



BOARD OF DIRECTORS

*Katherine Burnworth, President | Laura Goodsell, Vice-President | Donald W. Medart Jr., Treasurer
Arturo Proctor, Secretary | Enola Berker, Director | Rodolfo Valdez, Director | James Garcia, Director*

AGENDA

REGULAR MEETING OF THE BOARD OF DIRECTORS

THURSDAY, JUNE 26, 2025, 6:00 P.M.

**El Centro City Council Chamber
1275 Main Street, El Centro, CA 92243**

[Join Microsoft Teams](#)

Meeting ID: 266 458 658 729 2

Passcode: 9oX77RC6

CLOSED SESSION:

a. CONFERENCE WITH REAL PROPERTY NEGOTIATORS

Property: El Centro Regional Medical Center and Related Facilities

1415 Ross Ave, El Centro, CA 92243

Agency negotiators: AB 918 Ad Hoc Committee (Katherine Burnworth, James Garcia, Laura Goodsell), Christopher Bjornberg, Adriana Ochoa, Josh Schneiderman

Negotiating parties: City of El Centro

Under negotiation: Terms relating to acquisition of El Centro Regional Medical Center and related hospital facilities.

b. CONFERENCE WITH REAL PROPERTY NEGOTIATORS

Property: All Valley Urgent Care Facility

400 Mary Ave., Calexico, CA 92231

Agency negotiators: Katherine Burnworth, Christopher Bjornberg, Tomas Virgen

Negotiating parties: City of El Centro

Under negotiation: Terms relating to potential lease of space and urgent care support.

OPEN SESSION:

ANNOUNCEMENT OF CLOSED SESSION ACTIONS:

1. Call to Order
2. Roll Call
3. Pledge of Allegiance

4. **Approval of Request for Remote Appearance by Board Member(s), if Applicable**

5. **Consider Approval of Agenda**

In the case of an emergency, items may be added to the agenda by a majority vote of the Board of Directors. An emergency is defined as a work stoppage, a crippling disaster, or other activity that severely imperils public health, safety, or both. Items on the agenda may be taken out of sequential order as their priority is determined by the Board of Directors. The Board may take action on any item appearing on the agenda.

6. **Public Comments**

At this time the Board will hear comments on any agenda item. If any person wishes to be heard, they shall stand; address the president, identify themselves, and state the subject for comment. Time limit for each speaker is 3 minutes individually per item to address the Board. Individuals who wish to speak on multiple items will be allowed four (4) minutes in total. A total of 15 minutes shall be allocated for each item for all members of the public. The board may find it necessary to limit the total time allowable for all public comments on items not appearing on the agenda at any one meeting to one hour.

7. **Board Comments**

Reports on meetings and events attended by Directors; Authorization for Director(s) attendance at upcoming meetings and/or events; Board of Directors comments.

- a. Brief reports by Directors on meetings and events attended
- b. Schedule of upcoming Board meetings and/or events
- c. Report by Education and Outreach Ad-Hoc Committee
- d. Report by AB 918 Negotiation Ad-Hoc Committee

8. **Consent Calendar**

Any member of the Board may request that items for the Consent Calendar be removed for discussion. Items so removed shall be acted upon separately immediately following approval of items remaining on the Consent Calendar.

- a. Approve minutes for meetings of June 12, 2025
- b. Approve and file PMH Expenses/Financial Report for May 2025

9. **Items for Discussion and/or Board Action:**

- a. **Information Only**: Presentation by Baker Tilly on 2025 Audit Planning
- b. MEDICAL STAFF REPORT – Recommendations from the Medical Executive Committee for Medical Staff Membership and/or Clinical Privileges, policies/procedures/forms, or other related recommendations
- c. **Authorize**: Discussion and possible action to approve the FY 2026 Budget Presented by: Carly Loper
- d. **Authorize**: Discussion and possible action to approve Resolution 2025-0626, A Resolution of The Imperial Valley Board of Directors Approving the Asset

Transfer Agreement by and among City of El Centro, El Centro Regional Medical Center, and Imperial Valley Healthcare District

- e. **Discussion and Action:** Discussion and possible action to reject all proposals in response to RFP for Master Facility Planning Services
Staff Recommendation: Reject all proposals and direct staff to negotiate directly with solicited firms.
- f. **Authorize:** Approval of Second Amendment to Standard Industrial/Commercial Single-Tenant Lease with Tyson Medical Inc.
- g. **Authorize:** Approval of Social Media Policy
- h. **Authorize:** The execution of the Joint Powers Authority Agreement, the Application for Certificate of Consent to Self-Insure as a Public Agency Employer Self-Insurer and the Resolution to effectuate such application for Imperial Valley Healthcare District (“IVHD”).
Presented by: Carly Loper
Classification: Workers’ Compensation Insurance
- i. **Authorize:** Resolution 2025-02 of the Imperial Valley Healthcare District Board of Directors Authorizing Execution and Delivery of the Application to the Directors of Industrial Relations, State of California, for a certificate of consent to self-insure worker’s compensation liabilities.
- j. **Discussion and Direction** Regarding IVHD Bylaws Revisions and Creation of Standing Committees

10. Management Reports

- a. Finance: Carly C. Loper, MAcc – Chief Financial Officer
- b. Hospital Operations: Carol Bojorquez, MSN, RN – Chief Nursing Officer
- c. Clinics Operation: Carly Zamora MSN, RN – Chief of Clinic Operations
- d. Urgent Care: Tomas Virgen – Administrative Coordinator/ Support for AB 918
- e. Executive: Christopher R. Bjornberg – Chief Executive Officer
- f. Legal: Adriana Ochoa – General Counsel

11. Items for Future Agenda

This item is placed on the agenda to enable the Board to identify and schedule future items for discussion at upcoming meetings and/or identify press release opportunities.

12. Adjournment

- a. The next regular meeting of the Board will be held on July 10, 2025, at 6:00 p.m.

POSTING STATEMENT

A copy of the agenda was posted June 20, 2025, at 601 Heber Avenue, Calexico, California 92231 at 10:30 p.m. and other locations throughout the IVHD pursuant to CA Government code 54957.5. Disclosable public records and writings related to an agenda item distributed to all or a majority of the Board, including such records and written distributed less than 72 hours prior to this meeting are available for public

inspection at the District Administrative Office where the IVHD meeting will take place. The agenda package and material related to an agenda item submitted after the packets distribution to the Board is available for public review in the lobby of the office where the Board meeting will take place.

In compliance with the Americans with Disabilities Act, if any individuals request special accommodations to attend and/or participate in District Board meetings please contact the District at (760)970- 6046. Notification of 48 hours prior to the meeting will enable the District to make reasonable accommodation to ensure accessibility to this meeting [28 CFR 35.102-35.104 ADA title II].



MEETING MINUTES
June 12, 2025
REGULAR BOARD MEETING

THE IMPERIAL VALLEY HEALTHCARE DISTRICT MET IN REGULAR SESSION ON THE 12th OF JUNE AT 207 W. LEGION ROAD CITY OF BRAWLEY, CA. ON THE DATE, HOUR AND PLACE DULY ESTABLISHED OR THE HOLDING OF SAID MEETING.

BOARD ENTERED INTO CLOSED SESSION AT 5:00PM

CLOSED SESSION:

- a. **Property:** El Centro Regional Medical Center and Related Facilities 1415 Ross Ave, El Centro, CA 92243
Agency negotiators: AB 918 Ad Hoc Committee (Katherine Burnworth, James Garcia, Laura Goodsell), Christopher Bjornberg, Adriana Ochoa, Josh Schneiderman
Negotiating parties: City of El Centro
Under negotiation: Terms relating to acquisition of El Centro Regional Medical Center and related hospital facilities.
- b. **CONFERENCE WITH REAL PROPERTY NEGOTIATORS**
Property: All Valley Urgent Care Facility 400 Mary Ave., Calexico, CA 92231
Agency negotiators: Katherine Burnworth, Christopher Bjornberg, Tomas Virgen
Negotiating parties: City of El Centro
Under negotiation: Terms relating to potential lease of space and urgent care support.
- c. **CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION (Gov. 54956.9(d)(1))**
Name of case: Esquivel v. Pioneers Memorial Hospital USDC Southern 4906-0261-0506 District Civil Action No. 25-cv-1165-DMS-VET
- d. **CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION (Gov. Code 54956.9(d)(2))**
- One Potential Case

BOARD RECONVENED INTO OPEN SESSION AT 6:40PM

No reportable action taken in closed session

1. TO CALL ORDER:

The regular meeting was called to order in open session at 6:40 pm by Katie Burnworth.

2. ROLL CALL-DETERMINATION OF QUORUM:

President	Katherine Burnworth
Vice-President	Laura Goodsell
Treasurer	Donald W. Medart Jr.
Secretary	Arturo Proctor
Trustee	Enola Berker
Trustee	Rodolfo Valdez



Trustee

James Garcia

ABSENT:

Tomas Virgen - Support for IVHD (AB 918)

GUESTS:

Adriana Ochoa – Legal/Snell & Wilmer

Christopher R. Bjornberg - Chief Executive Officer

3. PLEDGE OF ALLEGIANCE WAS LED BY DIRECTOR BURNWORTH.

4. APPROVAL OF REQUEST FOR REMOTE APPEARANCE BY BOARD MEMBER(S)

None

5. CONSIDER APPROVAL OF AGENDA:

Motion was made by Director Goodsell and second by Director Medart Jr. to approve the agenda for the Regular and Special meeting agenda for June 12, 2025. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia

NOES: None

6. PUBLIC COMMENT TIME:

None

7. BOARD COMMENTS:

- a. Brief reports by Directors on meetings and events attended. Schedule of upcoming Board meetings and events.

None

- b. Report by Education and Outreach Ad-Hoc Committee

Director Garcia reported that we started Stronger Together efforts through TV, radio and print and advocacy on work on men's health have been published as well in the news, TV and KYMA and we are working with ECRMC visions as well.

- c. Report by AB 918 Ad Hoc Negotiation Committee re AB 918

None

8. CONSENT CALENDAR:

Motion was made by Director Medart Jr. and second by Director Goodsell to approve the consent calendar item A minutes for May 29, 2025. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Garcia

NOES: None



9. ACTION ITEMS:

- a. Information Only: Presentation by Pioneers Memorial Hospital

John Grass from the PMH Foundation gave a brief presentation and background on the foundation. The foundation has raised over 3.5 million and is still raising money for items to be purchased and donated to Pioneers Memorial Hospital. Donations are received throughout the year from various sources. He requested that the hospital honor their request for donations to remain at PMH but understanding to note that there are exceptions to them based on medical need, declared emergencies, those kinds of things where medical supplies and equipment need to be shared for the benefit of patients. A reassurance to the donors of how their gifts will be handled. He requested for the board may generate a letter to our donor to go out to encourage donations, encourage them that we all share the same goals, the same mission and that's the quality of healthcare. He also invited the board to attend the GALA on October 17th and would appreciate their support.

- b. Action Item: Policy and Procedure: Bloodborne Pathogen Exposure Control Plan

Motion was made by Director Berker and second by Director Proctor to approve the Policy and Procedure: Bloodborne Pathogen Exposure Control Plan. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

- c. Action Item: Policy and Procedure: Computer, Network and Email Usage (Acceptable Use)

Motion was made by Director Berker and second by Director Proctor to approve the Policy and Procedure: Computer, Network and Email Usage (Acceptable Use). Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

- d. Action Item: Policy and Procedure: Employee Health Standing Orders Work Instruction

Motion was made by Director Berker and second by Director Proctor to approve the Policy and Procedure: Employee Health Standing Orders Work Instruction. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

- e. Action Item: Policy and Procedure: Hazardous Material and Waste Management Plan



Motion was made by Director Berker and second by Director Proctor to approve the Policy and Procedure: Hazardous Material and Waste Management Plan. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

f. Action Item: Policy and Procedure: Hepatitis B Vaccination Program

Motion was made by Director Berker and second by Director Proctor to approve the Policy and Procedure: Hepatitis B Vaccination Program. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

g. Action Item: Policy and Procedure: Influenza Vaccination Program

Motion was made by Director Berker and second by Director Proctor to approve the Policy and Procedure: Influenza Vaccination Program. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

h. Action Item: Policy and Procedure: Standardized Procedure for Registered Nurses: Neonatal Endotracheal Intubation

Motion was made by Director Berker and second by Director Proctor to approve the Policy and Procedure: Standardized Procedure for Registered Nurses: Neonatal Endotracheal Intubation. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

i. Action Item: Policy and Procedure: Neonatal Enteral Feeding & Tube Management Feeding Tubes and Decompression Tubes in the NICU

Motion was made by Director Berker and second by Director Proctor to approve the Policy and Procedure: Neonatal Enteral Feeding & Tube Management Feeding Tubes and Decompression Tubes in the NICU. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

j. Action Item: Policy and Procedure: Standardized Procedure for Registered Nurses: Neonatal Thoracentesis/Needle Decompression



Motion was made by Director Berker and second by Director Proctor to approve the Policy and Procedure: Standardized Procedure for Registered Nurses: Neonatal Thoracentesis/Needle Decompression. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

- k. Action Item: Policy and Procedure: Standardized Procedure for Registered Nurses: Neonatal Umbilical Vessel Catheterization

Motion was made by Director Berker and second by Director Proctor to approve the Policy and Procedure: Standardized Procedure for Registered Nurses: Neonatal Umbilical Vessel Catheterization. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

- l. Action Item: Policy and Procedure: Non-Retaliation and Compliance Reporting

Motion was made by Director Berker and second by Director Proctor to approve the Policy and Procedure: Non-Retaliation and Compliance Reporting. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

- m. Action Item: Policy and Procedure: Organ and Tissue Procurement/Donation

Motion was made by Director Berker and second by Director Proctor to approve the Policy and Procedure: Organ and Tissue Procurement/Donation. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

- n. Action Item: Policy and Procedure: Postexposure Prophylaxis after 4906-0261-0506

Occupational Exposure to Blood or Body Fluids by needle/sharps injury and/or splashes Protocol

Motion was made by Director Berker and second by Director Proctor to approve the Policy and Procedure: Postexposure Prophylaxis after 4906-0261-0506 Occupational Exposure to Blood or Body Fluids by needle/sharps injury and/or splashes Protocol. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia
NOES: None

- o. Information Item Only: Discussion and Review of FY 2026 Budget



Presented By: Carly Loper

Carly reviewed with the board the FY 2026 Budget.

This item will be added to the agenda for the next board meeting.

- p. Staff Recommends Action to Authorize: BD Alaris System Equipment Purchase (IV Medication Pumps)

Presented by: Carol Bojorquez

Contract Value: \$742,875.93

Contract Term: 7 Year Term for alaris Support Program

Budgeted: Yes

Budgeted Classification: Medical Equipment

Motion was made by Director Goodsell and second by Director Garcia to approve the BD Alaris System Equipment Purchase (IV Medication Pumps) as presented. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia

NOES: None

- q. Staff Recommends Action to Authorize: MSP agreement with AYA Healthcare

Presented by: Carol Bojorquez

Contract Term: 1 Year

Budgeted: Yes

Budgeted Classification: Contracted Services

Motion was made by Director Garcia and second by Director Medart Jr. to approve the MSP agreement with AYA Healthcare as presented. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia

NOES: None

- r. Staff Recommends Action to Authorize: Amendment No. 1 to Services Agreement Between Imperial Valley Hospital District and Moving Mountains HR Consulting.

Presented by: Chief Executive Office

Motion was made by Director Berker and second by Director Proctor to approve Amendment No. 1 to Services Agreement Between Imperial Valley Hospital District and Moving Mountains HR Consulting. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia

NOES: None

- s. Staff Recommends Action to Authorize: Renew contract with Konica Minolta for repair coverage for X-ray panels and control stations

Presented by: Carly Zamora



Contract Value: X-ray Panel and Control Station Coverage: Annual Cost: \$24,150.00 5-Year Total: \$120,750.00 Additional Equipment Coverage: Annual Cost: \$4,200.00 5-Year Total: \$ 21,000.00

Contract Term: 5 years (06/01/2025 – 05/31/2030) Total: \$141,750.00

Budgeted: Yes

Budgeted Classification: Operations

Motion was made by Director Berker and second by Director Garcia to approve Renew contract with Konica Minolta for repair coverage for X-ray panels and control stations as presented. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia

NOES: None

- t. Staff Recommends Action to Authorize: Amendment No. 3 to Professional Services Agreement with Berkeley Research Group for Financial Consultant Services
Presented by: Legal Counsel
Contract Value: Proposal to add \$250,000 to Payment Cap

Motion was made by Director Goodsell and second by Director Garcia to approve Amendment No. 3 to Professional Services Agreement with Berkeley Research Group for Financial Consultant Services. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia

NOES: None

- u. AB 918 Ad Hoc Recommends Action to Authorize: Approval of Joint 4906-0261-0506 Powers and Affiliation Agreement by and among Imperial Valley Healthcare District and The Regents of the University of California on Behalf of UC San Diego Health
Presented by: Legal Counsel, UCSD, AB 918 Ad Hoc

Dr. Indudhara expressed his concerns about the Joint Powers Agreement. He requested IVHD to defer any vote on the matter until the medical staff have had time to review this document.

Ron Rubin also expressed his concerns about the agreements. He feels that the board did not do much in the agreement but changed the name. He said that the board does not have any power once the agreement is signed to do any management of the hospital and they have complete control. In his opinion, from what he has read the board does not have the ability to hire outside people or companies to analyze what the problems are. El Centro has lost 16 million dollars as of the end of March and feels that IVHD is not concerned about it because IVHD is signing the agreement.

Paty Maysent (presented over Teams) and Pablo Velez gave a presentation on USCD.

Attorney Adriana gave a presentation on the Joints Powers Agreement



Motion was made by Director Goodsell and second by Director Garcia to approve the Joint 4906-0261-0506 Powers and Affiliation Agreement by and among Imperial Valley Healthcare District and The Regents of the University of California on Behalf of UC San Diego Health. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Medart Jr., Proctor, Berker, Valdez, Garcia

NOES: None

10. MANAGEMENT REPORTS:

- a. Finance: Carly C. Loper, MAcc – Chief Financial Officer

None

- b. Hospital Operations: Carol Bojorquez, MSN, RN – Chief Nursing Officer

Carol went over the CNO report.

- c. Clinics Operation: Carly Zamora MSN, RN – Chief of Clinic Operations

Carly gave a brief report on the Clinic Operations.

- d. Urgent Care: Tomas Virgen – Administrative Coordinator/ Support for AB 918

Chris gave a brief report that we do finally get occupancy on the south side of the building in Calexico. That all finished up today.

- e. Executive: Christopher R. Bjornberg – Chief Executive Officer

Chris reported that the board had requested some data, and he provided all the information via email today. All that information goes over what services are being provided. It has a 4-year history on that so the board can see where it is up and down.

He also reported that there is still more work that is being done as far as on the facility side. Our RFP is done tomorrow and will have some good things to present at the 26th meeting to be able to decide on that master planning. With that they are still in need of a facility director and that's something that we've been working on. This week Dave from ECRMC and himself have done four interviews for that position. They are working on wrapping that up and that is something they are doing jointly with ECRMC and there are several other things that they are working on together. On top of all that, just in general with all the work that has been going on from the dissolution through now and still doing all the work. Our team is still doing all of that work like we talked about and still trying to wrap all that stuff up and still trying to make all those things happen and on top of that the team is working with ECRMC team to try to make this transition much better and easier because we have a little bit more of a runway

on that. The team here and many of the teams that you see out there and others that you don't even see that aren't here tonight are really working hard and doing a lot of work and he can't even express his thanks enough because they do such a phenomenal job and it



is a lot and is a lot that we have asked to do over the last five and a half months and will continue to work as we move forward to make this happen.

f. Legal: Adriana Ochoa – General Counsel

None

11. ITEMS FOR FUTURE AGENDA:

None

12. ADJOURNMENT:

With no future business to discuss, Motion was made unanimously to adjourn meeting at 8:34 p.m.



To: Board of Directors

Katherine Burnworth, President

Laura Goodsell, Vice President

Arturo Proctor, Secretary

Donald W. Medart Jr., Treasurer

Enola Berker, Trustee

Rodolfo Valdez, Trustee

James Garcia, Trustee

Additional Distribution:

Christopher R. Bjornberg, Chief Executive Officer

From: Carly Loper, Chief Financial Officer

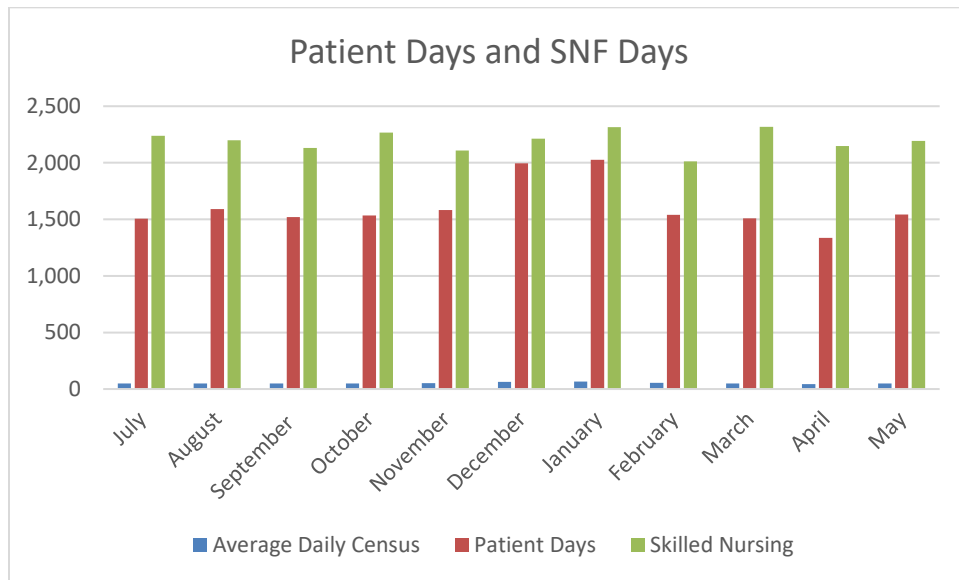
Financial Report – May 2025

Overview:

Financial operations for the month of May resulted in a profit of \$934,078 against a budgeted profit of \$353,585.

Patient Volumes:

For the month of May, inpatient admissions exceeded budget by 25.2% and exceeded the prior month by 19.3%. For the year-to-date period, inpatient admissions are ahead of budget by 15.8% and ahead of the prior year by 14.2%. May inpatient days fell below budget by (0.4%) but exceeded the prior month volumes by 38.9%. For the year-to-date period, inpatient days are below budget by (12.7%) and below the prior year by (11.3%).



Newborn deliveries in May fell below April's deliveries by (47.0%) and fell below the monthly budget by (11.3%). May's ED visits fell below April's visits by (4.2%) and fell below the budget for the month by (5.5%). Surgical case volumes fell below the prior month's volumes by (2.0%) and fell below the monthly budget by (36.4%).

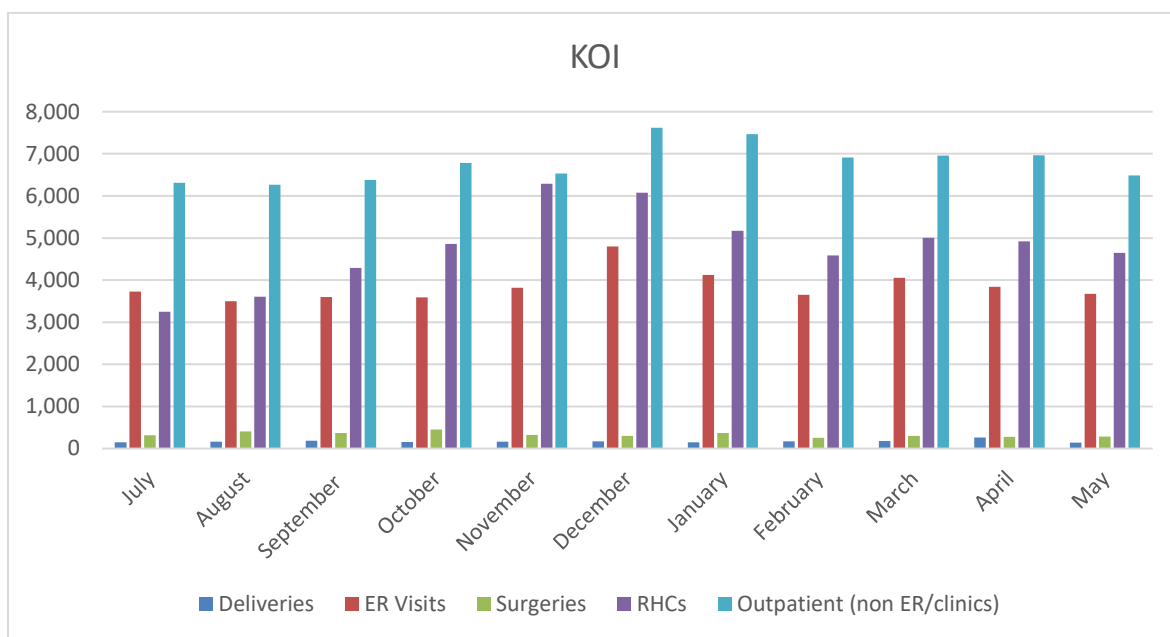
Pioneers Health Center (PHC) visits in May fell below the prior month's visits by (2.1%) and fell below the monthly budget by (31.6%). The Calexico Health Center (CHC) volumes in May fell below the prior month volumes by (21.4%) but exceeded the monthly budget by 3.0%. The Pioneers Children's Health Center (PCHC) exceeded the prior month's volumes by 2.9% but fell below the monthly budget by (13.0%).

Hospital outpatient volumes i.e., Lab, Imaging, Respiratory and other services fell below April's volumes by (6.6%) but exceeded the monthly budget by 21.0%.

For the month of May, Pioneers Memorial Skilled Nursing Center (PMSNC), *formerly Imperial Heights Health and Wellness Center*, inpatient days increased from April's days by 2.0% with 2,192 inpatient days in May compared to 2,149 inpatient days in April. PMSNC had an average daily census (ADC) of 70.7 for the month of May.

See Exhibit A (Key Volume Stats – Trend Analysis) for additional detail.

	Current Period			Year To Date		
	Act.	Bud	Prior Yr.	Act.	Bud	Prior Yr.
Deliveries	141	159	152	1,901	1,795	2,062
E/R Visits	3,678	3,891	4,101	42,384	42,418	43,064
Surgeries	287	451	281	3,643	4,371	3,234
GI Scopes	0	23	104	290	902	877
Calexico RHC	923	896	599	10,522	9,014	8,292
Pioneer Health	2,599	3,800	1,897	29,451	33,330	29,384
Children's RHC	749	861	435	8,267	8,740	7,686
O/P Visits	6,484	5,359	5,601	74,685	56,615	57,422



Gross Patient Revenues:

In May, gross inpatient revenues exceeded budget by 26.9% while outpatient revenues fell below budget by (8.8%).

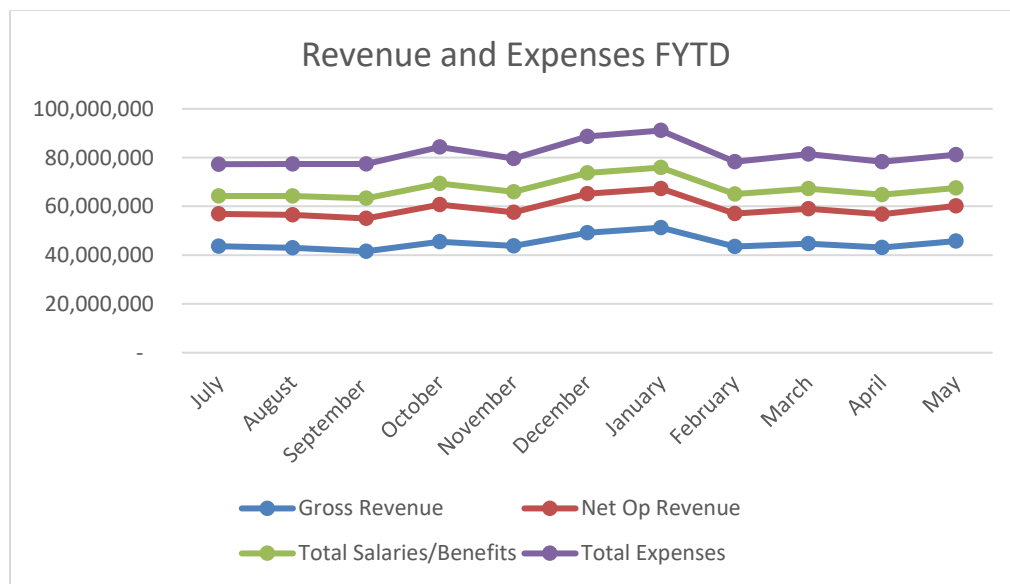
Net operating revenues (Gross revenues less contractual deductions) exceeded the monthly budget by \$709,303 or 5.3% and exceeded the prior month's revenues by \$801,279 or 6.0%.

Operating Expenses:

In total, May operating expenses were over budget by (\$9,191) or less than (0.1%). Staffing expenses, which include Salaries, Benefits and Contract Labor were under budget by \$615,817 or 7.7%. Non-salary expenses, which include Supplies, Professional Fees, Purchased Services and Other were over budget by (\$625,008) or (11.1%).

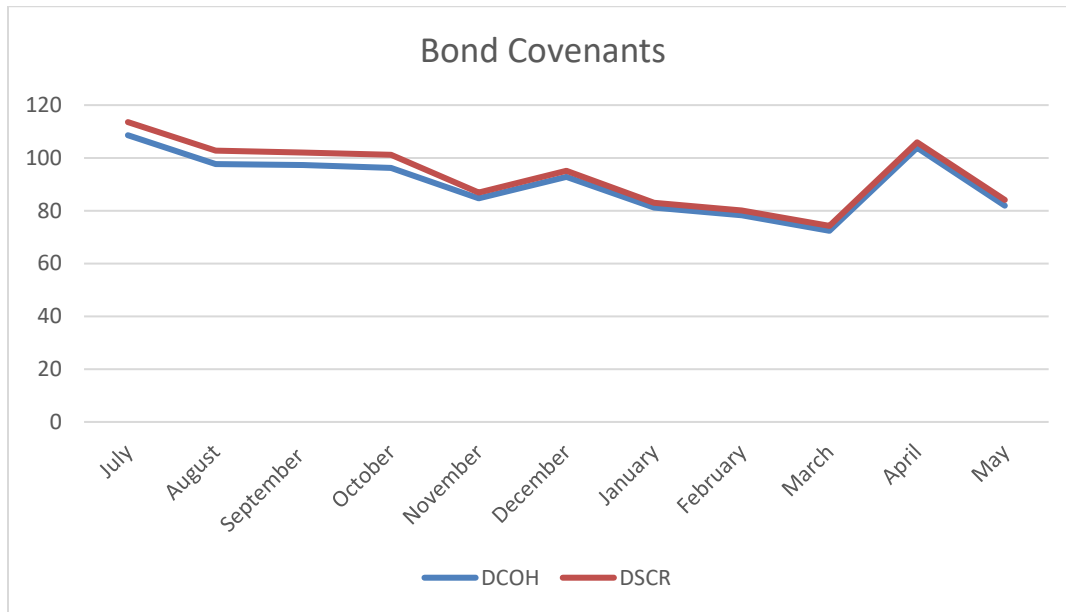
Below is a summary table of expenses compared to budget.

Exp. Category	Actual	Budget	Var.	Comment
Salaries	6,279	6,230	-0.8%	On Budget
Benefits	844	1,522	44.5%	Under Budget
Contract Labor	234	220	-6.4%	Over Budget
Pro Fees	1,435	1,243	-15.4%	Over Budget
Supplies	1,678	1,601	-4.8%	Over Budget
Purchased Serv	667	606	-10.1%	Over Budget
Other	1,009	822	-22.7%	Over Budget



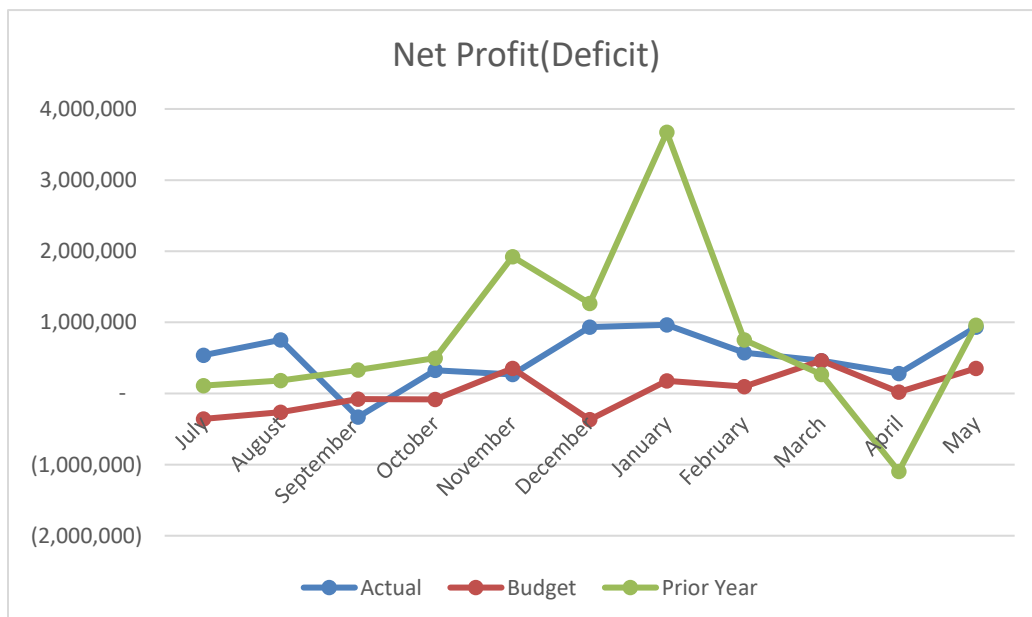
Bond Covenants:

As part of the Series 2017 Bond issue, the District is required to maintain certain covenants or “promises” to maintain liquidity (days cash on hand of 50 days) and profitability (debt service coverage ratio of 1.20). A violation of either will allow the Bond Trustee (US Bank) authorization to take certain steps to protect the interest of the individual Bond Holders.



Net Excess/(Deficit):

Fiscal year-to-date, District operations have resulted in a profit of \$5,701,546 against a budgeted gain of \$314,386, which is less than the prior year-to-date profit of \$8,868,098.



