vicariously liable for the actions of transferred employees, contractors, or VHPs, except in instances of gross, willful, or wanton misconduct of the assisting hospital personnel in assuring the credentials of transferees.
- Failure to respond or inadequacies. Parties are not bound to a specific course of action for which the failure to act constitutes an actionable claim for breach of contract or equitable relief, except with respect to the credentialing of transferred personnel. Execution of this MOU shall not result in any liability or responsibility for failure to respond to any request for assistance, inefficiency in answering such a request, or for the inadequacy of equipment or skills of the responding personnel.
- Workers' compensation coverage. Transferred employees and contractors shall be considered "employees" of the affected hospital for the purposes of workers compensation coverage in the event that an injury or death of the employee or contractor occurs in the scope of the work at the affected hospital.

This MOU is in no way meant to affect any of the participating hospitals' rights, privileges, titles, claims, or defenses provided under federal or state law or common law.

The participating entities shall maintain the confidentiality of patient and other records as required by law.

In the event of any conflict between any provisions of this MOU and any applicable law, rule, or regulation, this MOU shall be modified only to the extent necessary to eliminate the conflict and the rest of the MOU shall remain unchanged and in full force and effect.

The laws of the State of California shall govern this MOU.

The provisions of this MOU shall be applied consistent with these and other changing legal norms to the maximum extent possible during emergencies.

This MOU is not intended to provide the basis for post-emergency litigation. However, to the extent that litigation could result from the acts of the parties in carrying out the MOU (e.g., claims related to actual costs of reimbursement), parties agree to submit any actionable claim to arbitration and dispute resolution (or an analogous mechanism) prior to the inception of litigation.

In the event that a portion of this MOU is impossible to fulfill, the parties agree to attempt to comply with the remainder of the MOU to the maximum extent possible. If any party withdraws from the MOU, the remaining parties shall continue to recognize and honor the MOU.

The invalidity of any provision of this MOU shall not affect the validity of the remainder hereof.

This MOU constitutes the entire understanding between the parties respecting the subject matter contained herein and supercedes any and all prior oral or written agreements regarding such subject matter.

This MOU represents the entirety of the agreement of the parties with respect to the subject matter hereof and may not be amended except by written instrument signed by all of the affected parties.

The parties hereto agree that they will not discriminate against any patient affected by this MOU on the basis of race, age, creed, color, sex, national origin, inability to pay or handicap.

While response to a disaster (e.g., facility evacuation) represents a potential deviation from care, hospital personnel are held to the same standard of care as in any other activity of patient care. It is recognized that response to disasters may entail unavoidable interruptions of some aspect of patient care (e.g., giving medication on schedule) that are beyond the control of the hospital staff. The expectation is that hospital personnel will use such reasonably prudent practices as any professional person in their place might be expected to use.

In witness whereof, we have set our hands and seals that date below written.

_____	_____
Signed	Dated
_____	_____
Title	Hospital
_____	_____
Signed	Dated
_____	_____
Title	Hospital
_____	_____
Signed	Dated
_____	_____
Title	Hospital

Appendix A - Definitions

As used in this MOU, these terms shall be defined as follows:

"Affected hospital" means a hospital that has been impacted by an emergency. This would include an evacuating hospital, where a party is no longer able to safely provide acute patient care due to an internal or external emergency situation. It would also include requesting hospitals that request personnel or other resources pursuant to this MOU in order to adequately respond to an emergency causing a medical surge.

"Assisting hospital" means a hospital that is not directly impacted by an emergency. This would include receiving hospitals' that are asked and able to provide acute patient care to patients being transferred from an "affected" evacuating hospital. It also includes hospitals that consider requests and potentially provide personnel or other resources pursuant to this MOU, otherwise called lending hospitals.

"Contractor" means a healthcare professional who provides healthcare services at a hospital, but is not under the direct control of the hospital and exercises independent judgment and discretion.

"Designated representative" means an individual and at least one alternative designee identified by a party as having the authority to issue, receive, and answer requests for resources pursuant to this MOU.

"DOC" means Department Operations Center.

"Emergency" means an emergency, catastrophic event, disaster, public health crisis, or other exigency as defined in the jurisdiction(s) in which the parties are located, such as earthquake, wildfire, fire/explosion, floods, avalanche, hazardous materials events, extended utility outage, structural failure, pandemic influenza, or acts of terrorism.

"Emergency declaration" means the official declaration by an authorized government official of a state of emergency in the jurisdiction in which one or more parties is located.

"Employee" means a healthcare worker at a hospital who is employed to render healthcare services under the direct control of the hospital.

"EOC" means Emergency Operations Center.

"HCC" means Hospital Command Center.

"Healthcare coalition" means a member of the healthcare system involved in patient care at some point along the continuum of care from birth to death, from home to hospice.

"Healthcare services" means the provision of medical treatment, care, advice, or other services, or supplies, related to the health of individuals or human populations.

"Healthcare professional" means an individual licensed under state law to provide healthcare services.

"Healthcare surrogate" means the parent, court-appointed legal guardian, or other individual lawfully authorized to make health care decisions for a minor or individual who lacks the legal capacity to make decisions on his or her own behalf.

"Healthcare worker" means an individual, including a healthcare professional, who provides healthcare services.

"Hospital" means a general acute care facility licensed as such by the Licensing and Certification Program of the California Department of Public Health.

"Hospital Mutual Aid Network (H-MAN)" means the collective group of hospitals that are parties to the MOU.

"ICEMA" means the Inland Counties Emergency Medical Agency, which is the multi-county local emergency medical services agency for Inyo, Mono, and San Bernardino Counties.

"License to practice healthcare service" means the state authorization of an appropriately trained healthcare professional to provide healthcare services that would otherwise be unlawful without the authorization.

"MHOAC" means the Medical-Health Operational Area Coordinator, who functions in a support and coordination role and acts as the single point of contact for situation reporting and resource requesting as the Medical and Health Branch Director under the Operations Section of any Operational Area EOC that is established.

"National Incident Management System (NIMS)" means the federal coordinating program overseen by the Department of Homeland Security (DHS) requiring hospitals to formulate emergency plans including mechanisms to facilitate mutual aid in the event of inter-jurisdictional emergencies.

"Partners" means other individuals, programs, entities, departments, or agencies that support and coordinate with parties to this MOU in responding to emergencies, such as the MHOAC, ICEMA, local emergency management, and the structures they may activate, such as a DOC, EOC, and Unified Command.

"Party" means a hospital that has executed this MOU.

"Prescribing Power" means the authority to dispense prescription drugs for healthcare purposes pursuant to state licenses and institutional privileges.

"Scope of practice" means the extent of the authorization to provide healthcare services granted by a license to practice healthcare services in the state in which the healthcare professional practices. Scope of practice may be further limited by privileging and credentialing requirements imposed by the state or the hospital in which the healthcare professional practices.

"Standard of care" means the degree of prudence and skill that a healthcare professional, healthcare worker, or healthcare entity must provide to a patient based on prevailing circumstances and existing best practices.

"Unified Command" means the structure created by government officials to manage a response to an emergency.

"Volunteer health practitioner (VHP)" means a healthcare worker licensed or registered in one or more states who is not an employee or contractor of a requesting hospital and who voluntarily provides healthcare services at a requesting hospital, irrespective of individual compensation.

"Worker's compensation" means the government administered system for providing benefits to an individual injured or killed in the course of employment, regardless of fault.

THIS SHEET

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NORTHERN INYO HOSPITAL
PRIVATE PRACTICE PHYSICIAN
INCOME GUARANTEE AND PRACTICE MANAGEMENT AGREEMENT
Orthopedic Services

This Agreement is made and entered into on this 1st day of October 2013 by and between Northern Inyo County Local Hospital District ("District") and Rich Meredick, M.D. ("Physician").

RECITALS

A. District, which is organized and exists under the California Local Health Care District Law, *Health & Safety Code section 32000, et seq.,* operates Northern Inyo Hospital ("Hospital"), a critical access hospital serving northern Inyo County, California, including the communities of Bishop and Big Pine.

B. The District Board of Directors has found, by Resolution No. 09-01, that it will be in the best interests of the public health of the aforesaid communities to obtain a licensed physician and surgeon who is a board-certified/specialist in the practice of Orthopedics, to practice in said communities, on the terms and conditions set forth below.

C. Physician is a physician and surgeon, engaged in the private practice of medicine, licensed to practice medicine in the State of California, and a member of the American College of Orthopedic Surgeons. Physician desires to relocate his practice ("Practice") to Bishop, California, and practice Orthopedics in the aforesaid communities.

IN WITNESS WHEREOF, THE PARTIES AGREE AS FOLLOWS:

I.
COVENANTS OF PHYSICIAN

Physician shall locate his Practice to medical offices ("Offices") provided by District at a place to be mutually agreed upon in Bishop, California and shall, for the term of this Agreement, do the following:

1.01. **Services**. Physician shall provide Hospital with the benefit of his direct patient care expertise and experience, and shall render those services necessary to enable Hospital to achieve its goals and objectives for the provision of Orthopedics Services. The scope of services to be performed by Physician is described in Exhibit A attached hereto and incorporated by reference herein. Physician shall provide Hospital with patient medical record documentation of all direct patient care services rendered hereunder; such documentation shall be submitted to Hospital on an ongoing basis, and shall be in the form, and contain the information, requested by the Hospital such that a complete medical record can be assembled and appropriate billing can be completed.

1.02. **Limitation on Use of Space**. No part of any offices provided by the District either by lease or other arrangement shall be used at any time by Physician as anything other than the private practice of Orthopedic medicine unless specifically agreed to, in writing, by the parties.

1.03. **Medical Staff Membership and Service**: Physician shall:

a) Maintain Provisional or Active Medical Staff ("Medical Staff") membership with surgical privileges sufficient to support a full orthopedic practice.

b) Provide on-call coverage to the Hospital's Emergency Services within the scope of privileges granted to him by Hospital and as required by the NIH Medical Staff by-laws.

c) Maintain books, records, documents, and other evidence pertaining to all costs and expenses incurred, and revenue acquired, pursuant to this Agreement to the extent, and in such detail, as will properly reflect all net costs, direct and indirect, of labor, materials, equipment, supplies, services, and other costs and expenses of whatever nature, for which he may claim payment or reimbursement from the District. Physician acknowledges and agrees that any federal office authorized by law shall have access, for the purpose of audit and examination, to any books, documents, papers, and records of Physician which are relevant to this Agreement, at all reasonable times for a period of four (4) years following the termination of this Agreement, during which period Physician shall preserve and maintain said books, documents, papers, and records. Physician further agrees to transfer to the District, upon termination of this Agreement, any books, documents, papers or records which possess long-term [*i.e.,* more than four (4) years] value to the Hospital. Physician shall include a clause providing similar access in any sub-contract he may enter with a value of more than Ten Thousand Dollars ($10,000) or for more than a twelve (12) month period, when said sub-contract is with a related organization.

d) At all times comply with all relevant policies, rules and regulations of the Hospital, subject to California and federal statutes governing the practice of medicine.

e) District expressly agrees that said services might be performed by such other qualified physicians as the Physician may employ or otherwise provide so long as each such physician has received proper training, is properly licensed, has been granted privileges by the Hospital Medical Staff, and has received approval in writing from the Hospital.

f) Provide Emergency Department call as required by the Medical Staff By-laws.

II.
COVENANTS OF THE DISTRICT

2.01. Hospital Services.

a) Space. Hospital shall make the Offices available for the operation of Physician's Practice either through a direct let at no cost to the physician or through and arrangement with a landlord, also at no cost to the physician, other than the fees retained by the hospital (3.05).
b) Equipment. In consultation with Physician, Hospital shall provide all equipment as may be reasonably necessary for the proper operation and conduct of Physician's practice. Hospital shall repair, replace or supplement such equipment and maintain it in good working order.

2.02. General Services. District shall furnish ordinary janitorial services, maintenance services, and utilities, including telephone service, as may be required for the proper operation and conduct of Physician's Practice.

2.03. Supplies. District shall purchase and provide all supplies as may be reasonably required for the proper treatment of Physician's Practice patients. Physician shall inform Hospital of supply needs in a timely manner and shall manage the use of supplies in an efficient manner that promotes quality and cost-effective patient care.

2.04. Personnel. District shall determine the initial number and types of employees and place them in the Practice initially. Physician and Hospital will mutually agree to subsequent staffing requirements. Physician shall not be required to maintain any personnel that he does not feel are appropriate for the practice.

2.05. Business Operations. District shall be responsible for all business operations related to operation of the Practice, including personnel management, billing and payroll functions. Physician will provide the appropriate billing codes, which will be used unless changed by mutual consent of the Physician and Hospital. Hospital will incur and pay all operating expenses of the Practice.

2.06. Hospital Performance. The responsibilities of District under this Article shall be subject to District's discretion and its usual purchasing practices, budget limitations and applicable laws and regulations.

2.07. Practice Hours. The District desires, and Physician agrees, that Physician's Practice shall operate on a full-time basis, maintaining hours of operation in keeping with the full time practice of one Orthopedic surgeon while permitting a surgery schedule sufficient to service the patients of the Practice. Specific shifts will be scheduled according to normal operating procedures of the Practice and will be mutually agreed upon with Physician.

2.08. **Time Off.** Physician will provide:

1. 26 weeks of 24/7 Call,
2. 26 weeks of clinic service,
3. 26 weeks of surgery,
4. 12 weeks of clinic and surgery and needed,
5. 12 weeks off.

[Items 1-3 may be combined].

II.
COMPENSATION

3.01. **Compensation**. During the term of this agreement, District shall guarantee Physician an annual income of $488,436, payable to Physician at the higher of 50% of fees collected for services rendered in Section II or the rate of $18,786 every two (2) weeks, adjusted annually to reflected 50 % of fees collected so that payments will not exceed the minimum guarantee on an annualized basis. All payments shall be made on the same date as the District normally pays its employees.

3.02. **Billing for Professional Services**. Subject to section 2.05 above, Physician assigns to District all claims, demands and rights of Physician to bill and collect for all professional services rendered to Practice patients, for all billings for orthopedic services, for all billings consulting performed or provided by the Physician. Physician acknowledges that Hospital shall be solely responsible for billing and collecting for all professional services provided by Physician to Practice patients at Practice and for all orthopedic services performed at the Hospital, and for managing all Practice receivables and payables, including those related to Medicare and MediCal beneficiaries. Physician shall not bill or collect for any services rendered to Practice patients or Hospital patients, and all Practice receivables and billings shall be the sole and exclusive property of Practice. In particular, any payments made pursuant to a payer agreement (including co-payments made by patients) shall constitute revenue of the Practice. In the event payments are made to Physician pursuant to any payer agreement, Physician shall promptly remit the payments directly to Hospital.

3.03. **Retention**. Hospital will retain 50% of all fees collected from the activities of physician/practice in exchange for the services rendered in II above up to the guarantee amount.

3.04. **Malpractice Insurance.** Physician agrees to secure his own malpractice insurance with limits and coverage's appropriate for the physician to provide services under this agreement. Hospital agrees to reimburse 80% of malpractice premiums paid by Physician.

3.05. **Additional consideration.** Physician will be provided Medical, Dental, and Vision insurance by admittance to the NIH self funded group. Physician will also receive 250,000 in life insurance coverage.

IV.
TERM AND TERMINATION

4.01. **Term**. The term of this Agreement shall be for three (3) years beginning on October 1, 2013 and ending September 30, 2016. The Agreement may be renewed, by written instrument signed by both parties, no later than 120 days before its expiration date.

4.02. **Termination**. Notwithstanding the provisions of section 4.01, this Agreement may be terminated:

a) Immediately by Hospital in its sole discretion if Physician fails to maintain the professional standards described in Article V of this Agreement;

b) Immediately upon closure of the Hospital or Practice;

c) By either party upon written notice to the other party in the event that any federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation at any time while this Agreement is in effect that prohibits, restricts, limits or in any way substantially changes the arrangement contemplated herein or which otherwise significantly affects either party's rights or obligations under this Agreement; provided that in such event, Hospital must give notice to Physician equal to that provided to Hospital by the relevant federal, state or local government or agency. If this Agreement can be amended to the satisfaction of both parties to compensate for any such prohibition, restriction, limitation or change, this clause shall not be interpreted to prevent such amendment; or

d) By either party in the event of a material breach by the other party and, in such event, the non-breaching party shall have the right to terminate this Agreement after providing thirty (30) days' written notice to the breaching party, explaining the breach, unless such breach is cured to the satisfaction of the non-breaching party within the thirty (30) days.

e) By either party with 90 notice.

4.03. **Rights Upon Termination**. Upon any termination or expiration of this Agreement, all rights and obligations of the parties shall cease except those rights and obligations that have accrued or expressly survive termination.

4.04. **Accounts Receivable.** Physician shall have no claim to the accounts receivable.

4.05 **Professional Services Rendered Outside the District.** Any professional services provided outside the District by physician must be agreed to in advance, in writing, by the District. Hospital may not require Physician to work outside the District.

V.
PROFESSIONAL STANDARDS

5.01. **Medical Staff Membership.** It is a condition of this Agreement that Physician maintain Provisional or Active Medical Staff membership on the Hospital Medical Staff with appropriate clinical privileges and maintains such membership and privileges throughout the term of this Agreement.

5.02. **Licensure and Standards**. Physician shall:

a) At all times be licensed to practice medicine in the State of California;

b) Comply with all policies, bylaws, rules and regulations of Hospital, Hospital Medical Staff, and Practice, including those related to documenting all advice to patients and proper sign-off of lab and X-ray reports;

c) Be a member in good standing of the Provisional or Active Medical Staff of Hospital;

d) Maintain professional liability coverage in an amount required for membership on the Active Medical Staff of Hospital;

e) Participate in continuing education as necessary to maintain licensure and the current standard of practice; and

f) Comply with all applicable laws, rules and regulations of any and all governmental authorities, and applicable standards and recommendations of the Joint Commission.

g) At all times conduct himself, professionally and publicly, in accordance with the standards of the medical profession, the American College of Orthopedic Surgeons, the Hospital Medical Staff, and the District. Further, he shall not violate any California law which prohibits (1) driving a motor vehicle under the influence of alcohol or prescription drugs or the combined influence of such substances, (2) unlawful use of controlled substances, (3) being intoxicated in a public place in such a condition as to be a danger to himself or others, and/or (4) conduct justifying imposition of an injunction prohibiting harassment of Hospital employees in their workplace. Entry of any injunction, judgment, or order against Physician based upon facts, which constitutes the above offenses, shall be a material breach of this Agreement.