IMPERIAL VALLEY HEALTHCARE DISTRICT
STATEMENT OF REVENUE AND EXPENSE
FOR THE PERIOD ENDING MAY 31, 2025

LAST MONTH ACTUAL APRIL	LAST YEAR ACTUAL MAY	THIS MONTH ACTUAL MAY	THIS MONTH BUDGET MAY	% VAR		FYTD ACTUAL MAY	FYTD BUDGET MAY	% VAR	FYTD PRIOR YEAR MAY	% VAR
2,707	3,154	3,686	4,540	-18.83%	ADJ PATIENT DAYS	35,936	49,263	-27.05%	46,228	-22.26%
1,110	1,396	1,542	1,548	-0.39%	INPATIENT DAYS	15,377	17,621	-12.73%	17,333	-11.28%
462	504	551	440	25.23%	IP ADMISSIONS	5,636	4,868	15.78%	4,937	14.16%
46	45	50	50	-0.39%	IP AVERAGE DAILY CENSUS	46	53	-12.73%	52	-11.28%
4,502,920	3,457,051	4,627,358	7,353,170	-37.07%	GROSS PATIENT REVENUES					
13,170,259	15,797,333	14,494,947	7,720,413	87.75%	DAILY HOSPITAL SERVICES	47,398,365	82,655,085	-42.66%	79,141,949	-40.11%
25,433,294	24,253,745	26,581,622	29,136,929	-8.77%	INPATIENT ANCILLARY	164,365,981	85,310,642	92.67%	96,587,138	70.17%
					OUTPATIENT ANCILLARY	283,125,096	301,614,202	-6.13%	292,953,440	-3.35%
43,106,473	43,508,129	45,703,927	44,210,512	3.38%	TOTAL PATIENT REVENUES	494,889,442	469,579,929	5.39%	468,682,527	5.59%
10,228,981	9,442,613	10,173,409	9,682,555	-5.07%	REVENUE DEDUCTIONS					
13,643,163	13,341,498	13,219,010	12,654,846	-4.46%	MEDICARE CONTRACTUAL	118,145,657	102,842,815	-14.88%	103,792,483	-13.83%
-1,378,326	-1,423,762	-1,453,003	-1,421,250	-2.23%	MEDICAL CONTRACTUAL	149,684,726	134,412,871	-11.36%	140,685,944	-6.40%
-467,741	-11,210	0	0	100.00%	SUPPLEMENTAL PAYMENTS	-14,979,329	-15,095,746	0.77%	-18,010,033	16.83%
6,797,466	8,030,632	8,500,637	8,678,058	2.04%	PRIOR YEAR RECOVERIES	-2,497,742	0	100.00%	-3,568,727	
8,600	435,081	188,266	161,997	-16.22%	OTHER DEDUCTIONS	81,454,495	92,173,600	11.63%	90,326,926	9.82%
920,000	928,000	920,000	1,012,311	9.12%	CHARITY WRITE OFFS	485,993	1,720,641	71.76%	2,020,358	75.95%
0	-4,167		-4,310	100.00%	BAD DEBT PROVISION	10,138,743	10,752,217	5.71%	10,972,405	7.60%
29,752,144	30,738,685	31,548,319	30,764,207	-2.55%	INDIGENT CARE WRITE OFFS	-29,169	-45,776	36.28%	-45,834	-36.36%
13,354,329	12,769,444	14,155,608	13,446,305	5.28%	TOTAL REVENUE DEDUCTIONS	342,403,375	326,760,622	-4.79%	326,173,522	-4.98%
69.0%	70.7%	69.0%	69.6%		NET PATIENT REVENUES	152,486,068	142,819,307	6.77%	142,509,005	-7.00%
0	0	0	0			69.2%	69.6%		70%	
372,539	1,211,651	311,185	391,236	-20.46%	OTHER OPERATING REVENUE	0	0		580,000	-100.00%
372,539	1,211,651	311,185	391,236	-20.46%	GRANT REVENUES					
					OTHER	4,832,795	4,259,917	13.45%	5,397,265	-10.46%
13,726,868	13,981,095	14,466,793	13,837,541	4.55%	TOTAL OTHER REVENUE	4,832,795	4,259,917	13.45%	5,977,265	-19.15%
6,237,213	5,928,983	6,278,514	6,230,176	-0.78%	TOTAL OPERATING REVENUE	157,318,863	147,079,224	6.96%	148,486,270	5.95%
1,462,931	1,928,464	844,172	1,522,353	44.55%	OPERATING EXPENSES					
210,277	252,532	233,655	219,629	-6.39%	SALARIES AND WAGES	69,662,724	67,202,693	-3.66%	61,958,179	-12.44%
7,910,421	8,109,979	7,356,341	7,972,158	7.72%	BENEFITS	17,310,639	16,745,883	-3.37%	16,715,237	-3.56%
1,490,185	1,248,137	1,435,269	1,242,802	-15.49%	REGISTRY & CONTRACT	2,227,842	2,458,882	9.40%	3,025,832	26.37%
1,405,314	1,124,876	1,678,334	1,600,742	-4.85%	TOTAL STAFFING EXPENSE	89,201,205	86,407,458	-3.23%	81,699,248	-9.18%
459,333	656,064	667,131	605,599	-10.16%	PROFESSIONAL FEES	14,866,758	13,670,822	-8.75%	12,543,300	-18.52%
662,344	439,958	733,946	580,089	-26.52%	SUPPLIES	18,001,415	17,379,551	-3.58%	16,488,445	-9.18%
331,604	293,150	305,281	370,949	17.70%	PURCHASED SERVICES	6,845,857	6,710,570	-2.02%	7,962,525	14.02%
224,447	184,849	222,120	237,677	6.55%	REPAIR & MAINTENANCE	7,101,086	6,380,979	-11.29%	5,725,565	-24.02%
244,297	263,626	207,916	174,313	-19.28%	DEPRECIATION & AMORT	3,333,218	4,008,644	16.85%	3,076,690	-8.34%
784,905	899,713	1,008,868	821,686	-22.78%	INSURANCE	2,525,086	2,620,605	3.64%	2,508,717	-0.65%
13,512,850	13,220,352	13,615,206	13,606,015	-0.07%	HOSPITALIST PROGRAM	2,273,294	2,237,523	-1.60%	2,406,463	5.53%
214,018	760,743	851,587	231,526	-267.81%	OTHER	9,349,403	8,691,335	-7.57%	8,951,297	-4.45%
344	135,084	16,003	60,744	-73.66%	TOTAL OPERATING EXPENSES	153,497,322	148,107,487	-3.64%	141,362,250	-8.58%
117,632	117,632	117,632	117,632	0.00%	TOTAL OPERATING MARGIN	3,821,541	-1,028,263	-471.65%	7,124,020	46.36%
-51,196	-54,047	-51,144	-56,317	9.19%	NON OPER REVENUE(EXPENSE)					
0	0	0	0	0.00%	OTHER NON-OP REV (EXP)	1,105,154	668,184	65.40%	867,741	27.36%
66,780	198,669	82,491	122,059	-32.42%	DISTRICT TAX REVENUES	1,349,049	1,293,952	4.26%	1,489,162	-9.41%
280,798	959,412	934,078	353,585	-164.17%	INTEREST EXPENSE	-574,198	-619,487	7.31%	-612,825	6.30%
964.28	976.70	1,011.14	918.43	-10.09%	CARES HHS/ FEMA RELIEF FUNDING	0	0	0.00%	0	
837.21	892.08	915.77	822.13	-11.39%	TOTAL NON-OP REV (EXPENSE)	1,880,005	1,342,649	40.02%	1,744,078	7.79%
21.15	20.76	21.06	15.80	-33.31%	NET EXCESS / (DEFICIT)	5,701,546	314,386	-1713.55%	8,868,098	35.71%
803.19	852.00	860.70	794.81	-8.29%	TOTAL PAID FTE'S (Inc Reg & Cont.)	1,202.28	927.18	-29.67%	897.20	-34.00%
697.31	781.01	785.41	710.18	-10.59%	TOTAL WORKED FTE'S	1,001.47	832.22	-20.34%	801.40	-24.97%
161.09	124.69	150.44	123.62	-21.69%	TOTAL CONTRACT FTE'S	20.89	22.25	6.13%	20.64	-1.20%
139.90	111.08	130.37	111.95	-16.45%	PAID FTE'S - HOSPITAL	1,045.27	798.38	-30.92%	780.04	-34.00%
					WORKED FTE'S - HOSPITAL	860.21	715.60	-20.21%	692.01	-24.31%
					PAID FTE'S - SNF	157.01	128.80	-21.90%	117.17	100.00%
					WORKED FTE'S - SNF	141.26	116.63	-21.12%	109.39	100.00%

IMPERIAL VALLEY HEALTHCARE DISTRICT
BALANCE SHEET AS OF MAY 31, 2025

	<u>APRIL 2025</u>	<u>MAY 2025</u>	<u>MAY 2024</u>
ASSETS			
CURRENT ASSETS			
CASH	\$43,076,772	\$36,960,834	\$39,955,243
CASH - NORIDIAN AAP FUNDS	\$0	\$0	\$0
CASH - 3RD PRY REPAYMENTS	\$0	\$0	\$0
CDs - LAIF & CVB	\$66,244	\$66,244	\$65,505
ACCOUNTS RECEIVABLE - PATIENTS	\$92,954,857	\$103,756,392	\$89,626,773
LESS: ALLOWANCE FOR BAD DEBTS	-\$2,655,434	-\$2,452,781	-\$6,286,802
LESS: ALLOWANCE FOR CONTRACTUALS	-\$72,040,469	-\$78,747,142	-\$66,808,290
NET ACCTS RECEIVABLE	\$18,258,954	\$22,556,469	\$16,531,681
	19.64%	21.74%	18.45%
ACCOUNTS RECEIVABLE - OTHER	\$27,649,375	\$29,233,588	\$23,195,515
COST REPORT RECEIVABLES	\$59,499	\$59,499	\$2,129,441
INVENTORIES - SUPPLIES	\$3,170,967	\$3,351,533	\$3,180,524
PREPAID EXPENSES	\$2,558,343	\$3,065,221	\$1,968,239
TOTAL CURRENT ASSETS	\$94,840,154	\$95,293,388	\$87,026,148
OTHER ASSETS			
PROJECT FUND 2017 BONDS	\$616,332	\$697,378	\$424,385
BOND RESERVE FUND 2017 BONDS	\$968,353	\$968,353	\$968,320
LIMITED USE ASSETS	\$10,198	\$10,512	\$60,074
NORIDIAN AAP FUNDS	\$0	\$0	\$0
GASB87 LEASES	\$64,931,450	\$64,931,450	\$49,415,107
OTHER ASSETS PROPERTY TAX PROCEEDS	\$269,688	\$269,688	\$505,438
OTHER INVESTMENTS	\$420,000	\$420,000	\$0
UNAMORTIZED BOND ISSUE COSTS			
TOTAL OTHER ASSETS	\$67,216,021	\$67,297,381	\$51,373,324
PROPERTY, PLANT AND EQUIPMENT			
LAND	\$2,633,026	\$2,633,026	\$2,623,526
BUILDINGS & IMPROVEMENTS	\$63,118,597	\$63,118,597	\$62,919,140
EQUIPMENT	\$66,017,727	\$66,155,591	\$63,135,577
CONSTRUCTION IN PROGRESS	\$110,766	\$193,738	\$507,352
LESS: ACCUMULATED DEPRECIATION	-\$102,776,931	-\$103,082,212	-\$99,470,309
NET PROPERTY, PLANT, AND EQUIPMENT	\$29,103,185	\$29,018,740	\$29,715,285
TOTAL ASSETS	\$191,159,360	\$191,609,509	\$168,114,757

IMPERIAL VALLEY HEALTHCARE DISTRICT
BALANCE SHEET AS OF MAY 31, 2025

	<u>APRIL 2025</u>	<u>MAY 2025</u>	<u>MAY 2024</u>
LIABILITIES AND FUND BALANCES			
CURRENT LIABILITIES			
ACCOUNTS PAYABLE - CASH REQUIREMENTS	\$3,986,749	\$4,076,222	\$2,774,999
ACCOUNTS PAYABLE - ACCRUALS	\$9,109,714	\$8,437,227	\$8,844,747
PAYROLL & BENEFITS PAYABLE - ACCRUALS	\$7,092,710	\$7,255,560	\$5,605,433
COST REPORT PAYABLES & RESERVES	\$0	\$0	\$0
NORIDIAN AAP FUNDS	\$0	\$0	\$0
CURR PORTION- GO BONDS PAYABLE	\$0	\$0	\$230,000
CURR PORTION- 2017 REVENUE BONDS PAYABLE	\$0	\$0	\$320,000
INTEREST PAYABLE- GO BONDS	\$1,917	\$1,917	\$1,917
INTEREST PAYABLE- 2017 REVENUE BONDS	\$374,383	\$427,513	\$111,404
OTHER - TAX ADVANCE IMPERIAL COUNTY	\$0	\$0	\$0
DEFERRED HHS CARES RELIEF FUNDS	\$0	\$0	\$0
CURR PORTION- LEASE LIABILITIES(GASB 87)	\$3,756,205	\$3,756,205	\$1,722,161
SKILLED NURSING OVER COLLECTIONS	\$2,064,596	\$2,282,992	\$0
CURR PORTION- SKILLED NURSING CTR ADVANCE	\$0	\$0	\$0
CURRENT PORTION OF LONG-TERM DEBT	\$1,037,037	\$1,037,037	\$167,052
TOTAL CURRENT LIABILITIES	\$27,423,311	\$27,274,673	\$19,777,713
LONG TERM DEBT AND OTHER LIABILITIES			
PMH RETIREMENT FUND - ACCRUAL	\$991,305	\$658,000	\$120,000
NOTES PAYABLE - EQUIPMENT PURCHASES	\$0	\$0	\$0
LOANS PAYABLE - DISTRESSED HOSP. LOAN	\$26,962,963	\$26,962,963	\$28,043,566
LOANS PAYABLE - CHFFA NDPH	\$0	\$0	\$3,766,770
BONDS PAYABLE G.O BONDS	\$0	\$0	\$0
BONDS PAYABLE 2017 SERIES	\$14,468,003	\$14,466,018	\$14,489,841
LONG TERM LEASE LIABILITIES (GASB 87)	\$62,267,845	\$62,267,845	\$48,170,072
DEFERRED REVENUE -CHW	\$0	\$0	\$0
DEFERRED PROPERTY TAX REVENUE	\$275,438	\$275,438	\$511,188
TOTAL LONG TERM DEBT	\$104,965,554	\$104,630,264	\$95,101,437
FUND BALANCE AND DONATED CAPITAL	\$54,003,028	\$54,003,028	\$44,264,668
NET SURPLUS (DEFICIT) CURRENT YEAR	\$4,767,467	\$5,701,546	\$8,970,939
TOTAL FUND BALANCE	\$58,770,495	\$59,704,574	\$53,235,607
TOTAL LIABILITIES AND FUND BALANCE	\$191,159,360	\$191,609,511	\$168,114,757

IMPERIAL VALLEY HEALTHCARE DISTRICT
STATEMENT OF REVENUE AND EXPENSE - 12 Month Trend

	1	2	3	4	5	6	7	8	9	10	11	12	YTD
	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	May-25
ADJ PATIENT DAYS	3,210	3,336	3,200	2,948	3,036	3,243	3,868	3,776	2,876	3,264	2,707	3,686	39,140
INPATIENT DAYS	1,348	1,338	1,362	1,289	1,290	1,376	1,676	1,769	1,275	1,350	1,110	1,542	16,725
IP ADMISSIONS	461	486	487	495	479	501	591	585	488	511	462	551	6,097
IP AVERAGE DAILY CENSUS	45	43	44	43	42	46	54	57	46	44	46	50	46
GROSS PATIENT REVENUES													
DAILY HOSPITAL SERVICES	3,768,895	4,135,558	4,245,778	4,185,658	4,425,452	3,960,883	4,306,327	4,623,907	3,923,533	4,460,991	4,502,920	4,627,358	51,167,260
INPATIENT ANCILLARY	13,081,272	13,359,194	14,037,130	13,994,712	14,901,257	14,605,962	17,023,992	19,402,543	15,365,879	14,010,106	13,170,259	14,494,947	177,447,253
OUTPATIENT ANCILLARY	23,272,916	26,123,842	24,666,163	23,402,909	26,164,034	25,191,832	27,895,452	27,255,392	24,218,568	26,191,988	25,433,294	26,581,622	306,398,012
TOTAL PATIENT REVENUES	40,123,083	43,618,594	42,949,071	41,583,279	45,490,743	43,758,677	49,225,771	51,281,842	43,507,980	44,663,085	43,106,473	45,703,927	535,012,525
REVENUE DEDUCTIONS													
MEDICARE CONTRACTUAL	7,771,266	10,291,766	9,837,519	9,148,238	11,152,895	9,362,592	11,681,500	13,186,192	11,368,853	11,713,712	10,228,981	10,173,409	125,916,923
MEDICAL CONTRACTUAL	10,267,611	12,833,278	12,888,442	11,976,873	12,946,217	13,222,415	15,178,005	18,178,743	12,813,377	12,785,203	13,643,163	13,219,010	159,952,337
SUPPLEMENTAL PAYMENTS	-1,335,395	-1,374,159	-1,336,399	-1,378,326	-1,374,159	-1,374,159	-1,374,159	-1,374,159	-1,378,326	-1,184,154	-1,378,326	-1,453,003	-16,314,724
PRIOR YEAR RECOVERIES	-424,603	0	0	0	0	0	-1,925,640	0	-15,505	-88,856	-467,741	0	-2,922,345
OTHER DEDUCTIONS	7,494,293	7,851,346	7,376,244	8,022,745	6,839,814	8,171,185	9,491,219	4,827,640	6,597,941	6,978,258	6,797,466	8,500,637	88,948,788
CHARITY WRITE OFFS	144,857	103,048	44,424	60,153	10,063	12,363	26,134	25,780	7,162	0	8,600	188,266	630,850
BAD DEBT PROVISION	966,744	937,839	920,000	1,030,122	1,020,000	920,000	1,171,548	749,234	950,000	600,000	920,000	920,000	11,105,487
INDIGENT CARE WRITE OFFS	-3,450	-4,167	-4,167	-4,167	-4,167	-4,167	-4,167	-4,167	0	0	0	0	-32,619
TOTAL REVENUE DEDUCTIONS	24,881,323	30,638,952	29,726,063	28,855,638	30,590,663	30,310,229	34,244,440	35,589,263	30,343,502	30,804,163	29,752,143	31,548,319	367,284,698
NET PATIENT REVENUES	15,241,760	12,979,642	13,223,008	12,727,641	14,900,080	13,448,448	14,981,331	15,692,579	13,164,478	13,858,922	13,354,330	14,155,608	167,727,827
	62.01%	70.24%	69.21%	69.39%	67.25%	69.27%	69.57%	69.40%	69.74%	68.97%	69.02%	69.03%	68.65%
OTHER OPERATING REVENUE													
GRANT REVENUES	0	0	0	0	0	0	0	0	0	0	0	0	0
OTHER	581,000	273,801	307,025	728,012	296,651	392,693	909,432	343,185	362,386	535,886	372,539	311,185	5,413,795
TOTAL OTHER REVENUE	581,000	273,801	307,025	728,012	296,651	392,693	909,432	343,185	362,386	535,886	372,539	311,185	5,413,795
TOTAL OPERATING REVENUE	15,822,760	13,253,443	13,530,033	13,455,653	15,196,731	13,841,141	15,890,763	16,035,764	13,526,864	14,394,808	13,726,869	14,466,793	173,141,622
OPERATING EXPENSES													
SALARIES AND WAGES	5,967,105	5,849,650	5,850,323	6,387,066	6,843,129	6,700,034	6,537,237	6,670,775	6,039,904	6,268,879	6,237,213	6,278,514	75,629,829
BENEFITS	1,374,803	1,285,872	1,773,423	1,678,679	1,696,408	1,474,183	1,838,509	1,747,884	1,691,888	1,816,690	1,462,931	844,172	18,685,442
REGISTRY & CONTRACT	232,219	211,140	187,727	187,398	203,673	170,892	169,549	181,032	291,516	180,983	210,277	233,655	2,460,061
TOTAL STAFFING EXPENSE	7,574,127	7,346,662	7,811,473	8,253,143	8,743,210	8,345,109	8,545,295	8,599,691	8,023,308	8,266,552	7,910,421	7,356,341	96,775,332
PROFESSIONAL FEES	1,370,827	1,386,912	1,238,459	1,267,728	1,442,258	1,406,374	1,241,747	1,352,522	1,142,132	1,463,172	1,490,185	1,435,269	16,237,585
SUPPLIES	2,651,168	1,540,888	1,361,788	1,455,049	1,874,654	1,269,214	2,456,239	1,960,507	1,545,327	1,454,101	1,405,314	1,678,334	20,652,583
PURCHASED SERVICES	800,378	666,784	708,365	710,216	527,135	569,775	508,682	724,696	618,846	684,894	459,335	667,131	7,646,235
REPAIR & MAINTENANCE	661,148	461,240	445,422	675,929	847,788	668,786	795,518	820,025	266,691	723,397	662,344	733,946	7,762,234
DEPRECIATION & AMORT	278,685	286,396	287,071	288,299	288,299	288,299	293,647	399,610	282,356	282,356	331,604	305,281	3,611,903
INSURANCE	237,438	261,018	225,205	226,415	241,953	225,205	232,212	222,108	239,646	204,757	224,447	222,120	2,762,524
HOSPITALIST PROGRAM	223,290	239,321	245,047	259,019	272,176	122,990	0	266,507	167,004	249,017	244,297	207,916	2,496,584
OTHER	972,395	887,279	727,205	923,137	728,810	741,486	944,621	839,501	977,589	786,002	784,905	1,008,868	10,321,798
TOTAL OPERATING EXPENSES	14,769,456	13,076,501	13,050,035	14,058,935	14,966,283	13,637,238	15,017,961	15,185,167	13,262,899	14,114,248	13,512,850	13,615,206	168,266,779
TOTAL OPERATING MARGIN	1,053,304	176,942	479,998	-603,282	230,448	203,903	872,802	850,597	263,965	280,560	214,019	851,587	4,874,843
NON OPER REVENUE(EXPENSE)													
OTHER NON-OPS REVENUE	603,478	296,820	209,057	207,469	30,898	-2,357	-6,557	-6,426	245,308	114,595	344	16,003	1,708,632
CARES HHS RELIEF FUNDING	0	0	0	0	0	0	0	0	0	0	0	0	0
DISTRICT TAX REVENUES	117,632	117,632	117,632	117,632	117,632	117,632	117,632	172,729	117,632	117,632	117,632	117,632	1,466,681
INTEREST EXPENSE	-53,997	-53,947	-53,896	-53,846	-51,503	-53,369	-51,401	-51,350	-51,299	-51,247	-51,196	-51,144	-628,195
									0	0	0	0	
TOTAL NON-OPS REVENUE(EXPENSE)	667,113	360,505	272,793	271,255	97,027	61,906	59,674	114,953	311,641	180,980	66,780	82,491	2,547,118
NET EXCESS / (DEFICIT)	<u>1,720,417</u>	<u>537,447</u>	<u>752,791</u>	<u>-332,027</u>	<u>327,475</u>	<u>265,809</u>	<u>932,476</u>	<u>965,550</u>	<u>575,606</u>	<u>461,540</u>	<u>280,799</u>	<u>934,078</u>	<u>7,421,961</u>
TOTAL PAID FTE'S (Inc Reg & Cont.)	1,056.50	1,079.85	1,162.74	1,096.83	1,031.44	983.93	1,116.10	1,189.57	1,172.24	1,106.21	964.28	1,011.14	1,080.90
TOTAL WORKED FTE'S	929.50	935.01	1,045.12	770.43	748.59	748.38	948.70	993.61	1,051.28	981.75	837.21	915.77	908.78
TOTAL CONTRACT FTE'S	17.13	17.91	13.45	23.20	16.78	16.57	16.29	17.57	24.10	20.84	21.15	21.06	18.84
PAID FTE'S - HOSPITAL	948.45	938.27	1,020.05	981.91	927.71	880.21	964.18	1,040.82	1,008.51	914.42	803.19	860.70	940.70
WKD FTE'S - HOSPITAL	836.07	812.98	921.90	667.30	650.28	650.06	809.59	857.09	910.21	798.47	697.31	785.41	783.06
PAID FTE'S - SNF	108.06	141.57	142.68	114.92	103.73	103.73	151.92	148.75	163.74	191.79	161.09	150.44	140.20
WORKED FTE'S - SNF	93.43	122.03	123.23	103.13	98.32	98.32	139.11	136.53	141.07	183.28	139.90	130.37	125.72

Imperial Valley Healthcare District - Financial Indicators Report
(Based on Prior 12 Months Activities)
For The 12 Months Ending: May 31, 2025
excludes: GO bonds tax revenue, int exp and debt.

1. Debt Service Coverage Ratio

This ratio compares the total funds available to service debt compared to the debt plus interest due in a given year.

$$\text{Formula: } \frac{\text{Cash Flow} + \text{Interest Expense}}{\text{Principal Payments Due} + \text{Interest}}$$

$$\text{DSCR} = \frac{\$11,643,004}{\$5,421,903} = \mathbf{2.15}$$

Recommendation: To maintain a debt service coverage of at least 1.20% x aggregate debt service per the 2017 Revenue Bonds covenant.

2. Days Cash on Hand Ratio

This ratio measures the number of days of average cash expenses that the hospital maintains in cash and marketable investments. (Note: The proformas ratios include long-term investments in this calculation:)

$$\text{Formula: } \frac{\text{Cash} + \text{Marketable Securities}}{\text{Operating Expenses, Less Depreciation}} \times 365 \text{ Days}$$

$$\text{DCOHR} = \frac{\$37,027,078}{\$165,026,835} \times 365 = \mathbf{81.9}$$

Recommendation: To maintain a days cash on hand ratio of at least 50 days per the 2017 Revenue Bonds covenant.

3. Long-Term Debt to Capitalization Ratio

This ratio compares long-term debt to the Hospital's long-term debt plus fund balances.

$$\text{Formula: } \frac{\text{Long-term Debt}}{\text{Long-term Debt} + \text{Fund Balance (Total Capital)}}$$

$$\text{L.T.D.-C.R.} = \frac{\$108,490,068}{\$167,260,563} = \mathbf{64.9}$$

Recommendation: To maintain a long-term debt to capitalization ratio not to exceed 60.0%.

11 Mos 5/31/2025

	Current Month 5/31/2025	Year-To-Date 0 5/31/2025
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net Income (Loss)	\$934,078	\$5,701,532
Adjustments to Reconcile Net Income to Net Cash Provided by Operating Activities:		
Depreciation	\$305,281	\$3,333,219
(Increase)/Decrease in Net Patient Accounts Receivable	(\$4,297,514)	(\$7,133,099)
(Increase)/Decrease in Other Receivables	(\$1,584,213)	\$1,568,126
(Increase)/Decrease in Inventories	(\$180,566)	(\$516,287)
(Increase)/Decrease in Pre-Paid Expenses	(\$506,878)	(\$1,111,689)
(Increase)/Decrease in Other Current Assets	\$0	\$2,461,923
Increase/(Decrease) in Accounts Payable	\$89,473	(\$1,383,864)
Increase/(Decrease) in Notes and Loans Payable	(\$672,487)	(\$2,012,858)
Increase/(Decrease) in Accrued Payroll and Benefits	\$162,850	\$893,363
Increase/(Decrease) in Accrued Expenses	\$0	\$0
Increase/(Decrease) in Patient Refunds Payable	\$0	\$0
Increase/(Decrease) in Third Party Advances/Liabilities	\$0	\$0
Increase/(Decrease) in Other Current Liabilities	\$53,129	(\$481,037)
Net Cash Provided by Operating Activities:	(\$5,696,847)	\$1,319,330
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase of property, plant and equipment	(\$220,836)	(\$2,588,664)
(Increase)/Decrease in Limited Use Cash and Investments	(\$314)	\$30,447
(Increase)/Decrease in Other Limited Use Assets	(\$81,046)	(\$611,890)
(Increase)/Decrease in Other Assets	\$0	\$0
Net Cash Used by Investing Activities	(\$302,196)	(\$3,170,108)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Increase/(Decrease) in Bond/Mortgage Debt	(\$1,985)	(\$21,838)
Increase/(Decrease) in Capital Lease Debt	\$0	(\$3,766,770)
Increase/(Decrease) in Other Long Term Liabilities	(\$114,910)	\$2,635,473
Net Cash Used for Financing Activities	(\$116,895)	(\$1,153,134)
(INCREASE)/DECREASE IN RESTRICTED ASSETS	\$0	\$0
Net Increase/(Decrease) in Cash	(\$6,115,938)	(\$3,003,913)
Cash, Beginning of Period	\$43,143,016	\$40,030,991
Cash, End of Period	\$37,027,078	\$37,027,078



Key Operating Indicators May 2025

	Month			YTD		
	ACTUAL	BUDGET	PRIOR YR	ACTUAL	BUDGET	PRIOR YR
Volumes						
Admits	551	440	504	5,636	4,868	4,937
ICU	129	112	37	1,268	1,288	1,161
Med/Surgical	895	870	922	10,480	9,987	9,996
Newborn ICU	137	109	78	1,222	1,252	1,231
Pediatrics	90	68	66	774	762	769
Obstetrics	291	386	287	3,934	4,299	4,139
GYN	0	3	6	-	33	37
DOU	0	-	-	-	-	-
Total Patient Days	1,542	1,548	1,396	17,678	17,621	17,333
Adjusted Patient Days	3,686	4,540	3,154	41,313	49,259	46,228
Average Daily Census	50	50	45	53	53	52
Average Length of Stay	2.98	3.52	2.77	2.82	3.63	3.41
Deliveries	141	159	152	1,901	1,795	2,062
E/R Visits	3,678	3,891	4,101	42,384	42,418	43,064
Surgeries	287	451	281	3,643	4,371	3,234
Wound Care	242	270	245	3,182	3,679	3,463
Pioneers Health Center	2,599	3,800	1,897	29,451	33,330	29,384
Calexico Visits	923	896	599	10,522	9,014	8,292
Pioneers Children	749	861	435	8,267	8,740	7,686
Outpatients (non-ER/Clinics)	6,484	5,359	5,601	74,685	56,615	57,422
Surgical Health	69	81	17	608	637	566
Urology	270	415	370	3,687	3,439	3,479
WHAP	375	564	604	4,461	4,820	5,262
C-WHAP	599	478	200	4,262	3,818	3,869
CDLD	120	39	17	905	792	29
Skilled Nursing	2,192	2,435	2,338	24,143	26,784	26,809
FTE's						
Worked	915.77	822.13	892.08	998.74	829.77	801.40
Paid	1011.14	918.43	976.70	1199.26	924.44	897.20
Contract FTE's	21.06	15.80	20.76	20.83	22.21	20.66
FTE's APD (Worked)	7.70	5.61	8.77	8.10	5.64	5.82
FTE's APD (Paid)	8.51	6.27	9.60	9.72	6.29	6.52
Net Income						
Operating Revenues	\$14,466,793	\$13,837,541	\$13,981,095	\$157,318,863	\$147,079,224	\$148,486,270
Operating Margin	\$851,587	\$231,526	\$760,743	\$3,821,541	-\$1,028,263	\$7,124,020
Operating Margin %	5.9%	1.7%	5.4%	2.4%	-0.7%	4.8%
Total Margin	\$934,078	\$353,585	\$959,412	\$5,701,546	\$314,386	\$8,868,098
Total Margin %	6.5%	2.6%	6.9%	3.6%	0.2%	6.0%

Exhibit A - May 2025		Key Volume Stats -Trend Analysis													
		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total	YTD
Deliveries															
	Actual	152	167	184	159	167	170	148	169	178	266	141	0	1,901	1,901
	Budget	153	127	185	173	176	157	181	160	196	127	159	177	1,972	1,795
	Prior FY 2024	175	145	211	198	201	179	206	183	173	239	152	139	2,201	2,062
E/R Visits															
	Actual	3,728	3,498	3,597	3,590	3,817	4,803	4,125	3,654	4,055	3,839	3,678	0	42,384	42,384
	Budget	3,738	3,588	3,678	4,141	4,714	3,978	3,738	3,476	3,906	3,570	3,891	3,410	45,828	42,418
	Prior FY 2024	3,500	3,614	3,500	3,985	3,867	4,467	3,931	4,071	4,032	3,996	4,101	-	43,064	43,064
Surgeries															
	IP Actual	128	143	127	148	138	149	193	124	141	114	111	0	1,516	1,516
	IP Budget	96	107	126	100	105	102	114	115	145	124	123	112	1,369	1,257
	OP Actual	225	264	249	306	227	214	228	170	179	179	176	0	2,417	2,417
	OP Budget	232	303	260	299	277	247	270	255	355	288	328	281	3,395	3,114
	Total Actual	312	403	369	452	323	304	366	251	299	277	287	0	3,643	3,643
	Total Budget	328	410	386	399	382	349	384	370	500	412	451	393	4,764	4,371
	Prior FY 2024	303	316	289	324	272	273	290	296	291	299	281	276	3,510	3,234
Calexico															
	Actual	621	675	829	915	1,119	1,232	1,012	948	1,074	1,174	923	0	10,522	10,522
	Budget	696	926	844	792	731	793	816	769	860	891	896	824	9,838	9,014
	Prior FY 2024	697	926	844	792	731	793	816	769	803	522	599	630	8,922	8,292
Pioneers Health Center															
	Actual	1,937	2,115	2,308	2,688	3,473	3,496	2,856	2,580	2,744	2,655	2,599	0	29,451	29,451
	Budget	1,943	3,774	2,818	2,955	2,954	3,016	3,094	2,890	3,149	2,937	3,800	2,862	36,192	33,330
	Prior FY 2024	1,943	3,774	2,818	2,955	2,954	3,016	3,094	2,890	2,870	1,173	1,897	2,038	31,422	29,384
Pioneers Children															
	Actual	358	376	765	841	1,009	984	878	734	845	728	749	0	8,267	8,267
	Budget	776	959	719	939	835	671	767	713	798	702	861	735	9,475	8,740
	Prior FY 2024	776	959	719	940	835	671	767	713	596	275	435	351	8,037	7,686
Outpatients															
	Actual	6,314	6,270	6,378	6,780	6,531	7,619	7,471	6,911	6,961	6,966	6,484	0	74,685	74,685
	Budget	5,158	5,407	5,487	5,913	4,848	4,269	4,886	4,640	5,535	5,113	5,359	5,520	62,135	56,615
	Prior FY 2024	4,906	5,697	5,128	5,721	5,024	4,584	4,956	5,024	5,179	5,602	5,601	5,428	62,850	57,422
Wound Care															
	Actual	270	327	332	326	251	258	293	304	287	292	242	0	3,182	3,182
	Budget	311	415	366	357	285	364	370	341	333	267	270	262	3,941	3,679
	Prior FY 2024	366	399	314	294	307	270	333	324	349	262	245	206	3,669	3,463
WHAP															
	Actual	330	443	388	414	688	362	427	325	342	367	375	0	4,461	4,461
	Budget	382	491	428	411	402	322	433	422	510	455	564	538	5,358	4,820
	Prior FY 2024	430	520	477	512	436	348	631	533	476	295	604	543	5,805	5,262
C-WHAP															
	Actual	131	95	365	403	552	400	425	441	432	419	599	0	4,262	4,262
	Budget	303	341	308	325	358	310	301	330	338	426	478	377	4,195	3,818
	Prior FY 2024	229	376	348	186	316	398	524	513	524	255	200	148	4,017	3,869

GL Journal Transactions

Page 1 of 1

Entry Id:	5542	Entry Type:	Journal	Total Debits:	114,592.49
Company Id:	PMHD	Source:	GL Interface	Total Credits:	0.00
Accounting Date:	May 31, 2025	Currency:	USD	Entry Count:	14
Reversing Date:				Entry Status:	Open
Created By:	LCARRILLO	On:	June 19, 2025		

Comments: STATISTICS MAY 2025

<u>Data Type</u>	<u>Unit Id</u>	<u>Unit</u>	<u>Account No</u>	<u>Account</u>	<u>Amount</u>
Statistical	9900	HOSPITAL STATS	9962	ACTIVE MD STAFF	96.00
Statistical	9900	HOSPITAL STATS	9952	DIETRY MEAL SRV	7,891.00
Statistical	9900	HOSPITAL STATS	9950	CAFE MEALS SERV	23,123.00
Statistical	9900	HOSPITAL STATS	9953	TOTAL MEAL SRVD	31,014.00
Statistical	9900	HOSPITAL STATS	9957	CHILD CARE DAYS	513.00
Statistical	8660	EMPLOYEE HEALTH	9968	NUMBER OF VISIT	130.00
Statistical	7740	ACUTE DIALYSIS	9917	I/P TREATMENTS	81.00
Statistical	9900	HOSPITAL STATS	9956	LAUNDRY POUNDS	47,312.00
Statistical	9900	HOSPITAL STATS	9954	HSKPING SQ FEET	149.00
Statistical	9900	HOSPITAL STATS	9954	HSKPING SQ FEET	175.00
Statistical	7878	WOUNDCARE	9908	O/P PROCEDURES	242.00
Statistical	9900	HOSPITAL STATS	9959	TOTAL PAID FTES	1,011.14
Statistical	9900	HOSPITAL STATS	9960	NURSING PD FTES	663.35
Statistical	6580	SKILLED NURSING SERVIC	9900	PATIENT DAYS	2,192.00



Imperial Valley Healthcare District

2025 Audit Planning

Discussion with Management and
the Board of Directors



Agenda

1. Your Service Team
2. Scope of Services
3. Auditor's Responsibility in a Financial Statement Audit
4. Significant Risks Identified
5. Risks Discussion
6. Consideration of Fraud
7. Audit Timeline
8. Audit Deliverables
9. Expectations
10. Executive Session



Your Service Team



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Scope of Services

Relationships between Baker Tilly and Imperial Valley Healthcare District:

Annual Audit

Annual financial statement audit for the year ending June 30, 2025

Non-Attest Services

- Assist management with drafting the financial statements and related footnotes for the year ending June 30, 2025 (does not include assistance with drafting of the Management's Discussion and Analysis Section)

Auditor's Responsibilities in a Financial Statement Audit

Auditor is responsible for:

- forming and expressing an opinion on whether the financial statements are prepared, in all material respects, in conformity with applicable financial reporting framework
- communicating significant matters, as defined by professional standards, arising during the audit that are relevant to you
- when applicable, communicating particular matters required by law or regulation, by agreement with you, or by other requirements applicable to the engagement

The audit of the financial statements doesn't relieve management or you of your responsibilities.

The auditor is not responsible for designing procedures for the purpose of identifying other matters to communicate to you.



Significant Risks Identified

During the planning of the audit we have identified the following significant risks:

Significant Risks	Procedures
Revenue recognition and valuation of patient receivables	We will gain an understanding of management’s policies and procedures in determining contractual and bad debt allowances and perform walk-throughs of the related controls by testing revenue charges, accounts receivable, cash receipts, and zero balance accounts. We will perform a lookback analysis using current year cash receipts to assess the accuracy of the prior year estimate. We will develop our own independent estimate of the valuation of patient accounts receivable based on historical collection rates by payor and subsequent cash receipts and compare that expectation to the amount recorded by management.



Significant Risks Identified *(continued)*

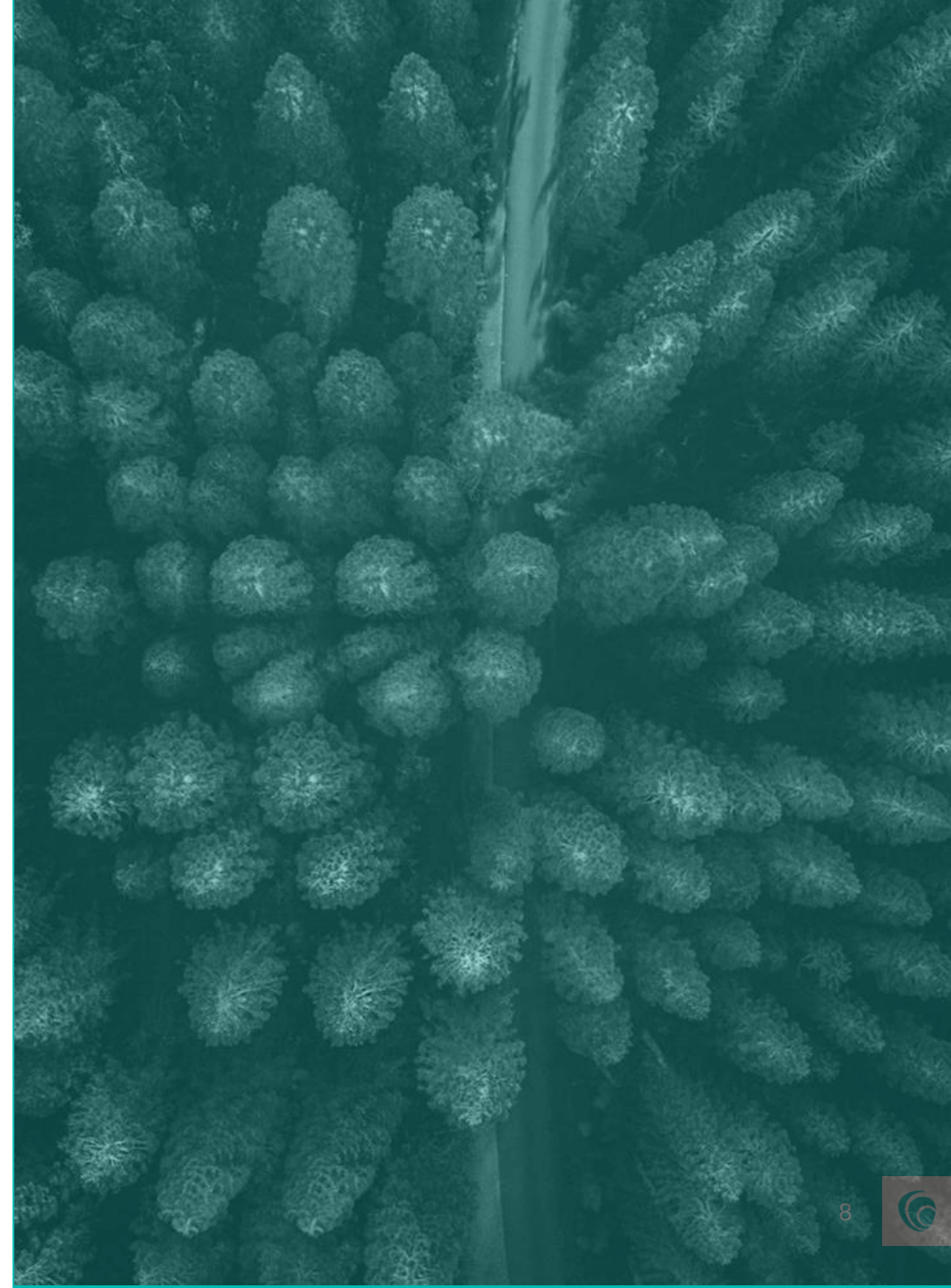
During the planning of the audit we have identified the following significant risks:

Significant Risks	Procedures
Third-party settlements and supplemental funding	We will obtained prior year audited cost reports and correspondence related to supplemental funding. We will obtain a roll forward of the cost report and supplemental funding receivables and payables and substantiate the activity and ending receivable or payable balances.
Management Override of Financial Reporting	We will perform journal entry testing with a focus on manual entries, review the board minutes, and perform fraud interviews with relevant members of the District.
Compliance with Debt Covenants	We will obtain managements calculations and recalculate them to ensure covenant compliance is being accurately calculated.



Risks Discussion

1. What are your views regarding:
 - IVHD's objectives, strategies and business risks that may result in material misstatements
 - Significant communications between the entity and regulators
 - Attitudes, awareness, and actions concerning
 - IVHD's internal control and importance
 - How those charged with governance oversee the effectiveness of internal control
 - Detection or the possibility of fraud
 - Other matters relevant to the audit
2. Do you have any areas of concern?