VI.
RELATIONSHIP BETWEEN THE PARTIES

6.01. **Professional Relations**.

a) Independent Contractor. No relationship of employer and employee is created by this Agreement. In the performance of Physician's work and duties, Physician is at all times acting and performing as an independent contractor, practicing the profession of medicine. District shall neither have nor exercise control or direction over the methods by which Physician performs professional services pursuant to this Agreement; provided, however, that Physician agrees that all work performed pursuant to this Agreement shall be in strict

accordance with currently approved methods and practices in Physician's professional specialty and in accordance with the standards set forth in this Agreement.

b) Benefits. Except as specifically set forth in this Agreement, it is understood and agreed that Physician shall have no claims under this Agreement or otherwise against Hospital for social security benefits, worker's compensation benefits, disability benefits, or any other employee benefit of any kind, except as indicated below in 6.01.c. In addition, Hospital shall have no obligation to reimburse Physician for any costs or expenses associated with Physician's compliance with continuing medical education requirements.

6.02. **Responsibility for Own Acts**. Each party will be responsible for its own acts or omissions and all claims, liabilities, injuries, suits, demands and expenses for all kinds which may result or arise out of any malfeasance or neglect, caused or alleged to have been caused by either party, their employees or representatives, in the performance or omission of any act or responsibility of either party under this contract. In the event that a claim is made against both parties, it is the intent of both parties to cooperate in the defense of said claim and to cause their insurers to do likewise. However, both parties shall have the right to take any and all actions they believe necessary to protect their interest.

VII.
GENERAL PROVISIONS

7.01. **No Solicitation**. Physician agrees that he will not, either directly or indirectly, during and after the term of this Agreement, call on, solicit or take away, or attempt to call on, solicit or take away any patients or patient groups with whom Physician dealt or became aware of as a result of Physician's past, present or future affiliation with Hospital and Practice.

7.02. **Access to Records**. To the extent required by Section 1861(v)(i)(I) of the Social Security Act, as amended, and by valid regulation which is directly applicable to that Section, Physician agrees to make available upon valid written request from the Secretary of HHS, the Comptroller General, or any other duly authorized representatives, this Agreement and the books, documents and records of Physician to the extent that such books, documents and records are necessary to certify the nature and extent of Hospital's costs for services provided by Physician.

Physician shall also make available such subcontract and the books, documents, and records of any subcontractor if that subcontractor performs any of the Physician's duties under this Agreement at a cost of $10,000.00 or more over a twelve (12) month period and if that subcontractor is organizationally related to Physician.

Such books, documents, and records shall be preserved and available for four (4) years after the furnishing of services by Physician pursuant to this Agreement. If Physician is requested to disclose books, documents or records pursuant to this subsection for purposes of an audit, Physician shall notify Hospital of the nature and scope of such request, and Physician shall make available, upon written request of Hospital, all such books, documents or records. Physician shall indemnify and hold harmless Hospital in the event that any amount of

reimbursement is denied or disallowed because of the failure of Physician or any subcontractor to comply with its obligations to maintain and make available books, documents, or records pursuant to this subsection. Such indemnity shall include, but not be limited to the amount of reimbursement denied, plus any interest, penalties and legal costs.

This section is intended to assure compliance with Section 1861 of the Social Security Act, as amended, and regulations directly pertinent to that Act. The obligations of Physician under this section are strictly limited to compliance with those provisions, and shall be given effect only to the extent necessary to insure compliance with those provisions. In the event that the requirements or those provisions are reduced or eliminated, the obligations of the parties under this section shall likewise be reduced or eliminated.

7.03. **Amendment.** This Agreement may be amended at any time by mutual agreement of the parties, but any such amendment must be in writing, dated, and signed by both parties.

7.04. **No Referral Fees**. No payment or other consideration shall be made under this Agreement for the referral of patients, by Physician, to Hospital or to any nonprofit corporation affiliated with District.

7.05. **Repayment of Inducement**. The parties stipulate and agree that the income guaranteed to Physician under this Agreement, and the covenants of the District to provide office space, personal, equipment, and certain other benefits, are the minimum required to enable Physician to relocate herself to Bishop, California; that he is not able to repay such inducement, and no such repayment shall be required.

7.06. **Assignment**. Physician shall not assign, sell, transfer or delegate any of the Physician's rights or duties, including by hiring or otherwise retaining additional physicians to perform services pursuant to this Agreement, without the prior written consent of Hospital.

7.07. **Attorneys' Fees**. If any legal action or other proceeding is commenced, by either party, to enforce rights, duties, and/or responsibilities under this Agreement, the prevailing party shall be entitled to recover reasonable attorney's fees and costs.

7.08. **Choice of Law**. This Agreement shall be construed in accordance with, and governed by, the laws of the State of California.

7.09. **Exhibits**. All Exhibits attached and referred to herein are fully incorporated by this reference.

7.10. **Notices**. All notices or other communications under this Agreement shall be sent to the parties at the addresses set forth below:

Hospital: Administrator
Northern Inyo Hospital
150 Pioneer Lane
Bishop, CA 93514

Physician: Rich Meredick, M.D.
152 Pioneer Lane, Suite A
Bishop, CA 93514

Notice may be given either personally or by first-class mail, postage prepaid, addressed to the party designated above at the address designated above, or an address subsequently specified in writing by the relevant party. If given by mail, notice shall be deemed given two (2) days after the date of the postmark on the envelope containing such notice.

7.11. **Records**. All files, charts and records, medical or otherwise, generated by Physician in connection with services furnished during the term of this Agreement are the property of Practice. Physician agrees to maintain medical records according to Practice policies and procedures and in accordance with community standards. Each party agrees to maintain the confidentiality of all records and materials in accordance with all applicable state and federal laws. Hospital agrees to permit Physician to have access, during or after the term of the Agreement, to medical records generated by Physician if necessary in connection with claims, litigation, investigations, or treatment of patients.

7.12. **Prior Agreements**. This Agreement represents the entire understanding and agreement of the parties as to those matters contained in it. No prior oral or written understanding shall be of any force or effect with respect to the matters contained in this Agreement. This Agreement may be modified only by a writing signed by each party or his/its lawful agent.

7.13. **Referrals**. This Agreement does not impose any obligation or requirement that Hospital shall make any referral of patients to Physician or that Physician shall make any referral of patients to Hospital. The payment of compensation pursuant to section 3.01 is not based in any way on referrals of patients to Hospital.

7.14. **Severability**. If any provision of this Agreement is determined to be illegal or unenforceable, that provision shall be severed from this Agreement, and the remaining provisions shall remain enforceable between the parties.

7.15. **Waiver**. The failure of either party to exercise any right under this Agreement shall not operate as a waiver of that right.

7.16. **Gender and Number.** Use of the masculine gender shall mean the feminine or neuter, and the plural number the singular, and vice versa, as the context shall indicate.

7.17. **Authority and Executive.** By their signature below, each of the parties represent that they have the authority to execute this Agreement and do hereby bind the party on whose behalf their execution is made.

7.18. **Construction.** This Agreement has been negotiated and prepared by both parties and it shall be assumed, in the interpretation of any uncertainty, that both parties caused it to exist.

NORTHERN INYO COUNTY
LOCAL HOSPITAL DISTRICT

By _____
John Ungersma, President
District Board of Directors

PHYSICIAN

By _____
Rich Meredick, M.D.

EXHIBIT A

SCOPE OF DUTIES OF THE PHYSICIAN

POSITION SUMMARY

The Physician is a Member of the Northern Inyo Hospital Active Medical Staff with privileges commensurate with a private practice in orthopedic medicine. Physician will be available to provide direct orthopedic diagnosis and treatment to Practice and Hospital patients. The Physician will provide orthopedic services commensurate with the needs of the District. It is generally thought that the District needs require the services of about 1.6 full time equivalent orthopedic physicians. All time off will be coordinated with Call coverage such that scheduled time off will not conflict with the Physician's call requirement.

Specifically, the Physician will:

1. Provide high quality orthopedic medical care services.

2. Be responsible to provide the clinical, surgical, and ER orthopedic coverage for the District and/or to provide other physician(s) to do the same as may be required by the NIH Medical staff and/or this agreement.

3. Direct the need for on-going educational programs that serve the patient and the NIH Medical Staff.

4. Evaluate and develop treatment plans to facilitate the individual healthcare needs of each orthopedic patient.

5. Work with all Practice personnel to meet the healthcare needs of all orthopedic patients.

6. Assess, evaluate, and monitor on-going health care and medication of Practice patients.

7. Manage surgical orthopedic emergencies.

8. Participate in professional development activities and maintain professional affiliations.

9. Participate with Hospital to meet all federal and state regulations.

10. Accept emergency call as provided herein.

11. Actively participate in Medical Staff governance by serving on committees as required by Medical Staff Bylaws, Rules and Policies, and accepting the appointments to chairs, Chiefs of service and other designation as requested by the Medical Staff.

12. Abide by any behavioral agreement currently in force by the Medical Staff.

13. Perform the surgical procedures in Exhibit B.

14. Perform "return to work" or other physical assessments on employees that are requested by the hospital and are within the scope of the physicians' practice.

15. Physician will coordinate the relationship(s) of other orthopedic related sub-specialties.

16. Support and utilize

Exhibit B

Physician agrees to, is privileged and is capable of performing the following procedures

1. Joint repair, including but not limited to total hip and knee replacement.
2. Sports medicine management
3. Fracture reduction and fixation.
4. More TBD

BETA Risk Management Authority ("BETARMA")
A Public Entity
CERTIFICATE OF COVERAGE

This is to certify that Healthcare Entity Comprehensive Liability Coverage which includes professional liability coverage is in effect for the Member named below, subject to the provisions of the coverage contract listed below.

NAMED MEMBER: Northern Inyo County Local Hospital District

GROUP: Eastern Sierra Emergency Physicians, Inc., a Professional Corporation

MEMBER: Michael Phillips, MD

SPECIALTY: Emergency Medicine

COVERAGE: Evidence of coverage for Michael Phillips, MD, for services rendered on behalf of Northern Inyo County Local Hospital District

Certificate Number: C-13-356

	Named Member Information	Member Information
Effective Date:	7/1/2013 at 12:01 a.m.	7/1/2013 at 12:01 a.m.
Expiration Date:	7/1/2014 at 12:01 a.m.	7/1/2014 at 12:01 a.m.
Retroactive Date:	7/1/2004 at 12:01 a.m.	7/1/2004 at 12:01 a.m.

Coverage Type: Professional Liability - Claims made and reported
General Liability - Occurrence

Healthcare Entity Comprehensive Liability Coverage
LIMITS OF LIABILITY

$1,000,000	Per Claim
$3,000,000	Aggregate Per Contract Period

This Certificate is issued as a matter of information only and confers no rights upon the Certificate Holder. This Certificate does not amend, extend or alter the coverage afforded under the coverage contract.

CERTIFICATE HOLDER

FOR INFORMATION ONLY

CANCELATION
Should the above described Coverage Contract be canceled by BETARMA before the expiration date thereof, BETARMA will endeavor to mail 30 days written notice to the Certificate Holder named to the left, but the failure to mail such notice shall impose no obligation or liability of any kind upon BETARMA, its agents or representatives.

R Colby Crowe
Authorized Representative of BETARMA

THIS SHEET

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RELOCATION EXPENSE AGREEMENT

THIS AGREEMENT, MADE AND ENTERED into this 1st day of September 2013, by and between the NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT, hereinafter referred to as "District" and Richard Meredick M.D., hereinafter referred to as "Physician."

I

RECITALS

1.01. District is a Local Healthcare District, organized and existing under the California Local Health Care District Law, Health and Safety Code Section 32000, et seq., with its principal place of business in Bishop, California, at which location it operates Northern Inyo Hospital (hereinafter "Hospital").

1.02. Physician is licensed to practice medicine in the State of California, and is certified by the American Board of Orthopedic Surgeons. Physician has applied for membership on the Medical Staff of Northern Inyo Hospital. Physician warrants that he is qualified for membership on the Provisional and Active Medical Staffs at Hospital and that there is no impediment to his obtaining such membership.

1.03. The Board of Directors (hereinafter "Board") of District has determined, pursuant to Health & Safety Code section 32121.3, that the Northern Inyo Hospital Medical Staff requires an additional physician practicing Orthopedics in order to insure adequate coverage of that medical specialty and, further, has determined that recruitment of such a physician would be in the best interests of the public health of the communities served by the District and would benefit the District.

1.04. Physician desires to relocate his practice in Bishop, California.

II

COVENANTS OF THE PARTIES

NOW, THEREFORE, IN CONSIDERATION OF THE PROMISES SET FORTH BELOW, THE PARTIES AGREE AS FOLLOWS:

2.01. Physician agrees to relocate his practice in Bishop, California; to apply for and use his best efforts to obtain membership on the Provisional and Active Medical Staffs of Northern Inyo Hospital, with privileges in General Orthopedics, to maintain such memberships for an aggregate period of at least two (2) years and to maintain an active practice in Orthopedics in the City of Bishop, California, for at least two (2) years.

2.02. District agrees to pay up to $16,000.00, as incurred, to Physician for moving expenses (which shall include items such as moving company fees, U-Haul and other conveyance expenses, travel expenses, and lodging) to support his move to Bishop, California.

2.03. District also agrees to pay Physician a $20,000 sign-on bonus, to be paid on the day both parties execute the Practice Management Contract, dated 1/10/2013.

2.04. Physician agrees that should he fail to perform all of the acts promised in Section 2.01 above, that he shall, not later than thirty (30) days after being given written notice by the District, repay to the District, $36,000.00, with interest at the rate of three and six tenths percent (3.6%) a prorated share, representing that portion of the two (2) years in which he is or will not be performing such acts, of those funds expended by the District pursuant to Section 2.02 and 2.03 above.

III

GENERAL PROVISIONS

3.01. This is the entire Agreement of the parties. It may not be modified except by a writing signed by each of the parties.

3.02. Any written notice given pursuant to the Agreement shall be deemed given when such notice is deposited in the U.S. Mail, first class postage prepaid, addressed to the respective parties as follows:

NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT

150 Pioneer Lane
Bishop, CA 93514

RICHARD MEREDICK, M.D.
C/O Northern Inyo Hospital
152-A Pioneer Lane
Bishop, CA 93514

3.03. If either party brings legal action to enforce any rights or obligations under this Agreement, the Court shall have the power to award reasonable attorney's fees to the prevailing party.

3.04. The rights and obligations set forth in this Agreement are personal to all parties, and may not be assigned without the express written consent of all parties.

3.05. This Agreement shall be binding upon the heirs, successors, assigns, and personal representatives of the respective parties.

3.06. The parties acknowledge and agree, in accord with the requirements of Health & Safety Code section 32121.3(c) (2), that no payment or other consideration shall be made for the referral of patients to the District's hospital or to any affiliated non-profit corporation, and that no such payment or consideration is contemplated or intended.

3.07. This Agreement shall be interpreted according to the laws of California.

3.08. The term of this agreement shall be from the first day Physician is granted privileges and is available to fulfill this agreement obligation until the last day of the twenty-fourth month thereafter.

EXECUTED at Bishop, California, on the day and year first above written.

NORTHERN INYO COUNTY LOCAL
HOSPITAL DISTRICT

By _____
President, Board of Directors
Northern Inyo County Local
Hospital District

By _____
Richard Meredick, M.D.
152-A Pioneer Lane
Bishop, CA 93514

THIS SHEET

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SUBJECT TO REVIEW AND APPROVAL
BY DEPARTMENT OF MANAGED HEALTH CARE, DEPARTMENT OF INSURANCE,
AND DEPARTMENT OF HEALTH CARE SERVICES

PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "Agreement") is made and entered by and between Northern Inyo Hospital ("Provider") and Celtic Insurance Company ("Celtic").

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a Company (as hereafter defined), and Provider desires to participate in such products as a "participating provider," all as hereinafter set forth.

WHEREAS, Celtic desires for Provider to provide such health care services to individuals in such products, and Celtic desires to have Provider participate in certain of such products as a "participating provider," all as hereinafter set forth.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the parties hereby agree to the provisions set forth below.

ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

1.1. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.7, all of which are hereby incorporated herein by reference and may be amended from time to time as provided herein.

1.2. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.3. "Company" means (collectively or individually, as appropriate in the context) Celtic and its affiliates, including the California Wellness Health Plan, except those specifically excluded by Celtic.

1.4. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement, and may be included within a Product Attachment.

1.5. "Contracted Provider" means a physician, hospital, health care professional or any other provider of items or services that (i) is employed by or has a contractual relationship with Provider, and (ii) has been approved for participation by a Company. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider and for which Provider has been approved for participation by a Company.

1.6. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by a Payor, under which a Company furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of the Company's provider networks or vendor arrangements, except those excluded by Celtic.

1.7. "Covered Person" or "Enrollee" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

1.8. "Covered Services" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be medically necessary under the applicable Coverage Agreement.

1.9. "Network" means a network of health care providers that have entered into contracts with Celtic to provide health care services to Covered Persons.

1.10. "Participating Provider" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with a Company to provide Covered Services to Covered Persons, and that is designated by a Company as a "participating provider" in such Product.

1.11. "Payor" means the entity (including a Company) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not a Company, such entity contracts, directly or indirectly, with a Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.12. "Payor Contract" means the contract with a Payor, pursuant to which Company furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of the Company's provider networks or vendor arrangements, except those excluded by Celtic. The term "Payor Contract" includes Company's or other Payor's contract with a governmental authority (also referred to herein as a "Government Contract") under which a Company or Payor arranges for the provision of Covered Services to eligible individuals.

1.13. "Product" means any program or health benefit arrangement designated as a "product" by Company (e.g., PPO Product, HMO Product, Medicaid Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through a Company (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by Celtic that provides Covered Persons in such product with incentives or access to Participating Providers in such product.

1.14. "Product Attachment" means an Attachment setting forth certain requirements, terms and conditions specific to one or more Products, including certain provisions that must be included in a provider agreement under the laws of the State, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

1.15. "Provider Manual" means the manuals, requirements, policies and procedures adopted by Company to be followed by Participating Providers, including, without limitation, those relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as the same may be amended from time to time by the Company.

1.16. "Provider Network Lease Agreement" means an agreement by which Celtic leases the Network to a Company.

1.17. "Regulatory Requirements" means all applicable statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Government Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

1.18. "State" is defined as the state identified in the applicable Attachment.

ARTICLE II – PRODUCTS AND SERVICES

2.1. Network Lease. Provider understands and agrees that Celtic may enter into a Provider Network Lease Agreement with a Company that will permit the Company to utilize the Network for the purpose of providing health care services to Covered Persons who are enrolled in a Product. Provider further understands and agrees that the Network that is leased to the Company by Celtic will include Provider and all Participating Provider(s) to the extent that Provider agrees to the terms of the applicable Product Attachment. With respect to any Product that is subject to the terms of the Knox-Keene Health Care Service Plan Act of 1975 ("Act"), any Company that enters into a Provider Network Lease Agreement shall be a health care service plan licensed by the Department of Managed Health Care ("DMHC") under the Act. Provider further understands and agrees that Company shall be responsible for undertaking all obligations and duties of a "Company" as set forth in this Agreement.