Consideration of Fraud in a Financial Statement Audit

Auditor's responsibility: Obtain reasonable assurance the financial statements as a whole are free from material misstatement – whether caused by fraud or error

To identify fraud-related risks of material misstatement, we:

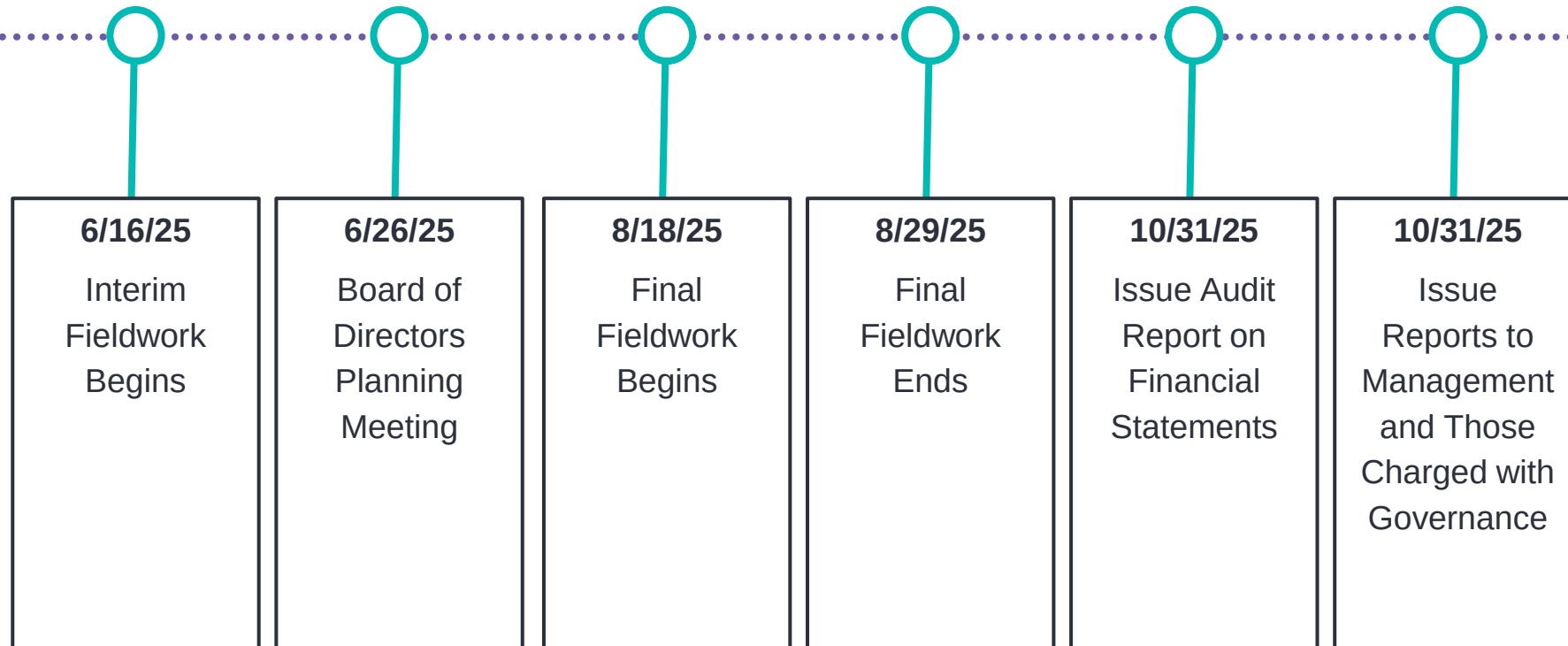
- Brainstorm with team
- Conduct personnel interviews
- Document understanding of internal control
- Consider unusual or unexpected relationships identified in planning and performing the audit

Procedures we perform:

- Examine general journal entries for nonstandard transactions
- Evaluate policies and accounting for revenue recognition
- Test and analyze significant accounting estimates for biases
- Evaluate rationale for significant unusual transactions



Audit Timeline



Audit Deliverables



Report of Independent Auditors

on financial statements for the year ended
June 30, 2025



Report to Management

(communicating internal control related
matters identified in an audit)



Report to Those Charged With Governance

(communicating required matters and other
matters of interest)

Expectations

IVHD will

- Have no adjusting journal entries after beginning of field work.
- Close books and records before beginning of field work.
- Provide auditor requested information in CAP schedule one week prior to the beginning of fieldwork.

Baker Tilly will:

- Communicate proposed adjustments with management when identified.
- Communicate control deficiencies with management when identified.
- Discuss any additional fees over estimate in engagement letter with management.

Executive Session

**THANK
YOU**



DATE: June 19, 2025

TO: Imperial Valley Healthcare District Board of Directors

FROM: Ramaiah Indudhara, M.D; Chief of Staff, Pioneers Memorial Hospital

SUBJ: PMH Medical Staff Recommendations for Approval

ITEMS FOR CONSIDERATION: Recommendations from the Medical Executive Committee for Medical Staff Membership and/or Clinical Privileges, policies/procedures/forms or other related recommendations.

SUMMARY AND BACKGROUND: The Medical Executive Committee, upon the recommendations of the Credentials Committee and the respective clinical services and/or chiefs and based on the completed credential files, policies and procedures, recommends that medical staff membership and/or clinical privileges be granted as outlined below:

1. Recommendation for **Initial Appointment** to the **Provisional Staff effective July 1, 2025** for the following:

- | | |
|--------------------------|-------------------|
| • Anderson, Jon, MD | Teleradiology |
| • El-Newihi, Hussein, MD | Gastroenterology |
| • Navarro, Roberto, MD | Internal Medicine |

2. Recommend **Reappointment** effective **July 1, 2025** for the following:

- | | |
|---------------------------|---|
| • Benedict, Matthew, MD | Teleradiology |
| • Berenji, Ramin, MD | Nephrology |
| • Coll, Jonathan, MD | Teleradiology |
| • DeMott, Megan, MD | Emergency Medicine |
| • Diaz, Amilcar, MD | Radiology |
| • Ghulam, Mehboob, DO | Internal Medicine, Wound Care |
| • Jean-Baptiste, Ryan, MD | Teleradiology |
| • Kato, Kambrie, MD | Teleradiology |
| • Krutzik, Ramona, MD | Endocrinology – Change to “Affiliate” Staff Status |
| • Monis, Sayed, MD | Neurology (Pain Medicine privileges not granted – No Board Certification) |
| • Nelson, James, MD | Emergency Medicine |
| • Pollock, Max, MD | Teleradiology |
| • Riad, Shareef, MD | Teleradiology |
| • Richley, Sunny, MD | Internal Medicine |
| • Roeder, Zachary, MD | Teleradiology |
| • Yamashita, John, MD | Pathology |
| • Castro, Arnold, FNP | Family Nurse Practitioner |
| • Zamora, George, NP | Nurse Practitioner |

3. Recommend **Release from Proctoring and/or Advancement** effective **July 1, 2025**:

- | | |
|----------------------------|-------------------|
| • Magana Avila, Sergio, MD | Internal Medicine |
| • Singh, Amanjung, MD | Internal Medicine |
| • Stein, Nicholas, DO | Internal Medicine |
| • Wallace, Nicolai, MD | Internal Medicine |

4. Recommend acceptance of the following **Resignations from Staff** effective **June 30, 2025** (unless otherwise noted):

- | | |
|-------------------------------|---------------------------------------|
| • Aharonian, Artin, MD | Teleradiology |
| • Emerling, Alec, MD | Emergency Medicine |
| • Goldthorpe, Clifford S., DO | Orthopedic Surgery |
| • Ro, Tae, MD | Teleradiology |
| • Tariq, Sohaib, MD | Cardiology |
| • Tetteh, Nii Aryee, MD | Family Medicine (Effective 4/30/2025) |
| • Wallenfelsz, Grant, MD | Emergency Medicine |
| • Donahue, Rachael, PA | Physician Assistant |

5. Recommend acceptance of the following policies/forms:
 - Admission Criteria for Post Anesthesia Care Unit - PACU (CLN-01565)
 - Anesthesia Equipment (CLN-01631)
 - Anesthesia Patient Care Guidelines (CLN-01647)
 - Anesthesia Safety (CLN-01633)
 - Antimicrobial Stewardship Program (CLN-02971)
 - Clinical Service of Anesthesia Rules & Regulations (MS R & R)
 - Criteria for Case Referrals to Morbidity and Mortality Meetings - NICU (CLN-02528)
 - Electrosurgical/Electrocautery Safety (CLN-01541)
 - Guidelines for Administration of Anesthesia (CLN-01629)
 - Guidelines for Assisting with Esophageal Dilation (CLN-01599)
 - Hypoglycemia in the Newborn; Standardized Procedure for RN (CLN-02506)
 - Intern Pharmacist (CLN-02893)
 - Neonatal Resuscitation Work Instruction (CLN-00250)
 - Postoperative Inpatient Assessment, Vital Signs and Care Guidelines (CLN-00024)
 - Preoperative Teaching (CLN-01515)
 - Prevention of Retained Surgical/Invasive Procedure Items (CLN-01500)
 - Surgical Patient Tissue and Hardware Handling for Pathology (CLN-01669)
 - Utilization Management Plan (ADM-00029)

Note: not all of these policies require Board approval. Only those requiring this approval will be forwarded to the Governing Body.
6. The transfer report was discussed. Of 15,834 ER visits, 2.7% or 439 patients were transferred to other facilities from January to April. The most common reasons were GI, Cardiology, Neurology, Neurosurgery and Pediatrics. There are additional GI providers who are either here now or are in process.
7. There was a meeting with administration/management and members of the Medical Staff on Monday, June 16th. There will be a monthly meeting scheduled with providers from both ECRMC and PMH invited to attend. This will be an effort to communicate and get feedback with regards to the direction of the merger and hospitals in the future.
8. It was reported that we had a profit of \$280k for April, \$4.8M for the year to date. Our Average Daily Census is 45 patients.
9. On-Call Contracts were discussed. Currently the contracts are for one facility, but when we merge, providers may be on call for the district, both facilities. These contracts are based on MGMA data and will need to be considered as they come up for renewal.
10. Clinical Service of Medicine – Dr. Tariq, the current Chairman of the Service has resigned. The MEC has asked that Dr. Michael Krutzik accept the position as Chairman until the next regular election cycle for leadership in the Medical Staff.
11. On an annual basis, all providers need to be Respiratory Mask Fit Tested per DNV. We have completed information on 81% of the Medical/Allied Health Staff. Reminders have been sent to those who have not complied with the requirement.
12. Clinical Service and Committee Reports:
 - Medicine – No meeting was held.
 - Emergency Medicine – Dr. Nelson reported that a meeting was held. He gave a description of the educational items that were discussed.
 - Surgery/Anesthesia/Pathology – Meeting was held and minutes were presented. No additional updates were provided.
 - OB/GYN – No meeting was held.
 - Pediatrics – No meeting was held..
 - Medical Imaging – No meeting was held.
 - Ambulatory Services – No meeting.



- Credentials & Bylaws – As noted above. In addition, the bylaws of the Medical Staff were discussed. It was agreed that Dr. Rapp will work with ECRMC counterparts to develop a set of bylaws that are fair and will represent both campus Medical Staff. Members of the MEC will work with an ad-hoc committee to assist in the process.
- MSQC – Dr. Su presented information discussed at the meeting and approved policies as listed above.
- Utilization Management – The most current report was available and discussed.

RECOMMENDATION: That Imperial Valley Healthcare District Board of Directors approves each of the recommendations of the Medical Executive Committee for medical staff membership and clinical privileges as outlined above, policies and procedures as noted and authorizes the chief executive officer to sign any documents to implement the same.

Respectfully submitted,
Ramaiah Indudhara, MD, MBA, FACS
Chief of Staff, Pioneers Health Center.
RI/cb

POLICIES FOR APPROVAL AT BOARD

	Policy	Policy No.	Page #	Revisions (see policy for full description)
1.	Clinical Service of Anesthesia Rules & Regulations	MS R & R	• 1-9	Updated Logo
2.	Criteria for Case Referrals to Morbidity and Mortality Meetings - NICU	CLN-02528	• 10-11	- Reviewed and submitted without change
3.	Hypoglycemia in the Newborn; Standardized Procedure for RN	CLN-02506	• 12-27	- Changed all values from 40 mg/dl to 45 mg/dl throughout the body of the policy, including attachments A & B - Changed all references of respiratory rate of 80 bpm to 70 bpm - Added a time for giving the bolus in 5.1.4.4.5.1 - Updated References
4.	Neonatal Resuscitation Work Instruction	CLN-00250	• 28-37	- Updated References - Updated Education requirements in 3.9 - Changed policy from a Standardized Procedure to Work Instruction - Updated Definitions - Added attachment A
5.	Utilization Management Plan	ADM-00029	• 28-43	Major Overhaul of UMP 8/2024

PIONEERS MEMORIAL HOSPITAL
CLINICAL SERVICE OF ANESTHESIA
RULES AND REGULATIONS



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RULES & REGULATIONS
FOR THE
CLINICAL SERVICE OF ANESTHESIA

I. INTRODUCTION

- 1.1 On April 22, 2013, the Board of Directors of the Pioneers Memorial Hospital ("Hospital") voted in accordance with the Medical Staff Bylaws and a prior Memorandum of Understanding between the Medical Staff and Hospital, to close the Clinical Service of Anesthesia ("Service") and to enter into an exclusive contract with an Anesthesia Group ("Group") to provide the anesthesia services subject to the Medical Staff Bylaws and Rules and Regulations. The Clinical Services of Anesthesia shall include both Anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) (collectively "Anesthetists.") All anesthetists shall maintain continuing medical education requirements in conformity with the requirements of their licensing Boards.
- 1.2 The members of the Service shall provide quality anesthesia services in a uniform manner and shall advise on all matters of central nervous system depressants and local and regional blockade to maintain uniform standards and safety throughout the Hospital.
- 1.3 The members of the Service shall work cooperatively with Hospital administration, nursing, and the hospital staff in the best interests of the patients of the Hospital.
- 1.4 The Service shall recommend policies for adoption by the Medical Executive Committee and the Governing Board to maintain and improve, as the case may be, the efficient safe delivery and access to anesthesia care.
- 1.5 The Service shall engage in active peer review, to include not only quality but patient and surgeon evaluations of the Service, and individual Service members as well.

II. MEMBERSHIP

- 2.1 Only those anesthetists-contracted with the Group shall be eligible for Medical Staff or Allied Health Professional (AHP) Membership and clinical privileges. Should a member leave the exclusive contract Group, or if an individual anesthetist's contract terminates, such anesthetist shall automatically lose his/her privileges in anesthesia without any hearing rights or other fair procedure under the Medical Staff Bylaws.
- 2.2 Membership in the Service shall require:
 - (1) Membership in the organized medical staff of the Hospital.
 - (2) Meeting all educational and training qualifications as are or may be specified in the Medical Staff Bylaws and Rules and Regulations.
 - (3) Presentation of additional proof of competence sufficient to satisfy the Credentials Committee and the Medical Executive Committee to grant such privileges in anesthesiology as may be requested by the applicant after the Service has reviewed his/her request and has made its recommendations regarding such privileges. The review by the Service shall include but not be limited to the following:
 - (i) The formal application, including letters of recommendation;
 - (ii) Independent inquiry as appropriate;
 - (iii) Clinical observation and discussion of applicable principles of anesthesia.
 - (4) Physician membership in the Service shall consist of Board Certified or Board Eligible (Actively in the examination process) physicians.
If not Board certified, must become Board Certified within three (3) years of obtaining privileges. Failure to obtain Board Certification within the specified

timeframe will be deemed ineligible for reappointment.

CRNA membership shall consist of CRNA's who hold a Bachelor of Science in Nursing from an approved nursing program, have graduated from an American Association of Nurse Anesthetists (AANA) accredited anesthesia program certified by the American Association of Medical Assistants (AAMA) council on Certification of Nurse Anesthetists and have been board certified by the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA). CRNA must have Current Registered Nurse (RN) license and Nurse Anesthetist certificate issued by the California Board of Registered Nursing. CRNA's must maintain BLS and ACLS as well as appropriate Continuing Education (as required to satisfy the NBCRNA for recertification and the California Board of Nursing requirements). CRNA's are not members of the Medical Staff.

- (5) **Qualifications of Chairperson**
The Service shall be directed by an Active Medical Staff member of the Group. The Chairperson must be board certified by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology and shall be approved by the Medical Executive Committee.

2.4 Medical/Allied Health Professional Staff Membership and Clinical Privileges

Practice at the Hospital is contingent upon continued Medical Staff or Allied Health Professional membership and is dependent on the clinical privileges granted. If a contracted anesthetist's Medical or Allied Health Professional Staff membership and clinical privileges expire or are terminated, the anesthetist's ability to practice is automatically terminated. Similarly, if a contracted anesthetist's clinical privileges are reduced, restricted, or terminated, the anesthetist's ability to practice is automatically limited or terminated. The hearing rights of Article VII of the Medical Staff Bylaws shall apply to providers if an action is taken that must be reported under Business and Professions Code Section 805. Allied Health Professional Staff shall have the right to challenge any recommendation which would constitute grounds for a hearing under Section 7.2 of the bylaws (to the extent that such grounds are applicable by analogy to the Allied Health Staff).

III. STAFFING/SCHEDULING

The Hospital and contracted group agree by contract to the number of anesthesiologists and CRNAs. The group will be responsible for scheduling in accordance with the Hospital needs.

IV. PROCTORING

Requests for clinical privileges shall be in writing and such requests shall be evaluated on the basis of the anesthetist's post graduate training, experience, demonstrated current competence, and judgment in accordance with procedures described in the Medical Staff Bylaws.

- (1) Anesthetists to be proctored shall include the following:
 - (a) All new members of the Service; and
 - (b) Anesthetists granted temporary privileges.
- (2) Only Anesthesiologists who have successfully completed their provisional requirements, including proctoring, may proctor other Anesthesiologists/CRNA's. CRNA's who have satisfactorily fulfilled their proctoring requirements may only proctor other CRNA's.

- (3) Prior to being recommended for unsupervised privileges in the Service, the CRNA applicant must:
 - (a) Be proctored while performing no less than three (3) general anesthesia cases, two (2) C-sections, two (2) peripheral/brachial plexus blocks and three (3) epidural blocks, and by at least two (2) different proctors with unlimited privileges in the Service.
 - (b) Have demonstrated competence in various anesthetic techniques including, but not limited to: general inhalation (including general intubation and the use of an LMA), general intravenous and regional blocks.
 - (c) Have the proctors written evaluations presented to the Service indicating the individual's competency in each of the cases that were performed. Said proctoring shall, whenever feasible, be completed within six months of appointment. All Anesthetists shall be required to assist in the proctoring program.

Wherever possible the Service Chair shall select an Anesthetist who is not scheduled for procedures at that time to proctor.

V. EFFICIENCY OF SERVICE

- 5.1 The Service Chairman, in cooperation with the chairs of the Clinical Services of Surgery and Obstetrics, Nursing, and Hospital administration, shall develop policies for the efficient operation of the Service with respect to scheduling and services. On the recommendation of the Services such policies shall be presented to the Medical Executive Committee for approval.
- 5.2 Solicitation of patients and/or surgeons by an Anesthetist is hereby deemed to be disruptive to the efficient delivery of anesthesiology services and shall be subject to Corrective Action as defined in the bylaws. If the individual continues despite corrective action, such actions may be cause for disciplinary removal from the staff for interfering in the efficient delivery of service.
- 5.3 Patient requests for a particular anesthetist for labor epidurals shall be permitted provided:
 - (1) A valid request form has been presented (from OB Doctor's Office);
 - (2) The anesthetist requested is "available;" and
 - (3) The anesthetist has privileges.
- 5.4 Patient requests for a particular anesthetist who is scheduled to be "off" the day of the proposed surgery, for other than labor epidurals, shall not be honored unless the anesthetist requested is "available", and with the concurrence of either the 1st call anesthetist or the Chairman. To accommodate these requests, the surgery should be scheduled a day when the anesthetist is on call for elective and emergency cases.
- 5.5 The services of the anesthetist scheduled "off" may be requested with the concurrence of the anesthetist on 1st call or the Chairman. This anesthetist would provide assistance if he/she chose and were "available".

VI. GOVERNANCE

- 6.1 The appointment of the Service Chair shall be governed by the terms of the contract subject to approval by the Medical Executive Committee.

- 6.2 The Service shall meet at least quarterly as part of the Clinical Service of Surgery. CRNA's are invited to participate in these meetings. At such meetings all matters relevant to the Service shall be presented including without limit, policies and procedures, credentialing, quality care reviews, complaints, and reviews of supplies and equipment. The Service shall prepare items for information and action to the Medical Executive Committee. The Group may hold separate operational meetings which may not include confidential medical staff information including but not limited to credentialing and peer review related items.
- 6.3 The Service Chairman is authorized and directed to act for and on behalf of the Service in implementing the Medical Staff Bylaws and Rules and Regulations and such Hospital policies approved by the Medical Staff relating to the Service as a whole.

Where necessary in the view of the Service Chairman, policy may be enacted by the Chairman with the concurrence of the Medical Executive Committee Chairman. Such policy shall be in writing, signed, dated, and given to nursing and clinical service members. Policies so enacted shall be in effect immediately in the Service and shall continue in effect until the next meeting of the Service at which time such policies will require a recommendation for ratification by the Medical Executive Committee.

VII. PROFESSIONAL CONSIDERATIONS

7.1 Nature of Services

The administration of anesthesia services requires that each member of the Service exercise his or her professional judgment and utilize the techniques and modalities that in his or her judgment are best suited under the circumstances. The modality of delivery of general anesthesia is left up to the discretion of the anesthetist.

7.2 Documentation of Anesthesia Care

- (1) Documentation is a factor in the provision of quality care, and is the responsibility of the anesthetist. Anesthesia care is a continuum and includes pre-anesthesia and post-anesthesia care. Documentation of anesthesia care must reflect all of these components.
- (a) Documentation of pre-anesthesia care must reflect a review of the patient's medical history, anesthesia history and medication history. An appropriate physical examination, including a pre-op physician examination, review of objective diagnostic data, assignment of ASA status and formulation and discussion of an anesthetic plan with the patient and/or responsible adult must be documented.
 - (b) Peri-anesthesia care and documentation shall include a patient re-evaluation prior to administration of anesthesia, monitoring of the patient in accordance with the American Society of Anesthesiologists (ASA) standards for intra-operative monitoring, the types and amounts of all drugs and anesthetic agents used and the items given, the type and amounts of all intra-venous fluids used including blood and blood products and times given, the anesthetic techniques used, unusual event during the anesthetic period and the status of the patient at the conclusion of anesthesia.
 - (c) Post-anesthesia care and documentation shall include a patient evaluation on admission and discharge from the post anesthesia care unit, a time base record of vital signs and level of consciousness, all drugs used and dosages, type and amounts of intra-venous fluids including blood and blood products, any unusual events including post-anesthesia and post-procedural complication and post-anesthesia visits.

In the case of outpatients, satisfaction of the discharge criteria shall be presumed to reflect that the patient has recovered from anesthesia and the requirements for post-anesthesia documentation have been met.

7.3 Readiness, Cleanliness, etc. of Anesthetic Equipment

The readiness, availability, cleanliness etc. of anesthetic equipment, anesthetic agents and medications prior to the administration of an anesthetic shall be documented in accordance with the current standards and guidelines of the American Society of Anesthesiologists and all regulatory agencies and in accordance with such additional other standards as may be established by the Service. Nursing shall cooperate with the Service in fulfilling this role.

7.4 Availability for Expeditious Completion of Surgery Schedule

All anesthesiologists shall assist with completion of the surgery schedule.

7.5 Availability for Emergencies

- (1) First and Second Call anesthesiologists must be within 30 minutes arrival time to the hospital.
- (2) On Call anesthesiologists shall notify Surgery Office, Medical Staff, and/or Nursing Office of their location, or that they are “available via telephone or other approved media”.

7.6 Advance Notification of Vacation Replacements

The Group is responsible for securing coverage for the member’s assignments during the members’ vacations and other days off.

7.7 Peer Review

- (1) The Service shall conduct peer review of all cases referred from the Medical Staff Quality Committee (MSQC), which shall include the review of any complication in which anesthesia may have been a contributing factor, in accordance with the current standards of the American Society of Anesthesiology, all regulatory agencies, Medical Staff and Hospital policies as approved by the Medical Staff. Additional cases may be reviewed for educational purposes.
- (2) The Service shall take action, including corrective or disciplinary action, as deemed appropriate to the circumstances and in accordance with the Medical Staff Bylaws and applicable law.

7.8 Provision of Services to Patients with Infectious Diseases

Members of the Service shall comply with policies that have been adopted by the Medical Staff for providing anesthesia services to patients with infectious diseases. Surgeons and anesthesiologists shall communicate the diagnosis or possible diagnosis, where known or suspected, of an infectious disease.

VIII. COMPLAINTS

All complaints with regard to the Service will be processed in accordance with the Patient Complaints and Grievances Policy (ADM-00056).

IX. MISCELLANEOUS PROVISIONS

9.1 Controlled Substances

The members of the Service shall cooperate with the administration, nursing, and the Hospital's pharmacy department in designing and maintaining such records of narcotics and other controlled substances which are now or may hereafter be required by hospital policy, any governmental agency and/or by any regulatory agency.

9.2 Acquisition and Use of Anesthesia Equipment

- (1) Individual requests for capital equipment, as defined by the Finance Committee of the District Board of Directors, must be presented to and approved by the Clinical Services of Surgery before its acquisition may be requested.
- (2) Items of personal equipment that are used in connection with patient care by a member must have the prior authorization of the Clinical Service Chairman and used at no charge to the patients. Such equipment must be certified as safe in accordance with hospital policy.
- (3) All new equipment, supplies or changes in equipment or supplies to be used by anesthesiologists must be approved by the Clinical Service Chairman and by the Clinical Service of Surgery.
- (4) All new equipment and supplies used by anesthesiologists shall be reviewed for safety and efficacy by the Service on the request of any anesthesiologist.

9.3 Education

- (1) Members of the Service shall actively encourage nursing supervisors and nursing personnel in the O.R., Recovery Room, ICU or CCU to submit requests for educational activities.
- (2) Members of the Service shall assist nursing supervisors in pertinent topic selection.
- (3) Anesthesiologists may be assigned by the Chairman to provide an educational program in accordance with regulatory standards and Hospital policy, for nursing personnel and other technical personnel in the OR, PACU, Recovery Room, ICU, or CCU upon request of nursing.

9.4 Recovery Room/PACU

- (1) The Service is primarily responsible for the treatment of anesthesia complications in the Recovery Room/PACU including the Recovery Room of Obstetric Patients. The attending surgeon will be notified of complications and of any treatment given.
- (2) The Recovery Room/PACU is under the medical jurisdiction and responsibility of the Service Chairman.
- (3) All patients undergoing major or minor surgery under any type of anesthesia are to be sent to the Recovery Room, unless otherwise directed by the attending anesthesiologists or surgeon.
- (4) Patients recovering in an area other than the Recovery Room/PACU shall be provided the care and documentation of care consistent with the standards set for the PACU.
- (5) Patients are to remain in the Recovery Room/PACU until the patient has met the criteria for discharge.

X. VIOLATION OF THESE RULES AND REGULATIONS

Violations of these Rules and Regulations and Policies promulgated under these Rules and Regulations are deemed disruptive to the efficient delivery of anesthesia services and as such interfere with access and quality of care. Such violations shall be cause for Corrective Action and if persistent and repetitive despite corrective action shall be cause for disciplinary action under the Medical Staff Bylaws and pursuant to applicable law.

XI. AMENDMENTS

Amendments to these Rules and Regulations shall require a majority vote of the voting members of the Service. Such amendments shall then proceed to the Medical Executive Committee pursuant to Article XIV of the Medical Staff Bylaws.

Approvals:

Credentials/Bylaws Committee:

Medical Executive Committee:

Board of Directors:

Imperial Valley Healthcare District

Title: Criteria for Case Referrals to Morbidity and Mortality Meetings - NICU		Policy No. CLN-02528
Current Author: Sandra Taylor, RNC-NIC, BSN		Page 1 of 2
Latest Review/Revision Date: 02/20/2025		Effective: 3/2023
Manual: Clinical / OB		

Collaborating Departments: Neonatal; Medical Staff; Quality, Dr Alshareef, NICU Manager MSQC	Keywords: Morbidity, Mortality		
Approval Route: List all required approval			
PSQC	Other:		
Clinical Service <u>Pediatrics</u> 4/2025	MSQC 5/2025	MEC 5/2025	BOD 6/2025

Note: If any of the sections of your final layout are not needed do not delete them, write "not applicable".

1.0 Purpose:

- 1.1 To establish criteria for the referral of cases related to infant death or unexpected adverse outcomes to Morbidity and Mortality (M&M) meetings

2.0 Scope: Neonatal and Perinatal Staff

3.0 Policy:

- 3.1 It is the policy of Pioneers Memorial Hospital to have a minimum of quarterly M&M reviews held within the Pediatric Committee Meetings.
- 3.2 Collaborative aims of M&M reviews are to improve the health of pregnant women, infants and children by collecting high quality information on perinatal outcomes and research utilization, which then allow for performance improvement and bench marking processes in perinatal care and neonatal intensive care units.

4.0 Definitions: Not applicable

5.0 Procedure:

- 5.1 The attending physician in collaboration with the obstetrician identifies neonates that meet the criteria for the M&M meeting.
- 5.2 These criteria include, but are not limited to:
 - 5.2.1 Death
 - 5.2.2 Transfer out to another facility
 - 5.2.3 Birth that requires extensive resuscitation, i.e., chest compressions, medications during resuscitation
 - 5.2.4 Apgars less than 5 at 5 minutes of age
 - 5.2.5 Major birth trauma (i.e., neonatal depression)
 - 5.2.6 Infants with documented Grade III or Grade IV Intraventricular Hemorrhage
 - 5.2.7 Complications from procedure resulting in the prolongation of hospital stay or disability
 - 5.2.8 Major congenital abnormalities
- 5.3 The team will consist of all disciplines involved in the decision making and care for mom and baby, i.e., pediatrician, obstetricians, risk management, quality/performance improvement representative; and/or laboratory, pathologist, NICU and/or OB nurses, radiology, social worker.

The electronic version of this policy supersedes any printed copy.

Imperial Valley Healthcare District

Title: Criteria for Case Referrals to Morbidity and Mortality Meetings - NICU		Policy No. CLN-02528
Current Author: Sandra Taylor, RNC-NIC, BSN		Page 2 of 2
Latest Review/Revision Date: 02/20/2025		Effective: 3/2023
		Manual: Clinical / OB

- 5.4 The M&M meeting is held quarterly, at a minimum.
- 5.5 Infant morbidity and mortality data concerning birth weight, survival, transfer, incidence of certain conditions, and other information, as require, shall be compiled in a CCS-approved format and shall be submitted to the Chief, Children's Medical Services Branch/CCS program; 714 P Street, Room 350; PO Box 942732, Sacramento, Ca 94234-7320; annually and are due on the first day of June for the preceding calendar year

6.0 References:

- 6.1 California Children's Services Manual of Procedures, 3.25 Standards for Neonatal Intensive Care Units (NICUs). Chapter 3.25.3, section K, number 2, page 27 (1/1/99)

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

- 8.1 Reviewed and submitted without change

Imperial Valley Healthcare District

Title: Standardized Procedure for Registered Nurses: Hypoglycemia in the Newborn		Policy No. CLN-02506
Current Author: Sandra Taylor, RNC-NIC, BSN		Page 1 of 9
Last Review/Revision Date: 02/21/2025		Effective: 2/1/1987
Manual: Clinical / OB		

Collaborating Departments: Perinatal/Neonatal; NICU Medical Director - Dr. Alshareef, NICU Manager		Keywords: hypoglycemia, glucose, blood glucose, Accu-check	
Approval Route: List all required approval			
PSQC		Other:	
Clinical Service <u>Pediatrics</u> 4/2025	MSQC 5/2025	MEC 5/2025	BOD 5/2025

APPROVALS		
AUTHORITY	SIGNATURE	DATE
ADMINISTRATION		
CHIEF NURSING OFFICER		
PHYSICIAN DEPARTMENT CHAIR		
PMHD BOARD OF DIRECTORS		

NOTE: If any of the sections of your final layout are not needed do not delete them, write "not applicable".

REVIEWED ANNUALLY

1.0 Purpose:

- 1.1 To provide guidelines for obtaining blood glucose in neonates at risk for developing hypoglycemia and to delineate the appropriate interventions for hypoglycemia in newborns in the Perinatal Couplet Care area and the Intermediate NICU.

2.0 Scope: Perinatal and Neonatal Staff

3.0 Policy:

- 3.1 Neonatal blood glucose testing and interventions will be initiated by competency validated RNs.
 - 3.1.1 Circumstances under which RN may perform Standardized Procedure function(s):
 - 3.1.2 Setting:
 - 3.1.2.1 Competencies validated RN may perform neonatal blood glucose testing and intervention in any area of Pioneers Memorial Hospital providing care to the newborn
 - 3.1.3 Scope of Supervision:
 - 3.1.3.1 Neonatal blood glucose testing and intervention is done under the direct or indirect supervision of the physician.
- 3.2 Blood glucose concentration should only be measured in any infant who have clinical manifestations or who are known to be at risk.
 - 3.2.1 Routine screening and monitoring of blood glucose concentrations is not needed in the healthy term newborn infant after a normal pregnancy and delivery
- 3.3 Newborns meeting one of the following criteria are to be observed for hypoglycemia and

Imperial Valley Healthcare District

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Current Author: Sandra Taylor, RNC-NIC, BSN		Page 2 of 9
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		Manual: Clinical / OB

bedside blood glucose monitoring and/or serum glucose testing will be implemented:

- 3.3.1 Within 1 hour of birth:
 - 3.3.1.1 Large for gestational age (LGA) with birth weight greater than the 90TH percentile on the infant growth chart (Attachment D [male] or E [female], gender specific)
 - 3.3.1.2 Small for gestational age (SGA) with birth weight less than the 10TH percentile in the infant growth chart (Attachment D [male] or E [female], gender specific)
 - 3.3.1.3 Premature (37 weeks or less by examination)
 - 3.3.1.4 Postmaturity (> 42 weeks gestation by examination)
 - 3.3.1.5 Asphyxiated or hypoxic infant (Apgar $\leq$ 5 at 5 minutes of age)
 - 3.3.1.6 Cold stressed infant (temperature less than 97.0°F at any time or less than 97.7°F after rewarming intervention)
 - 3.3.1.7 Admission to the Intermediate NICU
 - 3.3.1.8 Respiratory distress including – tachypnea greater than or equal to 80 bpm with grunting, flaring, retracting and/or O₂ desaturation (<88% spo₂) in the first hour of life
- 3.3.2 Within 30 minutes – 1 hour of life:
 - 3.3.2.1 Infants of diabetic mothers (insulin dependent or gestational diabetes)
- 3.3.3 At 2 hours of life:
 - 3.3.3.1 All infants with tachypnea greater than or equal to 70 bpm without other signs of distress
 - 3.3.3.2 Any infant that met criteria as listed above in 3.3.1
- 3.3.4 At 6 hours, 12 hours and 24 hours of age:
 - 3.3.4.1 All infants that were found to be LGA, SGA, <37 weeks, >42 weeks, Respiratory distress (as listed above in 3.3.1.8) or NICU admissions
- 3.3.5 At any time for infants exhibiting any of the following signs:
 - 3.3.5.1 Apnea
 - 3.3.5.2 Respiratory distress including – tachypnea greater than or equal to 70 bpm with grunting, flaring, retraction, and/or O₂ desaturation
 - 3.3.5.3 Temperature instability – temperature less than 97.7°F after intervention
 - 3.3.5.4 Hypotonia
 - 3.3.5.5 Lethargy
 - 3.3.5.6 Jitteriness
 - 3.3.5.7 Seizure activity
 - 3.3.5.8 Poor feeding – poor suck/swallow coordination for 2 consecutive feedings for infants greater than 12 hours of age
- 3.3.6 Note: If the infant is being fed, the test should be done prior to feeding
- 3.3.7 For any infant who is receiving IV therapy, testing should be done once every shift
- 3.4 The physician will be notified when point of care glucose value is:
 - 3.4.1 Less than 25 mg/dl after intervention for infants less than 24 hours old

Imperial Valley Healthcare District

Title: Standardized Procedure for Registered Nurses: Hypoglycemia in the Newborn		Policy No. CLN-02506
Current Author: Sandra Taylor, RNC-NIC, BSN		Page 3 of 9
Last Review/Revision Date: 02/21/2025		Effective: 2/1/1987
		Manual: Clinical / OB

- 3.4.2 Less than 25 mg/dl at any time for infants equal to or greater than 24 hours of age
- 3.4.3 Less than 45 mg/dl with any of the following signs for infants less than 24 hours of age:
 - 3.4.3.1 Apnea
 - 3.4.3.2 Hypotonia
 - 3.4.3.3 Lethargy
 - 3.4.3.4 Seizure activity
 - 3.4.3.5 Respiratory distress including: tachypnea greater than or equal to 80 bpm with grunting, flaring, retracting and/or O₂ desaturation
- 3.4.4 Less than 45 mg/dl with any signs and symptoms after intervention for infant less than 24 hours of age
- 3.4.5 Less than 50 mg/dl with any of the following signs for infants at or greater than 24 hours of age:
 - 3.4.5.1 Apnea
 - 3.4.5.2 Hypotonia
 - 3.4.5.3 Lethargy
 - 3.4.5.4 Seizure activity
 - 3.4.5.5 Respiratory distress including: tachypnea greater than or equal to 80 bpm with grunting, flaring, retracting and/or O₂ desaturation
- 3.4.6 Less than 50 mg/dl after intervention for infants equal to or greater than 24 hours of age
- 3.4.7 Between 25-44 mg/dl after intervention with 2nd dose of glucose gel for infant less than 24 hours of age without signs
- 3.4.8 Between 25-44 mg/dl after intervention with 2nd dose of glucose gel for infants less than 24 hours of age with ONLY signs of jitteriness and/or tachypnea greater than or equal to 80 bpm
- 3.4.9 Between 25-49 mg/dl for infants equal to or greater than 24 hours old with ANY of the following signs ONLY:
 - 3.4.9.1 Jitteriness
 - 3.4.9.2 Temperature instability
 - 3.4.9.3 Poor feeding
 - 3.4.9.4 Poor suck/swallow coordination for 2 consecutive feedings
- 3.5 The physician will be notified for all infants at any time with rebound hypoglycemia
- 3.6 For frequency of testing aimed at infants receiving parenteral therapy <Refer to policy CLN-02517; Intermediate NICU Standards of Practice>
- 3.7 RN Requirements:
 - 3.7.1 Education/Training/Experience:
 - 3.7.1.1 RNs successfully oriented to units caring for neonates will perform neonatal blood glucose testing and intervention after successful completion of blood glucose point of care testing competency validation and neonatal blood glucose testing and intervention posttest
 - 3.7.2 Initial and Ongoing Competency Evaluation:
 - 3.7.2.1 Initial competency evaluation includes successful completion of:

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- 3.7.2.1.1 Blood glucose point of care testing initial competency validation
- 3.7.2.1.2 Standardized Procedure: Blood Glucose in Neonates posttest with score of 100%
- 3.7.2.2 Annual competency evaluation includes successful completion of:
 - 3.7.2.2.1 Blood glucose point of care testing annual competency validation
 - 3.7.2.2.2 Validation of hypoglycemia management documentation on 1 patient/year, or if this opportunity is not possible, completes Standardized Procedure: Blood Glucose in Neonates posttest with score of 100%
- 3.8 RN authorized to perform standardized procedure function(s):
 - 3.8.1 A written record of initial and annual competency will be maintained in the employee file in their respective unit. A roster of RNs competency validated to perform blood glucose testing and intervention will be sent to the Chief Nursing Officer and Lab Point of Care coordinator annually by the nursing unit manager.