2.2. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement (including the provisions of Exhibit A that are applicable to Provider, the Contracted Provider, or their services, and the other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and the Provider Manual.

2.3. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a "Participating Provider" in each Product identified in a Product Attachment designated on the signature page of this Agreement.

2.3.1. If a Company desires to add one or more Contracted Providers to an additional Product, the Company will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. Provider shall have the right to negotiate and agree to the addition of a Product Attachment. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product if Provider opts out of such additional Product by giving the Company written notice of its decision to opt-out within ninety (90) days of the Company's giving of written notice, or less if otherwise permitted by applicable law. If Provider timely provides such opt-out notice, the applicable Contracted Providers will not constitute "Participating Providers" in such Product. If Provider does not timely provide such opt-out notice, then each applicable Contracted Provider shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.3.2. A Contracted Provider may only identify itself as a Participating Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that a Company or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. Neither Company nor Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

2.3.3. Attached hereto as Exhibit B is the initial list of the Contracted Providers participating under this Agreement as of the Effective Date. Provider shall provide a Company on an annual basis or more often upon request with a list containing the names, office telephone numbers, tax identification numbers, hospital affiliations, specialties and board status (if applicable), addresses, State license number, and National Provider Identifier of Contracted Providers and such other information as mutually agreed upon by the parties, and shall provide the Company with a list of modifications to such list at least thirty (30) days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the parties.

2.3.4. Provider shall, at all times during the term of this Agreement, require all of its providers to participate (or be eligible and willing to participate) under this Agreement as "Contracted Providers." Subject to the applicable Company's approval, Provider may add new providers to this Agreement as "Contracted Providers." In such case, Provider shall use best efforts to notify the Company, in writing, of the prospective addition at least sixty (60) days in advance. Each such new provider may become a "Contracted Provider" once he, she or it meets the requirements contained elsewhere in this Agreement. Provider shall maintain written agreements with each of its Contracted Providers (other than Provider) that require the Contracted Providers to comply with the terms and conditions of this Agreement and that address and comply with the Regulatory Requirements.

2.4. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements. Each Contracted Provider shall direct or refer Covered Persons to Participating Providers, unless otherwise authorized by a Company or Payor.

2.5. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of a Company and Payor, which generally will be described in the Provider Manual and include, but are not limited to, the following: credentialing criteria and requirements; policies and procedures requiring notification for certain Covered Services; medical management programs including those components relating to quality improvement, utilization management, disease management, and case management, and on-site reviews; grievance and appeal procedures; coordination of benefits and third party liability policies; and carve-out and third party vendor programs. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person's benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. Company shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means. Upon Provider's reasonable request, Company shall provide Provider with a copy of the Provider Manual. In the event of a material change to the Provider Manual, Company will use reasonable efforts to notify Provider in advance of such change. Such notice may be given by Company through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.6. Credentialing Criteria. Provider and each Contracted Provider agrees as follows: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare-certified provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that all employees of Provider or the Contracted Provider will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by the Company that such Contracted Provider has successfully completed the Company's credentialing process.

2.7. Eligibility Determinations. Provider or the Contracted Provider shall verify whether an individual seeking Covered Services is a Covered Person. Company will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. The Company does not guarantee that persons identified as "Covered Persons" are eligible for benefits. If a Company, Payor or its delegate determines that an

individual was not eligible for Covered Services at the time the services were rendered, such services shall not be eligible for payment under this Agreement.

2.8. Treatment Decisions. Company and Payor are not liable for, nor will they exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that determinations of a Company or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality or medical treatment decisions or alternatives.

2.9. Carve-Out Vendors. Provider acknowledges that a Company may, during the term of this Agreement and consistent with the provisions of Section 8.7, when applicable, carve out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as the Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third party vendors designated by the Company for those Covered Services identified by the Company from time to time for a particular Product.

2.10. Disparagement Prohibition. Provider, each Contracted Provider and the officers of Company shall not disparage the other during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with a Company's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this provision should be construed as limiting the ability of either party or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting a Company's ability to use and disclose information and data obtained from or about Provider or Contracted Provider, including this Agreement, to the extent determined reasonably necessary or appropriate by a Company in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.11. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, a Company or Payor may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements.

2.12. Notice of Certain Events. Provider shall give written notice to Celtic of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or the Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or the Contracted Provider from any state or federal health care program, including but not limited to Medicaid; and (iv) any lawsuit or claim filed or asserted against Provider or the Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify Celtic in writing within ten (10) days, and in any

such instance described in subsection (iv) above, Provider must notify Celtic in writing within thirty (30) days, from the date it first obtains knowledge of the same.

2.13. Use of Name. Provider and each Contracted Provider hereby authorize the applicable Company to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the Company for purposes of identifying the Products in which they participate, and may not use the registered trademark or service mark of the Company without the Company's prior written consent.

2.14. Compliance with Regulatory Requirements and Payor Contracts. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on a Company, the Company may, in its sole discretion, offset such amounts against any amounts due Provider or Contracted Providers from the Company or require Provider or the Contracted Provider to reimburse the Company for such amounts.

ARTICLE III – CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

3.1. Claims or Encounter Data Submission. As provided in the Provider Manual, Contracted Providers shall submit to the Company or its delegate claims for payment for Covered Services rendered to Covered Persons. Contracted Provider shall submit encounter data to the Company or its delegate in a form and manner that allows the Company to meet administrative functions and requirements under applicable Regulatory Requirements. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounters in accordance with the Provider Manual.

3.2. Compensation. The compensation for Covered Services provided to a Covered Person ("Compensation Amount") will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services hereunder. The applicable Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement.

3.3. Financial Incentives. The parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold, reduce, limit or delay Covered Services.

3.4. Hold Harmless. Provider agrees to hold harmless both the State and Covered Persons if the Payor cannot or will not pay for services performed. Provider and each Contracted Provider, agent, trustee or assignee thereof, agree that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, have or seek any recourse against a Covered Person for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. Provider shall report to Payor, in writing, any such copayments and surcharges paid by Covered Person to Provider. This provision survives termination or expiration of this Agreement for any

reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5. Recovery Rights. Payor or its delegate shall have the right to offset or recoup any and all amounts owed by Provider or a Contracted Provider to Payor or Company against amounts owed by the Payor or Company to the Provider or Contracted Provider. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider.

ARTICLE IV – RECORDS AND INSPECTIONS

4.1. Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.

4.2. Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) the Company and Payors, during regular business hours and upon prior notice; (ii) government agencies, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to Company or Payor or any of their delegates. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of their facilities and records by any Company, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

4.3. Record Transfer. Subject to applicable Regulatory Requirements, Provider and each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

ARTICLE V – INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement, Provider and each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance that are necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier, and in a minimum amount of one million dollars ($1,000,000) per occurrence, and three million dollars ($3,000,000) in the aggregate unless a lesser amount is accepted by Company or where State law mandates otherwise. Provider and each Contracted Provider will provide Company with at least fifteen (15) days notice of such cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon Company's request, Provider and each Contracted Provider will furnish Company with evidence of such insurance.

5.2. Indemnification by Provider and Contracted Provider. Provider and each Contracted Provider shall indemnify and hold harmless (and at Celtic's request defend) Company and Payor and all of their respective officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

5.3. Indemnification by Celtic. Celtic agrees to indemnify and hold harmless (and at Provider's request defend) Provider, Contracted Providers, and their officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by a Company or its directors, officers, agents or employees.

ARTICLE VI – DISPUTE RESOLUTION

6.1. Informal Dispute Resolution. Except as provided below or superseded by applicable Regulatory Requirements, any dispute between the parties (or involving a Contracted Provider) with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. If, at the conclusion of these applicable procedures, the matter is not resolved to each of the parties' satisfaction, or if there are no applicable procedures in the Provider Manual, then the parties agree that they shall engage in a period of good faith negotiations between designated representatives of the parties who have authority to settle the Dispute, which negotiations may be initiated by either party upon written request to the other, provided such request takes place within one (1) year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the matter has not been resolved within sixty (60) days of such request, either party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below by providing written notice to the other party.

6.2. Arbitration. Either party wishing to pursue the Dispute as provided in Section 6.1 shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than one (1) year following, as applicable, the end of the sixty (60) day negotiation period set forth in Section 6.1, or the date of notice of termination. Arbitration proceedings shall be conducted by an arbitrator chosen from the National Healthcare Panel at a mutually agreed upon location within the State. The arbitrator shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. The parties and the Contracted Providers, on behalf of themselves and those that they may now or hereafter represent, agree to and do hereby waive any right to pursue, on a class basis, any Dispute. Each party shall bear its own costs and attorneys' fees related to the arbitration except that the AAA's Administrative Fees, all Arbitrator Compensation and travel and other expenses, and all costs of any proof produced at the direct request of the arbitrator shall be borne equally by the parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, each party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein shall bar a party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity. Judgment on the award rendered may be entered in any court having jurisdiction thereof. Nothing contained in this Article VI shall limit a party's right to terminate this Agreement with or without cause in accordance with Section 7.2.

ARTICLE VII – TERM AND TERMINATION

7.1. Term. This Agreement is effective as of the effective date designated by Celtic on the signature page of this Agreement ("Effective Date"), and will remain in effect for an initial term of one (1) year(s), after which it will automatically renew for terms of one(1) year each, unless this Agreement is sooner terminated as provided in this Agreement or either party gives the other party written notice of non-renewal of this Agreement not less than ninety (90) days prior to the renewal date of this Agreement. In addition, either party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product, effective as of the renewal date of this Agreement, by giving the others written notice of such non-renewal not less than ninety (90)

days prior to the renewal date of this Agreement; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal.

7.2. Termination. This Agreement, or the participation of Provider or a Contracted Providers as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

7.2.1. Upon Notice. This Agreement may be terminated by either party giving the other party at least one hundred eighty (180) days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either party giving the other party at least one hundred eighty (180) days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2. With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either party giving at least ninety (90) days prior written notice of termination to the other party if such other party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other party (or the Contracted Provider) fails to cure the breach within the sixty (60) day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2 must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3. Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, Celtic has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by Celtic, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

7.2.4. Insolvency. This Agreement may be terminated immediately by a party giving written notice thereof to the other party if the other party is insolvent or has bankruptcy proceedings initiated against it.

7.2.5. Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by Celtic giving written notice thereof to Provider if the Contracted Provider fails to adhere to Company's credentialing criteria, including, but not limited to, if the Contracted Provider (i) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.6. Termination of Payor Contract. Any Product Attachment to this Agreement may be terminated by Celtic if the Payor Contract in connection with the applicable Product is terminated. Such termination will be effective no sooner than thirty (30) calendar days after Celtic's receipt of notice of the termination of a Payor Contract.

7.3. Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider

(including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until services being rendered to Covered Persons are complete or until such other time period as determined by applicable Regulatory Requirements, unless Company makes reasonable and medically appropriate provision for the assumption of such services by another provider. Provider shall, consistent with applicable Regulatory Requirements, assist in the transfer of care of Covered Persons and written notifications related thereto. Following the effective date of the termination of this Agreement, Contracted Provider shall continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.4. Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.1, 4.2, 5.2, 5.3, 6.2, 7.3, and 7.4 and Article VIII, survive the expiration or termination of this Agreement.

ARTICLE VIII - MISCELLANEOUS

8.1. Relationship of Parties. The relationship among the parties is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship.

8.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.3. Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated or transferred by Provider without Company's prior written consent. Celtic shall have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of Celtic, or purchaser of the assets or stock of Celtic, or the line of business or business unit primarily responsible for carrying out Celtic's obligations under this Agreement.

8.4. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define, or extend the specific terms of the section so designated.

8.5. Governing Law. The interpretation of this Agreement and the rights and obligations of the parties hereto will be governed by and construed in accordance with applicable federal and State laws.

8.6. Third Party Beneficiary. This Agreement is entered into by the parties signing it for their benefit and the benefit of each Company. Except as specifically provided in Section 3.4 (Hold Harmless) hereof, no Covered Person or third party, other than a Company, will be considered a third party beneficiary of this Agreement.

8.7. Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the parties. Unless the parties agree otherwise, Company shall provide 45 business days' notice of intent to change a material term of this Agreement, the Provider Manual, policy or procedure, unless state or federal law or regulations or accreditation requirements require a shorter timeframe for compliance. Nothing in this Section shall limit the ability of the parties to mutually agree to a proposed amendment at any time after Provider receives notice of such proposed amendment. Amendments to this Agreement may be subject to review and/or approval by the Department of Health Care Services and/or the Department of Managed Health Care.

8.7.1. Celtic may amend this Agreement by giving Provider written notice of the amendment to the extent such amendment is deemed necessary or appropriate by Celtic to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Provider upon the giving of such notice.

8.7.2. Celtic may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. Unless Provider notifies Celtic in writing of its objection to such amendment during the thirty (30) day period following the giving of such notice by Celtic, Provider shall be deemed to have accepted the amendment. If Provider objects to any proposed amendment, Celtic may exclude one or more of the Contracted Providers from being Participating Providers in the applicable Product (or any component program of, or Coverage Agreement in connection with, such Product).

8.8. Entire Agreement. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between the Company and Provider relating to a subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

8.9. Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

8.10. Waiver. The waiver by either party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.11. Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered by a service that provides written receipt of delivery, addressed as follows:

To Celtic at:

233 South Wacker Drive, South 700

Chicago, Illinois, 60606

To Provider at:

Attn: _____

Northern Inyo Hospital

150 Pioneer Lane

Bishop , CA 93514

_____

or to such other address as such party may designate in writing. Notices related to the California Medicaid and CHIP Product shall be sent to an address as provided in Section 7 of the "Product Attachment – California Medicaid and CHIP Product" attached to this Agreement.

8.12. Force Majeure. Neither party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by either party's employees, or any other similar cause beyond the reasonable control of such party.

8.13. Proprietary Information. Neither party shall disclose to a third party the substance of this Agreement, or any information of a confidential nature acquired from the other party during the course of this Agreement, except to agents of such party as necessary for such party's performance under this Agreement, or as required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges and agrees that all information relating to a Company's programs, policies, protocols and procedures is proprietary information and Provider shall not disclose such information to any person or entity without Celtic's express written consent.

8.14. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of the Agreement with Company.

* * * * *

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date set forth beneath their respective signatures.

Celtic Insurance Company	**Northern Inyo Hospital** (Legibly Print Name of Provider)
Signature: _____	Signature: _____
Print Name: _____	Print Name: _____
Title: _____	Title: _____
Date: _____	Date: _____
	Tax Identification Number: _____

To be completed by Celtic only:

Effective Date of Agreement: _____

Included in Agreement	Attachment/Exhibit
X	Exhibit A – Contracted Provider – Specific Provisions
X	Exhibit B – List of Contracted Providers
X	**Product Attachment** – California Medicaid and CHIP Product
X	Exhibit 1 of Attachment – State-Mandated Provisions for Licensed Health Care Service Plans and Governmental Contracts
X	Schedule of Attachment – Hospital Compensation Schedule - Medicaid
X	Schedule of Attachment – Group Compensation Schedule - Medicaid
X	Schedule of Attachment – Clinic Compensation Schedule - Medicaid
X	Schedule of Attachment – Ancillary Compensation Schedule - Medicaid
X	Schedule of Attachment – Covered Services and Exclusions - Medicaid

EXHIBIT A
CONTRACTED PROVIDER-SPECIFIC PROVISIONS

Provider and Contracted Providers shall comply with the applicable provisions of this Exhibit.

A.1 Hospitals. If Provider or a Contracted Provider is a hospital ("Hospital"), the following provisions apply.

A.1.1 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons twenty-four (24) hours per day, seven (7) days per week.

A.1.2 Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. The Contracted Provider shall notify Company's medical management department of any emergency room admissions by electronic file sent within twenty-four (24) hours or by the next business day of such admission. "Emergency Care" (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, "Emergency Care" means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

A.1.3 Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company's Participating Providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital's medical staff and bylaws, rules, and regulations.

A.1.4 Discharge Planning. Each Hospital agrees to cooperate with Company's system for the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care.

A.1.5 Credentialing Criteria. Each Hospital shall (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable; and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

A.2 Practitioners. If Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) ("Practitioner"), the following provisions apply.

A.2.1 Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider ("Participating Hospital") with respect to each Product in which the Practitioner participates. Upon Company's request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a written statement from another Participating Provider who has such admitting privileges, in good standing, certifying that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

A.2.2 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such

Practitioner participates. Practitioner shall notify Company in writing forty-five (45) days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

A.2.3 Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with formulary or preferred drug list when prescribing medications for Covered Persons.

A.2.4 Timely Access Standards. Provider and Contracted Providers shall comply with all applicable timely access standards as required by the Regulatory Requirements.

A.3 Ancillary Providers. If Provider or Contracted Provider is an ancillary provider (including but not limited to a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center)("Ancillary Provider"), the following provisions apply.

A.3.1 Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing forty-five (45) days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

A.4 FQHC. If Provider or a Contracted Provider is a federally qualified health center ("FQHC"), the following provision applies.

A.4.1 FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("FTCA") and Celtic has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "FTCA Coverage"), Section 5.1 of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to Celtic at any time upon request. FQHC shall promptly notify Celtic if, any time during the term of this Agreement, any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. Section 5.1 of this Agreement will apply to a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.

EXHIBIT B
LIST OF CONTRACTED PROVIDERS
(List ALL entities affiliated with this Agreement)

ENTITY/GROUP/CLINIC/FACILITY NAME	TAX ID #	GROUP NPI #

NOTE: A separate roster of all individual practitioners associated with each entity, group, clinic or facility is required using the Company designated roster format to ensure expedited loading of your Contracted Providers. This Exhibit is intended to capture all groups, clinics, and facilities associated with the Agreement. If the Agreement is for an individual practitioner, no roster is required; however, please enter the individual practitioner's information in the above table.

SUBJECT TO REVIEW AND APPROVAL
BY DEPARTMENT OF MANAGED HEALTH CARE, DEPARTMENT OF INSURANCE,
AND DEPARTMENT OF HEALTH CARE SERVICES

ATTACHMENT A
PRODUCT ATTACHMENT – CALIFORNIA MEDICAID AND CHIP PRODUCT
(INCLUDING REGULATORY REQUIREMENTS AND COMPENSATION SCHEDULE)

THIS PRODUCT ATTACHMENT (this "Attachment") is made and entered between Celtic Insurance Company ("Celtic") and Northern Inyo Hospital ("Provider").

WHEREAS, Celtic and Provider entered into that certain Participating Provider Agreement, as the same may have been amended and supplemented from time to time (the "Agreement"), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through California Health and Wellness Plan ("Plan").