4.0 Definitions:

- 4.1 PO – per os – oral
- 4.2 BPM – breaths per minute
- 4.3 AC – before feeding
- 4.4 mL – Milliliters
- 4.5 Glucose gel – 40% Dextrose oral gel for the treatment of hypoglycemia
- 4.6 Rebound hypoglycemia – a second episode of hypoglycemia following a previous hypoglycemia event that had resolved with appropriate treatment.
- 4.7 INICU – Intermediate Neonatal Intensive Care Unit

5.0 Procedure:

- 5.1 Treatment Pathways – Chose appropriate pathway based on infant's age, point of care blood glucose results and presenting symptoms (*See Attachments A, B and C*).
***NOTE:** must review the infants' history for any prior hypoglycemic events. If infant had any prior hypoglycemia, go directly to PATHWAY IV*

5.1.1 PATHWAY I

- 5.1.1.1 Infants less than 24 hours of age with point of care blood glucose less than 45 mg/dl without signs of hypoglycemia (*See Attachment A*)
 - 5.1.1.1.1 Under direct supervision of the nurse, place the infant skin to skin with mother if possible to achieve physiologic stability
 - 5.1.1.1.2 Administer glucose gel based on infant's birth weight

INFANT'S BIRTH WEIGHT IN KILOGRAMS	AMOUNT OF GLUCOSE GEL IN mL	DOSE OF 40% GLUCOSE GEL IN GRAMS
1.8 – 2.4 kg	1 mL	0.4 g
2.5 – 2.9 kg	1.25 mL	0.5 g
3 – 3.4 kg	1.5 mL	0.6 g

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3.5 – 3.9 kg	1.75 mL	0.7 g
4 – 4.4 kg	2 mL	0.8 g
4.5 – 4.9 kg	2.25 mL	0.9 g
5 kg and above	2.5 mL	1 g

5.1.1.1.3 Feed Infant

5.1.1.1.3.1 If breastfeeding, attempt to breastfeed immediately

5.1.1.1.3.2 If bottle feeding, bottle feed 5-15 mLs

5.1.1.1.4 Repeat point of care glucose 30 minutes after initiating breastfeeding or completion of bottle feeding

5.1.1.1.5 If the repeat point of care glucose is:

5.1.1.1.5.1 Less than 45 mg/dl with any signs and symptoms or less than 25 mg/dl, proceed to PATHWAY IV

5.1.1.1.5.2 Between 25-39 mg/dl, without signs, administer glucose gel again and immediately breastfeed or bottle feed 5-15 mLs

5.1.1.1.6 Repeat point of care glucose 30 minutes after intervention

5.1.1.1.7 If the point of care glucose remains 25-39 mg/dl, obtain STAT serum glucose and notify the physician immediately for further orders

5.1.1.1.8 If not physician response to notification within 20 minutes, call physician on call for the INICU

5.1.1.1.9 Once the point of care glucose is greater than or equal to 45 mg/dl, obtain AC (before feeding) point of care glucose two times

5.1.1.1.9.1 If one of the AC points of care glucose values is less than 45 mg/dl and infant is otherwise asymptomatic, call physician for further orders

5.1.1.1.9.2 If either AC point of care glucose is less than 45 mg/dl with any signs and symptoms or less than 25 mg/dl, proceed to PATHWAY IV

5.1.2 PATHWAY II

5.1.2.1 Infants less than 24 hours of age, point of care blood glucose less than 45 mg/dl with only signs of jitteriness and/or tachypnea greater than or equal to 70 bpm without other signs of distress (*See Attachment A*)

5.1.2.1.1 Under direct supervision of the nurse, place the infant skin to skin with mother if possible to achieve physiologic stability

5.1.2.1.2 Administer glucose gel based on infant's birth weight

INFANT'S BIRTH WEIGHT IN KILOGRAMS	AMOUNT OF GLUCOSE GEL IN mL	DOSE OF 40% GLUCOSE GEL IN GRAMS
1.8 – 2.4 kg	1 mL	0.4 g
2.5 – 2.9 kg	1.25 mL	0.5 g

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3 – 3.4 kg	1.5 mL	0.6 g
3.5 – 3.9 kg	1.75 mL	0.7 g
4 – 4.4 kg	2 mL	0.8 g
4.5 – 4.9 kg	2.25 mL	0.9 g
5 kg and above	2.5 mL	1 g

5.1.2.1.3 Feed Infant

5.1.2.1.3.1 If breastfeeding, attempt to breastfeed immediately

5.1.2.1.3.2 If bottle feeding, bottle feed 5-15 mLs. Bottle feed only if respiratory rate is less than 70 bpm. If respiratory rate is greater than or equal to 70 bpm, notify the physician

5.1.2.1.4 Repeat point of care glucose 30 minutes after initiating breastfeeding or completion of bottle feeding

5.1.2.1.5 If the repeat point of care glucose is:

5.1.2.1.5.1 Less than 45 mg/dl with an signs and symptoms other than jitteriness and/or tachypnea greater than or equal to 70 bpm, OR less than 25 mg/dl, proceed to PATHWAY IV

5.1.2.1.5.2 Between 25-44 mg/dl, and the infant is asymptomatic or shows ONLY signs of jitteriness and/or tachypnea greater than or equal to 70 bpm without other signs of distress, administer glucose gel again and immediately breastfeed or bottle feed 5-15 mLs. Bottle feed ONLY if respiratory rate is less than 70 bpm

5.1.2.1.6 Repeat point of care glucose 30 minutes after intervention

5.1.2.1.7 If point of care glucose remains 25-44 mg/dl, obtain STAT serum glucose and notify physician immediately for further orders

5.1.2.1.8 If no physician response to notification within 20 minutes, call physician on call for the INICU

5.1.2.1.9 Once the point of care glucose value is greater than or equal to 45 mg/dl, obtain AC point of care glucose two times

5.1.2.1.9.1 If one of the AC points of care glucose values is less than 45 mg/dl and infant is otherwise asymptomatic, call physician for further orders

5.1.2.1.9.2 If either AC point of care glucose is less than 45 mg/dl with any signs and symptoms or less than 25 mg/dl, proceed to PATHWAY IV

5.1.3 PATHWAY III

5.1.3.1 Infants equal to or greater than 24 hours of age with point of care glucose 25-49 mg/dl with ANY of the following signs ONLY (See *Attachment B*)

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5.1.3.1.1 Jitteriness

5.1.3.1.2 Temperature instability

5.1.3.1.3 Poor feeding – poor suck/swallow coordination for 2 consecutive feedings

5.1.3.2 Notify the physician STAT

5.1.3.3 Under direct supervision of the nurse, place the infant skin to skin with mother of baby if possible to achieve physiologic stability. If cold stressed (temperature less than 97.0°F), infant needs to be taken to Intermediate NICU for assessment and placed in open bed with radiant warmer for warmth and observation

5.1.3.4 Administer glucose gel based on infant's birth weight

INFANT'S BIRTH WEIGHT IN KILOGRAMS	AMOUNT OF GLUCOSE GEL IN mL	DOSE OF 40% GLUCOSE GEL IN GRAMS
1.8 – 2.4 kg	1 mL	0.4 g
2.5 – 2.9 kg	1.25 mL	0.5 g
3 – 3.4 kg	1.5 mL	0.6 g
3.5 – 3.9 kg	1.75 mL	0.7 g
4 – 4.4 kg	2 mL	0.8 g
4.5 – 4.9 kg	2.25 mL	0.9 g
5 kg and above	2.5 mL	1 g

5.1.3.5 Feed Infant:

5.1.3.5.1 If breastfeeding, attempt to breastfeed immediately

5.1.3.5.2 If bottle feeding, bottle feed 5-15 mLs. Bottle feed only if respiratory rate is less than 70 bpm

5.1.3.6 Repeat the point of care glucose 30 minutes after initiating breastfeeding or completion of bottle feeding

5.1.3.7 If the repeat point of care glucose remains less than 50 mg/dl, obtain STAT serum glucose and notify the physician immediately for further orders

5.1.3.8 If no physician response to notification within 20 minutes, call the physician on call for the INICU

5.1.3.9 If repeat point of care glucose value is greater than or equal to 50 mg/dl, obtain AC point of care glucose two times

5.1.3.9.1 If either one of these values is less than 50 mg/dl, obtain STAT serum glucose and call the physician immediately for further orders

5.1.3.9.2 If no physician response to notification within 20 minutes, call physician on call for the INICU

5.1.4 PATHWAY IV

5.1.4.1 Infant less than 24 hours of age with a point of care glucose less than 45 mg/dl OR infants greater than or equal to 24 hours of age with a point of care glucose less than 50 mg/dl with any of the following signs (See Attachment A or B)

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5.1.4.1.1 Apnea

5.1.4.1.2 Respiratory distress including: tachypnea greater than or equal to 70 bpm with grunting, flaring, retracting and/or O₂ desaturation

5.1.4.1.3 Hypotonia

5.1.4.1.4 Lethargy

5.1.4.1.5 Seizure activity

5.1.4.2 Infants equal to or greater than 24 hours of age with point of care glucose less than 25 mg/dl at any time

5.1.4.3 As indicated in PATHWAY I and II

5.1.4.4 Infants with rebound hypoglycemia

NOTE: Review history for previous hypoglycemia event

5.1.4.4.1 Do Not feed or gavage infant

5.1.4.4.2 If the infant is not already in the INICU, contact the INICU to transfer the infant into the INICU immediately

5.1.4.4.3 Notify the physician of the transfer. If no response within 20 minutes, call the physician on call for the INICU

5.1.4.4.4 Obtain a STAT serum glucose

5.1.4.4.5 Administer IV glucose (Physician response should not delay the IV glucose administration)

5.1.4.4.5.1 Glucose dose for bolus administration is 2 mL/kg of D10W given over 15 minutes

5.1.4.4.6 Repeat the point of care glucose 30 minutes after completion of the IV bolus

5.1.4.4.7 Notify the physician for further orders

5.1.4.4.8 Once the point of care glucose is 45 mg/dl or greater, obtain a point of care glucose every 2-3 hours two time

5.1.4.4.9 Maximal concentration of glucose in peripheral IV is D12.5W

5.1.4.4.10 If infant requires IV dextrose concentrations of >12.5%, insert an umbilical venous catheter

5.2 Documentation in the Electronic Medical Record:

5.2.1 Point of Care Glucose values

5.2.2 Laboratory Glucose values

5.2.3 Signs of hypoglycemia

5.2.4 Interventions

5.2.5 Response to interventions

5.2.6 Physician notification, as applicable

6.0 References:

6.1 New Intrauterine Growth Curves Based on US data – Pediatrics, Volume 125, pages e214-e244 (2010) American Academy of Pediatrics
<https://pediatrics.aappublications.org/content/125/2/e214>

6.2 Postnatal Glucose Homeostasis in Late-Preterm and Term Infants – Clinical Report from American Academy of Pediatrics. Pediatrics Vol 127 No 3 March 1, 2011. Pp 575-

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- 6.3 Fanaroff, A.A>, & Martin, R.J. (2020). Neonatal-Perinatal Medicine (11th ed.) St Louis: Elsevier/Mosby
- 6.4 Intensive Care Nursery House Staff Manual. (2004). Neonatal Hypoglycemia. pg. 154-154. The Regents of the University of California
http://www.ucsfbenioffchildrens.org/pdf/manuals/52_Hypoglycemia.pdf
- 6.5 Adamkin, D.H., et al. (2011) "Clinical Report – Postnatal glucose homeostasis in late-preterm and term infants" Pediatrics; 127. pg. 575-579
- 6.6 Thompson-Branch, A., (2017) AAP Sets Guidelines for Neonatal Hypoglycemia
<https://pedsinreview.aappublications.org/content/38/4/147>
- 6.7 Huntsman, R.J., et al (2008) Nonepileptic motor phenomena in the Neonate
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2606074/>
- 6.8 Sharp Hospital San Diego Policy & Procedure 47621.99 "Standardized Procedure – Blood Glucose in Neonates – Criteria for Obtaining & Interventions for Hypoglycemia" (2016)
- 6.9 Giouleka, S. et al (2023) "Diagnosis and Management of Neonatal Hypoglycemia: A Comprehensive Review of Guidelines"
<https://pmc.ncbi.nlm.nih.gov/articles/PMC10378472/>

7.0 Attachment:

- 7.1 Attachment A – Interventions for Hypoglycemia for infants less than 24 hours of age
- 7.2 Attachment B– Interventions for Hypoglycemia for infants greater than 24 hours of age
- 7.3 Attachment C – Blood Glucose in Neonates – Criteria for Obtaining and Interventions for Hypoglycemia
- 7.4 Attachment D – Intrauterine Growth Curves (2 sided) – Male
- 7.5 Attachment E – Intrauterine Growth Curves (2 sided) - Female

8.0 Summary of Revisions:

- 8.1 Changed all values from 40 mg/dl to 45 mg/dl throughout the body of the policy, including attachments A & B
- 8.2 Changed all references of respiratory rate of 80 bpm to 70 bpm
- 8.3 Added a time for giving the bolus in 5.1.4.4.5.1
- 8.4 Updated References

Pathway I (less than 24 hours)
BG less than 45mg/dl without signs/symptoms

Under direct supervision of the nurse, place infant skin to skin with mother of baby if possible to achieve physiologic stability.

Administer glucose gel per dosing guidelines

Breastfeed immediately OR bottle feed 5- 15 mLs

Repeat point of care glucose 30 minutes after initiating breastfeeding or completion of bottle feeding

BG less than 45 mg/dl with any s/s **OR** less than 25 mg/dl, proceed to Pathway IV.

If BG is 25-44 mg/dl without signs, administer glucose gel again and immediately breastfeeding OR bottle feed 5-15 mLs

Repeat BG 30 minutes after administering 2nd dose of glucose gel

If BG remains 25-44 mg/dl, obtain STAT serum glucose and notify physician immediately for further orders.

If BG is 45 mg/dl or greater, obtain BG 2 more times. If one of these values is less than 40 mg/dl and infant is asymptomatic, call physician for further orders.

See Pathway IV

If either point of care blood glucose is less than 45 mg/dl with any signs and symptoms **OR** less than 25mg/dl proceed to Pathway IV

Pathway II (Less than 24 hours)

BG less than 45 mg/dl with ONLY signs of jitteriness and/or tachypnea greater than or equal to 80

Under direct supervision of the nurse, place infant skin to skin with mother of baby if possible to achieve physiologic stability.

Administer glucose gel per dosing guidelines

Attempt to breastfeed immediately OR bottle feed 5-15 mLs. Bottle feed **ONLY** if RR less than 80. (If RR is 80 or greater, **NOTIFY PHYSICIAN**).

Repeat point of care glucose 30 minutes after initiating breastfeeding or completion of bottle feeding

BG less than 45 mg/dl with any s/s **OR** less than 25 mg/dl, proceed to Pathway IV.

If BG is 25-44 mg/dl **without new or additional s/s**, administer glucose gel again and immediately breastfeeding OR bottle feed 5-15 mLs. Bottle feed **ONLY** if RR less than 80.

Repeat BG 30 minutes after administering 2nd dose of glucose gel

See Pathway IV

If BG remains 25-44 mg/dl, obtain STAT serum glucose and notify physician immediately for further orders.

If BG is 45 mg/dl or greater, obtain BG two more times. If one of these values is less than 40 mg/dl and infant is asymptomatic, call physician for further orders.

Pathway III

Infants equal to or over 24 hours of age BG 25-49 mg/dl with ANY of the following signs **ONLY**:

- Jitteriness
- Temperature instability
- Poor feeding, poor suck/swallow coordination for 2 consecutive feedings

Notify Pediatric Provider STAT

Under direct supervision, place infant skin to skin with mother of baby if possible to achieve physiologic stability. If cold stressed (temperature less than 36.1°C) follow rewarming guidelines.

Administer glucose gel per dosing guidelines

Breastfeed immediately OR bottle feed 5-15 mLs. Bottle feed ONLY if RR less than 80

Repeat BG in 30 minutes after initiating breastfeeding or completion of bottle feeding.

If BG remains less than 50 mg/dl, obtain STAT serum glucose and notify physician immediately for further orders.

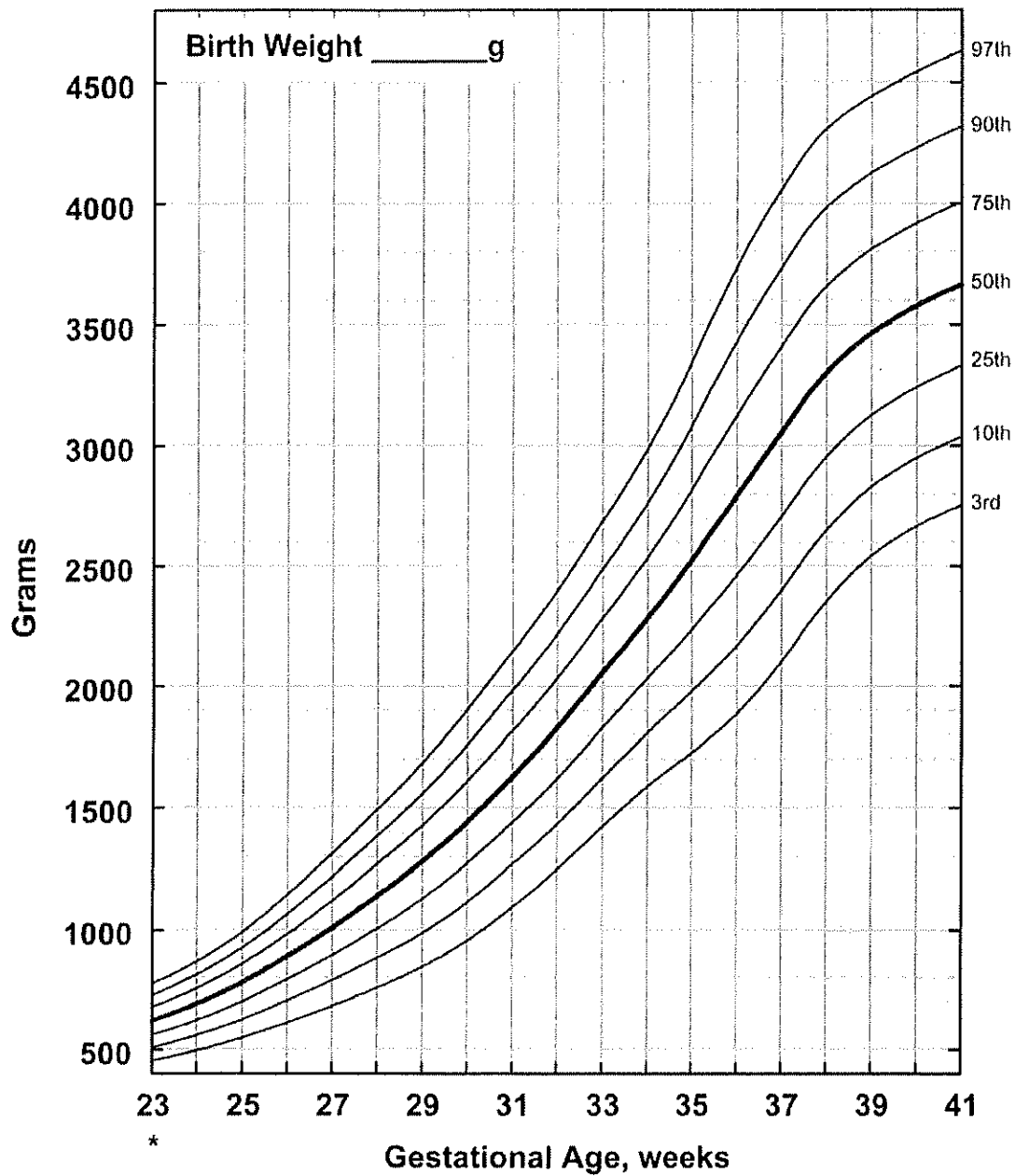
If BG is 50 mg/dl or greater, obtain BG two times. If either one of those values is less than 50mg/dl, obtain STAT serum glucose and notify physician immediately for further orders.

Intrauterine Growth Curves

Name _____

Record # _____

MALES

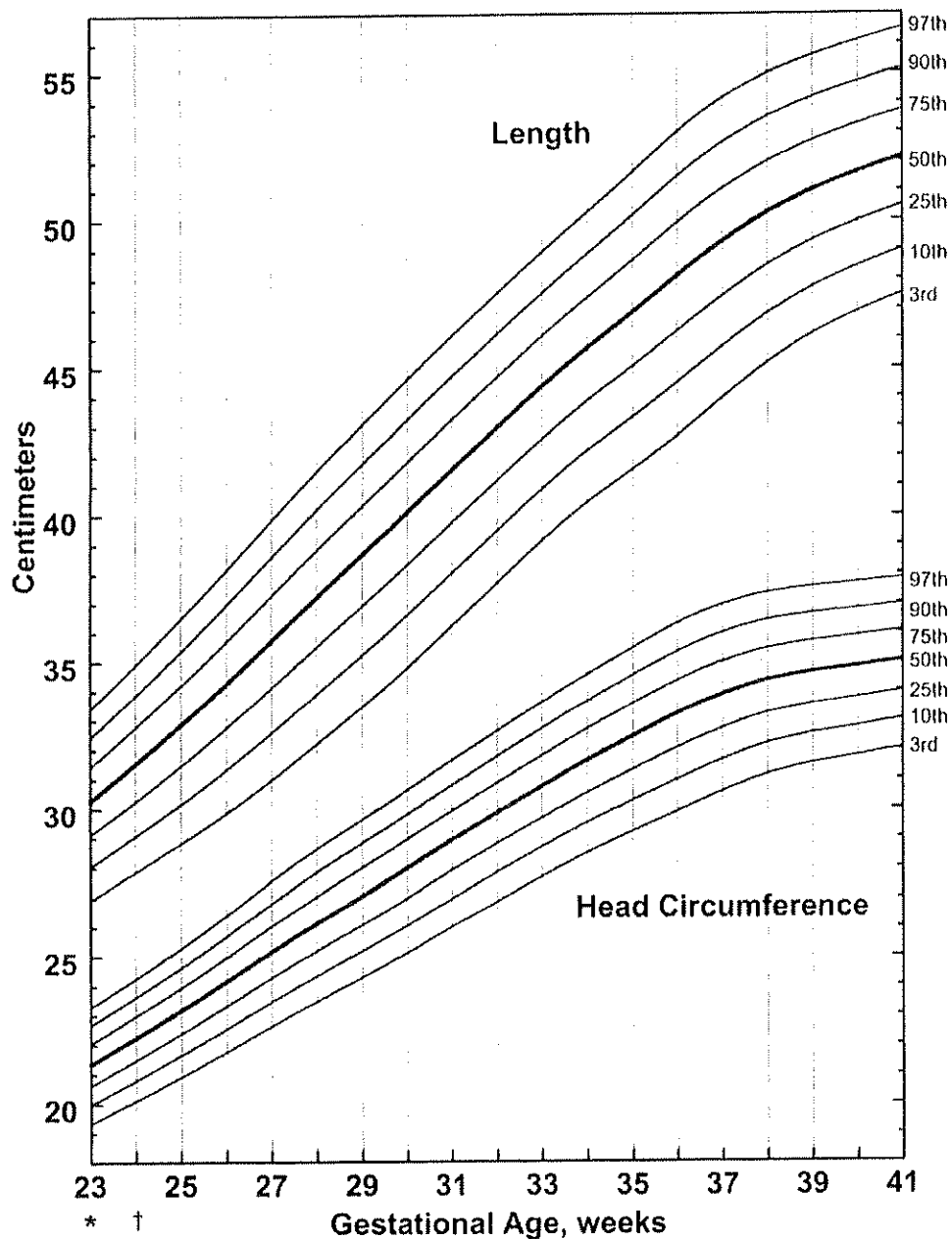


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BIRTH SIZE ASSESSMENT:

Date of birth: / / (wks GA)	Select one
Large-for-gestational age (LGA) >90 th percentile	☐
Appropriate-for-gestational age (AGA) 10-90 th percentile	☐
Small-for-gestational age (SGA) <10 th percentile	☐

* 3rd and 97th percentiles on all curves for 23 weeks should be interpreted cautiously given the small sample size.



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[illegible]

• 3rd and 97th percentiles on all curves for 23 weeks should be interpreted cautiously given the small sample size.

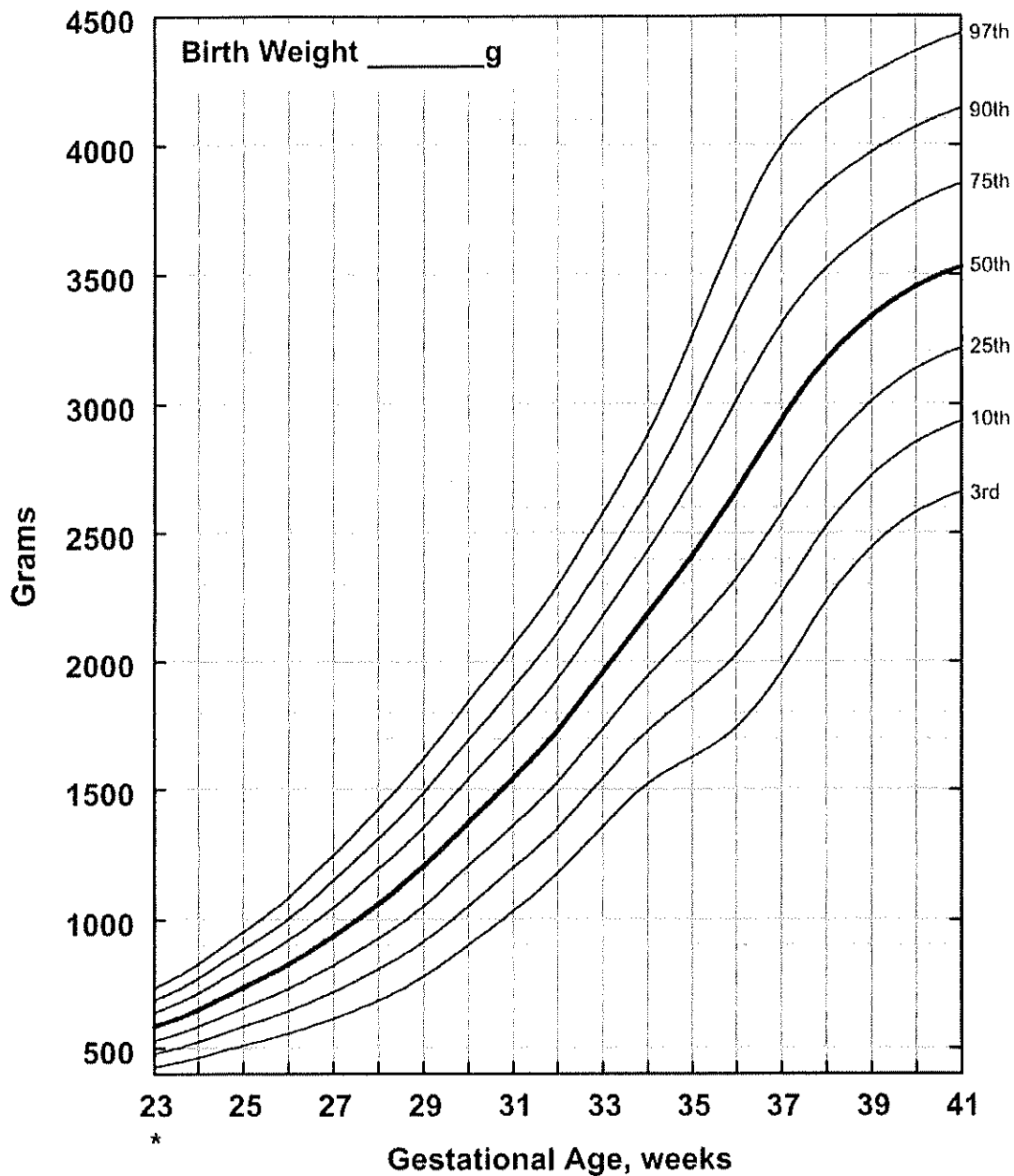
[†] Male head circumference curve at 24 weeks all percentiles should be interpreted cautiously as the distribution of data is skewed left.

Intrauterine Growth Curves

Name _____

Record # _____

FEMALES



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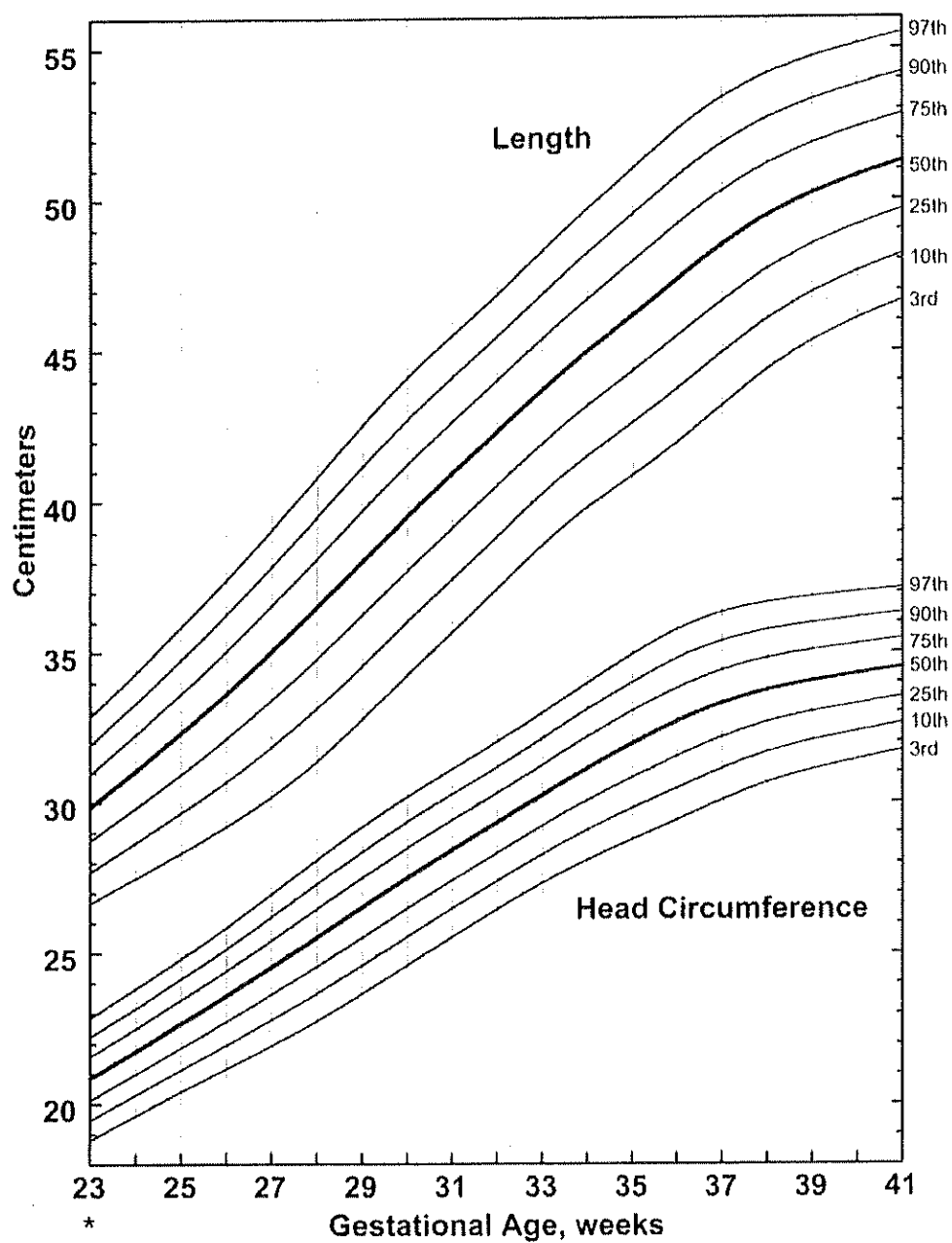
BIRTH SIZE ASSESSMENT

Date of birth: / / (wks GA)	Select one
Large-for-gestational age (LGA) >90 th percentile	☐
Appropriate-for-gestational age (AGA) 10-90 th percentile	☐
Small-for-gestational age (SGA) <10 th percentile	☐

* 3rd and 97th percentiles on all curves for 23 weeks should be interpreted cautiously given the small sample size.

Name _____

Record # _____

FEMALES

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Date																			
GA (wks)																			
WT (g)																			
L (cm)																			
HC (cm)																			

* 3rd and 97th percentiles on all curves for 23 weeks should be interpreted cautiously given the small sample size.

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Current Author: Sandra Taylor, RNC-NIC, BSN		Page 1 of 8
Latest Review/Revision Date: 03/26/2025		Effective: 10/1/2001
Manual: Clinical / OB		

Collaborating Departments: Perinatal, Neonatal, ED Dr Alshareef, NICU Manager		Keywords: Resuscitation of Newborn	
Approval Route: List all required approval			
PSQC	Other:		
Clinical Service <u>Credentials</u> ; OB/Pediatrics 04/2025	MSQC 05/2025	MEC 05/2025	BOD 06/2025

Note: If any of the sections of your final layout are not needed do not delete them, write "not applicable".

1.0 Purpose:

- 1.1 To outline the procedure for neonatal resuscitation in the delivery room, the emergency department or the neonatal nursery of Pioneers Memorial Hospital.
- 1.2 The purpose of resuscitation is to provide full oxygenation, ventilation and support of the circulation, using cardiac massage and, as necessary, intravascular medications.

2.0 Scope:

- 2.1 Neonatal RNs
- 2.2 Perinatal RNs
- 2.3 Neonatal ALS RNs
- 2.4 Pediatricians/attending physician

3.0 Policy:

- 3.1 All Perinatal/Neonatal RNs will maintain certification in the Neonatal Resuscitation Program (NRP) per the requirement set forth by the American Academy of Pediatrics (AAP).
 - 3.1.1 The AAP requires NRP Provider Card renewal every 2 years.
 - 3.1.1.1 These cards are delineated as either Essential or Advanced provider.
 - 3.1.2 PMHD requires that all RN staff have current NRP Provider Cards to work in the Perinatal/Neonatal Departments.
 - 3.1.2.1 All NICU employees will hold an Advanced Provider Card
 - 3.1.2.2 All Perinatal Employees and Respiratory Care Practitioners will hold an Essential Card
- 3.2 For all deliveries, at least 1 person should be present who is skilled in neonatal resuscitation and is responsible only for the infant. This person must be skilled in the initiation of resuscitation, the use of bag-mask ventilation.
- 3.3 Additional personnel should be available to assist in tasks that may be required as part of resuscitation, including all aspects of neonatal resuscitation. If the delivery is identified as high-risk, 2 or more skilled individuals should be assigned to the infant at delivery.
- 3.4 Advanced NRP RN will be called for all neonatal resuscitations in the Perinatal Unit.
<See policy CLN-00208; High-Risk Delivery, Criteria for Attendance by Neonatal Staff>
- 3.5 The Advanced RN nurse may perform all aspects of the procedure listed in this policy.
 - 3.5.1 The Essentials NRP certified RN is to utilize the bag and mask component of this

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policy only.

- 3.6 Circumstances under which the Advanced NRP RN may perform the procedure in:
 - 3.6.1 Setting – The competency validated Advanced NRP RN may perform the procedure in:
 - 3.6.1.1 The Perinatal Unit of PMH
 - 3.6.1.2 The Neonatal Nursery of PMH
 - 3.6.1.3 The Pediatric Unit
 - 3.6.1.4 The Emergency Department of PMH
- 3.7 If a resuscitation requires more personnel, a Code Neo should be called by dialing **4444** from any place within the facility.
- 3.8 Scope of Supervision:
 - 3.8.1 The competency validated Advanced NRP RN will receive indirect supervision by the attending physician
 - 3.8.2 A pediatrician/attending physician will be available at all times for consultation.
 - 3.8.3 Under all circumstances the Advanced NRP RN will carry out urgent delivery room and neonatal resuscitation according to the procedure or until a physician arrives.
 - 3.8.4 In the event that this procedure is altered via a physician's written or verbal order, the Advanced NRP RN will inform the physician that he/she is not certified to carry out the altered plan and must either adhere to the procedure or relinquish responsibility to the physician.
 - 3.8.5 Patient condition to notify the physician:
 - 3.8.5.1 The Advanced NRP RN or designee will immediately notify the attending pediatrician/physician whenever advanced life support (beyond simple stimulation or initial bag and mask support) is being initiated.
 - 3.8.5.2 The Advanced NRP RN will notify the pediatrician/physician whenever the delivery of an extremely small or complicated infant is anticipated so the pediatrician/physician may attend.
 - 3.8.5.3 Issues involving viability of life
 - 3.8.5.4 Any unsuccessful resuscitation
- 3.9 RN requirements
 - 3.9.1 Education/Training/Experience
 - 3.9.1.1 The Advanced NRP RN will keep current with the requirement of recertification per AAP guidelines (every 2 years with RQI NRP)
 - 3.9.1.2 Essentials NRP providers will have completed an online NRP class and remain current on their certification with hands on demonstration for completion of certification
 - 3.9.1.3 Annual competency validation assessments will be performed during manual skills (Mock Codes) biannually (January and July) by the NICU Clinical Educator
 - 3.9.1.4 In conjunction with the Mock codes, written tests covering Normal Newborn care, NICU care and math calculations will be completed with $\geq 80\%$ pass rate.

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3.9.1.5 Remediation will be done if unsuccessful with either manual skills or written tests.

4.0 Definitions:

- 4.1 Neonate – Defined as an infant <30 days of age
- 4.2 PPV – Positive pressure ventilation
- 4.3 PIP – Peak inspiratory pressure
- 4.4 SpO² –
- 4.5 CPR – Cardiopulmonary resuscitation
- 4.6 ETT – Endotracheal tube
- 4.7 LMA – Laryngeal mask airway
- 4.8 NRP – Neonatal Resuscitation Program as provided by the American Academy of Pediatrics = Evidence Based Approach to care of the newborn at birth
- 4.9 Advanced NRP RN – Advanced Neonatal Resuscitation Certified Registered Nurse
- 4.10 Essentials NRP RN – Essentials Neonatal Resuscitation Certified Registered Nurse
- 4.11 AAP – American Academy of Pediatrics
- 4.12 RQI – Resuscitation Quality Improvement
- 4.13 PMH – Pioneers Memorial Hospital

5.0 Procedure:

- 5.1 Database:
 - 5.1.1 Subjective:
 - 5.1.1.1 Historical information relevant to present illness
 - 5.1.1.2 History including reactions/allergies to medications
 - 5.1.2 Objective:
 - 5.1.2.1 Physical exam with focus on pulmonary and cardiovascular systems
 - 5.1.2.2 Assessment: Decision for emergency medication administration will be based upon subjective and objective data and in collaboration with attending physician when not an emergent lifesaving maneuver
 - 5.1.3 Plan:
 - 5.1.3.1 Patients and families will be provided with the appropriate information on emergency medication as soon as possible after administration.
 - 5.1.3.2 The Advanced NRP RN will notify the pediatrician or neonatologist to be present whenever the delivery of an extremely small or complicated infant is anticipated.
 - 5.1.3.3 In all emergencies, the primary physician will be notified as soon as practical while advanced life support is being initiated. Under all circumstances, the Advanced NRP RN will perform urgent delivery room and/or nursery resuscitation and emergency medication administration according to the procedure or until a physician arrives.
- 5.2 Informed consent is required prior to the procedure unless it is deemed an emergency and parental or guardian consent cannot be obtained.
- 5.3 A "Time Out" procedure is required to be performed according to policy.
- 5.4 Indications:

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- 5.4.1 Cardiopulmonary arrest
- 5.4.2 Severe and rapid deterioration in patient's condition
- 5.5 Precautions:
 - 5.5.1 Know the infant's weight
 - 5.5.1.1 If the infant's weight is not available, an estimate of the infant's weight is made for calculation of medication dosages until a time when an accurate weight can be measured.
- 5.6 Equipment:
 - 5.6.1 Radiant warmer
 - 5.6.2 Pulse oximeter
 - 5.6.3 Endotracheal tubes
 - 5.6.3.1 2.5
 - 5.6.3.2 3.0
 - 5.6.3.3 3.5
 - 5.6.3.4 4.0
 - 5.6.4 Stylet of appropriate size
 - 5.6.5 Resuscitation bag connected to an oxygen source, able to provide 100% FiO₂
 - 5.6.6 Infant oxygen masks
 - 5.6.6.1 Pre-term
 - 5.6.6.2 Term
 - 5.6.7 Oxygen blender
 - 5.6.8 Manometer
 - 5.6.9 Suction apparatus
 - 5.6.10 Suction Catheters
 - 5.6.10.1 5-6 Fr
 - 5.6.10.2 8 Fr
 - 5.6.10.3 10 Fr
 - 5.6.10.4 14 Fr
 - 5.6.11 Bulb syringe
 - 5.6.12 Laryngoscope handle
 - 5.6.13 Laryngoscope blades
 - 5.6.13.1 0 Miller
 - 5.6.13.2 1 Miller
 - 5.6.14 Meconium aspirator
 - 5.6.15 Emergency medications with appropriate size syringes
 - 5.6.15.1 Epinephrine 1:10,000
 - 5.6.15.2 Normal Saline for volume replacement
 - 5.6.16 Stethoscope
 - 5.6.17 Adhesive tape
 - 5.6.18 Umbilical catheter tray
 - 5.6.19 Umbilical tape
 - 5.6.20 Umbilical catheters
 - 5.6.20.1 3.5 Fr
 - 5.6.20.2 5.0 Fr

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- 5.6.21 Three way stopcocks
- 5.6.22 NG tubes
 - 5.6.22.1 5 Fr
 - 5.6.22.2 8 Fr
- 5.7 Steps in the procedure – The following are steps of a maximum effort. They may be suspended at any time if the infant responds appropriately. The infant will then be monitored according to its acuity.
 - 5.7.1 All delivery room equipment will be checked for function and availability at the beginning of every shift.
 - 5.7.2 The Advanced NRP RN is responsible for checking and reviewing appropriate antepartum and intrapartum history to help identify those at risk for delivering a depressed or sick infant. It is important to be forewarned for impending deliveries of ill newborns. Perinatal RN should inform the Neonatal RN regarding any concerns prior to delivery, if known.
 - 5.7.3 Be aware that the parents may hear and remember what is said in the delivery room.
- 5.8 Action Steps:
 - 5.8.1 Turn on the radiant warmer
 - 5.8.2 As the infant is being delivered, observe:
 - 5.8.2.1 Whether the oropharynx was suctioned well
 - 5.8.2.2 When infant had spontaneous activity and cry
 - 5.8.2.3 Any reflex tone or activity
 - 5.8.3 Place the infant under the radiant heat source
 - 5.8.4 Position the head and neck so the airway is open
 - 5.8.4.1 Place infant supine with the head and neck neutral or slightly extended in the “sniffing” position
 - 5.8.4.2 A shoulder roll may be placed under the infant’s shoulders and is useful if the infant has a large occiput from molding, edema or prematurity
 - 5.8.5 Clearing secretions if needed
 - 5.8.5.1 If infant is not breathing, is gasping, has poor tone or secretions are obstructing the airway
 - 5.8.5.2 Secretions may be removed from the upper airway by suctioning gently with the bulb syringe.
 - 5.8.5.3 Brief gentle suction is usually adequate to removed secretions. Suction the mouth before the nose.
 - 5.8.5.4 Be careful not to suction vigorously or deeply. Vigorous suction may injure tissues.
 - 5.8.5.5 Stimulation of the posterior pharynx during the first minutes after birth can produce a vagal response leading to bradycardia or apnea.
 - 5.8.5.6 Is using a suction catheter, the suction control should be set so that the negative pressure reads approximately 80 to 100 mm Hg when the tubing is occluded.
 - 5.8.5.7 If secretions are thick enough to completely obstruct the airway,

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directly suction the trachea with a meconium aspirator attached to an endotracheal tube.

- 5.8.5.7.1 Using 80-100 mm Hg, connect to suction tubing to the meconium aspirator and attach directly to the endotracheal tube connector. Gradually withdraw the tube to removed secretions from the trachea and posterior pharynx before reinserting a new endotracheal tube for ventilation.
- 5.8.6 Dry infant and remove wet blanket
 - 5.8.6.1 Drying is not necessary for very preterm infant's less than 32 weeks' gestation. They should be covered immediately in polyethylene plastic. This intervention will reduce heat loss.
- 5.8.7 Provide gentle tactile stimulation, if needed
 - 5.8.7.1 Positioning, clearing secretions and drying the infant will frequently provide enough stimulation to initiate breathing. If the infant does not have adequate respirations, brief additional tactile stimulation may stimulate breathing.
 - 5.8.7.2 Gently rub the infant's back, trunk or extremities.
 - 5.8.7.3 Overly vigorous stimulation is not helpful and can cause injury.
- 5.8.8 If the infant has persistent central cyanosis, place pulse oximeter probe on infant. The preferred site will be the right hand. This is the pre-ductal site. The targeted pre-ductal Spo₂ after birth:
 - 5.8.8.1 1 minute = 60% – 65%
 - 5.8.8.2 2 minutes = 65% – 75%
 - 5.8.8.3 3 minutes = 70% – 75%
 - 5.8.8.4 4 minutes = 75% – 80%
 - 5.8.8.5 5 minutes = 80% – 85%
 - 5.8.8.6 10 minutes = 85% – 95%
- 5.8.9 If the infant is apneic or has ineffective respirations to keep the heart rate >100, start positive pressure ventilation (PPV) with a bag and mask.
- 5.8.10 Use pressure sufficient to move the infant's chest (PIP between 20-25 cm H₂O)
 - 5.8.10.1 Higher pressures may be needed during the first several breaths and in infants with decreased lung compliance (PIP between 30-40 cm H₂O)
- 5.8.11 PPV should be done at a rate of 40-60 breaths per minute with 21% – 100% FiO₂
 - 5.8.11.1 Begin with 21% FiO₂ and increase or decrease FiO₂ as needed
- 5.8.12 Check the heart rate by auscultating the apical pulse or palpate the umbilical cord.
- 5.8.13 Chest compressions are indicated if after 30 seconds of PPV, the heart rate is below 60. (Do not proceed to chest compressions until you have established an open airway and ventilation that inflates the lungs).
 - 5.8.13.1 Chest compressions are given at a ratio of 3 compressions and 1 breath. These should be 90 compressions and 30 breaths in a 1 minute cycle.
 - 5.8.13.2 Chest compressions are given to a depth of one-third of the diameter

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of the chest and are coordinated with ventilations.

- 5.8.14 Continue with chest compressions with ventilator assistance until the heart rate is 80 or greater, or instructed to discontinue CPR by a physician assuming responsibility for the neonate's care.
 - 5.8.15 Notify the pediatrician/attending physician that resuscitation is in progress.
 - 5.8.16 If after 1-2 minutes of cardiac massage and PPV with bag and mask, and the infant are not responding appropriately, the infant should be intubated with the appropriate size ETT or a size 1 LMA. The intubation/LMA steps may be considered at any time the infant is not responding to PPV with the bag and mask.
 - 5.8.17 If endotracheal intubation is needed, follow the procedure outlined in policy CLN-00236; Endotracheal Intubation – Standardized Procedure.
 - 5.8.18 If the infant is intubated or has LMA and chest compressions continue and the heart rate is <60 after 30 additional seconds of chest compressions and ventilation, medications should be given.
 - 5.8.19 If vascular access is needed, follow the procedure outlined in policy CLN-00258; Neonatal Umbilical Vessel Catheterization – Standardized Procedure
 - 5.8.20 Epinephrine 1:10,000, is indicated if the heart rate is <60 beats per minute
 - 5.8.20.1 Should be given intravenously – 0.1 to 0.3 mL/kg
 - 5.8.20.2 May be given endotracheally – 0.5 to 1.0 mL/kg
 - 5.8.20.3 Epinephrine may be repeated every 3-5 minutes
 - 5.8.21 Volume expansion with normal saline is indicated when there is evidence of acute bleeding or signs of hypovolemia.
 - 5.8.21.1 Normal Saline, 10 mL/kg is given IV over 5-10 minutes, repeat 1-2 times as needed.
 - 5.8.22 O Rh-negative packed red blood cells should be considered as part of the volume replacement when severe fetal anemia is documented or expected.
 - 5.8.22.1 10 mL/kg over 5-10 minutes
 - 5.8.23 Continue with NRP procedure until a pediatrician or attending physician arrives. The decision to stop resides with the physician.
 - 5.8.24 The infant should be stabilized as much as possible and then transported to the Intermediated NICU for further evaluation and treatment.
- 5.9 Documentation:
- 5.9.1 The Advanced NRP RN will document attendance at the delivery and associated interventions.
 - 5.9.2 Document time of spontaneous respirations
 - 5.9.3 Time and length of bag and mask ventilation
 - 5.9.4 Intubation time and number of attempts
 - 5.9.5 If need for chest compressions, time started and duration
 - 5.9.6 Any medications given, time and response
 - 5.9.7 Disposition of infant

6.0 References:

- 6.1 American Academy of Pediatrics, American Heart Association, *Textbook of Neonatal*

The electronic version of this policy supersedes any printed copy.

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Resuscitation, 8th Ed (2021)

- 6.2 Rady Children's Hospital, San Diego, "Neonatal Resuscitation in the Delivery Area, Nursery or on Transport" SP 2-07 (2016)
- 6.3 March of Dimes "The STABLE program 7th ed. (2024)
- 6.4 Verklan, MT, et al, *Core Curriculum for Neonatal intensive Care Nursing*, 6th ed (2021)
- 6.5 Gardner, Carter, et al, *Merenstein & Gardner's Handbook of Neonatal Intensive Care*, 9th ed (2021)

7.0 Attachment List:

- 7.1 Algorithm for 8th ed Neonatal Resuscitation Program Guidelines

8.0 Summary of Revisions:

- 8.1 Updated References
- 8.2 Updated Education requirements in 3.9
- 8.3 Changed policy from a Standardized Procedure to Work Instruction
- 8.4 Updated Definitions
- 8.5 Added attachment A

Guidelines for Activation of "Code Neo"

1. The Code Neo Team consists of an NICU based intra-disciplinary team that responds to all neonatal emergencies within Pioneers Memorial Hospital
2. Coverage is 24/7
3. The appropriate team is activated by the NICU Charge Nurse
4. The Code Neo Team includes: NICU Charge Nurse (NRP RN), Respiratory Therapy, Pediatrician
5. In the event of simultaneous emergencies, the Emergency Department with Respiratory Therapy will be called
6. In the event an infant is subject to a Code Neo call, the infant will be transferred to the NICU for monitoring and evaluation by the attending pediatrician, if this has not occurred yet
7. For an infant born precipitously in the Emergency Department, the NICU Team will transport the required equipment to the location of the infant.
8. The infant will be transported to the NICU via the infant transport isolette or an open bed once the infant is stabilized to move to the NICU
9. The neonatal attending physician will assume the role of the code team leader when present. Otherwise any Advanced NRP credentialed clinician may assume the role of the code team leader to organize the resuscitative efforts of the newborn
10. All clinicians are responsible for documenting assessment and interventions in the neonates EMR
11. Designate the team members of their roles as soon as possible
 - a. Team Leader (Charge NRP RN or Pediatrician/Neonatologist)
 - b. Personnel responsible for airway management
 - c. Personnel responsible for assisting/chest compressions
 - d. Personnel responsible for medication set up and administration
 - e. Personnel responsible for documenting events/treatments/communication with others and family
 - f. Personnel responsible for gathering extra supplies and running lab work to lab
12. Criteria for Code Neo
 - a. Any infant that requires NRP resuscitation that includes advanced airways, chest compressions or medications
 - b. Apnea persisting past 1 minute of positive pressure ventilation (PPV) with bag and mask
 - c. Bradycardia not responding to PPV (Heart rate persistently <80 bpm)
 - d. Central cyanosis that persists > 5 minutes
 - e. Cyanosis (Circumoral, unresponsive to blow by oxygen administration of 100% Fio2)
 - f. "Floppy baby" (absent muscle tone/lack of respiratory effort = stunned infant requiring resuscitation)
 - g. Persistent oxygen saturation less than 85% (>10 minutes of life)
 - h. Seizure like activity, change in behavior/lethargy
 - i. Decreased muscle tone

- j. Respiratory rate persistently >70 bpm at 10 minutes of life
 - k. Grunting/flaring/retractions
 - l. HR persisting >200 bpm
 - m. Any incident where infant is dropped or has a fall
 - n. Initial presentation after home birth
 - o. Uncontrolled bleeding of the infant
 - p. Unexplained pain
 - q. Unresolved parental concern
 - r. Any Staff concerns
13. How to activate a Code Neo Response
- a. Call 4444
14. Any staff member from any department call the NICU to request help must use the G.I.R.L. acronym to state the following:
- a. Gestational Age of the infant
 - b. Indications for call (reason for impending birth or Code Neo Response)
 - c. Relevant information for the NICU Team
 - d. Location of the infant

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Collaborating Departments: Administration		Keywords: Case Management, Discharge Plan	
Approval Route: List all required approval			
PSQC 4/2025		Other: UM Committee 8/2024	
Clinical Service _____		MSQC 4/2025	MEC 4/2025 BOD 4/2025

Note: If any of the sections of your final layout are not needed do not delete them, write "not applicable".

1.0 Purpose:

- 1.1 To develop and maintain in effect a utilization management (UM) plan that provides for review of services furnished by the organization and by members of the medical staff to all patients including beneficiaries entitled to benefits under the Medicare and Medicaid programs.
 - 1.1.1 support high quality patient care;
 - 1.1.2 To promote effective and efficient use of hospital resources;
 - 1.1.3 To provide oversight and support to staff responsible for evaluating medical necessity for admissions and continued stay reviews; and
 - 1.1.4 To support and facilitate safe, appropriate, timely, and effective discharge planning.

2.0 Scope: Hospital Wide

3.0 Policy:

- 3.1 It shall be the policy of Pioneers Memorial Hospital (PMH) to adhere to Conditions of Participation (COP), Accreditation Standards, and California Code of Regulations (CCR) AND other State and Federal rules and regulations as it relates to medical necessity reviews, discharge planning, social services, and Clinical Documentation Improvement (CDI).
- 3.2 Medical Necessity Reviews (COP 482.30)
 - 3.2.1 Admissions to the hospital;
 - 3.2.2 Duration of stays; and
 - 3.2.3 The professional services.

4.0 Definitions:

- 4.1 Admission Review is Initial (First Medical Necessity Review)
- 4.2 Duration of Stays is review conducted after Initial (Admission) Review
- 4.3 Professional Services: Services Rendered by Professional Staff (Attending, specialists, OT, PT, Speech)
- 4.4 Governing Body: Hospital Board of Directors

5.0 Procedure:

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- 5.1 Establishment of UM Committee (UMC)
- 5.2 UM Committee Structures:
 - 5.2.1 The Governing Body (The Board) has the ultimate authority for the Utilization Management.
- 5.3 Composition of the Utilization management Committee (UMC):
 - 5.3.1 Membership will consist of at least two (2) physicians, including physicians in the major specialties as deemed necessary by the Medical Staff.
 - 5.3.1.1 No physician member of the UMC shall have review responsibility for any case in which he/she was, is or anticipates being professionally involved or if he has covering duties for the case being reviewed.
 - 5.3.1.2 No member of the UMC shall have direct financial interest, as defined by CMS in the hospital or any agency owned by the hospital.
 - 5.3.2 Chief Nursing Officer
 - 5.3.3 Director of Case Management
 - 5.3.4 Direct Patient Care Nursing Director
 - 5.3.5 Compliance Officer
 - 5.3.6 Director of Quality
 - 5.3.7 Director of Business Office/Finance
 - 5.3.8 Other key staff as needed
- 5.4 Scope and Frequency of review:
 - 5.4.1 The UMC will provide the review for all patients with respect to the medical necessity of-
 - 5.4.1.1 Admissions to the hospital;
 - 5.4.1.1.1 Review of admissions may be performed before, at, or after hospitalization.
 - 5.4.1.2 Duration of stays;
 - 5.4.1.2.1 Cases with a length of stay of 7 days or greater are assumed to be outlier cases with extended length of stay; cases that are reasonably assumed to be outlier cases based on extraordinarily high costs are also considered outlier cases.
 - 5.4.1.3 Medical necessity of professional services, including medications.
 - 5.4.1.3.1 Cases that are reasonably assumed to be outlier cases based on extraordinarily high costs are also reviewed at weekly interdisciplinary meeting.
 - 5.4.1.3.2 Drugs and biologicals are reviewed at the Pharmacy and Therapeutics Committee (P&T). The Director of Case Management attends this meeting.
- 5.5 Medical Necessity Determination regarding admissions or continue stays.

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- 5.5.1 Develop and approve screening criteria for inpatient admissions and observation placements using criteria that are evidence based and compliant with regulatory guidelines.
- 5.5.2 Establish and carry out a program that includes preadmission screening and review, admission screening and review, and continued stay reviews. Provide oversight to the screening process, including the appropriate processes of escalation of cases that fail screening criteria (Eg MCG, InterQual) to the physician advisors. This review process occurs both concurrently and retrospectively.
- 5.5.3 Optimize medical management of cases to reduce admissions without medical necessity and to minimize hospital stays by reducing non-acute days.
- 5.5.4 Recommend strategies and process changes to enhance the quality and efficiency of patient care while controlling cost.
- 5.5.5 Provide physician advisor oversight and support for the Case Management staff and any non-physician related screening activities.
- 5.5.6 Initiate and support the issuance of provider denial notices as indicated in the guidelines for Medicare, Medicaid, and as appropriate for third party payers.
- 5.5.7 Provide support and input to the medical staff regarding educational programs for physicians and other health professionals on utilization management topics.
- 5.5.8 Evaluate, report, and update at least annually the Utilization Management Plan to the MEC and Board of Directors.
- 5.6 Utilization Management Data Analysis:
 - 5.6.1 Analyze data and information compiled on utilization management indicators. Identify case-related and quality assessment problems, including:
 - 5.6.1.1 Medical Necessity of Short Stays <2 Midnights
 - 5.6.1.2 Length of Stay (LOS) for inpatients greater than 7 days and observations greater than 24 hours
 - 5.6.1.3 Avoidable Days/Delays by type, department, physician
 - 5.6.1.4 Readmission rates by DRG and physician
 - 5.6.1.5 Denials by payer, physician, and reason
 - 5.6.1.6 Recovery Audit Contractor (RAC) denials and status of appeals
 - 5.6.1.7 Number of Physician Advisor referrals to include reason, trends and any recommended follow up actions
 - 5.6.2 Focused reviews on professional services such as targeted therapeutics, pharmaceuticals, and use of biologicals are reviewed at the Pharmacy and Therapeutics meeting.
 - 5.6.3 Select high utilization indicators as identified by the committee
- 5.7 Review Processes
 - 5.7.1 Pre-admission and admission screening is done by the Case Management (CM) department or other appropriately trained personnel.

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5.7.1.1 Medical records are the source documents for conducting case reviews. Physician progress notes will be of sufficient frequency and quality to permit the staff to perform the review.

5.7.1.2 Staff will use criteria approved by the medical staff for initial screening reviews. Screening reviews will address, as appropriate, intensity of service, severity of illness and discharge criteria. Admit and discharge decisions will be made solely by a licensed independent practitioner. Screenings that do not meet criteria will be presented to physician advisors as described in this plan.

5.7.2 Procedure for Admission Reviews:

5.7.2.1 Admission reviews will be conducted, ideally, within 24 hours of admission/placement.

5.7.2.2 If the admission/placement does not meet established criteria, the case will first be discussed with the attending physician. If the attending physician is not able to provide additional information that ensures the patient meets criteria and there is not an alternate level of care order provided, the case is referred to the Physician Advisor.

5.7.3 Procedure for Continued Stay Reviews:

5.7.3.1 Although continued stay reviews are incorporated into the daily care coordination process, documentation of this review will be completed for inpatients based upon the expected LOS for the working Diagnostic Related Group (DRG) per Medicare for each particular patient. The continued stay reviews for observation patients will be done daily.

5.7.3.2 Extended stay cases are reviewed every 3 days by Case Manager. Extended stay review meetings will be conducted weekly focusing on those patients with a LOS of 7 days or greater. If, after this review, the Physician Advisor feels that medical necessity has not been established, he will give the attending physician an opportunity to present his views. If there is still disagreement, a second Physician Advisor will review the case. If he agrees with the first PA, that will be considered the final decision of the UMC. Once the decision is made that the admission, observation placement, or continued stay is not medically necessary, written notification is given after the determination, to the attending physician responsible for the care of the patient per Medicare guidelines. If the second P-A agrees with the attending physician, no further action is necessary.

5.8 Physician Advisors

5.8.1 The Physician Advisors are delegated authority as stated in the UMP, to provide final medical necessity determination of referred cases. Responsibilities of both internal and external Physician Advisors may include, but are not limited to:

5.8.1.1 Addresses quality of care concerns of referred cases.

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- 5.8.1.2 Provides secondary medical necessity determination of referred cases.
- 5.8.1.3 Reviewing individual cases meeting outlier status (cost, LOS, etc.) upon request.
- 5.8.1.4 Collaborating with attending physicians and specialists regarding over utilization and underutilization of services.
- 5.8.1.5 Provide education to peers as related to current trends in utilization of clinical resources
- 5.8.1.6 Provides education and training to ancillary staff pertaining to UM / DC planning issues.
- 5.8.1.7 Reviews and signs appeal correspondence related to medical necessity denials.
- 5.8.1.8 Documenting activities appropriately

5.9 Hospital Staff

- 5.9.1 The appropriate hospital staff will conduct admission initial review of all patients being placed into acute settings using screening criteria (MCG, Interqual) approved by the medical staff . If a patient fails to clearly meet the initial screen, the staff will escalate the case for further review by the UMC and/or its designee Physician Advisor.
- 5.9.2 The appropriate staff will conduct continued stay and discharge reviews using screening criteria approved by the medical staff. If it is unclear whether the patient meets continued stay criteria, the case will be escalated for further review by the UMC and/or its designee Physician Advisor.
- 5.9.3 Individual cases that meet outlier cost (according to Medicare definition for outlier payments) and LOS thresholds (currently identified as greater than 7 days for inpatients and greater than 24 hours for observation patients), will also be escalated for further review. The LOS cases will be reviewed at least every week.

5.10 Conflict of Interest and Confidentiality

- 5.10.1 All persons involved in case management activities will comply with the Conflict of Interest stipulated in the code of Conduct of PMH.
- 5.10.2 All medical information and/or records incident to the Utilization Program shall be considered confidential having been prepared for hospital department functioning primarily to review adequacy or quality of professional services and are privileged.

6.0 References:

- 6.1 Centers for Medicare and Medicaid Services (COPs 42 CFR Part 482.30, 482.43), 412.3
- 6.2 Title 22
- 6.3 DNV

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7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Major Overhaul of UMP 8/2024

IMPERIAL VALLEY HEALTHCARE DISTRICT

BOARD MEETING DATE: June 26, 2025

SUBJECT:

Authorize the approval of the FY 2026 Operating Budget Proposal for Imperial Valley Healthcare District ("District").

BACKGROUND:

The objective of the District's FY 2026 Operating Budget Proposal is to provide a comprehensive financial plan for the upcoming fiscal year with the aim of ensuring that resources are effectively managed, funds are appropriately allocated, and the District's strategic goals can be achieved while maintaining quality patient care and other essential hospital functions. For FY 2026, the Operating Budget was based on projections of the future revenue and expenses. This was achieved by calculating the revenue and expenses from the first nine months of the current fiscal year and using it to annualize or forecast an estimate for the next twelve months. These calculations and the use of a newly acquired budgeting program, Multiview, helped to provide efficient and transparent budget development. When calculating and estimating the Operating Budget, factors such as inflation, new anticipated expenses, patient volumes, industry and historical trends, market changes and growth assumptions are taken into consideration.

KEY HIGHLIGHTS:

- Total staffing costs are projected to increase by 4.6%, which includes a 3% annual District-wide rate adjustment
- Supplies are forecasted to increase by 2.8%
- Total expenses are expected to increase by 4.0%
- Volumes for Admissions, Patient Days, Surgeries, Deliveries, ER visits and Clinic visits are predicted to remain consistent with FY 2025 volumes

BUDGET VALUE: Projected net gain of \$349K

BUDGET TERM: FY 2026 (July 1, 2025 through June 30, 2026)

RESPONSIBLE ADMINISTRATOR: Carly Loper, Chief Financial Officer

RECOMMENDED ACTION:

Authorize the approval of the FY 2026 Operating Budget Proposal for Imperial Valley Healthcare District ("District"), as outlined.

Imperial Valley Healthcare District
Pioneers Memorial Hospital
2026 Budget Proposal



Imperial Valley Healthcare District

Pioneers Memorial Hospital

2026 Budget Proposal

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Budgeted Financial Statement Summary

- **Net Excess/(Deficit)** - The Budget for Fiscal Year 2026 is projected as a net gain of \$349K against a Fiscal Year 2025 projected net gain of \$6.0 M.
- **Revenues** - Total gross revenues are projected to stay consistent with FY 2025. Other operating revenues such as QIP (PRIME II), grants, cafeteria sales, rebates and refunds and others are expected to remain the same. Non-Operating Revenue is predicted to increase with the addition of the Heffernan District taxes.
- **Expenses** - Operating expenses are projected to increase 4.0% or \$6.8 M, from \$168.5 M for FY 2025 to \$175.3 M for FY 2026.

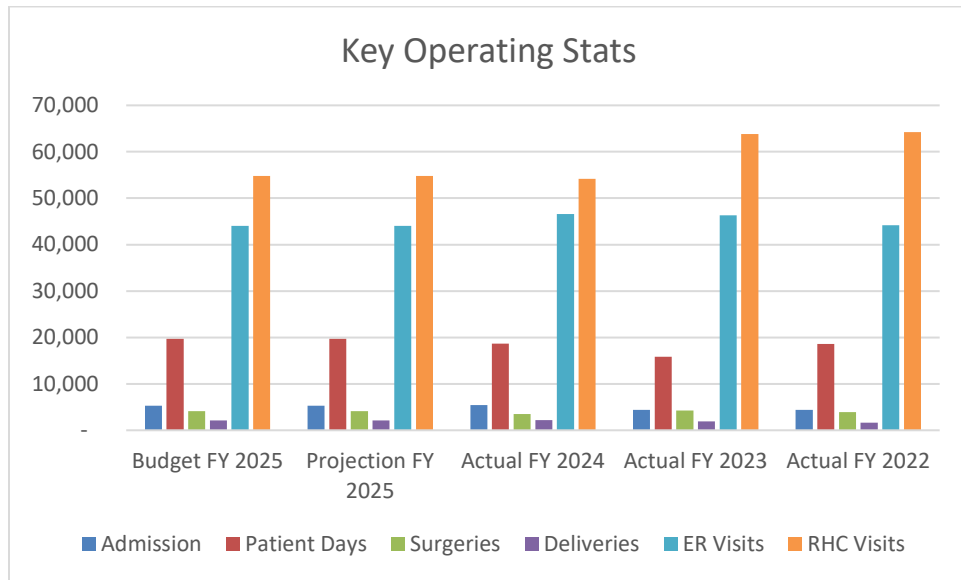
Budget Highlights

The following are key features of the proposed 2026 Budget:

- All volumes are expected to remain steady with FY 2025 volumes.
- Salaries are projected to increase by 4.8% or 3.6 M mostly due to a 3% annual rate adjustment. Total staffing is estimated to increase 4.6 % or \$4.6 M. Total staffing consists of salaries, benefits and contract labor.
- Supplies are projected to increase by 2.8% or \$556k due to inflation.
- Purchased Services and Repairs and Maintenance is estimated to increase due to inflation of about 2.5% or \$194k and \$190k, respectively.
- Capital Expenditures are estimated to be about \$6.1 M for the year.

Major Volume Indicators

	Budget FY 2025	Projection FY 2025	Actual FY 2024	Actual FY 2023	Actual FY 2022
Admission	5,323	5,323	5,398	4,393	4,419
Patient Days	19,735	19,735	18,681	15,816	18,607
Surgeries	4,105	4,105	3,510	4,257	3,945
Deliveries	2,123	2,123	2,201	1,904	1,629
ER Visits	44,015	44,015	46,553	46,323	44,206
RHC Visits	54,817	54,817	54,186	63,800	64,254



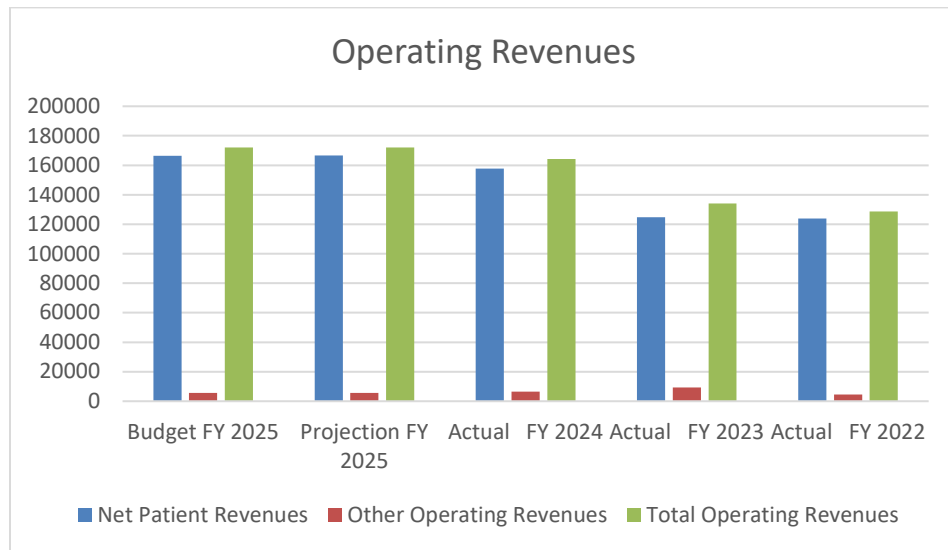
Payer Mix (patient days)

Medi-Cal Managed care is our single largest payer class followed by Medicare. These governmental payers are budgeted to comprise 78.8% of all inpatient volumes.

Total Operating Revenues (Net Patient Revenues & Other Revenues)

Total Operating Revenues, which are comprised of Net Patient Revenues (Gross Revenues less Deductions) and Other Operating Revenues (Grants, Prime, Cafeteria and Miscellaneous), are budgeted to stay consistent with current year.

	Budget FY 2025	Projection FY 2025	Actual FY 2024	Actual FY 2023	Actual FY 2022
Net Patient Revenues	166,489	166,635	157,856	124,839	123,964
Other Operating Revenues	5,582	5,532	6,556	9,311	4,624
Total Operating Revenues	172,071	172,167	164,412	134,150	128,588
*in thousands					



Net patient services revenues are budgeted to stay steady with a slight decrease of \$146K. This decrease is due to the fluctuations in projected Supplemental Payments.

For the FY 2026 Budget timeframe, much higher Supplemental Payments could potentially be recognized due to an increase in the District Hospital Directed Payment (DHDP) program netted against a decrease in the potential DSH payment from the federal government.

Salaries

Salary expenses are budgeted to increase by 4.8% or \$3.6 M for FY 2026. Most budgeted staffing levels were calculated on a *workload unit* adjusted basis. The calculation for this basis is done by assigning each department a productivity factor (worked hours allowed per statistic) and then it is applied to each department's budgeted statistic. This methodology was used to determine the total number of Full Time Equivalents (FTEs) to budget for each department as well as develop a benchmark for the departments' performance over the years.

Key assumptions used to calculate employee pay rates are shown below.

- A. Across-the-board pay rate adjustments (market adjustments) were included in the FY 2026 budget. These adjustments include an average of 3.0% merit that would increase salaries and employer taxes by \$3.8 M.
- B. A Holiday Bonus amount of \$500K was included in the FY 2026 Budget. The payout of this bonus will be dependent on factors established by the CEO and Board of Directors.

Registry and Contract Labor

Contract Labor is projected to stay consistent with a modest increase of 4.2% or \$100K. Nursing Administration continues to recruit nursing staff so the future use of registry nurses is minimal. The District's Security Services continue on a contract basis, which comprises of about 23.3% of the contract labor expense.

Employee Benefits

In total, Employee Benefits are expected to increase by 4.1% or \$826K. Payroll taxes will increase consistently with the increases in budgeted salary expenses. Workers' Compensation premiums are quoted to increase approximately 16.8% due to higher salaries and high Ex Mod.

Professional Fees

Professional fees, which include legal and audit services, are projected to increase 2.0% or \$312K. The largest variance for Professional Fees is legal fees, which accounts for an increase of 19.2%.

Supplies

The cost of supplies is expected to increase by 2.8% or \$556K due to inflation. Included in this increase is a 3.0% inflation rate for supplies and 7.0% for drugs.

Purchased Services and Repairs and Maintenance

The cost of Purchased Services is projected to increase by 2.5% or \$194K over FY 2025 costs.

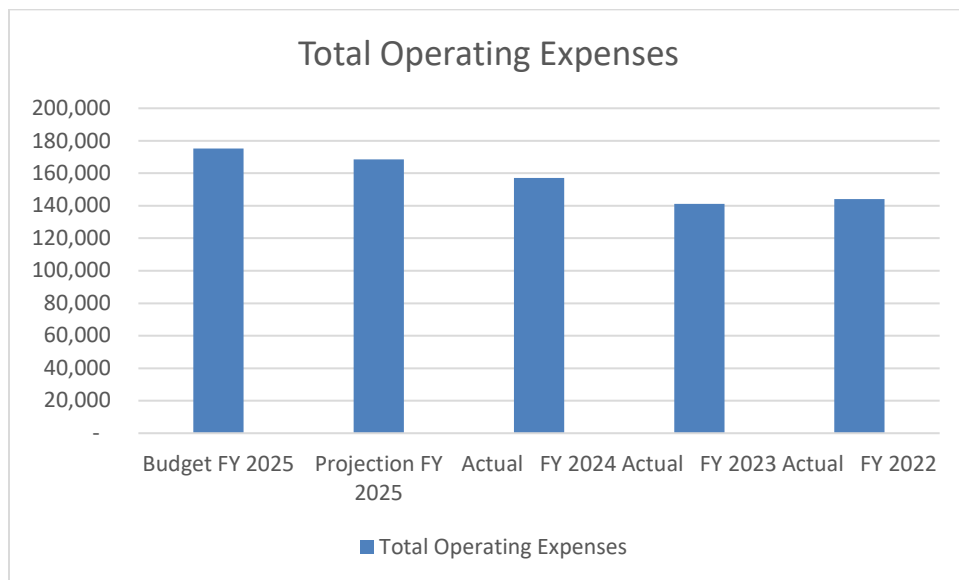
Repairs and maintenance costs are expected to increase 2.5% or \$190K. The increase is attributed to the continued essential maintenance support for software systems.

Other Expenses

Most other expenses are comprised of utilities, licenses, dues, outside training, travel, leases and other. Those expenses are expected to increase by 6.7% or \$670K due to inflation-driven increases for utilities and an increase in outside training. Other expenses have increased 42.7% or \$256K, mostly due to the newly adopted Employee Retention Program funds of \$25 per employee, per quarter.

Total Operating Expenses

	Budget FY 2025	Projection FY 2025	Actual FY 2024	Actual FY 2023	Actual FY 2022
Total Operating Expenses *in thousands	175,253	168,492	157,085	141,164	144,177



Capital Spending

The total capital spending is estimated to be about \$6.2 M with 30.8% of that amount from IT expenses, 18.1% from Plant Maintenance expenses and the rest from the clinical departments.

Balance Sheet Key Indicators

The table below provides a comparison of the key operating ratios between FY 2026 and FY 2025. The Days Cash on Hand is projected to decrease due to the increase in expenses and the anticipated repayment of the Distressed Loan to start in May 2026.

	Budget FY 2025	Projection FY 2025	Actual FY 2024	Actual FY 2023	Actual FY 2022
Gross A/R Days	62.7	65.5	63.9	71.2	65.9
Net A/R Days	37.5	41.3	35.7	57.7	44.8
Days Cash on Hand	71.6	102.9	94.9	44.3	65.7
Debt Service Coverage	0.80	1.84	5.63	2.87	(1.40)
Current Ratio	3.57%	3.94%	3.34%	2.54%	1.63%
Net Income Margin	0.20%	3.47%	5.92%	0.44%	(0.07)

Non-Operating Revenue/(Expense)

Pioneers Memorial Hospital District tax revenues are projected to be \$1.4 M while Heffernan District tax revenues are projected to be at least \$1.2 M. Interest expense for the Series 2017 Revenue bonds is \$629K.