WHEREAS, pursuant to the provisions of the Agreement, this Attachment is identified on the signature page of the Agreement and, as such, the Contracted Providers identified herein will be designated and participate as "Participating Providers" in the Product described in this Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement.

1.1 "Evidence of Coverage" means, as defined in subdivision (d) of Health and Safety Code Section 1345, any certificate, agreement, contract, brochure, or letter of entitlement issued to an Enrollee setting forth the coverage to which the Enrollee is entitled.

1.2 "Disclosure Form(s)" means, as defined in subdivision (a) of Health and Safety Code Section 1363, the materials containing information regarding the benefits, services, and terms of Coverage Agreement as the Department of Managed Health Care or Department of Health Care Services may require, so as to afford Enrollees with a full and fair disclosure of Coverage Agreement in readily understood language and in a clearly organized manner.

1.3 "State" means the State of California.

2. Product Participation.

2.1 California Medicaid and CHIP Product. This Attachment addresses the participation of Provider and the applicable Contracted Providers in the following Product: "California Medicaid and CHIP Product" (which is also referred to in this Attachment as the "Medi-Cal Product"). The term "California Medicaid and CHIP Product" refers to those programs and health benefit arrangements offered by California Health and Wellness Plan ("Plan") in connection with the Medi-Cal and the Healthy Families Programs or any successors thereto, that are administered, sponsored or regulated by the State (or any agency, department or division thereof). The Medi-Cal Product expressly includes the health benefit arrangement offered by or available from or through Plan in connection with Plan's contract with the California Department of Health Care Services(or any successor thereto). The Medi-Cal Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement. This Attachment applies only to the provision of health care

services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medi-Cal Product.

2.2 Participation. Unless otherwise specified in this Attachment, all Contracted Providers under the Agreement will participate in the Medi-Cal Product as "Participating Providers," and will provide to Covered Persons enrolled in the Medi-Cal Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Attachment and the Agreement (including the Provider Manual).

2.3 Attachment. This Attachment, consisting of Exhibit 1 (State-Mandated Provisions for Licensed Health Care Service Plans and Governmental Contracts), Schedule A (Reimbursement), Schedule E (Covered Services and Exclusions) constitutes the Product Attachment for the Medi-Cal Product. Where the Provider is a Risk-Bearing Organization, this Attachment shall also include Exhibit 2 (State-Mandated Provisions for Risk-Bearing Organizations). Where Provider is responsible for administrative and/or management activities that have been delegated to Provider by Plan's and Provider's mutual agreement, where required by law or applicable accreditation standards, this Attachment shall also include Exhibit 3 (Delegation Agreement).

2.4 Construction. Except as expressly provided herein, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of a conflict between the provisions of the Agreement and the provisions of this Attachment, this Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in the Medi-Cal Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Plan.

3. Term. This Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a party or a Contracted Provider terminates the participation of the Contracted Provider in the Medi-Cal Product in accordance with the applicable provisions of the Agreement or this Attachment.

4. State-Mandated Regulatory Requirements. Exhibit 1 to this Attachment, which is incorporated herein by this reference, sets forth the provisions that are required by State law and regulations and the Government Contract governing the operation of licensed health care service plans and contracts between such plans and providers. These requirements are set forth in the California Welfare and Institutions Code, related regulations (Title 22 of the California Code of Regulations), the Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code Section 1340 et seq.,) and related regulations (Section 1000 of Title 28 of the California Code of Regulations) (collectively, the "Act"), and the Government Contract. Any provision required to be in this Attachment or the Agreement by any of the above shall bind the Plan and Provider whether or not provided for herein.

5. Compensation Schedule. Schedule B to this Attachment, Compensation Schedule, incorporated herein by reference, sets forth the compensation for services provided by Provider under this Attachment. Except as modified or supplemented by this Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in the Medi-Cal Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

6. Carve outs. In accordance with the Government Contract, some benefits may not be within the scope of Covered Services for Medi-Cal and Healthy Families Program Enrollees. Subject to the conditions of the Government Contract, Covered Persons may receive coverage for such benefits may be covered outside of the Medi-Cal Product, with or without the necessity of such individuals' disenrollment from the Medi-Cal Product. For a complete list of these benefits please refer to Schedule A and the applicable Evidence of Coverage and Disclosure Forms.

7. Notices. Any notice required or permitted to be given under this Attachment is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered by a service that provides written receipt of delivery, addressed as follows:

to California Health and Wellness Plan at:

Attn:_____
_____
_____

to Provider at:

Attn: _____
150 Pioneer Lane
Bishop , CA 93514
_____

EXHIBIT 1 - STATE-MANDATED PROVISIONS FOR LICENSED HEALTH CARE SERVICE PLANS AND GOVERNMENTAL CONTRACTS

This Exhibit sets forth the special provisions that are required of all managed care health plans regulated by the Department of Managed Health Care and plans offering California Medicaid and CHIP Product under a Government Contract with the Department of Health Care Services.

1. Definitions. For purposes of this Exhibit 1, the following terms have the meanings set forth below. Capitalized terms used in this Exhibit 1 and not defined below will have the same meaning set forth in the Agreement.

1.1. "Clean Claim" means one that can be processed without obtaining additional information, as required under State law, regulation, and Government Contract, from the provider of service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity. "Contested Claim" means a claim, or portion thereof, lacking the information necessary to determine payor liability for the claim.

1.2. "Covered Person," or "Enrollee" means a Title XIX or Title XXI beneficiary who has been certified by the State as eligible to enroll in the Medi-Cal or Healthy Families Program and whose name appears on Plan enrollment information that will be transmitted monthly by the State to the Plan in accordance with an established notification schedule.

1.3. "Emergency Services" means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition until such care results in stabilization, within the capability of the facility. "Stabilization" has occurred when, in the opinion of the treating physician and surgeon, or other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician and surgeon, the Covered Person's medical condition is such that, within reasonable medical probability, no material deterioration of the Covered Person's condition is likely to result from, or occur during, the release or transfer of the Covered Person. Emergency Medical Services shall also include screenings, examinations, and evaluations for the purpose of determining whether a Psychiatric Emergency Medical Condition exists, and for which treatment is necessary to relieve or eliminate the Psychiatric Emergency Medical Condition. Additionally, Emergency Medical Services include at least a 72-hour supply of Medically Necessary discharge drugs.

1.4. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(i) placing the patient's health in serious jeopardy;
(ii) serious impairment of bodily functions; or
(iii) serious dysfunction of any bodily organ or part.

1.5. "Medically Necessary" or "Medical Necessity", for the purposes of this Attachment, means all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury, subject to utilization controls and consistent with the provisions of the Government Contract. When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in Title 22 CCR Section 51340 and 51340.1.

1.6. "Psychiatric Emergency Medical Condition" means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the Covered Person as being either of the following:

(a) An immediate danger to himself or herself or to others; or

(b) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

1.7. "Provider" means, for purposes of this Exhibit, Provider and each Contracted Provider.

1.8. "Quality Improvement System" means the procedures established by the Plan, as required by the Department of Managed Health Care, Department of Health Care Services, and Government Contract, for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs.

1.9. "Government Contract" means the then effective contract with the California Department of Health Care Services (or any successor thereto) for managed care services in connection with the Medicaid Program ("Medi-Cal"), CHIP Program ("Healthy Families Program"), or both.

1.10. "Title XIX" means the provisions of Title 42 United States Code Annotated Section 1396 et. seq. (the Social Security Act), including any amendments thereto. Title XIX provides medical assistance for certain individuals and families with low incomes and resources.

1.11. "Title XXI" means the provisions of the Social Security Act as amended in August 1997 to add Title XXI, known at the federal level as the Children's Health Insurance Program (CHIP), which provides health insurance coverage to uninsured children from low-income families, who are not Title XIX eligible.

2. Governing law. Provider shall comply with all provisions of the Government Contract, federal, State and local laws and regulations, and all amendments thereto. Provider understands and agrees that the Attachment and/or the Agreement shall be deemed automatically amended as necessary to comply with any applicable State or federal or regulation, or any applicable provision of the Government Contract.

3. Linguistic Services. Provider shall provide, or cooperate with Plan's arrangement for the provision of, 24-hour oral interpreter services at all key points of contact for monolingual, non-English-speaking or limited English proficient (LEP) Covered Persons either through interpreters, telephone language services, or any electronic options the Plan and Provider choose to utilize, in a manner that is appropriate for the situation in which language assistance is needed. Provider shall provide, or cooperate with Plan's provision of, the following: i) oral interpreters, signers, bilingual providers and provider staff; ii) fully translated written materials; iii) referrals to culturally and linguistically appropriate community service programs; iv) Telecommunications Device for the Deaf ("TDD"); and v) Telecommunications Relay Service. For the purposes of this section, "key points of contact" include telephone, advice, and urgent care transactions, outpatient encounters with providers including pharmacists, and appointment scheduling. Provider shall document in the Covered Person's medical record any offer of qualified interpreter services, as well as any instance in which such offer is declined.

4. EPSDT. Provider shall ensure the provision of Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") services and EPSDT Supplemental Services for Covered Persons under 21 years of age, except where EPSDT supplemental services are provided as California Children's Services or mental health services. Provider shall inform Covered Persons that EPSDT services are available for Covered Persons under 21 years of age, provide comprehensive screening and prevention services, (including, but not limited to, a health and developmental history, a comprehensive physical examination, appropriate immunizations, lab tests, and lead toxicity screening), and provide treatment for all medically necessary services. Provider shall ensure that appropriate EPSDT services are initiated in a timely fashion, as soon as possible but no later than sixty (60) calendar days following either a preventive screening or other visit that identifies a need for follow-up.

5. Triage or Screening Services. Plan will provide, or arrange for the provision of, telephone or triage services, on a 24-hour-a-day, 7 day-a-week basis as appropriate. Provider shall cooperate with the Plan's provision or arrangements for the provision of triage or screening services.

6. Timely access to care. Provider shall provide Covered Services in a timely manner appropriate for the nature of the Covered Person's condition consistent with good professional practice.

6.1. Covered Persons must be offered appointments within the following timeframes, except as may be otherwise permitted under Section 9.2 and 9.3 herein:

6.1.1. Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;

6.1.2. Urgent appointment for services that require prior authorization – within 96 hours of a request;

6.1.3. Non-urgent appointments with specialist physicians – within 15 business days of request;

6.1.4. Non-urgent appointments with a non-physician mental health care provider – within ten (10) business days of request;

6.1.5. Non-urgent primary care appointments – within ten (10) business days of request;

6.1.6. Non-urgent appointment for ancillary services for the diagnosis or treatment or injury, illness, or other health condition – within 15 business days of request;

6.1.7. The waiting time for any appointment will not exceed forty-five (45) minutes.

6.1.8. All other services not specified here shall meet the usual and customary standards for the community.

6.2. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the Covered Person's health.

6.3. Preventive care services and periodic follow-up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

6.4. When it is necessary to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Covered Person's health care needs, and ensures continuity of care consistent with good professional practice.

6.5. Interpreter services required hereunder shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment.

7. Quality Improvement System. Provider shall participate in and cooperate with Plan's Quality Improvement System in accordance with the Provider Manual, Government Contract and State and federal law and regulations.

8. Books and records. Provider shall make all of its books and records, pertaining to the goods and services furnished under the terms of this Agreement, available for inspection, examination or copying:

(a) By the United States Department of Health and Human Services, California Department of Health Care Services, California Department of Justice, California Department of Managed Health Care, other State or federal agencies or their duly authorized representatives.

(b) At all reasonable times at the Provider's place of business or at such other mutually agreeable location in California.

(c) In a form maintained in accordance with the general standards applicable to such book or record keeping.

(d) For a term of at least 10 years from the close of the current fiscal year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created.

(e) Including all encounter data for a period of at least ten years.

Provider shall further maintain such records and provide such information to Plan or to the applicable regulatory agency as may be necessary for compliance by Plan with the provisions of the Knox Keene Health Care Service Plan Act and the rules thereunder, and retain such records for at least two (2) years. Such obligation will survive termination of this Attachment, whether by rescission or otherwise. Plan shall have access at reasonable times upon demand to the books, records and papers of Provider relating to the health care services provided to Covered Persons, to the cost thereof, to payments received by Provider from Covered Persons (or from others on their behalf), and, unless Provider is compensated on a fee-for-service basis, to the financial condition of the Provider.

9. Reports. Provider agrees to submit reports as required by Plan.

10. Audits. Provider shall permit Plan, its duly authorized agents or representatives, accrediting agencies, State and federal government, during normal business hours, access to Provider's premises to inspect, audit, monitor or otherwise evaluate the performance of Provider's contractual activities and shall produce all records requested as part of such review or audit.

11. Site review. Provider shall participate in and cooperate with facility site reviews on all primary care provider sites and provider sites that serve a high volume of seniors and persons with disabilities. Provider agrees to permit, and require Participating Providers to permit, Plan and/or authorized agents or representatives of state and federal government to conduct periodic site evaluations of Provider's primary care sites. Provider agrees to comply with the agencies' recommendations, if any.

12. Credentialing; standards. Provider and all providers which Provider has contracted or employed shall comply with Company's processes and requirements for initial credentialing, recredentialing, recertification, and reappointment of providers. Provider warrants and represents that Provider and an all providers which Provider has contracted or employed are qualified in accordance with the current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. Provider warrants and represents that Provider and all providers with which Provider has contracted or employed are in good standing in the Medicare and Medicaid programs and have a valid National Provider Identification Number. Provider acknowledges that any provider that has been terminated from either Medicare or Medicaid cannot participate in Company's provider network.

13. Provider subcontracts. Provider agrees that subcontract or subcontract amendment, including but not limited to a subcontract to assign or delegate Provider's duties under this Agreement, shall be void unless prior written approval is obtained from Plan, the Department of Health Care Services, and Department of Managed Health Care. Provider agrees that any subcontract shall be in writing and comply with and adhere subcontractor to the applicable provisions of the Government Contract and the Agreement.

14. Provider disputes. Provider shall have the right to submit grievances and/or appeals through fast, fair and cost-effective dispute resolution process established by Plan. Plan shall handle all provider disputes in accordance with Health and Safety Code, § 1371 et. seq. Plan shall inform Provider of any changes to its provider dispute resolution mechanism.

15. Balance Billing; Surcharges; Copayments. Covered Persons shall not be liable for payment of any moneys owed by Provider or Plan. Provider and each Contracted Provider, agent, trustee or assignee thereof, agree that Provider and each Contracted Provider shall not assess any surcharge for Covered Services. Upon receipt of notice of any such surcharge, Plan will take appropriate action as authorized under this Agreement, Payor Contract, and applicable state and federal law.

16. Enrollee Grievances. Provider shall participate in and abide by the Plan's Grievance Procedure for Covered Persons and require its Participating Providers to do the same.

17. Claims Submission and Processing. Claims shall be submitted and paid in accordance with applicable State and federal law and Government Contract, unless the parties mutually agree in writing to an alternate payment schedule. Unless an alternate payment schedule is agreed to, the following timeframes shall apply to reimbursement for services provided Covered Persons under this Agreement:

17.1. Clean Claims. Clean and uncontested claims shall be paid no later than forty-five (45) working days after receipt of the claim. If a clean and uncontested claim is not reimbursed by delivery within the required timeframe, interest shall accrue at the rate of 15 percent per annum, beginning with the first calendar day after the required timeframe. Such accrued interest shall automatically be included in payment of the claim.

17.2. Contested Claims. If all or part of a claim is contested, the notice of the contest must include the following information: the portion of the claim that is contested and the specific reasons for contesting the claim. The notice of contested claim must be sent no later than forty-five (45) working days after receipt of the claim. If the reasonable basis for denying the claim is that additional information is needed, then reconsideration of the claim must be completed within forty-five (45) working days from receipt of the necessary information.

17.3. Emergency Claims. Claims for emergency services and care shall be processed in compliance with California Health & Safety Code §1371.35, as amended, or such other applicable provision.

17.4. Statutory Authority. The parties agree to comply with all applicable provisions of the California Health & Safety Code §1371, et seq., as amended, relating to claims payment procedures (the "Claims Payment Requirements"). To the extent that Subsections 17.1 and 17.2 of this Attachment do not conform in some manner with the terms of the Claims Payment Requirements, the Claims Payment Requirements shall supersede the language of Sections 17.1 and 17.2 hereof.

SUBJECT TO REVIEW AND APPROVAL
BY DEPARTMENT OF MANAGED HEALTH CARE, DEPARTMENT OF INSURANCE
AND DEPARTMENT OF HEALTH CARE SERVICES

SCHEDULE A

REIMBURSEMENT

SOLE COMMUNITY AND CRITICAL ACCESS HOSPITAL

COMPENSATION SCHEDULE – MEDI-CAL

Northern Inyo Hospital

Payment to Hospital for Covered Services rendered to a Covered Person shall be paid by Payor according to the terms set forth within this Schedule.

Inpatient Services. For inpatient Covered Services rendered to a Covered Person during a single admission, and billed under the Hospital's tax identification number ("TIN"), Payor shall pay Hospital the lesser of: (i) Hospital's Allowable Charges; or (ii) one hundred percent (100%) of the rates set forth below in Table 1. Such payment shall be inclusive of all services rendered.

Table 1

Category	Description	Payment Methodology	Negotiated Payment
Inpatient Admissions		Per Diem	$7,100.00

Year 1 Inpatient Rates. Both parties agree to establish an all inclusive Per Diem based on the most current and filed cost report that represents one hundred percent (100%) of the cost settled Per Diem. Payment for inpatient services as indicated above shall constitute the final payment from Payor to Hospital. No reconciliation or settlement of the Hospital-specific cost to charge ratio shall occur at year-end.

Year 2 Inpatient Rates. Both parties agree to negotiate within 12 months of the Effective Date of this Schedule a new reimbursement rate that shall be based on the DRG methodology being implemented by the State.

Outpatient Services. For outpatient Covered Services provided to a Covered Person and billed under the Hospital's tax identification number ("TIN"), Payor shall pay Hospital the lesser of: (i) Hospital's Allowable Charges; or (ii) one hundred percent (100%) of the rates set forth below in Table 2. Such payment shall be inclusive of all services rendered.

Table 2

Category	Description	Payment Methodology	Negotiated Payment
Outpatient Services		Cost to Charge Ratio	100% of the most current cost settled Cost to Charge Ratio

Year 1 Rates. Both parties mutually agree to establish a Cost to Charge ratio based on the most current and filed cost report that represents one hundred percent (100%) of the cost settled Outpatient Services. Payment for outpatient services as indicated above shall constitute the final payment from Payor to Hospital. No reconciliation or settlement of the Hospital-specific cost to charge ratio shall occur at year-end. Payor and Hospital shall utilize the most current cost settled report to determine the Outpatient Cost to Charge Ratio.

Year 2 Rates. Both parties mutually agree to negotiate within 12 months of the Effective Date of this Schedule a fixed rate reimbursement schedule for Outpatient Services being reimbursed on Cost to Charge Ratio.