(END OF PROPOSAL)

IMPERIAL VALLEY HEALTHCARE DISTRICT
PIONEERS MEMORIAL HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
FOR THE BUDGET YEAR ENDING JUNE 30, 2026

	BUDGET FY 2026	PROJECTED FY 2025	VARIANCE \$	VARIANCE %	ACTUAL FY 2024	ACTUAL FY 2023	ACTUAL FY 2022
GROSS PATIENT REVENUES	541,438,723	541,438,723	-	0.0%	508,908,402	450,470,549	449,558,132
TOTAL REVENUE DEDUCTIONS	374,949,743	374,803,888	145,855	0.0%	351,052,811	325,631,697	325,594,418
NET PATIENT REVENUES	166,488,980	166,634,835	(145,855)	-0.1%	157,855,591	124,838,852	123,963,714
OTHER OPERATING REVENUE GRANT REVENUES	50,000	-	50,000	0.0%	550,000	-	-
OTHER	5,532,093	5,532,093	-	0.0%	6,006,283	9,311,005	4,624,221
TOTAL OTHER REVENUE	5,582,093	5,532,093	50,000	0.9%	6,556,283	9,311,005	4,624,221
TOTAL OPERATING REVENUE	172,071,073	172,166,928	(95,855)	-0.1%	164,411,874	134,149,857	128,587,935
OPERATING EXPENSES							
SALARIES AND WAGES	79,843,688	76,195,996	3,647,692	4.8%	67,925,285	54,821,236	51,269,201
BENEFITS	20,830,478	20,004,715	825,763	4.1%	18,172,512	16,613,611	15,184,670
REGISTRY & CONTRACT	2,478,875	2,378,545	100,330	4.2%	3,378,617	5,881,464	8,342,844
TOTAL STAFFING EXPENSE	103,153,041	98,579,256	4,573,785	4.6%	89,476,414	77,316,311	74,796,715
PROFESSIONAL FEES	16,234,109	15,921,738	312,371	2.0%	14,004,128	15,498,022	15,815,125
SUPPLIES	20,446,778	19,890,358	556,420	2.8%	19,139,614	17,846,976	22,701,487
PURCHASED SERVICES	7,819,409	7,625,859	193,550	2.5%	8,857,315	7,849,584	8,725,179
REPAIR & MAINTENANCE	7,795,935	7,606,396	189,539	2.5%	6,831,255	6,017,487	6,176,387
DEPRECIATION & AMORT	3,424,866	3,595,112	(170,246)	-4.7%	3,355,375	3,572,979	4,128,969
INSURANCE	2,961,669	2,771,358	190,311	6.9%	2,746,154	2,215,447	2,252,242
HOSPITALIST PROGRAM	2,673,428	2,428,109	245,319	10.1%	2,629,754	2,661,055	1,816,000
OTHER	10,744,167	10,074,173	669,994	6.7%	10,044,685	8,186,109	7,765,370
TOTAL OPERATING EXPENSES	175,253,402	168,492,359	6,761,043	4.0%	157,084,695	141,163,970	144,177,474
TOTAL OPERATING MARGIN	(3,182,329)	3,674,569	(6,856,898)	-186.6%	7,327,179	(7,014,113)	(15,589,539)
NON OPER REVENUE(EXPENSE)							
OTHER NON-OP REV (EXP)	1,455,680	1,451,740	3,940	0.3%	1,432,178	870,825	(367,434)
DISTRICT TAX REVENUES	1,485,046	1,485,046	-	0.0%	1,645,836	1,461,057	1,383,909
HENFFERMAN DISTRICT TAX REV	1,226,800						
DISTRICT TAX G.O. Bonds							
INTEREST EXPENSE	(636,402)	(629,145)	(7,257)	1.2%	(666,822)	1,874,736	1,855,029
CARES HHS/ FEMA RELIEF FUNDING	-	-	-	0.0%	-	(698,622)	(722,954)
TOTAL NON-OP REV (EXPENSE)	3,531,124	2,307,641	1,223,483	53.0%	2,411,192	7,606,985	6,492,916
NET EXCESS / (DEFICIT)	348,795	5,982,210	(5,633,415)	-94.2%	9,738,371	592,872	(9,096,623)

IMPERIAL VALLEY HEALTHCARE DISTRICT
PIONEERS MEMORIAL HOSPITAL
PRODUCTIVITY AND RATIO ANALYSIS
BUDGET YEAR ENDING JUNE 30, 2026

	Budget FY 2026	% Change	Projection FY 2025	% Change	Actual FY 2024	% Change	Actual FY 2023	% Change	Actual FY 2022
Gross A/R Days	62.7	-4.3%	65.5	2.4%	63.9	-10.3%	71.2	8.1%	65.9
Net A/R Days	37.5	-9.2%	41.3	15.9%	35.7	-38.2%	57.7	28.7%	44.8
Days Cash On Hand	71.6	-30.5%	102.9	8.5%	94.9	114.2%	44.3	-32.6%	65.7
Current Ratio	3.57%	-9.4%	3.94%	17.9%	3.34%	31.7%	2.54%	56.3%	1.63%
Debt Service Coverage	0.80	-56.3%	1.84	-67.3%	5.63	95.8%	2.87	-305.8%	(1.40)
Debt to Capital	64.2%	-0.4%	64.5%	-3.3%	66.7%	5.6%	63.2%	25.0%	50.5%
Accounts Payable Days	54.9	3.0%	53.3	-21.3%	67.7	22.0%	55.5	9.9%	50.5
Average Age of Plant	31.2	8.5%	28.7	-3.3%	29.7	10.0%	27.0	19.2%	22.7
Deductible Ratio	69.25%	0.0%	69.22%	0.4%	68.98%	-4.6%	72.29%	-0.2%	72.43%
Net Income Margin	0.20%	-94.2%	3.47%	-41.3%	5.92%	1240.3%	0.44%	-106.2%	-7.07%

IMPERIAL VALLEY HEALTHCARE DISTRICT
PIONEERS MEMORIAL HOSPITAL
BALANCE SHEET
Budget FY 2026

	Budget FY 2026	Projection FY 2025	Actual FY 2024	Actual FY 2023	Actual FY 2022
ASSETS					
CURRENT ASSETS					
CASH	33,694,143	46,379,190	39,965,486	16,685,983	16,103,854
CDs - LAIF & CVB	64,218	66,244	65,505	63,099	62,023
ACCOUNTS RECEIVABLE - PATIENTS	92,973,817	96,835,608	89,112,026	87,933,623	81,145,287
LESS: ALLOWANCE FOR BAD DEBTS	(5,514,680)	(5,301,153)	(5,728,207)	(4,977,190)	(5,198,061)
LESS: ALLOWANCE FOR CONTRACTUAL;	(70,335,289)	(72,710,128)	(67,960,450)	(63,207,554)	(60,715,463)
NET ACCOUNTS RECEIVABLE	17,307,085	18,824,327	15,423,369	19,748,878	15,231,763
	18.62%	19.44%	17.31%	22.46%	18.77%
ACCOUNTS RECEIVABLE - OTHER	32,123,804	26,700,939	30,801,714	17,257,248	12,944,986
COST REPORT RECEIVABLES	889,567	59,499	2,521,422	368,285	1,410,849
INVENTORIES - SUPPLIES	3,207,429	3,157,704	2,835,246	3,316,624	3,520,142
PREPAID EXPENSES	2,205,514	2,872,296	1,953,532	2,077,178	1,919,051
TOTAL CURRENT ASSETS	89,491,759	98,060,199	93,566,273	59,517,296	60,305,246
OTHER ASSETS					
PROJECT FUND 2017 BONDS	617,546	634,042	505,516	496,742	489,020
BOND RESERVE FUND 2017 BONDS	968,323	968,353	968,324	968,300	968,316
LIMITED USE ASSETS	0	10,198	40,959	37,063	57,578
GASB87 LEASES	66,879,394	64,931,450	64,931,450	49,415,107	22,618,546
OTHER ASSETS PROPERTY TAX PROCEEDS	477,313	269,688	505,438	594,002	540,125
OTHER INVESTMENTS	0	420,000	0	0	0
TOTAL OTHER ASSETS	68,942,576	67,233,731	66,951,687	51,511,214	24,673,585
PROPERTY, PLANT AND EQUIPMENT					
LAND	2,633,026	2,633,026	2,623,526	2,623,526	2,623,526
BUILDINGS & IMPROVEMENTS	65,118,597	63,118,597	62,919,140	63,472,230	61,523,759
EQUIPMENT	73,124,294	66,112,086	63,203,579	59,457,987	59,489,753
CONSTRUCTION IN PROGRESS	1,241,664	137,355	766,043	338,266	1,782,302
LESS: ACCUMULATED DEPRECIATION	(106,752,332)	(103,327,466)	(99,748,993)	(96,575,063)	(93,656,440)
NET PROPERTY, PLANT, AND EQUIPMENT	35,365,249	28,673,598	29,763,294	29,316,946	31,762,900
TOTAL ASSETS	193,799,585	193,967,528	190,281,255	140,345,456	116,741,731

IMPERIAL VALLEY HEALTHCARE DISTRICT
PIONEERS MEMORIAL HOSPITAL
BALANCE SHEET
Budget FY 2026

	Budget FY 2026	Projection FY 2025	Actual FY 2024	Actual FY 2023	Actual FY 2022
LIABILITIES AND FUND BALANCES					
CURRENT LIABILITIES					
ACCOUNTS PAYABLE - CASH REQUIREMENTS	4,437,735	3,816,007	5,460,085	4,037,112	3,136,578
ACCOUNTS PAYABLE - ACCRUALS	9,398,388	9,100,055	10,450,085	8,645,023	9,234,616
PAYROLL & BENEFITS PAYABLE - ACCRUALS	6,195,975	6,866,756	6,362,197	5,358,973	6,444,858
CURRENT PORTION - GO BONDS PAYABLE	0	0	230,000	220,000	1,810,000
CURRENT PORTION - 2017 REVENUE BONDS	0	0	320,000	305,000	290,000
INTEREST PAYABLE - GO BONDS	0	0	2,875	5,625	24,197
INTEREST PAYABLE - 2017 REVENUE BONDS	161,033	163,450	165,867	168,408	170,825
CURRENT PORTION - LEASE LIAB (GASB87)	3,984,958	3,868,891	3,756,205	1,722,161	1,059,698
CURRENT PORTION - LONG-TERM DEBT (CHFF)	858,248	1,043,505	1,228,761	469,091	216,403
TOTAL CURRENT LIABILITIES	25,036,337	24,858,664	27,976,076	20,931,394	31,499,753
LONG TERM DEBT AND OTHER LIABILITIES					
PMH RETIREMENT FUND - ACCRUAL	924,639	941,305	305,518	416,228	347,190
NOTES PAYABLE - EQUIPMENT PURCHASES (C	26,444,444	26,962,963	26,962,963	191,724	415,155
LOANS PAYABLE - CHFFA NDPH	0	0	3,766,770	6,715,689	2,986,587
BONDS PAYABLE 2017 SERIES	14,448,151	14,468,003	14,487,856	14,831,679	15,160,502
LONG-TERM LEASE LIABILITIES (GASB 87)	66,059,957	64,135,880	62,267,845	48,170,072	21,651,051
DEFERRED PROPERTY TAX REVENUE	552,022	550,877	511,188	594,002	540,125
SKILLED NURSING OVER COLLECTIONS	0	2,064,596	0	0	0
TOTAL LONG-TERM DEBT	108,429,213	109,123,625	108,302,140	75,149,394	41,570,182
FUND BALANCE AND DONATED CAPITAL	59,985,239	54,003,028	44,264,668	44,264,668	43,671,796
NET SURPLUS (DEFICIT) CURRENT YEAR	348,795	5,982,211	9,738,371	0	0
TOTAL FUND BALANCE	60,334,034	59,985,239	54,003,039	44,264,668	43,671,796
TOTAL LIABILITIES AND FUND BALANCE	193,799,584	193,967,528	190,281,255	140,345,456	116,741,731

24 HR OBSERVATION

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	3,247,296	3,247,296	-	0%
SALARIES	-	-		
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	-	-		
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	-	-		
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	-	-		
ALL NON-LABOR	-	-		
TOTAL OPERATING EXPENSES				
NET OPERATING MARGIN	3,247,296	3,247,296	-	0%
OPERATING MARGIN	3,247,296	3,247,296	-	0%
NET INCOME	3,247,296	3,247,296	-	0%

ACUTE DIALYSIS

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	2,608,344	2,608,344	-	0%
SALARIES	-	-		
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	-	-		
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	-	-		
PURCHASED SERVICES	954,668	983,308	28,640	3%
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	-	-		
ALL NON-LABOR	954,668	983,308	28,640	3%
TOTAL OPERATING EXPENSES	954,668	983,308	28,640	3%
NET OPERATING MARGIN	1,653,676	1,625,036	(28,640)	-2%
OPERATING MARGIN	1,653,676	1,625,036	(28,640)	-2%
NET INCOME	1,653,676	1,625,036	(28,640)	-2%

ADMINISTRATION

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	1,208,228	1,200,192	(8,036)	-1%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	1,208,228	1,200,192	(8,036)	-1%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	33,121	34,114	993	3%
PURCHASED SERVICES	1,183,954	1,183,954	-	0%
REPAIRS AND MAINTENANCE	48,430	48,430	-	0%
OTHER EXPENSE	464,545	489,570	25,025	5%
ALL NON-LABOR	1,730,050	1,756,069	26,019	2%
TOTAL OPERATING EXPENSES	2,938,279	2,956,261	17,982	1%
NET OPERATING MARGIN	(2,938,279)	(2,956,261)	(17,982)	1%
OPERATING MARGIN	(2,938,279)	(2,956,261)	(17,982)	1%
NET INCOME	(2,938,279)	(2,956,261)	(17,982)	1%

ADMISSIONS

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-	-	0%
SALARIES	1,580,027	1,721,044	141,017	9%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	1,580,027	1,721,044	141,017	9%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	12,656	-		
SUPPLIES	68,712	63,674	(5,038)	-7%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	128,088	128,088	-	0%
OTHER EXPENSE	1,068	11,827	10,759	1007%
ALL NON-LABOR	210,524	203,588	(6,936)	-3%
TOTAL OPERATING EXPENSES	1,790,551	1,924,633	134,082	7%
NET OPERATING MARGIN	(1,790,544)	(1,924,633)	(134,089)	7%
OPERATING MARGIN	(1,790,544)	(1,924,633)	(134,089)	7%
NET INCOME	(1,790,544)	(1,924,633)	(134,089)	7%

ANESTHESIA

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	7,471,125	7,471,125	-	0%
SALARIES	30,225	31,131	906	3%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	30,225	31,131	906	3%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	3,061,412	3,061,412		
SUPPLIES	161,064	165,896	4,832	3%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	347	347	-	0%
OTHER EXPENSE	16,856	16,956	100	1%
ALL NON-LABOR	3,239,679	3,244,611	4,932	0%
TOTAL OPERATING EXPENSES	3,269,903	3,275,742	5,839	0%
NET OPERATING MARGIN	4,201,221	4,195,383	(5,838)	0%
OPERATING MARGIN	4,201,221	4,195,383	(5,838)	0%
NET INCOME	4,201,221	4,195,383	(5,838)	0%

BACK TO WORK

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	35,575	35,506	(69)	0%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	35,575	35,506	(69)	0%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	-	-		
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	-	-		
ALL NON-LABOR	-	-		
TOTAL OPERATING EXPENSES	35,575	35,506	(69)	0%
NET OPERATING MARGIN	(35,575)	(35,506)	69	0%
OPERATING MARGIN	(35,575)	(35,506)	69	0%
NET INCOME	(35,575)	(35,506)	69	0%

BLOOD BANK

Account	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	802,522	802,522	-	0%
SALARIES	-	-	-	
BENEFITS	-	-	-	
REGISTRY & CONTRACT	-	-	-	
TOTAL STAFFING EXPENSE	-	-	-	
CONTRACT LABOR	-	-	-	
PROFESSIONAL FEES	-	-	-	
SUPPLIES	430,339	443,250	12,911	3%
PURCHASED SERVICES	-	-	-	
REPAIRS AND MAINTENANCE	-	-	-	
OTHER EXPENSE	-	-	-	
ALL NON-LABOR	430,339	443,250	12,911	3%
TOTAL OPERATING EXPENSES	430,339	443,250	12,911	3%
NET OPERATING MARGIN	372,183	359,273	(12,910)	-3%
OPERATING MARGIN	372,183	359,273	(12,910)	-3%
NET INCOME	372,183	359,273	(12,910)	-3%

CAFETERIA

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	228,808	239,224	10,416	5%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	228,808	239,224	10,416	5%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	391,201	402,937	11,736	3%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	1,700	1,700	100%
OTHER EXPENSE	-	500	500	100%
ALL NON-LABOR	391,201	405,137	13,936	4%
TOTAL OPERATING EXPENSES	620,008	644,361	24,353	4%
NET OPERATING MARGIN	(620,008)	(644,361)	(24,353)	4%
OPERATING MARGIN	(620,008)	(644,361)	(24,353)	4%
NET INCOME	(620,008)	(644,361)	(24,353)	4%

CalAIM

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	231,576	125,405	(106,171)	-46%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	231,576	125,405	(106,171)	-46%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	59	61	2	3%
PURCHASED SERVICES	-	-	-	
REPAIRS AND MAINTENANCE	-	-	-	
OTHER EXPENSE	-	300	300	100%
ALL NON-LABOR	59	361	302	512%
TOTAL OPERATING EXPENSES	231,636	125,766	(105,870)	-46%
NET OPERATING MARGIN	(231,636)	(125,766)	105,870	-46%
OPERATING MARGIN	(231,636)	(125,766)	105,870	-46%
NET INCOME	(231,636)	(125,766)	105,870	-46%

CALEXICO HEALTH CENTER

Account	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	2,674,668	2,674,668	-	0%
SALARIES	882,717	978,203	95,486	11%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	882,717	978,203	95,486	11%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	82,113	84,583	2,470	3%
SUPPLIES	19,448	13,731	(5,717)	-29%
PURCHASED SERVICES	42,869	49,569	6,700	16%
REPAIRS AND MAINTENANCE	23,773	24,490	717	3%
OTHER EXPENSE	295,315	297,686	2,371	1%
ALL NON-LABOR	463,517	470,059	6,542	1%
TOTAL OPERATING EXPENSES	1,346,234	1,448,262	102,028	8%
NET OPERATING MARGIN	1,328,435	1,226,407	(102,028)	-8%
OPERATING MARGIN	1,328,435	1,226,407	(102,028)	-8%
NET INCOME	1,328,435	1,226,407	(102,028)	-8%

CARDIAC CATH SERVICES LAB

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	714,043	714,043		
SALARIES	-	-		
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	-	-		
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	4,396	4,527	131	3%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	199,502	199,502	-	0%
OTHER EXPENSE	-	100,009	100,009	100%
ALL NON-LABOR	203,906	304,038	100,132	49%
TOTAL OPERATING EXPENSES	203,906	304,038	100,132	49%
NET OPERATING MARGIN	510,137	410,005	(100,132)	-20%
OPERATING MARGIN	510,137	410,005	(100,132)	-20%
NET INCOME	510,137	410,005	(100,132)	-20%

CASE MANAGEMENT

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	1,043,342	1,272,065	228,723	22%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	1,043,342	1,272,065	228,723	22%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	93,567	93,567		
SUPPLIES	7,012	7,222	210	3%
PURCHASED SERVICES	-	-	-	
REPAIRS AND MAINTENANCE	110,743	110,743	-	0%
OTHER EXPENSE	34,639	43,239	8,600	25%
ALL NON-LABOR	245,960	254,771	8,811	4%
TOTAL OPERATING EXPENSES	1,289,301	1,526,836	237,535	18%
NET OPERATING MARGIN	(1,289,301)	(1,526,836)	(237,535)	18%
OPERATING MARGIN	(1,289,301)	(1,526,836)	(237,535)	18%
NET INCOME	(1,289,301)	(1,526,836)	(237,535)	18%

CENTRAL SUPPLY

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	2,612,032	2,612,032	-	0%
SALARIES	-	-		
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	-	-		
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	2,529,362	2,491,363	(37,999)	-2%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	147,231	151,231	4,000	3%
ALL NON-LABOR	2,676,593	2,642,595	(33,998)	-1%
TOTAL OPERATING EXPENSES	2,676,593	2,642,595	(33,998)	-1%
NET OPERATING MARGIN	(64,561)	(30,562)	33,999	-53%
OPERATING MARGIN	(64,561)	(30,562)	33,999	-53%
NET INCOME	(64,561)	(30,562)	33,999	-53%

CLINICAL LAB

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	55,741,653	55,741,653	-	0%
SALARIES	2,917,025	3,013,831	96,806	3%
BENEFITS	-	-	-	-
REGISTRY & CONTRACT	-	78,000	78,000	100%
TOTAL STAFFING EXPENSE	2,917,025	3,091,831	174,806	6%
CONTRACT LABOR	-	-	-	-
PROFESSIONAL FEES	90,000	90,000	-	0%
SUPPLIES	2,732,703	2,814,782	82,079	3%
PURCHASED SERVICES	944,250	944,250	-	-
REPAIRS AND MAINTENANCE	46,652	46,652	-	-
OTHER EXPENSE	98,385	101,885	3,500	4%
ALL NON-LABOR	3,911,991	3,997,570	85,579	2%
TOTAL OPERATING EXPENSES	6,829,016	7,089,401	260,385	4%
NET OPERATING MARGIN	48,912,637	48,652,252	(260,385)	-1%
OPERATING MARGIN	48,912,637	48,652,252	(260,385)	-1%
NET INCOME	48,912,637	48,652,252	(260,385)	-1%

CLINICS ADMIN CTR

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-	-	
SALARIES	1,400,632	2,150,576	749,944	54%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	1,400,632	2,150,576	749,944	54%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-	-	
SUPPLIES	8,095	8,338	243	3%
PURCHASED SERVICES	56,613	62,613		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	13,104	42,204	29,100	222%
ALL NON-LABOR	77,811	113,154	35,343	45%
TOTAL OPERATING EXPENSES	1,478,444	2,263,730	785,286	53%
NET OPERATING MARGIN	(1,478,444)	(2,263,730)	(785,286)	53%
OPERATING MARGIN	(1,478,444)	(2,263,730)	(785,286)	53%
NET INCOME	(1,478,444)	(2,263,730)	(785,286)	53%

COMMUNICATIONS

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	290,321	299,030	8,709	3%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	290,321	299,030	8,709	3%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	8,311	8,560	249	3%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	41,890	41,890	-	0%
OTHER EXPENSE	205,414	205,714	300	0%
ALL NON-LABOR	255,616	256,165	549	0%
TOTAL OPERATING EXPENSES	545,936	555,195	9,259	2%
NET OPERATING MARGIN	(545,936)	(555,195)	(9,259)	2%
OPERATING MARGIN	(545,936)	(555,195)	(9,259)	2%
NET INCOME	(545,936)	(555,195)	(9,259)	2%

CT SCANNER

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	77,594,268	77,594,268	-	0%
SALARIES	353,663	364,273	10,610	3%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	353,663	364,273	10,610	3%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-	-	
SUPPLIES	-	-	-	
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	148,713	148,713		
OTHER EXPENSE	33,486	33,486	400	1.2%
ALL NON-LABOR	182,198	182,598	400	0.2%
TOTAL OPERATING EXPENSES	535,862	546,871	11,010	2%
NET OPERATING MARGIN	77,058,407	77,047,697	11,010	0%
OPERATING MARGIN	77,058,407	77,047,697	(11,010)	0%
NET INCOME	77,058,407	77,047,697	(11,010)	0%

C-WHAP CLINIC

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	3,651,631	3,651,631	-	0%
SALARIES	623,980	521,945	(102,035)	-16%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	623,980	521,945	(102,035)	-16%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	923,321	923,321	-	0%
SUPPLIES	108,411	112,306	3,895	4%
PURCHASED SERVICES	5,414	5,414		
REPAIRS AND MAINTENANCE	3,849	3,849		
OTHER EXPENSE	184,129	181,251	(2,878)	-2%
ALL NON-LABOR	1,225,124	1,226,141	1,017	0%
TOTAL OPERATING EXPENSES	1,849,104	1,748,086	(101,018)	-5%
NET OPERATING MARGIN	1,802,527	1,903,545	101,018	6%
OPERATING MARGIN	1,802,527	1,903,545	101,018	6%
NET INCOME	1,802,527	1,903,545	101,018	6%

DAY CARE

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	244,388	254,721	10,333	4%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	244,388	254,721	10,333	4%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	1,654	1,703	49	3%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	733	3,533	2,800	382%
ALL NON-LABOR	2,387	5,236	2,849	119%
TOTAL OPERATING EXPENSES	246,775	259,958	13,183	5%
NET OPERATING MARGIN	(246,775)	(259,958)	(13,183)	5%
OPERATING MARGIN	(246,775)	(259,958)	(13,183)	5%
NET INCOME	(246,775)	(259,958)	(13,183)	5%

DIETARY

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	828,036	852,877	24,841	3%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	828,036	852,877	24,841	3%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	378,442	389,795	11,353	3%
PURCHASED SERVICES	4,444	4,444	-	0%
REPAIRS AND MAINTENANCE	5,320	5,320	-	0%
OTHER EXPENSE	1,338	3,038	1,700	127%
ALL NON-LABOR	389,544	402,597	13,053	3%
TOTAL OPERATING EXPENSES	1,217,580	1,255,474	37,894	3%
NET OPERATING MARGIN	(1,217,580)	(1,255,474)	(37,894)	3%
OPERATING MARGIN	(1,217,580)	(1,255,474)	(37,894)	3%
NET INCOME	(1,217,580)	(1,255,474)	(37,894)	3%

ECHO

	2025 Projected	2026 Budget	Variance \$	Variance \$
GROSS PATIENT REVENUE	2,136,472	2,136,472	-	0%
SALARIES	115,916	121,349	5,433	5%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	115,916	121,349	5,433	5%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	-	-		
PURCHASED SERVICES	-	38,400	38,400	0%
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	1,123	1,523	400	36%
ALL NON-LABOR	1,123	39,923	38,800	3455%
TOTAL OPERATING EXPENSES	117,039	161,272	44,233	38%
NET OPERATING MARGIN	2,019,433	1,975,200	(44,233)	-2%
OPERATING MARGIN	2,019,433	1,975,200	(44,233)	-2%
NET INCOME	2,019,433	1,975,200	(44,233)	-2%

E.E.G.

Account	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	87,008	87,008	-	0%
SALARIES	8,884	10,374	1,490	17%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	8,884	10,374	1,490	17%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	-	-		
PURCHASED SERVICES	57,253	9,180	(48,073)	-84%
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	-	-		
ALL NON-LABOR	57,253	9,180	(48,073)	-84%
TOTAL OPERATING EXPENSES	66,138	19,554	(46,584)	-70%
NET OPERATING MARGIN	20,871	67,454	46,583	223%
OPERATING MARGIN	20,871	67,454	46,583	223%
NET INCOME	20,871	67,454	46,583	223%

E.K.G.

Account	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	4,728,023	4,728,023	-	0%
SALARIES	94,397	94,659	262	0%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	94,397	94,659	262	0%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	294,923	277,709	(17,214)	-6%
SUPPLIES	-	-		
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	-	100	100	100%
ALL NON-LABOR	294,923	277,809	(17,114)	-6%
TOTAL OPERATING EXPENSES	389,320	372,467	(16,853)	-4%
NET OPERATING MARGIN	4,338,703	4,355,556	16,853	0%
OPERATING MARGIN	4,338,703	4,355,556	16,853	0%
NET INCOME	4,338,703	4,355,556	16,853	0%

EMERGENCY ROOM

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	101,027,820	101,027,820	-	0%
SALARIES	6,338,457	6,528,611	190,154	3%
BENEFITS	-	-	-	-
REGISTRY & CONTRACT	44,038	44,038	-	-
TOTAL STAFFING EXPENSE	6,382,495	6,572,649	190,154	3%
CONTRACT LABOR	-	-	-	-
PROFESSIONAL FEES	176,667	176,667	-	-
SUPPLIES	1,004,445	1,034,578	30,133	3%
PURCHASED SERVICES	-	-	-	-
REPAIRS AND MAINTENANCE	60,481	60,481	-	-
OTHER EXPENSE	89,662	109,262	19,600	22%
ALL NON-LABOR	1,331,254	1,380,988	49,734	4%
TOTAL OPERATING EXPENSES	7,713,750	7,953,637	239,887	3%
NET OPERATING MARGIN	93,314,070	93,074,183	(239,887)	0%
OPERATING MARGIN	93,314,070	93,074,183	(239,887)	0%
NET INCOME	93,314,070	93,074,183	(239,887)	0%

EMPLOYEE HEALTH

	2025	2026	
	Projected	Budget	Variance %
			Variance \$
GROSS PATIENT REVENUE	-	-	
SALARIES	197,798	175,977	(21,821)
BENEFITS	-	-	-11%
REGISTRY & CONTRACT	-	-	
TOTAL STAFFING EXPENSE	197,798	175,977	(21,821)
CONTRACT LABOR	-	-	-11%
PROFESSIONAL FEES	-	-	
SUPPLIES	7,299	5,547	(1,752)
PURCHASED SERVICES	(15,992)	21,936	37,928
REPAIRS AND MAINTENANCE	-	-	-24%
OTHER EXPENSE	2,880	2,080	(800)
ALL NON-LABOR	(5,814)	29,563	35,377
TOTAL OPERATING EXPENSES	191,984	205,539	13,555
			7%
NET OPERATING MARGIN	(191,984)	(205,539)	(13,555)
OPERATING MARGIN	(191,984)	(205,539)	(13,555)
NET INCOME	(191,984)	(205,539)	(13,555)
			7%

ENDOSCOPY

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	7,308,000	7,308,000	-	0%
SALARIES	-	-	-	
BENEFITS	-	-	-	
REGISTRY & CONTRACT	-	-	-	
TOTAL STAFFING EXPENSE	-	-	-	
CONTRACT LABOR	-	-	-	
PROFESSIONAL FEES	-	-	-	
SUPPLIES	139,303	143,482	4,179	3%
PURCHASED SERVICES	106	106		
REPAIRS AND MAINTENANCE	-	-	-	
OTHER EXPENSE	195	195	-	0%
ALL NON-LABOR	139,604	143,783	4,179	3%
TOTAL OPERATING EXPENSES	139,604	143,783	4,179	3%
NET OPERATING MARGIN	7,168,396	7,164,217	(4,179)	0%
OPERATING MARGIN	7,168,396	7,164,217	(4,179)	0%
NET INCOME	7,168,396	7,164,217	(4,179)	0%

GASTRO SERVICES

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	203,346	203,346	-	0%
SALARIES	224,842	231,588	6,746	3%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	224,842	231,588	6,746	3%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	532,785	532,785	-	0%
SUPPLIES	11,112	11,446	334	3%
PURCHASED SERVICES	4,498	4,498		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	57,607	58,207	600	1%
ALL NON-LABOR	606,002	606,936	934	0%
TOTAL OPERATING EXPENSES	830,845	838,523	7,678	1%
NET OPERATING MARGIN	(627,498)	(635,177)	(7,679)	1%
OPERATING MARGIN	(627,498)	(635,177)	(7,679)	1%
NET INCOME	(627,498)	(635,177)	(7,679)	1%

GENERAL ACCOUNTING

	2025	2026		
	Projected	Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	744,828	831,315	86,487	12%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	744,828	831,315	86,487	12%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	136,627	136,127	(500)	0%
SUPPLIES	11,253	10,317	(936)	-8%
PURCHASED SERVICES	4,000	4,120	120	3%
REPAIRS AND MAINTENANCE	-	7,700	7,700	100%
OTHER EXPENSE	314,726	322,926	8,200	3%
ALL NON-LABOR	466,606	481,190	14,584	3%
TOTAL OPERATING EXPENSES	1,211,433	1,312,505	101,072	8%
NET OPERATING MARGIN	(1,211,433)	(1,312,505)	(101,072)	8%
OPERATING MARGIN	(1,211,433)	(1,312,505)	(101,072)	8%
NET INCOME	(1,211,433)	(1,312,505)	(101,072)	8%

GOVERNING BOARD

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	351,706	-	(351,706)	-100%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	351,706	-	(351,706)	-100%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	967,707	1,200,000	232,293	24%
SUPPLIES	-	-		
PURCHASED SERVICES	40,267	38,267	(2,000)	-5%
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	39,099	19,834	(19,265)	-49%
ALL NON-LABOR	1,047,073	1,258,101	211,028	20%
TOTAL OPERATING EXPENSES	1,398,779	1,258,101	(140,678)	-10%
NET OPERATING MARGIN	(1,398,779)	(1,258,101)	140,678	-10%
OPERATING MARGIN	(1,398,779)	(1,258,101)	140,678	-10%
NET INCOME	(1,398,779)	(1,258,101)	140,678	-10%

GROUNDS

Account	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	-	-		
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	-	-		
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	3,781	3,894	113	3%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	-	-		
ALL NON-LABOR	3,781	3,894	113	3%
TOTAL OPERATING EXPENSES	3,781	3,894	113	3%
NET OPERATING MARGIN	(3,781)	(3,894)	(113)	3%
OPERATING MARGIN	(3,781)	(3,894)	(113)	3%
NET INCOME	(3,781)	(3,894)	(113)	3%

GYN UNIT

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	13,243	13,243		
SALARIES	790	814	24	3%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	790	814	24	3%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	-	-		
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	-	-		
ALL NON-LABOR	-	-		
TOTAL OPERATING EXPENSES	790	814	24	3%
NET OPERATING MARGIN	12,452	12,429	(23)	0%
OPERATING MARGIN	12,452	12,429	(23)	0%
NET INCOME	12,452	12,429	(23)	0%

HOUSEKEEPING

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	1,700,520	1,742,234	41,714	2%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	1,700,520	1,742,234	41,714	2%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	307,577	316,804	9,227	3%
PURCHASED SERVICES	3,713	3,713	-	0%
REPAIRS AND MAINTENANCE	18,412	18,412	-	0%
OTHER EXPENSE	2,445	6,645	4,200	172%
ALL NON-LABOR	332,147	345,574	13,427	4%
TOTAL OPERATING EXPENSES	2,032,667	2,087,808	55,141	3%
NET OPERATING MARGIN	(2,032,667)	(2,087,808)	(55,141)	3%
OPERATING MARGIN	(2,032,667)	(2,087,808)	(55,141)	3%
NET INCOME	(2,032,667)	(2,087,808)	(55,141)	3%

INTENSIVE CARE

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	8,790,943	8,790,943	-	0%
SALARIES	2,610,892	2,689,219	78,327	3%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	2,610,892	2,689,219	78,327	3%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	302,133	311,197	9,064	3%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	9,670	9,670	-	0%
OTHER EXPENSE	38,016	40,816	2,800	7%
ALL NON-LABOR	349,819	361,683	11,864	3%
TOTAL OPERATING EXPENSES	2,960,711	3,050,902	90,191	3%
NET OPERATING MARGIN	5,830,232	5,740,041	(90,191)	-2%
OPERATING MARGIN	5,830,232	5,740,041	(90,191)	-2%
NET INCOME	5,830,232	5,740,041	(90,191)	-2%

INFECTION CONTROL

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	166,251	179,028	12,777	8%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	166,251	179,028	12,777	8%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	18,667	18,667	-	0%
SUPPLIES	2,490	2,565	75	3%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	2,243	8,387	6,144	274%
ALL NON-LABOR	23,400	29,619	6,219	27%
TOTAL OPERATING EXPENSES	189,651	208,647	18,996	10%
NET OPERATING MARGIN	(189,651)	(208,647)	(18,996)	10%
OPERATING MARGIN	(189,651)	(208,647)	(18,996)	10%
NET INCOME	(189,651)	(208,647)	(18,996)	10%

INFORMATION SYSTEMS

	2025	2026		
	Projected	Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-	-	-
SALARIES	963,960	992,878	28,918	3%
BENEFITS	-	-	-	-
REGISTRY & CONTRACT	-	-	-	-
TOTAL STAFFING EXPENSE	963,960	992,878	28,918	3%
CONTRACT LABOR	-	-	-	-
PROFESSIONAL FEES	-	-	-	-
SUPPLIES	66,146	68,131	1,985	3%
PURCHASED SERVICES	64,969	64,969	-	0%
REPAIRS AND MAINTENANCE	3,920,148	3,920,148	-	0%
OTHER EXPENSE	951,610	952,510	900	0%
ALL NON-LABOR	5,002,873	5,005,758	2,885	0%
TOTAL OPERATING EXPENSES	5,966,833	5,998,636	31,803	1%
NET OPERATING MARGIN	(5,966,833)	(5,998,636)	(31,803)	1%
OPERATING MARGIN	(5,966,833)	(5,998,636)	(31,803)	1%
NET INCOME	(5,966,833)	(5,998,636)	(31,803)	1%

INFUSION THERAPY CENTER

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	498,252	498,252	-	0%
SALARIES	352,314	233,259	(119,055)	-34%
BENEFITS	-	-	-	-
REGISTRY & CONTRACT	-	-	-	-
TOTAL STAFFING EXPENSE	352,314	233,259	(119,055)	-34%
CONTRACT LABOR	-	-	-	-
PROFESSIONAL FEES	-	-	-	-
SUPPLIES	31,631	32,949	1,318	4%
PURCHASED SERVICES	-	-	-	-
REPAIRS AND MAINTENANCE	(300)	-	-	-
OTHER EXPENSE	2,406	2,606	200	8%
ALL NON-LABOR	33,737	35,555	1,818	5%
TOTAL OPERATING EXPENSES	386,051	268,814	(117,237)	-30%
NET OPERATING MARGIN	112,201	229,438	117,237	104%
OPERATING MARGIN	112,201	229,438	117,237	104%
NET INCOME	112,201	229,438	117,237	104%

INSERVICE EDUCATION

Account	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	1,873	1,930	57	3%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	1,873	1,930	57	3%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	8,401	8,653	252	3%
PURCHASED SERVICES	24,907	24,907	-	0%
REPAIRS AND MAINTENANCE	11,802	11,802	-	0%
OTHER EXPENSE	-	100	100	100%
ALL NON-LABOR	45,110	45,462	352	1%
TOTAL OPERATING EXPENSES	46,983	47,391	408	1%
NET OPERATING MARGIN	(46,983)	(47,391)	(408)	1%
OPERATING MARGIN	(46,983)	(47,391)	(408)	1%
NET INCOME	(46,983)	(47,391)	(408)	1%

INTERVENTIONAL RADIOLOGY

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	10,760,155	10,760,155	-	0%
SALARIES	446,501	454,635	8,134	2%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	446,501	454,635	8,134	2%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	640,000	640,000	-	0%
SUPPLIES	313,567	322,974	9,407	3%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	6,015	6,515	500	8%
ALL NON-LABOR	959,582	969,489	9,907	1%
TOTAL OPERATING EXPENSES	1,406,084	1,424,124	18,040	1%
NET OPERATING MARGIN	9,354,071	9,336,031	(18,040)	0%
OPERATING MARGIN	9,354,071	9,336,031	(18,040)	0%
NET INCOME	9,354,071	9,336,031	(18,040)	0%

IVHD (Heffernan)

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-	-	-
PROFESSIONAL FEES	242,307	242,307	-	0%
SUPPLIES	-	-	-	-
PURCHASED SERVICES	163,081	259,441	96,360	59%
REPAIRS AND MAINTENANCE	-	-	-	-
DEPRECIATION AND AMORTIZATION	-	-	-	-
INSURANCE	-	-	-	-
HOSPITALIST FEES AND BENEFITS	-	-	-	-
HOSPITALIST PROGRAM	-	-	-	-
OTHER EXPENSE	1,586	29,276	27,690	1746%
ALL NON-LABOR	406,973	531,023	124,050	30%
TOTAL OPERATING EXPENSES	406,973	531,023	124,050	30%
NET OPERATING MARGIN	(406,973)	(531,023)	(124,050)	30%
OPERATING MARGIN	(406,973)	(531,023)	(124,050)	30%
NET INCOME	(406,973)	(531,023)	(124,050)	30%

LAUNDRY & LINEN

	2025	2026		
	Projected	Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	-	-		
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	-	-		
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	19,360	19,941	581	3%
PURCHASED SERVICES	754,328	754,328	-	0%
REPAIRS AND MAINTENANCE	1,651	1,651	-	0%
OTHER EXPENSE	-	-		
ALL NON-LABOR	775,339	775,920	581	0%
TOTAL OPERATING EXPENSES	775,339	775,920	581	0%
NET OPERATING MARGIN	(775,339)	(775,920)	(581)	0%
OPERATING MARGIN	(775,339)	(775,920)	(581)	0%
NET INCOME	(775,339)	(775,920)	(581)	0%

LDRP

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	30,458,444	30,458,444	-	0%
SALARIES	7,288,313	7,506,962	218,649	3%
BENEFITS	-	-	-	-
REGISTRY & CONTRACT	1,221,204	1,221,204	-	0%
TOTAL STAFFING EXPENSE	8,509,517	8,728,166	218,649	3%
CONTRACT LABOR	-	-	-	-
PROFESSIONAL FEES	841,167	841,167	-	0%
SUPPLIES	1,195,930	1,231,808	35,878	3%
PURCHASED SERVICES	322,600	322,600	-	0%
REPAIRS AND MAINTENANCE	56,898	56,898	-	0%
OTHER EXPENSE	8,850	17,350	8,500	96%
ALL NON-LABOR	2,425,444	2,469,822	44,378	2%
TOTAL OPERATING EXPENSES	10,934,961	11,197,988	263,027	2%
NET OPERATING MARGIN	19,523,483	19,260,456	(263,027)	-1%
OPERATING MARGIN	19,523,483	19,260,456	(263,027)	-1%
NET INCOME	19,523,483	19,260,456	(263,027)	-1%

MED/SURG

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	29,973,881	29,973,881	-	0%
SALARIES	7,833,511	8,068,517	235,006	3%
BENEFITS	-	-		
REGISTRY & CONTRACT	119,298	119,298		
TOTAL STAFFING EXPENSE	7,952,809	8,187,814	235,005	3%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	584,694	602,234	17,540	3%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	7,027	7,027	-	0%
OTHER EXPENSE	45,909	60,709	14,800	32%
ALL NON-LABOR	637,630	669,970	32,340	5%
TOTAL OPERATING EXPENSES	8,590,438	8,857,785	267,347	3%
NET OPERATING MARGIN	21,383,443	21,116,097	(267,346)	-1%
OPERATING MARGIN	21,383,443	21,116,097	(267,346)	-1%
NET INCOME	21,383,443	21,116,097	(267,346)	-1%

MEDICAL RECORDS

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	1,172,756	1,472,689	299,933	26%
BENEFITS	-	-		
REGISTRY & CONTRACT	108,643	106,958	(1,685)	-2%
TOTAL STAFFING EXPENSE	1,281,399	1,579,647	298,248	23%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	15,993	11,688	(4,305)	-27%
PURCHASED SERVICES	89,700	101,513	11,813	13%
REPAIRS AND MAINTENANCE	159,270	159,284	14	0%
OTHER EXPENSE	3,739	9,868	6,129	164%
ALL NON-LABOR	268,702	282,353	13,651	5%
TOTAL OPERATING EXPENSES	1,550,101	1,862,000	311,899	20%
NET OPERATING MARGIN	(1,550,101)	(1,862,000)	(311,899)	20%
OPERATING MARGIN	(1,550,101)	(1,862,000)	(311,899)	20%
NET INCOME	(1,550,101)	(1,862,000)	(311,899)	20%

MEDICAL STAFF

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	233,188	276,432	43,244	19%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	233,188	276,432	43,244	19%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	50,202	63,166	12,964	26%
SUPPLIES	67,964	70,003	2,039	3%
PURCHASED SERVICES	10,850	11,550	700	6%
REPAIRS AND MAINTENANCE	82,260	82,260	-	0%
OTHER EXPENSE	26,003	29,744	3,741	14%
ALL NON-LABOR	237,280	256,724	19,444	8%
TOTAL OPERATING EXPENSES	470,468	533,156	62,688	13%
NET OPERATING MARGIN	(470,468)	(533,156)	(62,688)	13%
OPERATING MARGIN	(470,468)	(533,156)	(62,688)	13%
NET INCOME	(470,468)	(533,156)	(62,688)	13%

M.R.I.