Additional Provisions:

1. Application of 72-Hour Rule. Payments made to Hospital for inpatient services shall include all costs relating to a Covered Person's pre-admission diagnostic testing and procedures, including, but not limited to, laboratory services, pathology services, radiology services, and medical/surgical supplies, occurring within 72 hours of an admission.

2. Readmissions. Payor reserves the right to perform a retrospective utilization review of twenty-four (24) day readmissions for Covered Persons who are readmitted as an inpatient to the same hospital or different hospital for the same condition within twenty-four (24) calendar days of the discharge date. Payor may deny payment for readmissions based on medical records review of the admission and readmission.

3. Interim Bills. Hospital is required to submit interim bills for inpatient members on 30 day intervals to the Payor.

4. Payment for Professional Services. Payment for those professional Covered Services, including but not limited to services provided by Hospital-based physicians, Certified Registered Nurse Anesthetists ("CRNAs") or other professionals, that are billed on a Claim Form under Hospital's TIN and provider identification number in connection with inpatient Covered Services is included in any payment for such inpatient Covered Services pursuant to this Schedule. Payment for those professional Covered Services that are billed on a CMS 1500 or its successor form under Hospital's TIN and provider identification number in connection with outpatient Covered Services shall be determined pursuant to the Medicaid physician services fee schedule.

5. Coordination for Transplant Services. Hospital agrees to coordinate transplant Covered Services and reimbursement for such Covered Services with Payor's designated transplant vendor.

6. Multiple Dates of Service on Single Claim Form. Hospital is required to identify each date of service on the Claim Form when submitting claims for multiple dates of service.

7. Code Change Updates. Updates to billing-related codes (e.g., CPT, HCPCS, ICD-9, DRG, and revenue codes) shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

8. Fee Change Updates. Updates to such fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; or (ii) the effective date of such fee schedule updates, as determined by such governmental agency. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to such fee schedule.

9. Chargemaster Updates. Hospital shall provide Payor with 120 days written notice prior to the effective date of any increase to Hospital's chargemaster ("Chargemaster Increase"). Such written notice shall include the effective date of the Chargemaster Increase and the percentage increase (the "Chargemaster Increase Percentage") for each of the following categories: (i) inpatient charges, (ii) outpatient charges, and (iii) all charges (i.e., the aggregate percentage increase for both inpatient and outpatient charges).

Payor and Hospital agree to limit the effect of Chargemaster Increases. If, during any consecutive twelve (12) month period during the term of this Agreement, there are Chargemaster Increases for any payment for Covered Services hereunder that are based on a percentage of Hospital's Allowable Charges for such category of services, payment will be adjusted to ensure that such amount does not increase by a percentage greater than the Chargemaster Increase Percentage. Specifically, each payment for Covered Services as provided hereunder will be adjusted to the percentage represented by the following formula, rounded to the second decimal point:

$$\frac{\text{Current Percentage of Allowable Charges}}{(1+\text{Chargemaster Increase Percentage})}$$

Payor will give written notice to Hospital of any adjustments to payments hereunder as a result of the foregoing limitation on Chargemaster Increases, along with the calculations in connection therewith, and such adjustments shall be effective as of the effective date of Hospital's Chargemaster Increases.

Hospital shall provide Payor with a copy of Hospital's chargemaster in a mutually agreed upon format (i) as of the Effective Date of this Agreement, (ii) within 120 days of Hospital's notice to Payor of any Chargemaster Increase, and (iii) at any time upon Payor's written request. If Payor determines, based on review of the chargemaster and/or claims or other data, that (a) Hospital has failed to provide written notice of a Chargemaster Increase as required above, or (b) the Chargemaster Increase Percentage for which Payor received notice from Hospital was not the Chargemaster Increase Percentage implemented by Hospital, Payor may retroactively adjust payments to Hospital using the methodology set forth above and may recoup as overpayments the difference between the amounts paid to Hospital for Covered Services and the amounts that would have been paid to Hospital for Covered Services had the payment adjustments as set forth herein been made. Recovery of such overpayments by Payor shall be recouped in accordance with the terms and conditions of the Agreement.

10. Payment under this Schedule. All payments under this Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and the Billing Manual.

Definitions:

1. **Allowable Charges** means those Hospital billed charges for services that qualify as Covered Services.

SUBJECT TO REVIEW AND APPROVAL
BY DEPARTMENT OF MANAGED HEALTH CARE, DEPARTMENT OF INSURANCE
AND DEPARTMENT OF HEALTH CARE SERVICES

SCHEDULE B

GROUP COMPENSATION SCHEDULE - MEDI-CAL

Northern Inyo Hospital

For Covered Services provided to Covered Persons, Payor shall pay Group the lesser of: (i) the Group's Allowable Charges; or (ii) one hundred percent (100%) of the State's Medi-Cal fee schedule or Payor's equivalent fee schedule in effect on the date of service and specific to the services rendered.

Notwithstanding anything to the contrary contained herein, in no event will the rate or fee payable hereunder, paid by Payor exceed the applicable, final, minimum payment rate required in sections 1902(a)(13), 1902(jj), 1932(f), and 1905(dd) of the Social Security Act, as amended by the Patient Protection and Affordable Care Act of 2010, Health Care and Education Reconciliation Act of 2010, or other such legislation.

Additional Provisions:

1. Code Change Updates. Updates to billing-related codes (e.g., CPT, HCPCS, ICD-9, DRG, and revenue codes) shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency. Claim processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

2. Fee Change Updates. Updates to such fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; or (ii) the effective date of such fee schedule updates, as determined by such governmental agency. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to such fee schedule.

3. Payment under this Exhibit. All payments under this Exhibit are subject to the terms and conditions set forth in the Agreement, the Provider Manual and the Billing Manual.

Definitions:

1. **Allowable Charges** mean those Group billed charges for services that qualify as Covered Services.

SUBJECT TO REVIEW AND APPROVAL
BY DEPARTMENT OF MANAGED HEALTH CARE, DEPARTMENT OF INSURANCE,
AND DEPARTMENT OF HEALTH CARE SERVICES

SCHEDULE C

CLINIC COMPENSATION SCHEDULE – MEDI-CAL

Northern Inyo Hospital

For Covered Services provided to Covered Persons, Payor shall pay Clinic the lesser of: (i) the Clinic's Allowable Charges; or (ii) one hundred percent (100%) of the State's Medi-Cal fee schedule or Payor's equivalent fee schedule in effect on the date of service and specific to the services rendered.

Additional Provisions:

1. Code Change Updates. Updates to billing-related codes (e.g., CPT, HCPCS, ICD-9, DRG, and revenue codes) shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency. Claim processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

2. Fee Change Updates. Updates to such fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; or (ii) the effective date of such fee schedule updates, as determined by such governmental agency. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to such fee schedule.

3. Payment under this Exhibit. All payments under this Exhibit are subject to the terms and conditions set forth in the Agreement, the Clinic Manual and the Billing Manual.

Definitions:

1. **Allowable Charges** mean those Clinic billed charges for services that qualify as Covered Services.

SUBJECT TO REVIEW AND APPROVAL
BY DEPARTMENT OF MANAGED HEALTH CARE, DEPARTMENT OF INSURANCE,
AND DEPARTMENT OF HEALTH CARE SERVICES

SCHEDULE D

ANCILLARY COMPENSATION SCHEDULE – MEDI-CAL

Northern Inyo Hospital

For Covered Services provided to Covered Persons, Payor shall pay Provider the lesser of: (i) the Provider's Allowable Charges; or (ii) one hundred percent (100%) of the State's Medi-Cal fee schedule or Payor's equivalent fee schedule in effect on the date of service and specific to the services rendered.

Additional Provisions:

1. Code Change Updates. Updates to billing-related codes (e.g., CPT, HCPCS, ICD-9, DRG, and revenue codes) shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency. Claim processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

2. Fee Change Updates. Updates to such fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; or (ii) the effective date of such fee schedule updates, as determined by such governmental agency. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to such fee schedule.

3. Payment under this Exhibit. All payments under this Exhibit are subject to the terms and conditions set forth in the Agreement, the Provider Manual and the Billing Manual.

Definitions:

1. **Allowable Charges** mean those Provider billed charges for services that qualify as Covered Services.

SCHEDULE E

COVERED SERVICES AND EXCLUSIONS

Available upon contract awardnorthe

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Exempt payee

☐ Other (see instructions) ▶

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I Instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,
- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

Disregarded entity. Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.

Note. Check the appropriate box for the federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the tax classification in the space provided. If you are an LLC that is treated as a partnership for federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name/ disregarded entity name" line.

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the "Business name/ disregarded entity name," sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 5 and 7 through 13. Also, C corporations.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt payees 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, below, and items 4 and 5 on page 4 indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt Payee* on page 3.

Signature requirements. Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity [4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

*Note. Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

CALIFORNIA
HEALTH AND WELLNESS PLAN

Disclosure of Ownership And Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to California Health and Wellness Plan within 30 days of the change. Please attach a separate sheet if necessary to provide complete information.

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity	
Name of Individual, Group Practice, or Disclosing Entity:	
DBA Name:	
Address:	
Federal Tax Identification Number:	Provider CAQH #:

Section I

List the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.

List the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section II

Are any of the individuals listed above related to each other? ☐ Yes ☐ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of relation

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐ Yes ☐ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

CALIFORNIA
HEALTH AND WELLNESS PLAN

Disclosure of Ownership And Control Interest Statement

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? ☐ Yes ☐ No (verify through IUIS-OIG Website)

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more that $25,000 or any significant business transactions with any subcontractors? ☐ Yes ☐ No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5-year period. (42 CFR 455.105).
Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information 1) as a Disclosing Entity? ☐ Yes ☐ No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature _____ Title (or indicate if authorized Agent) _____

Name (please print) _____ Date _____

Please return the form by fax to, or by mail in the enclosed postage paid envelope to:

California Health and Wellness Plan
1215 K Street 17th floor, Suite 1722
Sacramento, 95814
(P) 877-658-0305 • (F) 877-502-7255 • www.CAHealthWellness.com

THIS SHEET

INTENTIONALLY

LEFT BLANK

SHARED SAVINGS PARTICIPATION AGREEMENT

THIS SHARED SAVINGS PARTICIPATION AGREEMENT ("Agreement") is entered into this __ day of ____, 2013, by and between **NATIONAL RURAL ACO CORP.** ("ACO"), and _____ ("Participant").

RECITALS

A. The ACO is developing a network of integrated health care providers capable of meeting the health care needs within their communities.

B. The ACO will contract with the Department of Health and Human Services ("DHHS"), the Centers for Medicare & Medicaid Services ("CMS"), certain states (Medicaid), other governmental entities and agencies, and with commercial third-party payors, as an accountable care organization, participating in the Medicare Shared Savings Program (the "Program") and similar shared savings programs.

C. The mission of the ACO is better health for populations, better care for individuals, and lower growth in health care expenditures.

D. The ACO intends to create and contract with a network of participants that will be accountable for the quality, cost and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO.

E. The Participant is a hospital, physician, physician group, FQHC or RHC enrolled in Medicare that employs or contracts with "ACO Professionals," and desires to be an "ACO Participant" of the ACO, as those terms are defined by applicable federal regulation.

F. The Participant intends to work with the ACO, and other ACO participants, to manage and coordinate care for Medicare fee-for-service beneficiaries, and to be accountable for the quality, cost and overall care of its patients that are Medicare fee-for-service beneficiaries assigned to the ACO.

G. The ACO and the Participant are entering into this Agreement in order to set forth the Participant's and the Provider's rights and obligations in, and representation by, the ACO, including how the opportunity to share in shared savings and other financial arrangements will encourage the ACO participants and the ACO providers/suppliers to adhere to the ACO quality assurance and improvement program and evidence-based clinical guidelines.

NOW, THEREFORE, in consideration of the mutual and respective terms, covenants and agreements contained herein, and intending to be legally bound, the ACO and the Participant agree as follows:

ARTICLE I

AGREEMENT

The ACO and the Participant hereby agree and contract that the Participant shall be an ACO participant of the ACO. The Participant shall provide the items and services described in

Article II, and the ACO shall provide the items and services described in Article III. The ACO and the Participant agree to work collectively (together with other ACO Participants) to manage and coordinate care for Medicare fee-for-service beneficiaries, and to be accountable for the quality, cost and overall care for Medicare fee-for-service beneficiaries assigned to the ACO.

ARTICLE II

OBLIGATIONS OF PARTICPANT

2.1 General Obligations. The Participant supports and agrees to promote the mission of the ACO and the Medicare Shared Savings Program: Better health for populations, better care for individuals, and lower growth in health care expenditures. The Participant agrees to implement and comply with the ACO's processes to promote evidence-based medicine, to promote patient engagement, to report on quality and cost measures, and to promote coordination of care, which are more fully described in Section 3.2 below ("ACO Processes"). The Participant agrees to meet and satisfy the performance standards established by the ACO for each of these processes. The Participant also agrees to comply with the quality assurance and improvement program, and the evidence-based clinical guidelines, established by the ACO from time to time. The Participant understands and agrees that the Participant may be excluded from sharing in any shared savings payments, and/or terminated from participation in the ACO, if the Participant fails to meet the performance standards for each of the ACO Processes, or fails to comply with the ACO quality assurance and improvement program or evidence-based clinical guidelines. Additionally, the Participant agrees to be accountable for the quality, cost and overall care of its patients that are Medicare fee-for-service beneficiaries assigned to the ACO. The Participant has received a copy of the participation agreement that has or will be entered into by CMS and the ACO ("Participation Agreement"), and the Participant agrees that it will comply with the requirements of the Participation Agreement that apply to ACO participants. Finally, the Participant agrees to participate in and comply with the requirements of the Medicare Shared Savings Program under 42 CFR Part 425.

2.2 Providers. The Participant employs or contracts with physicians, physician assistants, nurse practitioners and certified nurse specialists who provide professional medical services to patients who are Medicare fee-for-service beneficiaries (collectively, "Providers" and individually, a "Provider"). Each of the Providers has agreed to be an "ACO Provider" of the ACO, as that term is defined by applicable federal regulation, and to participate in the Program under this Agreement. Each of the Providers has agreed to be accountable for the quality, cost and overall care of the Provider's patients that are Medicare fee-for-service beneficiaries assigned to the ACO. Upon execution of this Agreement the Participant shall provide to the ACO the National Provider Identifier ("NPI") for each and every Provider that is an employee or independent contractor of the Participant.

2.2.1. Provider Qualifications. At all times during the terms of this Agreement, each Provider shall:

a. Remain current in the Provider's field of practice by attending appropriate seminars and continuing education programs;

b. Be permanently licensed to practice in the state or states in which the Provider is located or provides services, and shall not have had his/her license sanctioned, suspended, or revoked at any time;

c. Be licensed without restriction under state and federal laws to prescribe and dispense, as applicable, controlled substances, narcotics, and other pharmaceuticals;

d. Not have been excluded from participation in Medicare, Medicaid or any other governmental health program; and

e. Be a member of the Participant's (or other hospital's) medical, ancillary, associate or affiliate staff, with appropriate clinical privileges.

The Participants shall immediately notify the ACO of any change in the above described status of any Provider, and or the failure of any Provider to continuously satisfy the requirements of this Section.

2.2.2. Quality of Service. All services rendered by Providers pursuant to the terms of this Agreement shall comply with all applicable federal, state and local statutes, ordinances, rules and regulations. Specifically, the Providers shall comply with the applicable requirements of the Medicare Shared Savings Program under 42 CFR Part 425, and with the requirements of federal criminal law, the false claims act, the anti-kickback statute, the civil monetary penalties law, and the physician self-referral law. In addition, the Providers shall comply with the requirements of the Participation Agreement that apply to providers/suppliers. The Participant shall provide each Provider with a copy of the Participation Agreement.

2.2.3. Provider Agreement. Each Provider shall sign and deliver to the ACO a Provider Agreement pursuant to which the Provider agrees to perform all of the duties and responsibilities of "providers" under the terms of 42 CFR Part 425. Such Provider Agreement shall be in form and substance substantially the same as Exhibit A, which is attached hereto and incorporated herein.

2.3 Disclosure of Participation. Except as disclosed on Schedule 2.3, the Participant represents and warrants that it has not participated in the Program under the same or a different name. The Participant is not related to, and does not have an affiliation with, any other accountable care organization. The Participant further represents and warrants that it has not been excluded from any governmental health care program, and that it has not been previously terminated from the Program.

2.4 Provider's Opportunity to Receive Shared Savings and Other Performance/Incentive Compensation. The Participant will develop a model and mechanism that will permit the Providers to share in the shared savings received by the Participant. A Provider's opportunity to receive shared savings will be contingent on the Provider meeting the ACO's performance standards for each of the processes identified in Section 3.2 below, as well as adhering to the ACO's quality and assurance improvement program and evidence-based clinical guidelines. In addition, the Participant will develop a model and mechanism that integrates the Provider's performance and compliance with such processes, and with the ACO's quality

program and clinical guidelines, as a component of any performance/incentive compensation received by the Provider. Such models and mechanisms shall be developed and implemented in accordance with the terms of the Provider's employment or independent contractor agreement with the Participant. If a Provider repeatedly fails to meet the performance standards of one (1) or more ACO Processes, or repeatedly fails to adhere to the ACO's quality program or clinical guidelines, the Provider will receive a warning, technical assistance and mentoring, and a corrective action plan. A Provider may be terminated from participation in the ACO if the Provider continually fails to meet the performance standards for each of the ACO Processes, or fails to comply with the ACO's quality program or clinical guidelines after receiving a warning, assistance and mentoring, and a corrective action plan. If a Participant disagrees with the determination of the ACO, the Participant may request reconsideration of the determination by sending a written request for reconsideration to the ACO's board of directors. The written request must include all of the facts and circumstances relied on by the Participant. The ACO's board of directors will respond to the Participant's request within thirty (30) days, or such longer period as may be deemed necessary by the ACO's board of directors.

2.4.1. Participant Policies and Procedures. The Participant will develop and implement employment and operational policies and procedures that implement the ACO Processes. The Participant's employees and independent contractors will be required to comply with such policies and procedures.

2.4.2. Training and Support. The Participant will provide its employees and independent contractors with education, training and technical assistance in meeting the performance standards for each of the ACO's Processes, and in complying with the ACO's quality program and clinical guidelines. In addition to the education, training and technical assistance, the ACO will regularly meet with participants whose providers are failing to meet the applicable performance standards in order to formulate a plan by which such Providers will improve the performance, and meet all applicable performance standards. If a Provider continues to fail to meet such performance standards, however, such Provider may be expelled from participating in the ACO.

2.5 Provider's Rights, Obligations, and Representations by the ACO. This Agreement, the Provider's employment or independent contractor agreement, and the Provider Agreement, together, describe the Provider's rights and obligations in, and representation by, the ACO.

2.6 Certifications. The Participant acknowledges and agrees that the Participant, and its providers, are participating in the ACO by and through this Agreement. The Participant further acknowledges and agrees that the Participation Agreement and applicable federal regulations requires the ACO to make certain representations to CMS concerning the ACO, the Participant and its providers. To the extent the ACO is in full compliance with its obligations under this Agreement, and to the extent any representation or certification concerning the Participant or Providers is addressed in this Agreement, the ACO may make those representations and certifications about the Participant and Providers as may be required by applicable federal regulation or the Participation Agreement.

2.7 Requirement for Data Submission and Certification. The Participant shall submit to the ACO all data and information required for compliance with the requirements of the

Program, including those data and measures designated by CMS under 42 CFR Part 425.500, in a form and manner specified by CMS. To the extent reasonably feasible, the ACO will pull such data and information from the Participant's electronic medical records. The Participant will provide electronic access to such data and information, and will assist the ACO in its collection and reporting of Participant and Provider data required for compliance with the Program requirements. An individual with legal authority to bind the Participant shall certify the accuracy, completeness and truthfulness of the data and information submitted by the Participant (including the data and information collected by the ACO from the Participant's electronic medical records), to the best of his or her knowledge, information and belief.

2.8 Reporting of NPIs. The Participant must maintain, update and annually furnish to the ACO, at least thirty (30) days prior to the beginning of each performance year, and at such other times as requested by the ACO, a list of each Provider's NPI. The Participant must notify the ACO within fifteen (15) days of any changes to the list of NPIs. In addition, the Participant shall provide a full and complete list of all of the Participant's Providers, and their corresponding NPIs, upon execution of this Agreement. Participant must also notify the ACO within fifteen (15) days of any changes affecting or related to its Taxpayer Identification Number ("TIN").

2.9 Beneficiary Inducements. The Participant shall not offer or provide any gift or other remuneration to beneficiaries as an inducement for the beneficiary to receive items or services from the Participant or any other participant or provider, or for remaining in the ACO or with the Participant or with any other participant or provider, except as may be permitted by the Program or other applicable federal regulation.

2.10 Prohibition on Certain Required Referrals. The Participant shall not:

a. Condition the participation of Providers in the ACO on referrals of federal health care program business that the Provider knows or should know is being (or would be) provided to beneficiaries who are not assigned to the ACO; or

b. Require that beneficiaries be referred only to Participant, Providers or other ACO participants or providers within the ACO, or to any other provider or supplier, except that this prohibition does not apply to referrals made by employees or contractors who are operating within the scope of their employment or contractual arrangement with the Participant, provided that the employees and contractors remain free to make referrals without restriction or limitation if the beneficiary expresses a preference for a different provider, practitioner, or supplier; the beneficiaries insured determines the provider, practitioner or supplier; or the referral is not in the beneficiary's best medical interest in the judgment of the referring party.

2.11 Exclusivity. The Participant hereby agrees to commit to participating in the ACO and to the Participation Agreement between the ACO and CMS. Each Participant TIN on which beneficiary assignment is dependent shall be exclusive to the ACO for the purposes of beneficiary assignment. The Participant further agrees that from January 1, 2014 through December 31, 2016, the Participant will be exclusive to the ACO, the Participant will only participate in the Program as a participant of the ACO, and that the Participant will not participate in the Program as a participant, provider or supplier of any accountable care organization other than the ACO, unless this Agreement is terminated as provided for in Section

5.2.1 by mutual agreement or Section 5.2.2 because the ACO and CMS did not enter into and execute a Participation Agreement on or before January 1, 2014.

2.12 Marketing Requirements. The Participant and the Providers shall only participate in those marketing activities, and use and provide those marketing materials, that have been approved, or are deemed approved, by CMS. The Participant and the Providers shall immediately discontinue the use of any marketing materials or marketing activities that have been disapproved by CMS. In addition, neither the Participant nor the Providers shall participate in any marketing activity, or use or provide any ACO marketing materials that have not been approved by the ACO. The Participant and the Providers shall immediately discontinue the use of any marketing materials or any marketing activities that have been disapproved by the ACO.

2.13 Notification to Beneficiaries. The ACO intends to notify beneficiaries in accordance with Section 3.12 that the Providers are participating in the Program. However, if the ACO instead requests that the Participant notify the beneficiaries, the Participant shall do all of the following:

a. Notify beneficiaries at the point of care that the Providers are participating in the Medicare Shared Savings Program;

b. Post signs in its offices and clinics to notify beneficiaries that the Providers are participating in the Medicare Shared Savings Program; and

c. Make available standardized written notices regarding participation in the ACO and, if applicable, data opt-out. Such written notices must be provided by the Participant in the settings in which beneficiaries receive primary care services.

2.14 Audits and Record Retention. The Participant agrees that CMS, the DHHS, the Comptroller General, the federal government or their designees have the right to audit, inspect, investigate, and evaluate any books, contracts, records, documents and other evidence of the Participant related to Participant activities that pertain to the following:

a. The Participant's compliance with the program; and

b. The quality of services performed and determination of amount due to or from CMS under the Participation Agreement.

If as a result of any inspection, evaluation, or audit, it is determined that the amount of shared savings due to the Participant has been calculated in error, CMS reserves the right to reopen the initial determination and issue a revised initial determination.

The Participant agrees to the following:

a. To maintain and give CMS, the DHHS, the Comptroller General, the federal government or their designees access to all books, contracts, records, documents and other evidence (including data related to Medicare utilization and costs, quality performance measures, shared savings distributions, and other financial arrangements related to the Participant activities) sufficient to enable the audit, evaluation, investigation and inspection of

the Participant's compliance with the Program requirements, quality of services performed, right to any shared savings payment or obligation to repay losses, ability to bear the risk of potential losses, and ability to repay any losses to CMS;

b. To maintain such books, contracts, records, documents and other evidence for a period of ten (10) years from the final date of the agreement period or from the date of completion of any audit, evaluation, or inspection, whichever is later, unless:

(1) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the Participant at least thirty (30) days before the normal disposition date; or

(2) There has been a termination, dispute or allegation of fraud or similar fault against the Participant or Provider, in which case the Participant must retain records for an additional six (6) years from the date of any resulting final determination of the termination, dispute or allegation of fraud or similar fault.

2.15 Electronic Health Records Technology. The Participant agrees to implement and maintain a certified electronic health record infrastructure, including appropriate education, training and technical assistance for the Providers, so that the Participant and Providers can meet the quality performance measures and standards related to electronic health records and "meaningful use." The Participant must also connect to an ACO approved health information exchange no later than December 15, 2013.

2.16 At-Risk Beneficiaries. Neither the Participant, nor any Providers, shall avoid at-risk Medicare beneficiaries.

2.17 Support Services Fee; PQRS Administrative Fee. Participant acknowledges and agrees that the ACO will provide those administrative and management services required to operate an effective accountable care organization, and to satisfy the requirements of the Program. Those administrative and management services include, but are not limited to, the administrative and management services listed on Schedule 3.5. The Participant also acknowledges and agrees that the ACO may select and contract with vendors that will provide certain management services and information technology solutions and services required to successfully develop and manage the ACO.

To fund the ACO's acquisition, development and provision of the administrative, information technology and management services listed on Schedule 3.5 and elsewhere in this Agreement (collectively and separately the "administrative and management services"), Participant agrees to pay ACO the support services fee described and specified on Schedule 3.5 (the "Support Services Fee"). Any monthly Support Services Fee shall be paid to the ACO by the Participant on or before the first day of each month during the term of this Agreement, beginning on the first day of the first full month following the Participant's execution of this Agreement.

The Participant and Providers acknowledge and agree that the ACO will provide certain administrative services in connection with the Physician Quality Reporting System ("PQRS") incentive under the Program, as more fully provided for in Section 3.15 of this Agreement. To

compensate the ACO for the administrative services it provides in connection with the PQRS incentive, the Participants and the Providers agree that the ACO will receive, and may retain, ten percent (10%) of any PQRS incentive payment received by the ACO (if any) that is attributable to the covered professional services furnished by the Participant's Provider(s) during the applicable calendar year (the "PQRS Administrative Fee").

2.18 ACO Not Practicing Medicine. Nothing in this Agreement shall be construed to designate ACO as an entity engaged in the practice of medicine and surgery or in violation of any law, rule, regulation, statute or common law prohibiting non-physicians from engaging in the unauthorized practice of medicine and surgery.

2.19 Participant's and Providers' Continuing Responsibility to Patients. Nothing in this Agreement shall be construed to limit or affect the Participant's, or its Providers', responsibility to patients under applicable law and medical ethics.

2.20 Fee for Service Payments. The Participant acknowledges and agrees that it will be reimbursed by Medicare, and not by the ACO, for covered services that Participant and its Providers provide to its patients who are Medicare beneficiaries, in accordance with applicable Medicare payment rules.

2.21 Care Coordinator; Care Coordination Team. The Principal Participant shall employ a qualified individual to be the Participant's Care Coordinator. The Care Coordinator shall be an employee of the Principal Participant and be paid by the Principal Participant. The Principal Participant shall select and maintain a Participant care coordination team that will assist the Care Coordinator to coordinate the care provided to the Program beneficiaries attributed to the Community's Providers ("Care Coordination Team"). The Care Coordination Team shall also provide the Providers with education, training and technical assistance in meeting the performance standards for each of the ACO's Processes, and in complying with the ACO's quality program and clinical guidelines. The Care Coordinator will be a member of the Care Coordination Team.

ARTICLE III

OBLIGATIONS OF ACO

3.1 General Obligations. The ACO, together with its participants and providers/suppliers, in accordance with the terms of this Agreement and the Participation Agreement, shall be accountable for the quality, cost and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO. The ACO shall promote evidence-based medicine and beneficiary engagement, internally report on quality and cost metrics, and coordinate care. The ACO shall also adopt a focus on patient centeredness that is promoted by its governing body, its participants and providers, and is integrated into practice by the ACO working with participants, providers and suppliers. The ACO has and will develop defined processes to fulfill these requirements.

3.2 ACO Processes. The ACO has and will define, establish, implement, evaluate and periodically update processes ("ACO Processes") to accomplish each of the following:

3.2.1. Promote Evidence-Based Medicine. These processes must cover diagnoses with significant potential for the ACO to achieve quality improvements, taking into account the circumstances of individual beneficiaries.

3.2.2. Promote Patient Engagement. These processes will address the following areas:

a. Compliance with the patient experience of care survey requirement provided for in 42 CFR Part 425.500;

b. Compliance with beneficiary representative requirements provided for in 42 CFR Part 425.106;

c. A process for evaluating the health needs of the ACO's population, including consideration of diversity in its patient populations, and a plan to address the needs of its population;

d. Communication of clinical knowledge/evidence-based medicine to beneficiaries in a way that is understandable to them;

e. Beneficiary engagement and shared decision making that takes into account the beneficiaries' unique needs, preferences, values and priorities; and

f. Written standards for beneficiary access and communication and a process for beneficiaries to access their medical records.

3.2.3. Report on Quality and Cost Measures. The ACO will develop an infrastructure for the Participant, other ACO participants, and ACO providers/suppliers to internally report on quality and cost metrics that will enable the ACO to monitor, provide feedback and evaluate ACO participants and ACO providers/suppliers performance and to use these results to improve care over time.

3.2.4. Promote Coordination of Care. The ACO will coordinate care across and among primary care physicians and providers, specialists, and acute and post-acute providers and suppliers. The ACO will define specific methods and processes that will be established to coordinate care throughout an episode of care and during its transitions, such as discharge from a hospital or transfer of care from a primary care physician to a specialist, both inside and outside of the ACO.

3.2.5. Implementation of ACO Processes. The ACO will develop, define and implement the ACO Processes and corresponding performance standards. The ACO will develop policies and procedures that will facilitate and effectuate the implementation of the ACO Processes. Such policies and procedures will be both ACO policies and procedures, and Participant policies and procedures. Additionally, the ACO, the Participants, and the other ACO participants will develop and provide the education, training and technical assistance necessary to promote and facilitate the Providers' compliance with the ACO Processes, as well as the ACO's quality program and evidence-based clinical guidelines. The ACO will also regularly review the performance of each Provider to provide prompt feedback to Participants about their

Provider's performance. In addition to the education, training and technical assistance, the ACO will regularly meet with Participants whose Providers repeatedly fail to meet the performance standards of one (1) or more ACO Processes or repeatedly fail to adhere to the ACO's quality program or clinical guidelines. Such Providers will receive a warning, assistance and mentoring, and a corrective action plan. If a Provider continues to fail to meet such performance standards, such Provider may be expelled from participating in the ACO. If a Participant disagrees with a determination of the ACO, the Participant may request reconsideration of the determination by sending a written request for reconsideration to the ACO's board of directors. The written request must include all the facts and circumstances relied on by the Participant. The ACO's board of directors will respond to the Participant's request within thirty (30) days, or such longer period as may be deemed necessary by the ACO's board of directors.

3.3 Shared Savings and Other Performance/Incentive Compensation. The ACO board of directors shall develop a method and mechanism by which the ACO participants, and the ACO providers through the ACO participants, may receive shared savings to encourage the ACO participants and providers to meet the performance standards for each of the ACO Processes, and to adhere to the ACO's quality program and evidence-based clinical guidelines. The Participant's, and each other participant's and provider's receipt of shared savings shall be based on its/his/her performance on each of the ACO Processes and its/his/her adherence to the ACO's quality program and evidence-based clinical guidelines, in addition to such participant's/provider's financial performance. The Participant, and each Provider, will only share in the shared savings it generates if it/he/she satisfies the performance requirements described in this Section. Neither the Participant, nor any other participant or provider may receive any portion of shared savings unless it/he/she satisfies the performance standards for each of the ACO Processes and complies with requirements of the ACO's quality program and evidence-based clinical guidelines.

Ninety percent (90%) of all shared savings payments received by the ACO from the Program or from any other governmental or commercial shared savings program (the "Participant/Provider Distribution"), shall be distributed to qualifying ACO participants in accordance with the terms of this Agreement. Distribution of shared savings payments to qualifying ACO participants will be allocated based on the individual participant's financial performance, and on its implementation of the ACO's Processes and the ACO's quality program and evidence-based clinical guidelines. All of each year's Participant/Provider Distribution will be distributed to qualifying participants each year. No part of the Participant/Provider Distribution will be retained, used or held over by the ACO. The participants receiving shared savings payments will use and/or distribute its share of the Participant/Provider Distribution as the individual participant determines, so long as the use and/or distribution is in compliance with applicable law, the requirements of this Agreement, and the goals and objectives of the Program. The remaining ten percent (10%) of any shared savings payment received by the ACO from the Program or any other governmental or commercial shared savings program (the "ACO Distribution"), shall be used by the ACO for the provision and purchase of services for the operation of the ACO. Up to fifty percent (50%) of the ten percent withhold may be used to provide local support services for the participants.

3.4 ACO Budget. The ACO will develop a budget that allocates Support Services Fees, shared savings, financial and human investments, grants and contributions to the provision

and purchase of administrative and management services for the operation of the ACO, the development and provision of operational infrastructure (including, without limitation, clinical expertise, personnel, information technology capability, community and beneficiary involvement and input, and organizational infrastructure), the development and implementation of new care processes, and the development and implementation of a financial model and method that will encourage providers to implement and comply with the ACO Processes, the ACO quality program, and the evidence-based clinical guidelines.

3.5 Administrative and Management Services. The ACO will provide those administrative and management services required to operate an effective accountable care organization, and to satisfy the requirements of the Program. Such administrative and management services include, without limitation, those administrative and management services listed on Schedule 3.5. In addition, the ACO may select and contract with vendors that will provide those management services and information technology solutions and services required to successfully develop and manage the ACO.

3.6 Compliance Plan. The ACO shall have a compliance plan that includes at least the following elements:

a. A designated compliance officer who is not legal counsel for the ACO and who reports directly to the ACO's governing body;

b. Mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance;

c. A method for the Participant, Providers, and other ACO participants and providers to anonymously report suspected problems related to the ACO to the compliance officer;

d. Compliance training for the ACO and ACO participants and providers, including, without limitation, the Participant and Providers; and

e. Reporting by the ACO of probable violations of law to an appropriate law enforcement agency. The ACO's compliance plan must be in compliance with and updated periodically to reflect changes in law and regulations.

3.7 Requirements for Data Submission and Certification. The ACO shall submit to CMS all data and information required for compliance with the requirements of the Program, including those data and measures designated by CMS under 42 CFR Part 425.500, in a form and manner specified by CMS. With respect to the data and information that are generated or submitted by the ACO, an individual with legal authority to bind the ACO shall certify the accuracy, completeness and truthfulness of the data and information to the best of his or her knowledge, information and belief. At the end of each performance year, an individual with legal authority to bind the ACO shall certify to the best of his or her knowledge, information and belief:

a. That the ACO, and its ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities are in compliance with Program requirements; and

b. The accuracy, completeness and truthfulness of all data and information that are generated or submitted by the ACO, ACO participants, ACO providers/suppliers, or other individuals or entities performing functions or services related to ACO activities, including any quality data or other information or data relied upon by CMS in determining the ACO's eligibility for, in the amount of a shared savings payment.

3.8 Beneficiary Inducements. The ACO shall not offer or provide any gift or other remuneration to beneficiaries as an inducement for the beneficiary to receive items or services from the ACO or any ACO participant or provider, or for remaining in the ACO or with any ACO participant or provider, except as may be permitted by the Program or other applicable federal regulation.

3.9 Prohibition on Certain Required Referrals. The ACO shall not:

a. Condition the participation of ACO participants, ACO providers/suppliers, or other individuals or entities performing functions or services related to ACO activities in the ACO, on referrals of federal health care program business that the ACO knows or should know is being (or would be) provided to beneficiaries who are not assigned to the ACO; or

b. Require that beneficiaries be referred only to participants or providers/suppliers within the ACO, or to any other provider or supplier, except that this prohibition does not apply to referrals made by employees or contractors who are operating within the scope of their employment or contractual arrangement, provided that the employees and contractors remain free to make referrals without restriction or limitation if the beneficiary expresses a preference for a different provider, practitioner, or supplier; the beneficiaries insured determines the provider, practitioner or supplier; or the referral is not in the beneficiary's best medical interest in the judgment of the referring party.

3.10 Required Reporting of NPIs and TINs. The ACO must maintain, update and annually furnish to CMS at the beginning of each performance year, and at such other times as specified by CMS, a list of each ACO participant's TIN and ACO providers'/suppliers' NPI that is required to be submitted under CFR Part 425.204. The ACO must notify CMS within thirty (30) days of any changes to the list of NPIs and TINs. The ACO must submit data on the quality measures determined by CMS, according to the method of submission established by CMS.