	2025	2026		
	Projected	Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	5,702,513	5,702,513	-	0%
SALARIES	298,524	315,941	17,417	6%
BENEFITS	-	-	-	-
REGISTRY & CONTRACT	-	-	-	-
TOTAL STAFFING EXPENSE	298,524	315,941	17,417	6%
CONTRACT LABOR	-	-	-	-
PROFESSIONAL FEES	-	-	-	-
SUPPLIES	-	-	-	-
PURCHASED SERVICES	-	-	-	-
REPAIRS AND MAINTENANCE	223,499	223,499	-	0%
OTHER EXPENSE	114,395	114,795	400	0%
ALL NON-LABOR	337,895	338,295	400	0%
TOTAL OPERATING EXPENSES	636,419	654,235	17,816	3%
NET OPERATING MARGIN	5,066,094	5,048,277	(17,817)	0%
OPERATING MARGIN	5,066,094	5,048,277	(17,817)	0%
NET INCOME	5,066,094	5,048,277	(17,817)	0%

NEO-NATAL ICU

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	3,468,592	3,468,592	-	0%
SALARIES	1,785,988	1,839,568	53,580	3%
BENEFITS	-	-	-	-
REGISTRY & CONTRACT	111,034	111,034	-	0%
TOTAL STAFFING EXPENSE	1,897,022	1,950,602	53,580	3%
CONTRACT LABOR	-	-	-	-
PROFESSIONAL FEES	-	-	-	-
SUPPLIES	116,278	119,766	3,488	3%
PURCHASED SERVICES	-	-	-	-
REPAIRS AND MAINTENANCE	15,208	15,208	-	0%
OTHER EXPENSE	54,851	68,851	14,000	26%
ALL NON-LABOR	186,336	203,825	17,489	9%
TOTAL OPERATING EXPENSES	2,083,358	2,154,426	71,068	3%
NET OPERATING MARGIN	1,385,234	1,314,166	(71,068)	-5%
OPERATING MARGIN	1,385,234	1,314,166	(71,068)	-5%
NET INCOME	1,385,234	1,314,166	(71,068)	-5%

NUCLEAR MED

Account	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	729,181	729,181	-	0%
SALARIES	58,282	60,030	1,748	3%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	58,282	60,030	1,748	3%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	10,661	11,354	693	7%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	-	100	100	100%
ALL NON-LABOR	10,661	11,454	793	7%
TOTAL OPERATING EXPENSES	68,942	71,484	2,542	4%
NET OPERATING MARGIN	660,239	657,697	(2,542)	0%
OPERATING MARGIN	660,239	657,697	(2,542)	0%
NET INCOME	660,239	657,697	(2,542)	0%

NURSING ADMIN

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	2,329,857	2,229,177	(100,680)	-4%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	2,329,857	2,229,177	(100,680)	-4%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	4,600	4,738	138	3%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	26,454	88,425	61,971	234%
ALL NON-LABOR	31,055	93,163	62,108	200%
TOTAL OPERATING EXPENSES	2,360,912	2,322,340	(38,572)	-2%
NET OPERATING MARGIN	(2,360,912)	(2,322,340)	38,572	-2%
OPERATING MARGIN	(2,360,912)	(2,322,340)	38,572	-2%
NET INCOME	(2,360,912)	(2,322,340)	38,572	-2%

NURSING FLOAT

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-	-	
SALARIES	391,756	403,509	11,753	3%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	391,756	403,509	11,753	3%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	-	-		
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	-	400	400	100%
ALL NON-LABOR	-	400	400	100%
TOTAL OPERATING EXPENSES	391,756	403,909	12,153	3%
NET OPERATING MARGIN	(391,756)	(403,909)	(12,153)	3%
OPERATING MARGIN	(391,756)	(403,909)	(12,153)	3%
NET INCOME	(391,756)	(403,909)	(12,153)	3%

PAIN MANAGEMENT

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	4,531	4,531	-	0%
SALARIES	-	-		
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	-	-		
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	156,777	156,777	-	0%
SUPPLIES	-	-		
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	-	-		
ALL NON-LABOR	156,777	156,777	-	0%
TOTAL OPERATING EXPENSES	156,777	156,777	-	0%
NET OPERATING MARGIN	(152,246)	(152,246)	-	0%
OPERATING MARGIN	(152,246)	(152,246)	-	0%
NET INCOME	(152,246)	(152,246)	-	0%

PATHOLOGY LAB

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	1,723,361	1,723,361	-	0%
SALARIES	158,452	164,901	6,449	4%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	158,452	164,901	6,449	4%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	53,550	55,156	1,606	3%
PURCHASED SERVICES	108,593	108,593	-	0%
REPAIRS AND MAINTENANCE	(3,033)	(3,033)	-	0%
OTHER EXPENSE	2,360	2,660	300	13%
ALL NON-LABOR	161,471	163,377	1,906	1%
TOTAL OPERATING EXPENSES	319,923	328,278	8,355	3%
NET OPERATING MARGIN	1,403,438	1,395,083	(8,355)	-1%
OPERATING MARGIN	1,403,438	1,395,083	(8,355)	-1%
NET INCOME	1,403,438	1,395,083	(8,355)	-1%

PATIENT ACCOUNTING

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE				
SALARIES	1,453,374	1,610,520	157,146	11%
BENEFITS	-	-	-	
REGISTRY & CONTRACT	-	-	-	
TOTAL STAFFING EXPENSE	1,453,374	1,610,520	157,146	11%
CONTRACT LABOR	-	-	-	
PROFESSIONAL FEES	-	-	-	
SUPPLIES	15,859	16,222	363	2%
PURCHASED SERVICES	648,593	648,593	-	0%
REPAIRS AND MAINTENANCE	15,250	15,250	-	0%
OTHER EXPENSE	95,432	106,140	10,708	11%
ALL NON-LABOR	775,134	783,625	8,491	1%
TOTAL OPERATING EXPENSES	2,228,508	2,394,146	165,638	7%
NET OPERATING MARGIN	(2,228,508)	(2,394,146)	(165,638)	7%
OPERATING MARGIN	(2,228,508)	(2,394,146)	(165,638)	7%
NET INCOME	(2,228,508)	(2,394,146)	(165,638)	7%

PCHC (PEDS ON MAIN)

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	1,839,166	1,839,166	-	0%
SALARIES	651,576	671,469	19,893	3%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	651,576	671,469	19,893	3%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	511,188	580,262	69,074	14%
SUPPLIES	91,007	90,736	(271)	0%
PURCHASED SERVICES	3,995	4,114	119	3%
REPAIRS AND MAINTENANCE	6,161	6,321	160	3%
OTHER EXPENSE	205,680	203,587	(2,093)	-1%
ALL NON-LABOR	818,030	885,018	66,988	8%
TOTAL OPERATING EXPENSES	1,469,607	1,556,487	86,880	6%
NET OPERATING MARGIN	369,560	282,679	(86,881)	-24%
OPERATING MARGIN	369,560	282,679	(86,881)	-24%
NET INCOME	369,560	282,679	(86,881)	-24%

PEDIATRICS

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	1,983,089	1,983,089	-	0%
SALARIES	861,402	887,244	25,842	3%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	861,402	887,244	25,842	3%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	48,070	49,513	1,443	3%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-	-	0%
OTHER EXPENSE	29	829	800	2759%
ALL NON-LABOR	48,099	50,341	2,242	5%
TOTAL OPERATING EXPENSES	909,501	937,585	28,084	3%
NET OPERATING MARGIN	1,073,589	1,045,504	(28,085)	-3%
OPERATING MARGIN	1,073,589	1,045,504	(28,085)	-3%
NET INCOME	1,073,589	1,045,504	(28,085)	-3%

PERSONNEL

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	935,657	799,829	(135,828)	-15%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	935,657	799,829	(135,828)	-15%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	23,153	6,337	(16,816)	-73%
PURCHASED SERVICES	313,296	313,296	-	0%
REPAIRS AND MAINTENANCE	26,452	26,452	-	0%
OTHER EXPENSE	25,212	9,339	(15,873)	-63%
ALL NON-LABOR	388,113	355,424	(32,689)	-8%
TOTAL OPERATING EXPENSES	1,323,770	1,155,252	(168,518)	-13%
NET OPERATING MARGIN	(1,323,770)	(1,155,252)	168,518	-13%
OPERATING MARGIN	(1,323,770)	(1,155,252)	168,518	-13%
NET INCOME	(1,323,770)	(1,155,252)	168,518	-13%

PHARMACY EXPENSES

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	46,177,595	46,177,595	-	0%
SALARIES	2,140,007	2,261,244	121,237	6%
BENEFITS	-	-	-	-
REGISTRY & CONTRACT	-	-	-	-
TOTAL STAFFING EXPENSE	2,140,007	2,184,408	44,401	2%
CONTRACT LABOR	-	-	-	-
PROFESSIONAL FEES	-	-	-	-
SUPPLIES	2,957,093	3,156,787	199,694	7%
PURCHASED SERVICES	159,895	159,895	-	0%
REPAIRS AND MAINTENANCE	2,667	2,667	-	0%
OTHER EXPENSE	455,273	461,133	5,860	1%
ALL NON-LABOR	3,574,928	3,780,482	205,554	6%
TOTAL OPERATING EXPENSES	5,714,935	5,964,890	249,955	4%
NET OPERATING MARGIN	(40,462,660)	(40,212,705)	249,955	-1%
OPERATING MARGIN	(40,462,660)	(40,212,705)	249,955	-1%
NET INCOME	(40,462,660)	(40,212,705)	249,955	-1%

PHYSICAL THERAPY

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	2,627,114	2,627,114	-	0%
SALARIES	796,101	828,359	32,258	4%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	796,101	828,359	32,258	4%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	4,816	4,011	(805)	-17%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	98,574	103,754	5,180	5%
ALL NON-LABOR	103,390	107,764	4,374	4%
TOTAL OPERATING EXPENSES	899,491	936,123	36,632	4%
NET OPERATING MARGIN	1,727,623	1,690,990	(36,633)	-2%
OPERATING MARGIN	1,727,623	1,690,990	(36,633)	-2%
NET INCOME	1,727,623	1,690,990	(36,633)	-2%

PIONEERS HEALTH CENTER

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	8,194,677	8,194,677	-	0%
SALARIES	1,658,941	1,467,255	(191,686)	-12%
BENEFITS	-	-	-	-
REGISTRY & CONTRACT	-	-	-	-
TOTAL STAFFING EXPENSE	1,658,941	1,467,255	(191,686)	-12%
CONTRACT LABOR	-	-	-	-
PROFESSIONAL FEES	1,217,224	1,217,224	-	0%
SUPPLIES	80,130	82,534	2,404	3%
PURCHASED SERVICES	11,048	11,348	300	3%
REPAIRS AND MAINTENANCE	23,280	23,280	-	0%
OTHER EXPENSE	299,538	299,599	61	0%
ALL NON-LABOR	1,631,220	1,621,662	(9,558)	-1%
TOTAL OPERATING EXPENSES	3,290,161	3,088,917	(201,244)	-6%
NET OPERATING MARGIN	4,904,517	5,105,761	201,244	4%
OPERATING MARGIN	4,904,517	5,105,761	201,244	4%
NET INCOME	4,904,517	5,105,761	201,244	4%

PLANT MAINTENANCE

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	1,211,012	1,264,896	53,884	4%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	1,211,012	1,264,896	53,884	4%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	375,297	386,556	11,259	3%
PURCHASED SERVICES	49,934	49,934	-	0%
REPAIRS AND MAINTENANCE	848,223	848,223	-	0%
OTHER EXPENSE	213,116	213,116	-	0%
ALL NON-LABOR	1,486,570	1,497,829	11,259	1%
TOTAL OPERATING EXPENSES	2,697,582	2,762,725	65,143	2%
NET OPERATING MARGIN	(2,697,582)	(2,762,725)	(65,143)	2%
OPERATING MARGIN	(2,697,582)	(2,762,725)	(65,143)	2%
NET INCOME	(2,697,582)	(2,762,725)	(65,143)	2%

PLANT OPERATIONS

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	-	-		
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	-	-		
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	-	-		
PURCHASED SERVICES	71,148	71,148	-	0%
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	2,092,731	2,137,325	44,594	2%
ALL NON-LABOR	2,163,879	2,208,472	44,593	2%
TOTAL OPERATING EXPENSES	2,163,879	2,208,472	44,593	2%
NET OPERATING MARGIN	(2,163,879)	(2,208,472)	(44,593)	2%
OPERATING MARGIN	(2,163,879)	(2,208,472)	(44,593)	2%
NET INCOME	(2,163,879)	(2,208,472)	(44,593)	2%

PRIME

Account	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	64,805	58,842	(5,963)	-9%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	64,805	58,842	(5,963)	-9%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	105	-	(105)	-100%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	3,297	2,500	(797)	-24%
ALL NON-LABOR	3,402	2,500	(902)	-27%
TOTAL OPERATING EXPENSES	68,207	61,343	(6,864)	-10%
NET OPERATING MARGIN	(68,207)	(61,343)	6,864	-10%
OPERATING MARGIN	(68,207)	(61,343)	6,864	-10%
NET INCOME	(68,207)	(61,343)	6,864	-10%

PUBLIC RELATIONS

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	106,892	112,985	6,093	6%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	106,892	112,985	6,093	6%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	15,417	15,880	463	3%
PURCHASED SERVICES	217,878	217,878	-	0%
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	4,255	4,255	-	0%
ALL NON-LABOR	237,550	238,013	463	0%
TOTAL OPERATING EXPENSES	344,442	350,997	6,555	2%
NET OPERATING MARGIN	(344,442)	(350,997)	(6,555)	2%
OPERATING MARGIN	(344,442)	(350,997)	(6,555)	2%
NET INCOME	(344,442)	(350,997)	(6,555)	2%

PULMONARY LAB

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	22,316	22,316	-	0%
SALARIES	2,615	2,738	123	5%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	2,615	2,738	123	5%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	72	74	2	3%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	-	-		
ALL NON-LABOR	72	74	2	3%
TOTAL OPERATING EXPENSES	2,687	2,812	125	5%
NET OPERATING MARGIN	19,628	19,504	(124)	-1%
OPERATING MARGIN	19,628	19,504	(124)	-1%
NET INCOME	19,628	19,504	(124)	-1%

PURCHASING

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	409,283	574,979	165,696	40%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	409,283	574,979	165,696	40%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	6,202	6,288	86	1%
PURCHASED SERVICES	107,451	107,451	-	0%
REPAIRS AND MAINTENANCE	7,826	8,026	200	3%
OTHER EXPENSE	206,181	211,423	5,242	3%
ALL NON-LABOR	327,660	333,189	5,529	2%
TOTAL OPERATING EXPENSES	736,944	908,167	171,223	23%
NET OPERATING MARGIN	(736,944)	(908,167)	(171,223)	23%
OPERATING MARGIN	(736,944)	(908,167)	(171,223)	23%
NET INCOME	(736,944)	(908,167)	(171,223)	23%

QUALITY RESOURCE

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	249,050	550,994	301,944	121%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	249,050	550,994	301,944	121%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	5,563	5,729	166	3%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	2,972	3,372	400	13%
ALL NON-LABOR	8,534	9,101	567	7%
TOTAL OPERATING EXPENSES	257,584	560,095	302,511	117%
NET OPERATING MARGIN	(257,584)	(560,095)	(302,511)	117%
OPERATING MARGIN	(257,584)	(560,095)	(302,511)	117%
NET INCOME	(257,584)	(560,095)	(302,511)	117%

RADIO ROOM

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	544,814	561,158	16,344	3%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	544,814	561,158	16,344	3%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	10,667	10,667	-	0%
SUPPLIES	1,612	1,661	49	3%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	-	600	600	100%
ALL NON-LABOR	12,279	12,927	648	5%
TOTAL OPERATING EXPENSES	557,093	574,086	16,993	3%
NET OPERATING MARGIN	(557,093)	(574,086)	(16,993)	3%
OPERATING MARGIN	(557,093)	(574,086)	(16,993)	3%
NET INCOME	(557,093)	(574,086)	(16,993)	3%

RADIOLOGY

Account	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	18,908,897	18,908,897	-	0%
SALARIES	1,624,830	1,673,575	48,745	3%
BENEFITS	-	-	-	-
REGISTRY & CONTRACT	132,006	132,006	-	-
TOTAL STAFFING EXPENSE	1,756,835	1,805,580	48,745	3%
CONTRACT LABOR	-	-	-	-
PROFESSIONAL FEES	1,621,065	1,621,065	-	0%
SUPPLIES	556,467	579,884	23,417	4%
PURCHASED SERVICES	16,476	16,476	-	0%
REPAIRS AND MAINTENANCE	625,007	820,007	195,000	31%
OTHER EXPENSE	51,041	56,423	5,382	11%
ALL NON-LABOR	2,870,057	3,093,856	223,799	8%
TOTAL OPERATING EXPENSES	4,626,893	4,899,436	272,543	6%
NET OPERATING MARGIN	14,282,005	14,009,461	(272,544)	-2%
OPERATING MARGIN	14,282,005	14,009,461	(272,544)	-2%
NET INCOME	14,282,005	14,009,461	(272,544)	-2%

RECOVERY

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	9,609,516	9,609,516	-	0%
SALARIES	2,272,477	2,340,651	68,174	3%
BENEFITS	-	-	-	-
REGISTRY & CONTRACT	-	-	-	-
TOTAL STAFFING EXPENSE	2,272,477	2,340,651	68,174	3%
CONTRACT LABOR	-	-	-	-
PROFESSIONAL FEES	-	-	-	-
SUPPLIES	43,994	45,314	1,320	3%
PURCHASED SERVICES	-	-	-	-
REPAIRS AND MAINTENANCE	-	-	-	-
OTHER EXPENSE	-	2,600	2,600	100%
ALL NON-LABOR	43,994	47,914	3,920	9%
TOTAL OPERATING EXPENSES	2,316,471	2,388,565	72,094	3%
NET OPERATING MARGIN	7,293,045	7,220,951	(72,094)	-1%
OPERATING MARGIN	7,293,045	7,220,951	(72,094)	-1%
NET INCOME	7,293,045	7,220,951	(72,094)	-1%

RESPIRATORY THERAPY

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	9,568,279	9,568,279	-	0%
SALARIES	1,154,173	1,321,995	167,822	15%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	1,154,173	1,321,995	167,822	15%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	109,333	135,273	25,940	24%
SUPPLIES	286,739	292,336	5,597	2%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	72,418	57,051	(15,367)	-21%
OTHER EXPENSE	25,302	37,399	12,097	48%
ALL NON-LABOR	493,792	522,060	28,268	6%
TOTAL OPERATING EXPENSES	1,647,965	1,844,054	196,089	12%
NET OPERATING MARGIN	7,920,313	7,724,225	(196,088)	-2%
OPERATING MARGIN	7,920,313	7,724,225	(196,088)	-2%
NET INCOME	7,920,313	7,724,225	(196,088)	-2%

RISK MANAGEMENT

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	114,043	117,464	3,421	3%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	114,043	117,464	3,421	3%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-	-	
SUPPLIES	-	-	-	
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	(127,161)	15,211	142,372	-112%
ALL NON-LABOR	(127,161)	15,211	142,372	-112%
TOTAL OPERATING EXPENSES	(13,118)	132,675	145,793	-1111%
NET OPERATING MARGIN	13,118	(132,675)	(145,793)	-1111%
OPERATING MARGIN	13,118	(132,675)	(145,793)	-1111%
NET INCOME	13,118	(132,675)	(145,793)	-1111%

SECURITY

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	63,185	65,080	1,895	3%
BENEFITS	-	-		
REGISTRY & CONTRACT	529,548	553,563	24,015	5%
TOTAL STAFFING EXPENSE	592,733	618,643	25,910	4%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	8,211	8,458	247	3%
PURCHASED SERVICES	267	267	-	0%
REPAIRS AND MAINTENANCE	1,250	1,250	-	0%
OTHER EXPENSE	4,390	4,490	100	2%
ALL NON-LABOR	14,118	14,465	347	2%
TOTAL OPERATING EXPENSES	606,851	633,108	26,257	4%
NET OPERATING MARGIN	(606,851)	(633,108)	(26,257)	4%
OPERATING MARGIN	(606,851)	(633,108)	(26,257)	4%
NET INCOME	(606,851)	(633,108)	(26,257)	4%

SKILLED NURSING SERVICES

	2025 Projected	2026 Budget	Var \$	Var %
GROSS PATIENT REVENUE	25,705,783	25,705,783	-	0%
SALARIES	6,822,707	7,027,388	204,681	3%
BENEFITS	-	-		
REGISTRY & CONTRACT	112,775	112,775		
TOTAL STAFFING EXPENSE	6,935,481	7,140,163	204,682	3%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	55,400	55,400	-	0%
SUPPLIES	771,272	794,410	23,138	3%
PURCHASED SERVICES	1,090,827	1,090,827	-	0%
REPAIRS AND MAINTENANCE	55,383	55,383	-	0%
OTHER EXPENSE	2,008,931	2,070,202	61,271	3%
ALL NON-LABOR	4,010,029	4,094,437	84,408	2%
TOTAL OPERATING EXPENSES	10,945,510	11,234,600	289,090	3%
NET OPERATING MARGIN	14,760,273	14,471,183	(289,090)	-2%
OPERATING MARGIN	14,760,273	14,471,183	(289,090)	-2%
NET INCOME	14,760,273	14,471,183	(289,090)	-2%

SPECIALTY CENTER AT PIONEERS

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	211	-	(211)	-100%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	211	-	(211)	-100%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	-	-		
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	885	-	(885)	-100%
OTHER EXPENSE	64,192	64,192	-	0%
ALL NON-LABOR	65,077	64,192	(885)	-1%
TOTAL OPERATING EXPENSES	65,288	64,192	(1,096)	-2%
NET OPERATING MARGIN	(65,288)	(64,192)	1,096	-2%
OPERATING MARGIN	(65,288)	(64,192)	1,096	-2%
NET INCOME	(65,288)	(64,192)	1,096	-2%

SPEECH THERAPY

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	421,558	421,558	-	0%
SALARIES	81,768	141,981	60,213	74%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	81,768	141,981	60,213	74%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	83	-	(83)	-100%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	-	100	100	100%
ALL NON-LABOR	83	100	17	20%
TOTAL OPERATING EXPENSES	81,850	142,081	60,231	74%
NET OPERATING MARGIN	339,708	279,477	(60,231)	-18%
OPERATING MARGIN	339,708	279,477	(60,231)	-18%
NET INCOME	339,708	279,477	(60,231)	-18%

STERILE PROCESSING

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	-	-		
SALARIES	392,839	400,975	8,136	2%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	392,839	400,975	8,136	2%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	137,017	141,242	4,225	3%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	54,627	54,627	-	0%
OTHER EXPENSE	6,926	7,926	1,000	14%
ALL NON-LABOR	198,569	203,794	5,225	3%
TOTAL OPERATING EXPENSES	591,409	604,769	13,360	2%
NET OPERATING MARGIN	(591,409)	(604,769)	(13,360)	2%
OPERATING MARGIN	(591,409)	(604,769)	(13,360)	2%
NET INCOME	(591,409)	(604,769)	(13,360)	2%

SURGERY

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	28,340,516	28,340,516	-	0%
SALARIES	2,404,929	2,477,077	72,148	3%
BENEFITS	-	-	-	-
REGISTRY & CONTRACT	-	-	-	-
TOTAL STAFFING EXPENSE	2,404,929	2,477,077	72,148	3%
CONTRACT LABOR	-	-	-	-
PROFESSIONAL FEES	1,353,394	1,353,394	-	0%
SUPPLIES	3,069,142	3,161,216	92,074	3%
PURCHASED SERVICES	66,000	66,000	-	0%
REPAIRS AND MAINTENANCE	296,056	296,056	-	0%
OTHER EXPENSE	393,096	413,186	20,090	5%
ALL NON-LABOR	5,177,687	5,289,852	112,165	2%
TOTAL OPERATING EXPENSES	7,582,616	7,766,929	184,313	2%
NET OPERATING MARGIN	20,757,900	20,573,588	(184,312)	-1%
OPERATING MARGIN	20,757,900	20,573,588	(184,312)	-1%
NET INCOME	20,757,900	20,573,588	(184,312)	-1%

SURGICAL HEALTH AT PIONEERS

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	414,526	414,526	-	0%
SALARIES	88,842	94,499	5,657	6%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	88,842	94,499	5,657	6%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	1,052,760	1,052,760	-	0%
SUPPLIES	4,973	5,123	150	3%
PURCHASED SERVICES	4,935	4,935	-	0%
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	66,285	66,485	200	0.3%
ALL NON-LABOR	1,128,953	1,129,302	349	0%
TOTAL OPERATING EXPENSES	1,217,795	1,223,801	6,006	0%
NET OPERATING MARGIN	(803,269)	(809,275)	(6,006)	1%
OPERATING MARGIN	(803,269)	(809,275)	(6,006)	1%
NET INCOME	(803,269)	(809,275)	(6,006)	1%

ULTRASOUND

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	9,014,637	9,014,637	-	0%
SALARIES	819,771	865,454	45,683	6%
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	819,771	865,454	45,683	6%
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	-	-		
SUPPLIES	29,863	30,759	896	3%
PURCHASED SERVICES	-	-		
REPAIRS AND MAINTENANCE	40,687	40,687	-	0%
OTHER EXPENSE	187	987	800	428%
ALL NON-LABOR	70,737	72,433	1,696	2%
TOTAL OPERATING EXPENSES	890,509	937,888	47,379	5%
NET OPERATING MARGIN	8,124,129	8,076,750	(47,379)	-1%
OPERATING MARGIN	8,124,129	8,076,750	(47,379)	-1%
NET INCOME	8,124,129	8,076,750	(47,379)	-1%

UROLOGY

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	2,652,642	2,652,642	-	0%
SALARIES	419,900	445,888	25,988	6%
BENEFITS	-	-	-	-
REGISTRY & CONTRACT	-	-	-	-
TOTAL STAFFING EXPENSE	419,900	445,888	25,988	6%
CONTRACT LABOR	-	-	-	-
PROFESSIONAL FEES	518,963	518,963	-	0%
SUPPLIES	91,235	95,616	4,381	5%
PURCHASED SERVICES	8,482	8,482	-	0%
REPAIRS AND MAINTENANCE	3,174	3,174	-	0%
OTHER EXPENSE	73,992	74,592	600	1%
ALL NON-LABOR	695,846	700,827	4,981	1%
TOTAL OPERATING EXPENSES	1,115,746	1,146,715	30,969	3%
NET OPERATING MARGIN	1,536,896	1,505,927	(30,969)	-2%
OPERATING MARGIN	1,536,896	1,505,927	(30,969)	-2%
NET INCOME	1,536,896	1,505,927	(30,969)	-2%

VASCULAR ACCESS CENTER

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	172,531	172,531	-	0%
SALARIES	-	-		
BENEFITS	-	-		
REGISTRY & CONTRACT	-	-		
TOTAL STAFFING EXPENSE	-	-		
CONTRACT LABOR	-	-		
PROFESSIONAL FEES	470,121	470,121	-	0%
SUPPLIES	-	-		
PURCHASED SERVICES	22,133	22,133	-	0%
REPAIRS AND MAINTENANCE	-	-		
OTHER EXPENSE	62,545	62,624	79	0%
ALL NON-LABOR	554,799	554,878	79	0%
TOTAL OPERATING EXPENSES	554,799	554,878	79	0%
NET OPERATING MARGIN	(382,268)	(382,347)	(79)	0%
OPERATING MARGIN	(382,268)	(382,347)	(79)	0%
NET INCOME	(382,268)	(382,347)	(79)	0%

WHAP

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	1,156,422	1,156,422	-	0%
SALARIES	580,292	722,569	142,277	25%
BENEFITS	-	-	-	-
REGISTRY & CONTRACT	-	-	-	-
TOTAL STAFFING EXPENSE	580,292	722,569	142,277	25%
CONTRACT LABOR	-	-	-	-
PROFESSIONAL FEES	93,862	93,862	-	0%
SUPPLIES	42,082	43,345	1,263	3%
PURCHASED SERVICES	1,956	1,956	-	0%
REPAIRS AND MAINTENANCE	8,273	8,273	-	0%
OTHER EXPENSE	123,479	123,549	70	0%
ALL NON-LABOR	269,652	267,336	(2,316)	-1%
TOTAL OPERATING EXPENSES	849,944	989,905	139,961	16%
NET OPERATING MARGIN	306,478	166,517	(139,961)	-46%
OPERATING MARGIN	306,478	166,517	(139,961)	-46%
NET INCOME	306,478	166,517	(139,961)	-46%

WOUNDCARE

	2025 Projected	2026 Budget	Variance \$	Variance %
GROSS PATIENT REVENUE	3,549,199	3,549,199	-	0%
SALARIES	266,613	296,275	29,662	11%
BENEFITS	-	-	-	-
REGISTRY & CONTRACT	-	-	-	-
TOTAL STAFFING EXPENSE	266,613	296,275	29,662	11%
CONTRACT LABOR	-	-	-	-
PROFESSIONAL FEES	586,867	586,867	-	0%
SUPPLIES	58,851	61,039	2,188	4%
PURCHASED SERVICES	2,003	2,003	-	0%
REPAIRS AND MAINTENANCE	9,964	9,964	-	0%
OTHER EXPENSE	120,501	120,801	300	0%
ALL NON-LABOR	778,185	780,674	2,489	0%
TOTAL OPERATING EXPENSES	1,044,798	1,076,949	32,151	3%
NET OPERATING MARGIN	2,504,401	2,472,250	(32,151)	-1%
OPERATING MARGIN	2,504,401	2,472,250	(32,151)	-1%
NET INCOME	2,504,401	2,472,250	(32,151)	-1%

IVHD - PMH Capital Budget
Fiscal Years
2026, 2027, 2028

Dept	Dept #	Project Name	Justification Code	Cost of equipment	Quantity	Comments	FY 2026	FY 2027	FY 2028
Hospital Wide		BD Alaris Pumps	OB	\$742,876	1	BD Alaris PC unit 111, pump module 224 syringe module 15 pca module 6 and EtCO@2module 6	\$742,876		
Hospital Wide		Defibrillators	OB	\$30,000	20	Defibrillators are lifesaving equipment used during emergency codes throughout the hospital; all crash carts have them.		\$600,000	
ICU	6010	GE Ultrasound	OB	\$54,846	1	Dr. Krutzik is requesting to replace the ultrasound we currently have because the equipment is obsolete and does not work properly. He needs the US for the proper care of critical patients in the ICU.	\$54,846		
ICU	6010	C-MAC	PS	\$12,560	1	Dr. Krutzik is requesting the purchase of C-MAC to able to perform safe intubation on patients that require mechanical ventilation	\$12,560		
ICU	6010	ENTRAFLO H20 Feeding Pumps	OB	\$1,555	10	Need to replace current pumps which will no longer have feeding sets available for sale	\$15,555		
Peds	6290	Phototherapy System	OB	\$10,656	1	To replace old phototherapy system that is retired and no longer supported (needed ASAP)	\$10,656		
NICU	6070	Transport Isolette	RG/PS	\$16,235	1	Required for inter-departmental transport of newborns (i.e. transport from ER to NICU)	\$16,235		
NICU	6070	GE cardiac monitors	RG	\$17,693	4	Will add 4 NICU beds to accommodate trending increase in acuity & census		\$70,771	
Med/Surg	6170	ENTRAFLO H20 Feeding Pumps	OB	\$1,555	10	Need to replace current pumps which will no longer have feeding sets available for sale	\$15,555		
Med/Surg	6170	Welch Allyn Vital signs monitors	PS	\$3,995	3	We need 2 vital sign machines, Some DOU rooms do not have a vital sign machine	\$11,984		
Med/Surg	6170	Bladder Scanner	OB	\$11,400	1	The bladder scanner series 700 is no longer supported; need to replace with new bladder scanner	\$11,400		
Med/Surg	6170	Hill-Rom beds	PS	\$15,292	2	We need to replace old beds that keep breaking; we have a need for beds with bed alarm so we can keep patients safe	\$30,583	\$30,583	\$30,583
Med/Surg	6170	Overbed Tables	OB	\$397	15	Need to replace old overbed tables, too old and coming apart	\$5,953		
LDRP	6400	HALO Bassinets- 3960	PS	\$4,670	10	The current cribs we have are old and impractical for mothers in recovery. They are made of wood which makes them difficult to sanitize properly. These new cribs would also help facilitate a safer environment for mothers/infants in our care	\$46,700		
LDRP	6400	Steris 5095 Surgical Set up		\$53,429	2	Our current OR beds constantly need to be repaired. The mattresses are torn.	\$106,858		
LDRP	6400	Affinity 4 Birthing beds	PS	\$11,007	2	Requesting 3 more labor beds due to our increase in census	\$22,014		
LDRP	6400	ALSO course for preceptors	PS	\$815	12	Requesting to send Precepting nurses to receive specialized training for OB emergencies, given our increased acuity of patients.	\$9,780		

IVHD - PMH Capital Budget
Fiscal Years
2026, 2027, 2028

Dept	Dept #	Project Name	Justification Code	Cost of equipment	Quantity	Comments	FY 2026	FY 2027	FY 2028
LDRP	6400	Drager Bilirubin Meters	PS	\$13,402	1	Currently only one Bili Meter works. They are constantly being calibrated and this is causing unnecessary lab draws because readings are inaccurate	\$13,402		
LDRP	6400	Sleeper Chairs		\$1,775	5	We don't have enough sleeper beds for the support person in couplet care	\$8,873		
ER	7010	Zebra BCMA Scanner	PS	\$1,000	10	Several scanners are not compatible with medication scanning	\$10,000		
ER	7010	Base Station Radio Installation	OB	\$7,500	1	Current base station radio is obsolete. New radio and handsets have been purchased but installation was not included.	\$7,500		
ER	7010	Stryker ER Gurneys	PS, OB	\$7,333	3	Grand total \$22,000	\$22,000		
ER	7010	Welch Allyn Vital signs monitor	PS, OB	\$4,000	2	Grand total \$12,000	\$8,000		
ER	7010	Bladder Scanner	OB	\$11,400	1	The bladder scanner is obsolete and unreliable; replacement is needed to maintain quality care	\$11,400		
ER	7010	ER Flooring	PS, RG	\$66,000	1	New flooring required for infection control. Can't patch cracks and holes; is an infection control risk.	\$66,000		
LAB	7500	Biosafety Cabinet BSL Class II	RG, PS	\$30,000	1	Current BSL Cabinet is defective; Lab staff needs protection when processing microbiology samples	\$30,000		
LAB	7500	Carbon Dioxide Incubator	RG,OB, PS	\$8,000	1	Needed to properly grow anaerobic organisms isolated from cultures.	\$8,000		
LAB	7500	Double Door Refrigerator	RG, PS, OB, NSR	\$20,000	1	Lab needs more storage for additional reagents; old fridge also goes out of temp randomly	\$20,000		
LAB	7500	Microscope	PY, PS, RG	\$11,036	1	Needed to perform microscopic examination in the Urinalysis area; currently sharing with Hematology	\$11,036		
PATHOLOGY	7520	Tissue Processor	PY,OB	\$80,000	1	Current processor in use is showing signs of 'end of life'	\$80,000		
PATHOLOGY	7520	Cyostat	PS, OB, RG	\$29,899	1	Current one in use is broken, no longer covered by service agreement due to age of equipment.	\$29,899		
Ultrasound	7670	Ultrasound Machine	PY	\$104,785	2	This equipment, now thirteen years old, is in need of an upgrade to keep pace with advancing technology. By investing in newer and faster equipment, we can significantly enhance our ultrasound throughput, leading to improved efficiency and better patient care.	\$104,785	\$104,785	

IVHD - PMH Capital Budget
Fiscal Years
2026, 2027, 2028

Dept	Dept #	Project Name	Justification Code	Cost of equipment	Quantity	Comments	FY 2026	FY 2027	FY 2028
Radiology	7630	Radiographic/Fluoroscopic Equip	OB,PY	\$550,000	1	Due to its age, the equipment in the Indio Room is 15 years old and runs unsupported software. Additionally, parts for this machine are no longer being manufactured. Our only fluoroscopic room desperately needs updating. The image quality on this unit is inadequate for the type of studies our radiologists are currently performing. This will be our fifth submission for this item. Services that may be affected in case this machine fails include Modified Barium Swallow, Barium Enemas, and other common fluoroscopic procedures		\$550,000	
Ultrasound	7670	Ultrasound bed	PS	\$12,000	1	Added a new bay in ultrasound suite, but we are borrowing bed, from other department.	\$12,000		
CT	7680	Construction for CT Machine	RG	\$100,000	1	Construction needed for HCAI CT permit	\$100,000		
Cardiopulmonary	7720	Adult Ventilators Hamilton C1	OB	\$22,407	8	Replacement for End of Life Philips Respironics V60s : Request 10 Hamilton C1 ventilators to replace our end of life Philips V60 NIV machines (BIPAP/CPAP/HFT). The Hamilton C1s, for use on pediatrics to adults patients, with several modes including High Flow Therapy (HFT), NIV (BIPAP/CPAP), and also used as transport ventilator for intubated patients. They have an internal battery, for safely moving patients between departments.	\$179,256	\$44,814	
Cardiopulmonary	7720	Comprehensive Ventilators Hamilton C6	OB	\$43,223	3	Replacement for End of Life PB 840s : Request five Hamilton C1 ventilators to replace our old PB 840 models (end of life 12/2025). The Hamilton C6s are advanced, for all patients, from newborns to adults. They have an internal battery, for safely moving patients between departments.	\$129,669	\$86,446	
Cardiopulmonary	7720	Fisher & Paykel 850 Full Setup Ventilator Heaters	PS	\$1,280	11	Patient Safety: All patients placed on C1 and C6 ventilators require heated humidification. The F&P 850 Heater is clinically proven to deliver optimal humidity and guarantees consistent, effective humidification for every ventilated patient (both invasive and non-invasive), meeting best practice standards and reducing the risk of adverse events.	\$14,080		
Pharmacy	8390	Pysis Cameras	PY, RG	\$3,000	20	Noted by the DEA during past and present on-site visits including all DEA provided controlled substance webinars etc. This is standard of practice and does meet due diligence requirements. These security cameras were recommended by Diversion Specialist Kimberly Knew in 2015 and the current DEA audit. Was approved FY22 but spending was frozen.	\$60,000		
Pharmacy	8390	Delivery Car	RG	\$27,000	1	Staff continue to use personal vehicles to deliver medications to offsite departments throughout the county, this is something that Compliance disallows but we are forced to do when there is no vehicle etc.	\$27,000		
Pharmacy	8390	Cold Storage Med/Vacc	RG, PS	\$5,000	2	Replacement of Dorm style household grade fridges with pharmaceutical grade equipment.	\$10,000		
Pharmacy	8390	Badge Reader for Med Rooms	RG	\$5,008	15	Med Room badge readers for security and control. Constant issues with personnel gaining access through shared codes.	\$75,120		

IVHD - PMH Capital Budget
Fiscal Years
2026, 2027, 2028

Dept	Dept #	Project Name	Justification Code	Cost of equipment	Quantity	Comments	FY 2026	FY 2027	FY 2028
Pharmacy	8390	Pharmacy Relocation Remodel & Cleanrooms	PS, RG, OB	\$2,000,000	1	Pharmacy is 50-years plus past its shelf life, being untouched all this time. Space is a safety issue and doesn't meet the districts current and future needs. Pharmacy has insufficient space to store critical medication and lacks appropriate space for receiving and even preparation of medication for patients having only one table space which during pandemic was a struggle to make the 2,000 covid vaccines all while meeting direct patient care needs etc. State, and Federal laws and regulations require changes to compounding cleanrooms in order to be able to support current and future service lines, if unchanged the district will need to reevaluate future service lines and discontinue some service lines such as Cath lab as the pharmacy department wouldn't be able to support the compounded medication needs, other service lines may need to be degraded in acuity due to inability of pharmacy to compound medications in a manner required due to current facilities in place.	\$200,000	\$1,800,000	
Pharmacy	8390	HVAC Compounding Room Repair	PS, RG, OB	\$50,000	1	AAON HVAC unit was ordered many years ago with Johnson Controls thermostatic control, the system doesn't have ability to control without contacting Johnson Controls. We've spent tens of thousands trying to get them to adjust controls and often they don't have the staff with the knowledge the system is running bad schedules and/or bad setpoints causing not temps and high humidity that shouldn't be present but we cannot fix the controls. DMG is the main contractor for AAON HVAC installs and required by AAON to service. DMG reviewed the system and is going to supply quote to repair to a manner that would allow our team and/or DMG team to adjust the systems controls.	\$50,000		
Pharmacy	8390	Flooring in Pharmacy		\$12,500	1	Ballpark cost for tear up preparation and installation, \$12,500 dollars. Thats not including the anti-room with hood. We would also have patching and painting to do when we remove the old cove base. Time frame would be around 4-5 weeks. Let me know if you need anything else."	\$12,500		
C-WHAP	7188	Olympus Cystoscope Light Source for Tower	PS	\$7,236	1	Current light source is end of life, needs replacing, unable to visualize during procedure	\$7,236		
PHC	7183	Medline Exam Room Chair	PS	\$8,602	1	Current Exam Room Chair needs to be replaced due to no Patient Support Rails on Chair in procedure Room.	\$8,602		
PHC	7183	EKG Machine	PY/OB	\$12,000	1	Patient Testing, obsolete equipment not able to repair-approved last fiscal year	\$12,000		
CHC	7083	EKG Machine	PY/OB	\$12,000	1	Patient Testing, obsolete equipment not able to repair-approved last fiscal year	\$12,000		
CHC	7083	Bladder Scanner	NSR	\$9,596	1	Urology Line of Service to be added to Calexico Health Center, need Bladder Scanner to perform diagnostics.	\$9,596		
Urology	7197	Stryker Exam Room Stretcher	PS	\$7,246	1	Current Exam Room Chair needs to be replaced due to no Patient Support on Stretcher in procedure Room and no accessibility for Urology Procedures.	\$7,246		