3.11 Marketing Requirements. The ACO agrees that it will only participate in those marketing activities, and use (and provide to Participant and Providers) those marketing materials, that have been approved or are deemed approved by CMS. The ACO shall discontinue the use and promotion of any marketing materials or activities that have been disapproved by CMS. All ACO marketing materials and activities must meet all of the following requirements:

a. Use of template language developed by CMS, if available;

b. Not be used in a discriminatory manner or for discriminatory purposes;

c. Not be used in such a way as to constitute an improper beneficiary inducement or in any way that violates the requirements of 42 CFR 425.304(a); and

d. Not be materially inaccurate or misleading.

3.12 Notification of Beneficiaries. The ACO has the option of notifying beneficiaries on the preliminary prospective assignment list and quarterly assignment list provided to the ACO by CMS. If the ACO chooses this option to notify beneficiaries, it must use the standardized written notice developed by CMS. Because beneficiary notifications under this option meet the definition of marketing materials and activities, such notifications must meet all the applicable marketing requirements described in 42 CFR Part 425.310.

3.13 Audits and Record Retention. The ACO agrees that CMS, the Comptroller General, the federal government or their designees have the right to audit, inspect, investigate, and evaluate any books, contracts, records, documents and other evidence of the ACO related to ACO activities that pertain to all of the following:

a. The ACO's compliance with the program;

b. The quality of services performed and determination of amount due to or from CMS under the Participation Agreement; and

c. If as a result of any inspection, evaluation, or audit, it is determined that the amount of shared savings due to the ACO has been calculated in error, CMS reserves the right to reopen the initial determination and issue a revised initial determination.

The ACO agrees to the following:

a. To maintain and give CMS, the DHHS, the Comptroller General, the federal government or their designees access to all books, contracts, records, documents and other evidence (including data related to Medicare utilization and costs, quality performance measures, shared savings distributions, and other financial arrangements related to ACO activities) sufficient to enable the audit, evaluation, investigation and inspection of the ACO's compliance with the Program requirements, quality of services performed, right to any shared savings payment or obligation to repay losses, ability to bear the risk of potential losses, and ability to repay any losses to CMS;

b. To maintain such books, contracts, records, documents and other evidence for a period of ten (10) years from the final date of the agreement period or from the date of completion of any audit, evaluation, or inspection, whichever is later, unless:

(1) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the ACO at least thirty (30) days before the normal disposition date; or

(2) There has been a termination, dispute or allegation of fraud or similar fault against the ACO, its ACO participants, its ACO providers/suppliers, or other

individuals or entities performing functions or services related to ACO activities, in which case the ACO must retain records for an additional six (6) years from the date of any resulting final determination of the termination, dispute or allegation of fraud or similar fault.

3.14 Patient Experience of Care Survey. For the performance years beginning in ____ and for subsequent performance years, the ACO shall select a CMS-certified vendor to administer the patient experience of care survey, and shall report the results to CMS accordingly.

3.15 Physician Quality Reporting System. The ACO, on behalf of the Providers and the other ACO providers/supplies who are eligible professionals, shall submit the measures determined under 42 Part CFR 425.500 using the GPRO web interface established by CMS, to qualify on behalf of their eligible professionals for the PQRS incentive. Under the Program, the ACO, on behalf of the Providers and the other ACO providers/suppliers who are eligible professionals, must satisfactorily report the measures determined by CMS during the reporting period according to the method of submission established by CMS. Subject to Section 3.16 below, if any of the Providers or the other ACO providers/suppliers who are eligible professionals within the ACO qualify for a PQRS incentive payment, each ACO participant TIN, on behalf of the applicable ACO providers/suppliers, will receive an incentive, for those years an incentive is available, based on the allowed charges under the physician fee schedule for that TIN. The PQRS incentive under the Program is equal to 0.5 percent of CMS' estimate of the eligible professionals' total Medicare Part B Physician Fee Schedule allowed charges for covered professional services furnished during the calendar year reporting period from January 1 through December 31, for 2014.

3.16 PQRS Payments. If the Participant and/or the Participant's Provider(s) are eligible professionals under the PQRS program for whom the ACO receives a PQRS incentive payment, the ACO shall promptly pay over to the Participant that portion of the annual PQRS incentive payment received by the ACO (if any) that is attributable to the covered professional services furnished by the Participant's Provider(s) during the applicable calendar year, less the PQRS Administrative Fee.

3.17 At-Risk Beneficiaries. The ACO shall not in any way avoid at-risk Medicare beneficiaries.

ARTICLE IV

DATA SHARING

4.1 Obligations of ACO. The ACO will request the CMS aggregate reports and the name, date of birth, gender, and HICN of beneficiaries used to generate the ACO's benchmark. The ACO will also request beneficiary identifiable Part A, B and/or D claims data. The ACO shall observe all relevant statutory and regulatory provisions regarding the appropriate use of such data, and the confidentiality and privacy of individually identifiable health information. The ACO shall comply with all of the terms and requirements of the Data Use Agreement it executes with CMS. The ACO shall not limit or restrict appropriate sharing of medical record data with providers and suppliers, both in and outside the ACO, in accordance with applicable law. The ACO shall request the data referred to above pursuant to established CMS policies and processes. The ACO shall submit an appropriate request so that the data is provided to the ACO

at the beginning of the agreement period, during each quarter, in conjunction with the annual reconciliation, and at the beginning of each performance year. The ACO shall provide CMS with the necessary certifications to obtain such data. The ACO shall request the CMS aggregate data reports, as well as the beneficiary identifiable claims data, for preliminary prospective assigned beneficiaries and other beneficiaries who receive primary care services from an ACO participant or provider during the agreement period. The ACO shall execute and deliver to CMS any requisite Data Use Agreement, and shall submit formal requests for data, in accordance with the requirements of CMS, necessary to obtain the data described herein.

4.2 Data Use Agreement. The ACO agrees to enter into a Data Use Agreement with CMS ("DUA"). The ACO shall comply with the limitations on use and disclosure that are imposed by HIPAA, the applicable DUA, and the statutory and regulatory requirements of the Program. The ACO shall not misuse or disclose data in a manner that violates any applicable statutory and regulatory requirements, or in any way fails to comply with requirements of the DUA, or take any other action which will result in the ACO being ineligible to receive future aggregate data reports and/or beneficiary identifiable data.

4.3 Beneficiary Opt-Out. Before requesting claims data about a particular beneficiary or beneficiaries, the ACO shall inform the beneficiary(ies) that it may request personal health information about the beneficiary(ies) for purposes of its care coordination and quality improvement work, and give the beneficiary a meaningful opportunity to decline having his/her claims information shared with the ACO. The ACO may contact preliminary prospective assigned beneficiaries in writing to request data sharing. If these beneficiaries do not decline within thirty (30) days after the letter is sent, the ACO may request identifiable claims data from CMS. These beneficiaries must also be provided a form explaining the beneficiaries' opportunity to decline data sharing as a part of their first primary care service visit with an ACO participant or ACO provider upon whom assignment is based during the agreement period. For beneficiaries that have a primary care service office visit with an ACO participant or provider who provides primary care services, the ACO must supply the beneficiaries with a written notification explaining their opportunity to decline data sharing. This form must be provided to each beneficiary as a part of their first primary care service visit with an ACO participant or provider upon whom assignment is based during the agreement period.

4.4 Participant Obligations. The Participant and the Providers shall comply with all relevant statutory and regulatory provisions regarding the appropriate use of data and the confidentiality and privacy of individually identifiable health information, and shall comply with the terms of the DUA. Neither the Participant nor the Providers will limit or restrict appropriate sharing of medical record data with providers and suppliers, both within and outside of the ACO, in accordance with applicable law. The Participant and the Providers shall at all times use the data contained in the CMS aggregate data reports, and/or the beneficiary identifiable data in a way and manner that is consistent with requirements of the Program, and the applicable provisions of 42 CFR Part 425, Subpart H. The Participant and the Providers shall supply beneficiaries with written notification explaining their opportunity to decline data sharing. The Participant and the Providers shall provide this form to each beneficiary as a part of such beneficiary's first primary care service visit with the Provider that is providing primary care services.

ARTICLE V

TERM AND TERMINATION

5.1 Term. The term of this Agreement shall commence on _____, 2013, and shall continue through December 31, 2016 (the "Initial Term"). Thereafter, this Agreement shall automatically renew for successive one (1) year terms unless and until terminated as provided for in this Agreement (the "Renewal Term" or "Renewal Terms").

5.2 Termination. This Agreement may be terminated as follows:

5.2.1. Mutual Agreement. This Agreement may be terminated upon the mutual consent and agreement of the ACO and the Participant. Such termination shall be evidenced by a written Termination Agreement that is signed by both the ACO and the Participant.

5.2.2. Failure to Execute a Participation Agreement. If the ACO and CMS fail to execute a Participation Agreement on or before January 1, 2014, then either party may terminate this Agreement, without cause, upon at least ninety (90) days prior written notice to the other party. If the ACO enters into and executes a Participation Agreement with CMS on or before January 1, 2014, then this Agreement may not be terminated without cause prior to the expiration of the Initial Term.

5.2.3. Termination for Failure to Meet Performance Standards. This Agreement may be terminated at any time by the ACO, in its sole discretion, if the Participant or Providers fail to meet the performance standards for each of the ACO Processes, fail to comply with requirements of the ACO's quality assurance and improvement program or evidence-based clinical guidelines, or in any other way fails to fully comply with its obligations under this Agreement, and such failure is not cured to the satisfaction of the ACO within ninety (90) days of the date the Participant receives notice from the ACO of such failure. If the Participant disagrees with the determination of the ACO, the Participant may request reconsideration of the determination by sending a written request for reconsideration to the ACO's board of directors. The written request must include all of the facts and circumstances relied on by the Participant. The ACO's board of directors will respond to the Participant's request within thirty (30) days, or such longer period as may be deemed necessary by the ACO's board of directors. The decision of the ACO's board of directors upon reconsideration shall be final.

5.2.4. Termination by Participant.

a. This Agreement may be terminated by the Participant, upon thirty (30) days prior written notice, in the event that the Participation Agreement between the ACO and CMS is terminated at any time during the Initial Term of this Agreement.

b. So long as the Participant's termination of the Agreement, and consequent withdrawal from the ACO, will not cause the ACO's assigned population to fall below 6,000 assigned beneficiaries, the Participant may terminate this Agreement at any time upon ninety (90) days prior written notice to the ACO. If the Participant's termination of the Agreement, and consequent withdrawal from the ACO, will cause the ACO's assigned population to fall below 6,000 assigned beneficiaries, then the Participant may not terminate this

Agreement under this paragraph 5.2.4.b without the consent and agreement of the ACO's board of directors, which will not be unreasonably withheld. The determination of whether or not the Participant's termination of the Agreement will cause the ACO's assigned population to fall below 6,000 assigned beneficiaries shall be based on the prior quarter's CMS assignment reports. The Participant's termination of the Agreement will cause the ACO's assigned population to fall below 6,000 assigned beneficiaries if the total number of beneficiaries assigned to the ACO by CMS, less the beneficiaries assigned to the ACO based on the Participant's TIN and its Provider's NPIs, is less than 6,000. As used herein, the terms "assigned population" and "assigned beneficiaries" shall have those meanings given those terms in 42 CFR Part 425.

5.2.5. Termination During Renewal Term(s). This Agreement may be terminated during any Renewal Term, without cause, upon ninety (90) days prior written notice to the other party, so long as such termination is not inconsistent with the ACO's obligations under any specific product or program agreement then in effect.

5.2.6. Exclusion of Participant/Provider. This Agreement may be terminated at any time by the ACO, effective upon delivery of notice of termination to the Participant, upon receipt by the ACO of information indicating that Participant has been temporarily or permanently debarred, excluded or ruled ineligible for participation in Medicare, Medicaid or any other federal or state health care program, at any administrative level. The ACO may also terminate this Agreement pursuant to the terms of this Section if the ACO receives notice or information indicating that an officer, director, shareholder or controlling employee of the Participant, or any Provider, has been temporarily or permanently debarred, excluded or ruled ineligible for participation in Medicare, Medicaid or any other federal or state health care program, at any administrative level, if the Participant has not immediately terminated its relationship with such officer, director, shareholder controlling employee or Provider. Termination of this Agreement by the ACO pursuant to the terms of this Section shall give rise to the indemnification obligations of the Participant under the terms of this Agreement.

5.2.7. Failure to Comply with the Terms of the Participation Agreement and Federal Regulations. This Agreement may be terminated by the ACO at any time, if the Participant fails to fully comply with all the applicable requirements of 42 CFR Part 425 or the Participation Agreement. Termination of this Agreement by the ACO pursuant to the terms of this Section will give rise to the indemnification obligations of the Participant under the terms of this Agreement. Notwithstanding the foregoing, in the event Federal Regulations permit any opportunity for a cure, ACO shall afford the Participant the opportunity to cure any defect related to participation during such cure period, not to exceed thirty (30) days.

5.2.8. Other Terminations. This Agreement may be also terminated by either party upon 120 day notice to the other party or as otherwise provided for in this Agreement.

ARTICLE VI

INDEPENDENT CONTRACTOR

6.1 Independent Contractor. In performing their respective responsibilities and duties under this Agreement, it is understood and agreed that the Participant and the Providers are at all times acting as an independent contractor and not as a partner, joint venturer, employee or agent

of the ACO. The ACO shall neither have nor exercise any control or direction over the medical judgment of the Providers, or the methods or manner in which the Providers perform professional services. The Participant shall be solely responsible for paying any compensation due the Providers, whether as employees or independent contractors, including, without limitation, any shared savings payments and/or performance/incentive compensation. The Participant shall be responsible for the withholding and payment of all applicable federal, state and local taxes and for maintaining any insurance that may be required under Michigan law.

6.2 Facilities, Equipment, Supplies, Support Personnel and Billing. The Participant shall be responsible for maintaining its office and clinic facilities, equipment and supplies, and shall provide such personnel as may be reasonably required for the Providers to provide professional services to its patients. The ACO shall not have any obligation or responsibility whatsoever for the maintenance and operation of the Participant's hospital facilities, offices, clinics, or ancillary facilities, or for any equipment, supplies, or professional or support personnel. The Participant shall have the sole right to bill, and collect from, patients and third-party payers, including, without limitation, Medicare, for all professional services rendered by the Providers.

ARTICLE VII

CHANGE IN LAW

It is the belief and understanding of the parties that this Agreement complies in all respects with all applicable federal, state and local statutes, rules and regulations. Specifically, it is the parties' intent and belief that this Agreement complies with the requirements of 42 CFR Part 425, the Participation Agreement, and the requirements of the Program. Pursuant to the requirements of 42 CFR Part 425.212, the ACO and the Participant are subject to all statutory changes, and to all regulatory changes except those specified in 42 CFR Part 425.212. In those instances where there are changes in laws or regulations that require a modification of this Agreement, the parties agree to meet and negotiate such changes as soon as reasonably possible. The parties must agree to an amendment that complies with the changes in laws or regulations, and not terminate this Agreement, unless such change in law or regulation specifically permits the termination of the Participation Agreement without any penalty or assessment to or against the ACO. If such change in law or regulation specifically permits the termination of the Participation Agreement without any penalty or assessment to or against the ACO, then either party may terminate this Agreement by providing written notice to the other party, if the parties are not able to negotiate a mutually acceptable change or revision to this Agreement within ninety (90) days of the effective date of such change in law or regulation.

ARTICLE VIII

INSURANCE AND INDEMNIFICATION

8.1 Insurance and Indemnification: Participant. The Participant shall maintain general liability insurance, and professional liability insurance covering the acts of the Providers that are within the scope of their duties assigned by the Participant, under the terms of such commercial insurance policy as may be acquired by the Participant from time to time, or, at the Participant's option, under the terms of any self-insurance plan which the Participant may adopt

from time to time. Such insurance coverage shall either be an occurrence type or a claims-made type with appropriate tail coverage. All such insurance or self-insurance coverage shall be governed by and subject to the expressed terms, conditions and limitations set forth in the insurance policy and/or plan documents. The Participant shall supply the ACO with evidence of such insurance coverage upon request. The Participant shall provide the ACO with not less than thirty (30) days advance written notice of any cancellation, reduction or material change in the insurance required herein. Anything contained in this Agreement to the contrary notwithstanding, the failure of the Participant to meet the requirements of this Section shall be cause for immediate termination of this Agreement by the ACO. The Participant agrees to indemnify, defend and hold the ACO harmless from and against any and all actions (litigation and administrative actions whether filed or threatened), claims, liabilities, losses, damages and expenses, including the ACO's reasonable attorneys' fees, resulting from or in any way related to the Participant's failure to fully perform all of its duties and obligations under this Agreement, and/or any actual or alleged professional malpractice or other negligence by the Participant or the Providers. The Participant agrees that if the Participant fails to fully perform any of its duties or obligations under this Agreement, and if such failure results in the termination of the Participation Agreement by CMS, then the Participant's indemnification obligation shall include indemnifying the ACO from and against any repayment obligations that may result, in whole or in part, directly or indirectly, from the Participant's failure to fully perform any of its duties or obligations under this Agreement. The general and broad provisions of this Section are not in any way limited or modified by any other Section or provision of this Agreement. This provision shall survive the expiration or termination of this Agreement.

8.2 Insurance and Indemnification: ACO. The ACO shall maintain general liability insurance, and professional liability insurance covering the acts of the ACO, and the acts of its employees and agents that are within the scope of their duties assigned by the ACO, under the terms of such commercial insurance policy as may be acquired by the ACO from time to time, or at the ACO's option, under the terms of any self-insurance plan which the ACO may adopt from time to time. All such insurance or self-insurance coverage shall be governed by and subject to the expressed terms, conditions and limitations set forth in the insurance policy and/or plan documents. The ACO shall supply the Participant with evidence of such insurance coverage upon request. The ACO shall provide the Participant with not less than thirty (30) days advance written notice of any cancellation, reduction or material change in the insurance required herein. Anything contained in this Agreement to the contrary notwithstanding, the failure of the ACO to meet the requirements of this Section shall be cause for immediate termination of this Agreement by the Participant. The ACO agrees to indemnify, defend and hold the Participant harmless from and against any and all actions (litigation and administrative actions whether filed or threatened), claims, liabilities, losses, damages and expenses, including the Participant's reasonable attorneys' fees, resulting from or in any way related to the ACO's failure to fully perform all of its duties and obligations under this Agreement, and/or any actual or alleged negligence by the ACO or its employees. This provision shall survive the expiration or termination of this Agreement.

ARTICLE IX

GENERAL PROVISIONS

9.1 Confidentiality. Each party and its respective employees, agents, representatives, contractors or other designees shall maintain in confidence all business and financial information of the other party not generally known to the public (the "Confidential Information"), including without limitation, the information that the Participant discloses to the ACO pursuant to the terms of this Agreement. Each party shall use and disclose the Confidential Information of the other party only (i) as expressly permitted by this Agreement; (ii) with the prior written consent of the party that owns the Confidential Information; (iii) as necessary to fulfill the purposes of this Agreement; or (iv) as required by law. To the extent that the parties exchange Confidential Information, the parties expressly agree that any such information is the property of the party by whom it was disclosed. The provisions of this Section shall survive the expiration or termination of this Agreement.

9.2 Binding Effect. The terms of this Agreement shall be binding upon and inure to the benefit of and be enforceable by and against the ACO and Participant, and their successors and permitted assigns. This Agreement is self effectuating, but the parties agree to execute any other documents or agreements that either party may request to implement and effectuate the terms of this Agreement.

9.3 Notices. All payments, notices and formal communications required or permitted to be given under any provision of this Agreement shall be in writing and shall be deemed to have been sufficiently given or served for all purposes if delivered personally to the party to whom the same is directed, or when sent by registered or certified mail, or private next day mail, postage and/or charges prepaid, addressed as follows:

ACO:	Participant:
National Rural ACO Corp.	_____
_____	_____
_____	_____
Attn: _____	_____

Any such notice shall be deemed given on the date delivered or deposited in a regularly maintained receptacle for the deposit of United States Mail or private next day mail service addressed as provided above. Either party may change its address for purposes of this Agreement by giving the other party notice of such change in the manner provided above.

9.4 Severability. If any term or provision of this Agreement is illegal, or the application thereof to any party or in any circumstance shall to any extent be invalid or unenforceable, the remainder of this Agreement, and the application of such term or provision to persons or circumstances other than those with respect to which it is held invalid or unenforceable, shall not be affected thereby, and each term, covenant, condition, and provision of this Agreement shall be valid and enforceable to the fullest extent provided by law.

9.5 Controlling Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Delaware.

9.6 Entire Agreement. This Agreement, including any and all exhibits, schedules, attachments and addendums attached hereto, represents the entire agreement and understanding between the parties relative to the subject matter hereof and supersedes, terminates and replaces all prior agreements and understandings, whether oral or written. This Agreement may not be amended, altered or modified unless done so by means of a written instrument signed by both of the parties. No waiver of any provision of this Agreement shall be valid unless in writing and signed by the party against whom such enforcement of waiver is sought. One or more waivers of any obligation or provision of this Agreement shall not be construed as a waiver of a subsequent breach of such obligation or provision, or as a waiver of a breach of any other obligation or provision. This Agreement may not be assigned without the prior written consent of the other party, which will not be unreasonably withheld. This Agreement shall be binding upon and inure to the benefit of the ACO and the Participant, and their permitted successors and assigns.

9.7 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be treated as an original but all of which, collectively, shall constitute a single document.

9.8 Rights and Remedies Cumulative. All rights, remedies, and benefits provided to the parties hereunder shall be cumulative, and shall not be exclusive of any such rights, remedies, and benefits provided by law.

9.9 No Third-Party Beneficiaries. Except for other participants, as provided for in Schedule 3.5, this Agreement is for the benefit of the ACO and the Participant and their successors in interest by virtue of an assignment which is not prohibited hereunder, and is not entered into the benefit of any other person or entity whatsoever, including, without limitation, the Providers. Without limiting the generality of the foregoing, this Agreement shall not be construed as establishing any obligation, duty or standard of care or practice different from or in addition to whatever obligations, duties or practices may exist separate and apart from this Agreement with respect to any person not a party to this Agreement.

9.10 Construction/Interpretation. The parties specifically agree that the terms of this Agreement have been fully and fairly bargained over by the parties. The parties specifically agree and covenant that this Agreement is not to be construed against one party or another by reason of the fact that this Agreement was drafted by one party or its legal counsel. Whenever necessary in this Agreement and where the context requires, the gender of words shall include the masculine, feminine and/or neuter, and the number of all words shall include the singular and the plural. The word "include," "including" or a variant thereof shall be deemed to be without limitation, and the word "or" is not exclusive.

9.11 Captions. The captions and headings appearing in this Agreement are inserted only as a matter of convenience, and in no way explain, interpret, define, limit or describe the scope or meaning of any of the provisions of this Agreement.

IN WITNESS WHEREOF, AND INTENDING TO BE LEGALLY BOUND, the parties have executed this Agreement as provided for below.

NATIONAL RURAL ACO CORP.	**ACO PARTICIPANT**
	______________________________ Legal Entity Name
	______________________________ dba Name
	______________________________ ACO Participant TIN
______________________________ Signature (on behalf of the ACO)	______________________________ Signature (on behalf of the ACO Participant)
______________________________ Name	______________________________ Name
______________________________ Title	______________________________ Title
______________________________ Date	______________________________ Date
______________________________ Address	______________________________ Address
______________________________ City, State, Zip Code	______________________________ City, State, Zip Code
______________________________ Business Phone	______________________________ Business Phone
______________________________ Business Fax	______________________________ Business Fax

- -

Required Participant Information:

Medicare Enrolled TIN: yes / no (circle one)

Merged or acquired within the last three years: yes / no (circle one)

Is the Participant a FQHC, RHC, Method II Critical Access Hospital or Electing Teaching Amendment Hospital? (If yes, circle the appropriate entity type)

If the Participant is a FQHC, RHC, Method II Critical Access Hospital or Electing Teaching Amendment Hospital:

CCN: ___________ (must be 6-digit number, without dashes, spaces or non-numeric values)

CCN Legal Name: ______________________________
(enter the CCN legal name as it is registered in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)). Do not use abbreviations.

For Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs):

Organizational NPI: _______________ (NPI must be a 10-digit number, without dashes, spaces or non-numeric values)

Organizational NPI Name: ______________________________

EXHIBIT A

PROVIDER AGREEMENT

I, the undersigned physician, physician assistant, clinical nurse specialist or nurse practitioner am an employee of, or have an independent contractor relationship with, _____ ("Participant"). I understand that the Participant has entered into a participation agreement ("Agreement") with **NATIONAL RURAL ACO CORP.** ("ACO"), which is applying for participation in the Medicare Shared Savings Program, ("Program"). I hereby agree to participate in the Program as an employee/independent contractor of the Participant and a provider of the ACO. I further agree with the Participant and the ACO as follows:

Qualifications.

I agree to maintain all those qualifications required in my employment or independent contractor agreement with the Participant, including, without limitation those qualifications pertaining to licensure, certification, continuing medical education, staff membership and privileges, and eligibility to participate in state and federally funded healthcare programs.

Medicare Shared Savings Program.

- I support the mission of the ACO and the Medicare Shared Savings Program of better health for populations, better care for individuals and lower cost of Medicare expenditures.

- I support and agree to implement and comply with the ACO's processes to promote evidence based medicine, to promote patient engagement, to facilitate reporting of quality and cost measures, and to promote coordination of care. I agree to be held accountable for meeting the ACO's performance standards for each of these processes.

- I agree to adhere to the quality assurance and improvement program and to the evidence-based clinical guidelines of the ACO. I understand and agree that I may be excluded from sharing in any shared savings payments, and/or terminated from participation in the ACO, if I fail to meet the performance standards for each of the ACO processes, the quality assurance and improvement program, or the ACO's evidence-based clinical guidelines.

- If I provide primary care services, as that term is defined under applicable federal regulation, I agree that from January 1, 2014 through December 31, 2016, I will be exclusive to the ACO, that I will only participate in the Program as a provider of the ACO, and that I will not participate in the Program as a participant, provider or supplier of any accountable care organization other than the ACO, except by mutual agreement with the Participant and approval of the ACO, or if my employment or independent contractor agreement with the Participant is terminated or if the Agreement is terminated.

Regulatory Requirements.

- I agree to comply with all applicable requirements of federal and state law. Specifically, I agree to participate in and comply with requirements of the Medicare Shared Savings Program under 42 CFR Part 425, and to comply with the requirements of Federal criminal law, the False Claims Act, the Anti-Kickback Statute, the Civil Monetary Penalties Law and the Physician Self-Referral Law.

- I agree to comply with all the requirements and conditions of the ACO's participation agreement ("Participation Agreement") with the Centers for Medicare and Medicaid Services ("CMS") that apply to providers/suppliers.

- I agree to submit all data and information required for compliance with the requirements of the Program, or provide access to such data and information, including those data and measures designated by CMS, in the form and manor specified by CMS. I agree that such data and information will be accurate, complete and truthful to the best of my knowledge, information and belief.

- I agree that I will not offer or provide any gift or other remuneration to Medicare beneficiaries as an inducement for receiving items or services from the ACO, the Participant or me, or for remaining in the ACO, or with the Participant or me, except as may be permitted by applicable federal regulation.

- I agree to only use those ACO-related marketing materials, and participate in those marketing activities, that have been approved, or are deemed approved, by CMS. I agree to discontinue the use of any ACO-related marketing materials or activities that have been disapproved by CMS.

- I agree to inform my patients that are Medicare beneficiaries that I am participating in the Program, and post in my office or clinic signs indicating that I am participating in the Program.

- I agree to observe all relevant statutory and regulatory provisions regarding the appropriate use of data and the confidentiality and privacy of individually identifiable health information. I agree to comply with the terms of the ACO's Data Use Agreement with CMS.

- I agree that in my practice I will not avoid at-risk Medicare beneficiaries. However, this does not prevent me from terminating my relationship with a patient for reasons that are permitted under applicable state and federal law.

- I agree to support and assist in the implementation and development of the ACO's and Participant 's electronic health record tools and infrastructure.

- If I am an independent contractor of the Participant, rather than an employee, or if I am a sole proprietor, I agree that CMS, the Department of Health and Human Services ("DHHS"), the Comptroller General, the Federal Government or their designees have the right to audit, inspect, investigate, and evaluate any of my books, contracts, records, documents and other evidence that are related to the ACO's participation in, and compliance with, the Program, the Participation Agreement and applicable federal regulations, or that are related to the payment or repayment of any amount under the terms of the Program.

- If I am an independent contractor of the Participant, rather than an employee, or if I am a sole proprietor, I agree to maintain and give CMS, the DHHS, the Comptroller General, the Federal Government or their designees access to my books, contracts, records, documents, and other evidence (including data related to Medicare utilization and cost, quality performance measures, shared savings distributions, and other financial arrangements related to ACO activities) sufficient to enable the audit, evaluation, investigation, and inspections of the ACO's compliance with Program requirements, the quality of services performed, ACO's right to any shared savings payment or obligation to repay losses, ACO's ability to bear the risk of potential loss, and its ability to repay any losses to CMS. I agree to maintain such books, contracts, records, documents, and other evidence for a period of ten years from the expiration or termination of the Participation Agreement or from the date of completion of any audit, evaluation or inspection, whichever is later, or until such later date as may be determined by CMS

Eligibility.

- I represent and warrant that I am not excluded from any governmental healthcare program.

- I represent and warrant that I have not participated in the Program under the same or different name, and that I am not related to or have any affiliation with other Program accountable care organizations.

- I represent and warrant that I have not previously been terminated from the Program.

Effect of this Agreement.

This Provider Agreement ("Provider Agreement") constitutes an addendum to my employment or independent contractor agreement with the Participant. All the terms and provisions of my employment or independent contractor agreement with the Participant shall remain the same, and in full force and effect, except to the extent modified by this Provider Agreement. In the event of any conflict between the language of my employment or independent contractor agreement with the Participant, and the language of this Provider Agreement, the language of this Provider Agreement shall be controlling. Nothing in this Provider Agreement shall create an employer/employee relationship between the ACO and myself, and I understand and agree that I am not an employee of the ACO. I agree that this Provider Agreement is self-effectuating, but I also agree to execute any other documents or agreements that the Participant may request to implement and effectuate the terms of this Agreement.

Effective Date and Execution.

This Provider Agreement shall become effective on _____, 2013. This Provider Agreement may be executed in several counterparts, each of which shall be an original, but all of which shall constitute one and the same instrument. This Provider Agreement may be terminated by mutual agreement with the Participant and approval of the ACO, and shall terminate if my employment or independent contractor agreement with the Participant is terminated, or if the Agreement is terminated.

General.

- I agree to participate in the Program as an employee or independent contractor of the Participant and as an ACO provider, in accordance with the terms of the Participation Agreement and the Agreement. I agree to be accountable for the quality, cost and overall care of my patients that are Medicare fee-for-service beneficiaries assigned to the ACO.

IN WITNESS WHEREOF, I and the Participant have executed this Provider Agreement to be effective as of the date set forth above.

PROVIDER:

_____
Signature

_____
Printed Name

_____
National Provider Identification Number

PARTICIPANT

By: _____

_____
Printed Name

Its: _____

_____
Tax Identification Number

SCHEDULE 3.5

1. Administrative and Management Services, General. Those administrative and management services to be acquired, developed, provided and/or arranged for by the ACO shall include, without limitation, the following:

- ACO operational management, including the ACO general manager;
- ACO governance;
- ACO medical director;
- ACO required committees;
- Data informatics and reports;
- Financial analysis and reports;
- Performance improvement team;
- Financial and legal professional services;
- Local network financial support;
- Patient engagement tool, which shall be:
  - Customized with the participant's logo or trademark;
  - Available for use by web, IPhone, IPad, or Android platforms;
  - Real time, provider-level patient satisfaction surveys; and
  - Communication channels (reminders, appointments and announcements);
- CG-CAHPS surveys;
- Job Descriptions, training, policies and procedures for the following:
  - Care coordinator (nurse practitioner or physician assistant);
  - Care team (pharmacist, therapist and nutritionist); and
- Data warehouse interfaced with the participant's health information exchange or EHR, which shall include the following:
  - Upload of historic beneficiary data into the data warehouse;
  - Upload CMS all-provider claims data within 30 days of receipt;
  - Generate patient lists and disease registries; and
  - Automate quality reporting where possible;
- Provide quality reports and dashboards for participants and providers;

Except for the ACO governance, the ACO's medical director and the ACO committees, the ACO may obtain one (1) or more of the above administrative or management services from vendors.

2. Support Services Fee.

2.1 Payment of the Support Services Fee. To fund, and to compensate the ACO for, the ACO's acquisition, development and provision of the administrative and management services, Participant agrees to pay ACO during the term of this Agreement a Support Services Fee consisting of both an:

initial up-front payment of _____ and No/100 Dollars ($_____), and

an ongoing monthly payment of _____ and No/100 Dollars ($_____) per month.

The ACO is a nation wide accountable care organization consisting of rural participants located in rural communities across the country. By participating in the ACO, each participant agrees to work with other participants in its Community to manage and coordinate care for those Medicare fee-for-service beneficiaries in its Community that are assigned to the ACO.

The administrative and management services provided by the ACO are structured and organized to support the management and coordination of care provided to assigned Medicare beneficiaries in the Community. As a consequence, the Support Services Fee is specific to each Community, depending on the administrative and management services needed and selected by the participants located in the Community. In each Community, one participant (the Principal Participant) shall be responsible for the payment of the Support Services Fee. If there is more that one participant in the Community, then the Principal Participant responsible for the payment of the Support Services Fee may seek and collect pro rata reimbursement from each other participant located in the same Community.

The fee schedule used to calculate the Community's Support Services Fee, the name of the Principal Participant responsible for payment of the Support Services Fee and the name of each participant located in the Community are set forth below. As used herein, "Community" means the geographic region and zip codes in which the participant(s) and its patients are located. Anything to the contrary notwithstanding, the Participant is obligated to pay to the ACO the Support Services Fee specified above.

2.2 Calculation of the Community Support Services Fee.

2.2.1 Initial Up-Front Payment. An Application Fee of $5,000.00 covering administrative costs related to submitting the Medicare Shared Savings Program application is due on signing. The Principal Participant pays the Application Fee when it submits its signed Participation Agreement to the ACO. The balance of the initial up-front payment ($5,000.00 for the Patient Engagement Tool Customization and $10,000.00 for Capitalization of Start-Up Costs) is due when the ACO receives notice from CMS that the ACO has been accepted into the Medicare Shared Savings Program.

2.2.2 Monthly Support Services Fee. A Monthly Support Services Fee of $5,000.00 per month for ACO operations is required. A $500.00 per month fee for patient engagement is also required. A Monthly Support Services Fee for quality reporting ($2,000.00), care coordination support ($2,000.00) and for data analytics ($500.00) is also required unless the Community participants can opt out of such services. If the Participant wishes to opt out of the quality reporting, coordination of care support, or data analytics services, the Participant must provide a description, satisfactory to the ACO, of how these services will be delivered without the support of the ACO. If the description provided by the Participant is not satisfactory to the ACO, then the per month rates for quality reporting, coordination of care support, and data analytics services will be required. The monthly Support Services Fee shall be paid to the ACO by the Participant on or before the first day of each month during the term of this Agreement, beginning on the ACO's commencement of such services, as invoiced by the ACO. The Monthly Support Services Fees are based on the ACO's cost to provide such services. If the costs incurred by the ACO to provide such services are reduced, the Monthly Support Services Fees may also be reduced.

2.3 Identification of the Principal Participant and other Community Participants.

Name of Principal Participant which is responsible for payment of the Community Support Services Fee and employing the Care Coordination Team:

_____

Name of all participants that are included in the Community:

_____

_____

_____

_____

_____

_____

Fee	Description	Due	Price
Application Fee	Administrative expenses	**One-time**, with submission of Participation Agreement, July 2013	$5,000
Initiation Fee	Covers ACO start-up costs and purchases stock in NRACO	**One-time**, upon acceptance by CMS, November 2013	$10,000
Patient Engagement Tool Initiation Fee	Customization of Patient Engagement tool	**One-time**, with initiation of Chatterplug tool (available July 2013 onward)	$5,000
Support Services Fee	Covers administrative, legal, governance costs of NRACO	**Monthly**, beginning January 2014	$5,000
Patient Engagement Tool Monthly Fee	Real-time feedback on CG-CAHPS quality measures, entry to patient portal, patient connectivity	**Monthly**, after initiation of Chatterplug tool	$500
Data Warehouse Fee	Data warehouse that connects with CMS' Quality Reporting system, generates disease registries for care coordination team	**Monthly**, once your EMR/HIE is connected with Inland Empire HIE (optional*)	$2,000
Data Analytics Fee	Provision of summarized monthly data feeds from CMS	**Monthly**, once CMS begins providing monthly feeds of all-provider data (optional*)	$500
Care Coordination Fee	Care coordination oversight, including job descriptions, training webinars, policies, procedures	**Monthly**, once work with Stratis Health begins (optional*)	$2,000

*Optional services require a description, satisfactory to the ACO, of how these services will be delivered without the support of the ACO.

A community that is utilizing all required services through the ACO would have an Initial Up-Front Payment of $20,000 and an ongoing Monthly Payment of $10,000. A check for $5,000 (application fee) is due with participation agreements.

END