IVHD - PMH Capital Budget
Fiscal Years
2026, 2027, 2028

Dept	Dept #	Project Name	Justification Code	Cost of equipment	Quantity	Comments	FY 2026	FY 2027	FY 2028
Dietary	8340	Convection Steamer	OB	\$32,000	1	Continually breaking down. Engineering continually buying parts to fix it. Steamer is a crucial cooking equipment needed.	\$32,000		
Dietary	8340	Cafeteria Seating	OB	\$12,500	1	Booths and chairs in cafeteria falling apart	\$12,500		
Sterile Processing	8380	Sterilizer	OB, PS	\$43,498	1	The existing unit has reached the end of its service life. Need for SPD/OR	\$43,498		
Sterile Processing	8380	V-Pro Sterilizer	OB, PS	\$144,331	1	The existing unit has reached the end of its service life. Need for SPD/OR	\$144,331		
Sterile Processing	8380	SPD Bigger Sink	PY	\$45,258	1	Ergonomically sink to accommodate increase cases and new service line. Approved last year budget still unable to find vendor with sink that is not requiring HCAI. Still looking.	\$45,258		
Surgery	7420	Anesthesia Machine	OB, PS	\$93,174	1	Our anesthesia machines is now obsolete, leaving the Operating Room department short on functional machines.	\$93,174		
Surgery	7420	Vascular Bed/Table	OB, PS	\$45,124	1	Current table is obsolete and unable to find parts to fix it.	\$45,124		
Surgery	7420	Olympus Reprocessor	OB, PS	\$49,258	1	Current Medivator is obsolete and no longer repairable. Need to replace.	\$49,258		
Surgery	7420	Stryker Towers	PS	\$195,000	2	Current Olympus towers continue to malfunction during cases	\$390,000		
Surgery	7420	Drying Cabinet	OB, PS	\$47,000	1	Drying cabinet is obsolete.	\$47,000		
Recovery	7427	Bladder Scanner	OB, PS	\$11,400	1	The current model is obsolete and no longer supported. Need to replace.	\$11,400		
Recovery	7427	Gurneys	PS	\$8,333	3	Lack of Gurneys in the pre/post op for patients. Need additional 3.	\$25,000		
Interventional Radiology	7649	Ultrasound Machine	PS	\$37,120	1	Currently borrowing from OB or other areas when performing procedures	\$37,120		
Interventional Radiology	7649	Gurneys	PS	\$7,500	2	This was placed in last year budget, have been borrowing gurneys wherever we can borrow from.	\$15,000		
Interventional Radiology	7649	Welch Allyn Vital Signs Monitor	PS, OB	\$4,000	2	Current monitors are not working and need to perform procedure.	\$8,000		
Employee Health	8660	TSI Porta Count Machine (Fit Testing)	RG, Staff Safety	\$14,235	1	The existing portacount machine overheats due to an increase in the number of fit tests being performed. We can get a 2,000 reduction in cost (from 16,235 to 14,235) by trading in our existing portacount. We are required to fit test ee's with potential exposure to ATD ee's upon hire and annually.	\$14,235		

IVHD - PMH Capital Budget
Fiscal Years
2026, 2027, 2028

Dept	Dept #	Project Name	Justification Code	Cost of equipment	Quantity	Comments	FY 2026	FY 2027	FY 2028
Employee Health	8660	Sara Steady	PS, RG, OB	\$2,117	3	Would replace existing Sara Steady (2 OB, 1 MS). Existing equipment has exceeded it's 10 year manufacturer recommended operational life. Per OSHA we must provide employees with a musculoskeletal injury prevention plan that implements the use of patient lift equipment.	\$6,350		
Employee Health	8660	Maxi Move V	PS, RG, OB	\$8,223	2	1 ICU, 1 MS Existing equipment has exceeded it's 10 year manufacturer recommended operational life. Per OSHA we must provide employees with a musculoskeletal injury prevention plan that implements the use of patient lift equipment.	\$16,446		
Employee Health	8660	Sara Flex and -Wipeable Standing Slings	PS, RG, OB	\$6,433	1 and 4	Existing equipment has exceeded its 10 year manufacturer recommended life and slings to be utilized with Sara Flex Only	\$6,433		
Employee Health	8660	Tenor Bariatric Lift	PS, RG, OB	\$7,443	1	Used as lift equipment for patients with a weight capacity of up to 704 pounds. One lift to be used wherever needed throughout acute care.	\$7,443		
Human Resources	8650	Flooring	PS, OB	\$10,056	1	Carpet is so dirty, it can no longer be cleaned and causing respiratory illness	\$10,056		
Purchasing	8400	Storeroom and Supply Rooms Remodel	OB	\$210,670	1	Need to make improvements to our storeroom shelving units, as well as some supply rooms throughout the hospital	\$210,670		
General Accounting	810	Flooring	PS, OB	\$10,000	1	Carpet needs to be replaced with flooring that is easily cleanable and that doesn't cause illness to staff	\$10,000		
DPNF	6580	Washers	OB RG	\$20,445	2	Units are over 20 years old	\$40,890		
DPNF	6580	Bariatric patient beds	RG	\$1,718	8	Rental Replacements	\$13,744		
DPNF	6580	Dryer	RG	\$5,850	1	unit aged out	\$5,850		
DPNF	6580	Standard Patient bed	nsr	\$1,089	5	bed replacement and rental replacement	\$5,444		
DPNF	6580	Patient Low Beds for fall reductions	PS	\$1,071	4	Fall reduction and patient safety	\$4,284		
						Hospital Total	\$3,610,591	\$3,498,069	\$30,583
Comm	8470	Nurse Call System	PS,PY, OB	\$288,190	1	Equipment needed for test Ultrasound image depth	\$288,190	\$288,190	\$288,190
Comm	8470	ESU 2350	PS, RG, OB, PY	\$7,591	1	TEST ELECTROSURGICAL UNIT OUT OF CALIBRATION	\$7,591		

IVHD - PMH Capital Budget

Fiscal Years
2026, 2027, 2028

Dept	Dept #	Project Name	Justification Code	Cost of equipment	Quantity	Comments	FY 2026	FY 2027	FY 2028
Plant Maint	8460	PMC (IS) Server Room	OB	\$8,795	1	Units serve the IS Server room & maintain appropriate temperature for IS servers and equipment. Units frequently break down throughout the summer, they are over 12-15 years old and parts are becoming obsolete.	\$8,795		
Plant Maint	8460	Oncology 12.5 Ton A/C Unit	PS/OB	\$22,668	1	Patient Safety - Unit serves oncology patient care/treatment areas. Unit is over 20 years old, parts are becoming obsolete, unit breaks down a few times per year.	\$22,668		
Plant Maint	8460	Pickup Truck	OB	\$37,872	1	The hospital service trucks are very old and becoming more unreliable, they require frequent and costly repairs. The oldest truck is a 2002.	\$37,872		
Plant Maint	8460	DOU A/C	PS/OB	\$12,000	1	Unit is old and parts are becoming obsolete. Unit struggles to maintain appropriate temperature in the DOU area.	\$12,000		
Plant Maint	8460	Nursing Home East/West	OB	\$22,000	1	Unit breaks down a few times a year, parts are becoming obsolete. Unit controls AC temperatures for the buildings in back of the hospital, (HR, Accounting, Support Services, etc.)	\$22,000		
Plant Maint	8460	ICU Vacuum Pump	PS/OB	\$18,000	1	Unit breaks down a few times a year. it cannot maintain the vacuum pump demand for ICU patients.	\$18,000		
Plant Maint	CIP 11.40	Sewer Consolidation Project	RG	\$801,000	Ongoing Project	Ongoing project with the City of Brawley. Still working with Dexter Wilson as a requirement to maintain city permit	\$200,000	\$200,000	\$401,000
Plant Maint	8460	Compressors for Chillers	OB	\$125,000	2	Need to replace compressors for Chillers	\$250,000		
DayCare	8880	Flooring - BACK TRAILER	PS	\$9,000	1	Carpet in the back trailer is coming apart	\$9,000		
Security	8420	CCTV Server software and license upgrade	OB	\$53,994	1	Hospital Cameras Systems	\$53,994		
Medical Records	8700	Replace Flooring in Medical Records office	PS	\$10,164	1	Recently removed rolling file shelves and would like to have the flooring in medical records replaced as it is very dilapidated and has some cracked areas, which may become tripping hazards. Floor also looks like a patchwork quilt	\$10,164		
						Eng Totals	\$940,274	\$488,190	\$689,190
IS	8480	Wireless network upgrades	OB	\$240,000	1	Wireless network EOL	\$240,000		
IS	8480	WOW Upgrades of CareAware Devices	OB	\$9,000	20	EOL carts or implementation of CareAware Nursing Mobility	\$180,000		
IS	8480	SAN upgrade	OB	\$110,000	1	SAN EOL	\$110,000		
IS	8480	Monitors (24")	OB	\$200	25	Stock	\$5,000		
IS	8480	UPS Upgrades	OB	\$2,500	12	UPS Upgrades EOL	\$30,000		
IS	8480	Barcode Readers (wireless)	OB	\$1,000	10	Stock	\$10,000		

IVHD - PMH Capital Budget
Fiscal Years
2026, 2027, 2028

Dept	Dept #	Project Name	Justification Code	Cost of equipment	Quantity	Comments	FY 2026	FY 2027	FY 2028
IS	8480	Workstation Replacement	OB	\$1,000	120	Windows 7 and 10 EOL, moving people who work remotely to laptop + dock	\$120,000		
IS	8480	ESX Hosts	OB	\$25,000	7	Replace EOL equipment, half the amount we currently have	\$175,000		
IS	8480	Network Switch	OB	\$10,000	8	Replace EOL equipment, only accounting for 50% of need	\$80,000		
District Wide	IT	Additional Cerner Implementation Fees		\$653,000	1	CERNER Implementation for various modules. Adapt, Anesthesia, CareAware, Health Data, HL7, Patient Portal and UCC Campaigns	\$653,000		
						IS Totals	\$1,603,000	\$0	\$0
						Total Hospital Capital Purchases	\$6,153,865	\$3,986,259	\$719,773

RESOLUTION NO. 2025-0626

A RESOLUTION OF THE IMPERIAL VALLEY HEALTHCARE DISTRICT BOARD OF DIRECTORS APPROVING THE ASSET TRANSFER AGREEMENT BY AND AMONG THE CITY OF EL CENTRO, EL CENTRO REGIONAL MEDICAL CENTER, AND IMPERIAL VALLEY HEALTHCARE DISTRICT

WHEREAS, Imperial Valley Healthcare District (“**IVHD**”) is a California healthcare district established by the California Legislature pursuant to Assembly Bill 918 (2023), Health and Safety Code (the “**Code**”) section 32499.5 *et seq.*, that is duly organized and existing under the laws of the State of California;

WHEREAS, Code section 32499.6 directed the IVHD Board of Directors (the “**Board**”) to enter into negotiations with the City of El Centro and the El Centro Regional Medical Center (“**ECMRC**”) to decide the terms of the acquisition of the ECMRC general acute care hospital and associated other rural health clinics and certain other healthcare facilities in Imperial County, California (the “**Healthcare Establishment**”);

WHEREAS, pursuant to Code section 32499.6, the Board did enter into negotiations with ECMRC to decide the terms of the acquisition of the Healthcare Establishment;

WHEREAS, by letter dated November 5, 2024, IVHD made a written offer to acquire all of the assets and liabilities of the Healthcare Establishment consistent with the Term Sheet attached to that letter;

WHEREAS, by letter dated March 13, 2025, IVHD made a renewed written offer to acquire all of the assets and liabilities of the Healthcare Establishment consistent with the Term Sheet attached to that letter;

WHEREAS, IVHD and ECMRC have reached an agreement for IVHD to acquire all of the assets and liabilities of the Healthcare Establishment, the terms of which are set forth in that certain Asset Transfer Agreement, attached hereto as Exhibit A; and

WHEREAS, this Board now desires to approve the Asset Transfer Agreement, attached hereto as Exhibit A, consistent with the goals of Assembly Bill 918 (2023).

NOW, THEREFORE, this Board of Directors of IVHD does hereby find, resolve, and order as follows:

Section 1. The Asset Transfer Agreement attached hereto as Exhibit A is hereby approved;

Section 2. The Board Chair is hereby authorized to execute the Asset Transfer Agreement on behalf of IVHD;

Section 3. Adriana S. Ochoa, as legal counsel for IVHD, or her designee(s), acting alone or together, is(are) hereby authorized and directed to make such non-substantive corrections or revisions, as appropriate, and to take or cause to be taken all such other actions as may be required to fulfill the purposes of this resolution; and

Section 4. This resolution shall take effect immediately upon its adoption.

IT IS SO RESOLVED. PASSED, ADOPTED AND SIGNED ON THIS 26TH DAY OF JUNE 2025.

SECRETARY'S CERTIFICATE

I, Arturo Proctor, Secretary of the Board of Directors of Imperial Valley Healthcare District, a California healthcare district, County of Imperial, California, hereby certify as follows:

The attached is a full, true, and correct copy of the resolution(s) duly adopted at a meeting of the Board of Directors of Imperial Valley Healthcare District, which was duly held on June 26, 2025, at which meeting a quorum of the members of the Board of Directors was present; and at such meeting such resolution(s) was/were adopted by the following vote:

AYES:

NOES:

ABSTAIN:

ABSENT:

I have carefully compared the same with the original minutes of such meeting on file and of record in my office; the attached resolution is a full, true, and correct copy of the original resolution adopted at such meeting and entered in such minutes; and such resolution has not been amended, modified, or rescinded since the date of its adoption, and the same is now in full force and effect.

WITNESS my hand this 26th day of June 2025

Secretary
Imperial Valley Healthcare District

EXHIBIT A

ASSET TRANSFER AGREEMENT

by and among

CITY OF EL CENTRO,

EL CENTRO REGIONAL MEDICAL CENTER,

and

IMPERIAL VALLEY HEALTHCARE DISTRICT

ASSET TRANSFER AGREEMENT

by and among

CITY OF EL CENTRO,

EL CENTRO REGIONAL MEDICAL CENTER,

and

IMPERIAL VALLEY HEALTHCARE DISTRICT

Effective Date: _____, 2025

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ASSET TRANSFER AGREEMENT

This Asset Transfer Agreement (the “Agreement”) is made and entered into as of _____, 2025 (the “Effective Date”), by and among the **CITY OF EL CENTRO**, a California municipal corporation and charter city (the “City”) and **EL CENTRO REGIONAL MEDICAL CENTER**, a separate public agency and enterprise operation of the City of El Centro organized and operated under the provisions of Title 4, Division 3, Part 2, Chapter 5, Article 8 Govt. Code Sections 37650 et seq. (“ECRMC”) (the City and ECRMC collectively, the “Sellers”), on the one hand, and **IMPERIAL VALLEY HEALTHCARE DISTRICT**, a California healthcare district (“IVHD”), on the other hand (the City, ECRMC, and IVHD are collectively referred to as the “Parties” and each individually a “Party”).

RECITALS

A. The City owns the real property and improvements located at 1415 Ross Avenue, El Centro, California 92243 and the residential real property and improvements set forth on Schedule 1 (the “City-Owned Properties”) and holds the Hospital’s general acute care hospital license with the California Department of Health; and

B. ECRMC: (i) owns and operates the real property and improvements set forth on Schedule 2 (the “ECRMC-Owned Properties”); (ii) operates the City-Owned Properties; and (iii) operates the 161 bed acute care hospital located at 1415 Ross Avenue, El Centro, California 92243 known as El Centro Regional Medical Center (the “Hospital”, and together with the ECRMC-Owned Properties and the City-Owned Properties, the “Facilities” and the ownership and operation thereof, the “Business”), and provides various outpatient services in outpatient centers surrounding the Hospital.

AGREEMENT

NOW, THEREFORE, in consideration of the mutual promises and covenants contained in this Agreement, and for their mutual reliance and incorporating into this Agreement the above recitals, the Parties hereto hereby agree as follows:

ARTICLE I SALE AND TRANSFER OF ASSETS; CONSIDERATION; CLOSING

1.1 Sale of Assets.

(a) At the Closing, Sellers will sell, assign, transfer, convey and deliver to IVHD, and IVHD will purchase, acquire and accept from Sellers, free and clear of any Encumbrances other than Permitted Exceptions, Sellers’ right, title and interest in, to and under all of their assets, properties and rights of every kind and nature, whether real or personal, tangible or intangible, owned and used by ECRMC in material fashion in the operation of the Business and owned by the City and solely used by ECRMC in the operation of the Business (collectively, the “Assets,” and, for sake of clarity, not including the Excluded Assets), including without limitation:

(i) all of the tangible personal property owned by ECRMC and used by ECRMC in material fashion in the operation of the Business, including but not limited to equipment, furniture, fixtures, machinery, office furnishings, leasehold improvements, trucks, automobiles, trailers and other titled vehicles free from any liens, unless otherwise agreed to by the Parties (the “Personal Property”);

(ii) all of Sellers’ rights to all licenses, permits, approvals, certificates of exemption, franchises, accreditations and registrations and other governmental licenses, permits or approvals listed on Schedule 1.1(a)(ii) and issued to Sellers for use exclusively by ECRMC in the operation of the Business;

(iii) all of Sellers’ interest in and to the Owned Real Property and all of Sellers’ interest in and to all of the following (the “Assigned Leases”): (a) the real property leases (the “Lessor Leases”) for all real property pursuant to which a Seller leases space as a tenant, subtenant, lessee or sublessee and which are listed on Schedule 1.1(a)(iii) (the “Leased Real Property” and together with the Owned Real Property, the “Real Property”); and (b) the real property leases pursuant to which a Seller is the landlord, sublandlord, lessor or sublessor and which are listed on Schedule 1.1(a)(iii) (the “Tenant Leases”);

(iv) all security deposits from lessees under leases for the Leased Real Property and all security deposits made by the Sellers under any Assigned Contracts or Assigned Leases;

(v) all ECRMC Intellectual Property;

(vi) all portions of goodwill associated with the ECRMC Intellectual Property or the Business;

(vii) any easements, appurtenances, development rights, mineral rights, water rights, and air rights that may exist in connection with the Business;

(viii) all of Sellers’ interest in, and all of Sellers’ obligations due under Contracts pertaining to the Business (the “Assigned Contracts”);

(ix) all inventories of supplies, drugs, food, janitorial and office supplies and other disposables and consumables (i) located at the Hospital, or (ii) used exclusively in the operation of the Hospital;

(x) all prepaid rentals, deposits, prepayments and similar amounts relating to the Assigned Contracts and/or the Assigned Leases, which were made with respect to ECRMC’s operation of the Business;

(xi) all operating manuals, files with respect to ECRMC’s operation of the Business, including all patient records, medical records, employee records, financial records, equipment records, construction plans and specifications, and medical and administrative libraries;

(xii) all rights in all warranties of any manufacturer or vendor in connection with the Personal Property used in the Business;

(xiii) ECRMC's right or interest in the telephone and facsimile numbers used exclusively with respect to ECRMC's operation of the Business;

(xiv) all claims, causes of action, choses in action, rights of recovery, rights of set-off and rights of recoupment of ECRMC against third parties related to or associated with the Business;

(xv) cash, cash equivalents and short-term investments of cash, securities, and other investments held by ECRMC;

(xvi) all accounts receivable and interest thereupon, notes and interest thereupon and other receivables of ECRMC, including all claims, rights, interests and proceeds related thereto, including all accounts and other receivables, both billed and unbilled, in each case arising from the rendering of services or provision of goods, products or supplies to inpatients and outpatients at the Business provided by ECRMC;

(xvii) the right to collect and receive all payments (including without limitation all supplemental payments from the Medi-Cal program or a health plan participating in the Medi-Cal program, such as rate range payments, directed payments, payments where the non-federal share are intergovernmental payments, quality incentive payments, disproportionate share payments and AB 915 payments, as well as grants made under the Hospital Quality Assurance Fee Program), or patient receivables of ECRMC related to Medicare, Medicaid and other third-party patient claims due from beneficiaries or governmental third-party payors arising from the ownership or operation of the Business by ECRMC prior to Closing, including without limitation the rendering of services to patients at the Facilities, billed and unbilled, recorded or unrecorded, accrued and existing in respect to services rendered up to the Closing Date;

(xviii) all rights to settlements and retroactive adjustments, if any, of payments made to ECRMC for Medicare, Medicaid, and any other cost reports, for cost reporting periods ending prior to the Effective Time pursuant to the auditing and settlement of ECRMC's cost reports, appeals and other risk settlements, including Medicare bad debt;

(xix) all amounts accrued or paid with respect to Meaningful Use attested to, or for which the requirements for attestation have been met;

(xx) all disproportionate share hospital payments;

(xxi) all payments due to ECRMC under the California Department of Health Care Services Hospital Quality Assurance Fee Program from the State of California or any of its administrative entities or other entities, including without limitation Medi-Cal managed care plans, payments or grants due to the Sellers from the California Health Foundation & Trust, cost report, claims, electronic health records or similar appeals and the Sellers Cost Report settlements;

(xxii) all Medicare Accelerated and Advance Payments and COVID-19 Funds;

(xxiii) all Benefit Plans listed on Schedule 1.1(a)(xxiii) and the assets of such Benefit Plans and any asset that would revert to the employer upon the termination of any

such Benefit Plans, including any assets representing a surplus or overfunding of any such Benefit Plans (the “Assumed Benefit Plans”);

(xxiv) the Hospital’s (A) Medicare, Medicaid, and other government payment program provider numbers, and (B) rights under the corresponding Medicare, Medicaid, and other government payment program provider agreements;

(xxv) all of ECRMC’s services, participation or provider agreements with private health plans, insurers, or other third-party payors and any of ECRMC’s managed care, prepaid, capitated or other full-risk health plan agreements;

(xxvi) all insurance policies and contracts and coverages obtained by Sellers or listing Sellers as an insured party, a beneficiary or loss payee pertaining exclusively to the Hospital, including prepaid insurance premiums, and all rights to insurance proceeds under any of the foregoing, and all subrogation proceeds related to any insurance benefits arising from the foregoing;

(xxvii) all tax refunds, rights to tax refunds for tax periods (or portions thereof) of ECRMC arising prior to the Effective Time related to the ownership or operation of the Assets or the Business by ECRMC, and tax assets and copies of tax returns and other tax records of ECRMC;

(xxviii) all bank accounts of ECRMC; and

(xxix) any other assets owned or leased by ECRMC (which are not otherwise specifically described above in this Section 1.1(a)) that are used exclusively in the operation of the Hospital.

(b) Excluded Assets. Notwithstanding the foregoing, IVHD expressly understands and agrees that it is not purchasing or acquiring, and Sellers are not selling, transferring, or assigning, any of the following assets or properties used in the operation of the Business (the “Excluded Assets”):

(i) the Sellers’ rights or claims related to the Transaction or pursuant to or under this Agreement and any ancillary document hereto;

(ii) solely to the extent related to the transaction that is the subject of this Agreement, all writings and other items that are protected from discovery by the attorney-client privilege, the attorney work product doctrine or any other cognizable privilege or protection;

(iii) personnel records and other records that Sellers are required by Law to retain;

(iv) any rights or documents relating to the Excluded Assets;

(v) those assets of Sellers specifically identified on Schedule 1.1(b)(v);
and

(vi) All Benefit Plans that are not Assumed Benefit Plans and all assets attributable thereto (the “Excluded Benefit Plans”).

(c) City Assets Not Used in Operation of the Business. For the avoidance of doubt, the City is not transferring any of its assets to IVHD that are not used by ECRMC solely in operation of the Business, and any such assets shall constitute Excluded Assets for purposes of this Agreement.

(d) Assumption of All Liabilities. On and subject to the terms and conditions of this Agreement and the Sale Order, at the Closing, IVHD will assume and agree to pay, perform and discharge when due all Liabilities of ECRMC and all liabilities of the City that relate to the Business (collectively, the “Assumed Liabilities”), including without limitation, liabilities and obligations under, arising out of, or related to:

(i) subject to the conditions of Section 5.11 and 7.7, the Installment Purchase Agreement, dated as of April 1, 2018 (“Installment Purchase Agreement”), as amended, among the City, ECRMC and El Centro Financing Authority, a public entity duly organized and existing as a joint exercise of powers authority under and by virtue of the laws of the State of California (the “Authority”);

(ii) subject to the conditions of Section 5.11 and 7.7, the Trust Agreement, dated as of April 1, 2018 (the “Trust Agreement”), as amended, between the Authority and MUFG Union Bank, N.A. (the predecessor-in-interest to U.S. Bank Trust Company, National Association), pursuant to which the Authority issued its Hospital Revenue Refunding Bonds, Series 2018, on or about April 19, 2018 in the original aggregate amount of \$125,000,000.00 (the “Bonds”);

(iii) any and all other Contracts entered into by the City or ECRMC in connection with the Bonds;

(iv) the Assigned Contracts;

(v) the Assigned Leases;

(vi) the Facilities;

(vii) the Assets;

(viii) the Business Employees;

(ix) the Terminated Employees;

(x) the Hired Employees;

(xi) the Real Property;

(xii) the Benefit Plans (for the avoidance of doubt, including all Assumed Benefit Plans and all Excluded Benefit Plans, provided, that consistent with Section 5.6(e), the

sole Benefit Plan for which sponsorship shall be transferred from ECRMC to IVHD is the ECRMC Pension Plan);

- (xiii) the Memorandums of Understanding;
- (xiv) patient credit balances and other current expenses and liabilities;
- (xv) operating licenses, permits, or accreditations;
- (xvi) Accrued PTO due to the Carryover Employees;
- (xvii) All self-insured workers' compensation claims liabilities; and
- (xviii) other specifically assumed liabilities set forth in Schedule 1.1(d)(xviii).

1.2 Financial Terms.

(a) At the Closing, IVHD will pay each Seller One Dollar (\$1.00) to acquire the Assets and assume the Liabilities (the "Purchase Price"), and the City will make a one-time cash payment to IVHD of Five Million Dollars (\$5,000,000.00) (the "Financial Contribution").

(b) Notwithstanding any other provision in this Agreement, the Parties may deduct and withhold any withholding taxes required under the Code to be deducted and withheld from any payments to be made pursuant to this Agreement upon advice of such party's legal counsel or tax advisor; provided, however, that at least five (5) business days prior to deducting or withholding any such amounts, Sellers will provide IVHD with an opportunity for legal counsel or Tax advisors of IVHD to discuss the same with Sellers' advisors, and the Parties will otherwise reasonably cooperate to obtain reduction of or relief from such deduction or withholding to the extent permitted by applicable Law. To the extent that any such amounts are so withheld and timely paid to the appropriate Tax authority, such withheld amounts will be treated for all purposes of this Agreement as having been delivered and paid to the Person in respect of which such deduction and withholding was made.

1.3 Closing Date; Proceedings at Closing.

(a) The consummation of the Transaction (the "Closing") will take place remotely via the exchange of documents, signature pages and payments (the day on which the Closing actually occurs, the "Closing Date") within three (3) business days following the satisfaction or waiver of the conditions set forth in Article VI and Article VII, and other than those conditions that by their nature are to be satisfied at Closing but subject to fulfillment or waiver of those conditions. The Closing will be deemed to occur and to be effective as of 12:01 a.m. Pacific Time on the day immediately after the Closing Date (the "Effective Time").

(b) All proceedings to be taken and all documents to be executed and delivered by all parties at the Closing will be deemed to have been taken, executed, and delivered simultaneously, and no proceedings will be deemed taken nor any documents executed or

delivered until all have been taken, executed and delivered. At the Closing, the Sellers will deliver (or cause to be delivered) to IVHD possession and control of all of the Assets.

1.4 Items to be Delivered by Sellers at Closing. At or before the Closing, Sellers will deliver to IVHD the following:

(a) a Bill of Sale substantially in the form of Exhibit 1.4(a) attached hereto (the “Bill of Sale”), duly executed by Sellers;

(b) a Power of Attorney, authorizing IVHD to operate and order under Seller’s DEA registration(s) between Closing Date and the date that IVHD obtains its own DEA registration(s);

(c) Real Estate Assignment Agreements (the “Real Estate Assignments”) in the form of Exhibit 1.4(c) attached hereto with respect to the Assigned Leases, each duly executed by the applicable Seller;

(d) Grant Deeds with respect to each Seller’s right title and interest in and to (i) all of the real property described in Schedule 1.4(d), and (ii) all plants, buildings, structures, installments, improvements, fixtures, betterments, additions and improvements in the progress of construction and situated or located on such real property(collectively, the “Owned Real Property”), duly executed by each Seller;

(e) an Assigned Contract Transfer Agreement (the “Transfer Agreement”) in the form of Exhibit 1.4(e) attached hereto, duly executed by ECRMC and the City (as applicable);

(f) an IRS Form W-9, duly executed by each Seller;

(g) a certificate, dated as of the Closing Date, and signed by an authorized officer or representative of each Seller, that each of the conditions set forth in Section 7.3 have been satisfied;

(h) a certificate signed by the secretary or other authorized officer or representative of each Seller, dated as of the Closing Date, certifying as to the resolutions adopted in connection with this Agreement and the Transaction and the incumbency of the persons executing this Agreement and the other Transaction Documents;

(i) Owner’s affidavits in substantially the form attached hereto as Exhibit 1.4(i);

(j) written resolutions of the Board of Directors of ECRMC and a related plan amendment ceasing further benefit accruals under the ECRMC Pension Plan;

(k) written resolutions of the Board of Directors of ECRMC and a related plan amendment terminating each Benefit Plan, including each ECRMC Defined Contribution Plan, with the exception of the ECRMC Pension Plan;

(l) the written resolutions of the Board of Directors of ECRMC and a related amendment transferring sponsorship of the ECRMC Pension Plan;

(m) copies of the Required Third-Party Consents;

(n) the Financial Contribution, which the City will deliver by wire transfer of immediately available funds to an account specified in writing by IVHD; and

(o) any such other instruments, certificates, consents, or other documents which the Parties deem reasonably necessary to carry out the Transaction and to comply with the terms hereof.

1.5 Items to be Delivered by IVHD at Closing. At or before the Closing, IVHD will deliver or cause to be delivered to Sellers the following:

(a) payment of the Purchase Price;

(b) a certificate, dated as of the Closing Date, and signed by an authorized officer of IVHD, that each of the conditions set forth in Section 7.3 have been satisfied;

(c) a certificate signed by the secretary or other authorized officer of IVHD, dated as of the Closing Date, certifying as to the resolutions adopted in connection with this Agreement and the Transaction and the incumbency of the officers of IVHD executing this Agreement and the other Transaction Documents;

(d) a fully executed Joint Powers and Affiliation Agreement by and among IVHD and The Regents of the University of California on behalf of UC San Diego Health (“UC San Diego Health”), which agreement covers the operations of the Hospital and supersedes the existing Joint Powers and Affiliation Agreement by and between UC San Diego Health and Sellers;

(e) the Bill of Sale, duly executed by IVHD;

(f) the Real Estate Assignments, duly executed by IVHD;

(g) the Transfer Agreement, duly executed by IVHD;

(h) Assignment of the Installment Purchase Agreement, duly executed by IVHD;

(i) a preliminary change of ownership report for each Owned Real Property; and

(j) any such other instruments, certificates, consents, or other documents which IVHD and Sellers mutually deem reasonably necessary to carry out the Transaction and to comply with the terms hereof.

1.6 Risk of Loss. The risk of loss or damage to any of the Assets, Owned Real Property, the Business and all other tangible and intangible property, transfer of which is contemplated by this Agreement, are as set forth in this Section 1.6. With respect to the Owned Real Property, if prior to the Closing, all or any material part of the Owned Real Property is destroyed or materially damaged by fire or the elements or by any other cause (any such damage or destruction, a “Casualty”) or is made subject to an eminent domain or similar proceeding (“Condemnation”), ECRMC will promptly (but not less than twenty (20) business days after obtaining actual knowledge of such destruction, damage, or condemnation) deliver written notice of such destruction, damage or condemnation to IVHD (copying the City), which notice will describe such destruction or damage or proceeding in reasonable detail. The Seller that owns the applicable parcel(s) of Owned Real Property shall have no obligation to repair or replace (or cause to be repaired or replaced) any such damage, destruction or taken property. Such Seller shall, at Closing, provide IVHD with the Condemnation proceeds or net proceeds from Casualty insurance actually received by such Seller on account of such Casualty or Condemnation (except to the extent (a) required to reimburse such Seller’s collection costs or applied to repairs by such Seller prior to the Closing Date, or (b) attributable to lost rents or other items applicable to any period prior to the Closing). If as of the Closing Date, such Seller has not received any such insurance or condemnation proceeds, then such Seller shall, upon the Closing, assign to IVHD all rights of such Seller, if any, to the insurance or condemnation proceeds (except to the extent (a) applied to repairs by such Seller prior to the Closing Date, or (b) attributable to lost rents or other items applicable to any period prior to the Closing). In connection with any assignment of insurance proceeds hereunder, such Seller pay to IVHD an amount equal to the applicable deductible amount under such Seller’s insurance (but not more than the amount by which (x) the cost as of the Closing Date to repair the damage as determined in good faith by IVHD is greater than (y) the insurance proceeds to be assigned to IVHD). Sellers and IVHD hereby expressly waive the provisions of California Civil Code Section 1662 and agree that the provisions of this Section 1.6 shall govern their obligations in the event of damage or destruction to the Owned Real Property or condemnation of all or part of the Owned Real Property.

ARTICLE II REPRESENTATIONS AND WARRANTIES OF THE CITY

As an inducement to IVHD to enter into this Agreement and to consummate the Transaction, and except as set forth in the Disclosure Schedules and Disclosure Schedule Supplements, the City hereby represents and warrants to IVHD as follows:

2.1 Authorization. The City has full power and authority to enter into this Agreement and has full power and authority to perform its obligations hereunder and to carry out the Transaction.

2.2 Binding Agreement. The execution and delivery by the City of the Transaction Documents to which the City is a party and the consummation of the transaction contemplated thereby have been duly authorized by all requisite action on the part of the City. The Transaction Documents to which the City is a party have been duly and validly executed and delivered by the City and, assuming due and valid execution by IVHD, constitute legal, valid, and binding obligations of the City, enforceable against the City in accordance with their respective terms subject to (a) applicable bankruptcy, reorganization, insolvency, moratorium, and other Laws

affecting creditors' rights generally from time to time in effect, and (b) general principles of equity that may limit the enforcement of equitable remedies.

2.3 Organization and Good Standing. The City is duly organized, validly existing and in good standing under the Laws of the State of California, is duly authorized to transact business in the State of California, and every other jurisdiction in which it conducts business or the nature of its business and operations would require qualification as a foreign municipal corporation. The City has full power and authority to own, operate and lease its properties and to carry on its business as now conducted.

2.4 No Violation. Except as set forth in Disclosure Schedule 2.4, neither the execution and delivery by the City of the Transaction Documents to which the City is a party, the transfer of Assets to IVHD, nor the consummation of the transactions contemplated thereby and the compliance with any of the material provisions hereof by the City will (a) conflict with or result in a breach of or constitute a default by the City under any contract, agreement, instrument or other document to which the City is a party or by which the City or any of its assets or properties are bound or subject or to which any entity in which the City has an interest, is a party, or by which any such entity is bound, except for such conflicts, breaches or defaults as to which requisite waivers or consents have been obtained, (b) require any approval or consent of, filing or registration with, or other action by, any Governmental Entity, (c) violate any Law, rule, regulation, or ordinance to which the City is or may be subject, (d) to City's Knowledge, violate any judgment, order or decree of any court or other Governmental Entity to which the City is subject, or (e) result in the creation of any Encumbrance upon the Assets or the Facilities, other than Permitted Exceptions.

2.5 Brokers and Finders. Neither the City nor any officer or director of the City has engaged, either directly or indirectly, or incurred any liability to, any finder or broker in connection with the Transaction.

2.6 Real Property.

(a) To the City's Knowledge, there are no eminent domain proceedings or zoning or other public land use proceedings pending and served upon the City, or threatened in writing by a Governmental Entity against the City-Owned Properties.

(b) There is no material legal action, investigation or proceedings in any court or before or by any federal, state, county or municipal department, commission, board, bureau or agency or other Governmental Entity of any kind pending, or to the City's Knowledge, anticipated, or threatened, (i) against the City and related to any of the City-Owned Properties, (ii) against any portion of the City-Owned Properties, or (iii) relating to any of the Lessor Leases in connection with ECRMC's operation of the Business.

(c) The City has not granted or conveyed to any individual or entity (other than IVHD and the Tenant Leases) any right or option to acquire the City-Owned Properties or any portion thereof or interest therein.

(d) The City has not received any notice of any violation of any law, rule, regulations, municipal ordinance or other governmental requirement affecting the City-Owned

Properties, and the City has no knowledge that any governmental authority contemplates issuing such a notice, or that any such violation exists.

(e) Except as disclosed on Disclosure Schedule 2.6(e), (i) the City obtained and is in compliance with all permits required pursuant to Environmental Laws for the occupation of the City-Owned Properties, and the City is in compliance with all such permits; (ii) the City has not received any order, notice, or other communication from (nor to the City's Knowledge has any action been threatened by) any Person of any alleged obligation of the City to undertake or bear the cost of any remediation action; and (iii) there are no pending or, to the City's Knowledge, threatened, claims, liens, or other restrictions of any nature, resulting from any violation or failure to comply with any applicable Environmental Law with respect to any City-Owned Property.

(f) Except as disclosed in Disclosure Schedule 2.6(f) with respect to the City-Owned Properties to the City's Knowledge:

(i) As to each Lessor Lease, there is no Person in possession of any portion of the premises leased under such Lessor Lease other than the City or ECRMC. As to each Lessor Lease, other than this Agreement, there are no Contracts entered into by the City which grant any party the right to acquire the leasehold interests in the premises leased thereunder or any portion thereof.

(ii) As to each Tenant Lease, there is no other Person in possession of any portion of the premises leased thereunder. As to each Tenant Lease, other than this Agreement, there are no Contracts entered into by the City which grant to any party the right to acquire the leasehold interests in the premises leased thereunder or any portion thereof.

(iii) Except for this Agreement, the City has not entered into any contract which grants any party the right to acquire the City-Owned Properties or portion thereof and which remains pending.

(iv) As to each of the Tenant Leases, each of the Tenant Leases is in full force and effect.

(v) None of the Tenant Leases and none of the rents or other amounts payable under the Tenant Leases have been assigned, pledged or encumbered by the City, and the Tenant Leases may be assigned by the City.

(vi) No tenant under a Tenant Lease has asserted any claim which could adversely affect the right of the landlord to collect rent from such tenant. No written notice of default or breach on the part of landlord or any tenant under any of the Tenant Leases has been given or received by the City to or from any tenant which has not been cured.

(vii) No brokerage or leasing commissions or other compensation is or will be due or payable to any party, including any renewals or extensions thereof.

(viii) As to each of the Lessor Leases, each of the Lessor Leases is in full force and effect.

(ix) No landlord under a Lessor Lease has asserted any claim which could adversely affect the right of the City to occupy the leased premises. No written notice of default or breach on the part of landlord or any tenant under any of the Lessor Leases has been given or received by the City to or from any landlord which has not been cured.

(x) No brokerage or leasing commissions or other compensation is or will be due or payable to any party, including any renewals or extensions.

(xi) There are no required guaranties under such Lessor Leases.

(xii) All work and tenant improvements required to be completed under the terms of such Lessor Lease by such landlord or the City has been completed and there are no additional material obligations in connection therewith.

(xiii) There are no obligations to reimburse a landlord under the Lessor Lease for abated rent.

2.7 Title to Assets. Subject to the exclusions contained in the Title Policy with respect to real property Assets, the City is the sole and lawful owner of, and has good title to, or a valid leasehold interest in, all of the City-Owned Properties and City Assets, free and clear of all Encumbrances other than the Permitted Exceptions.

2.8 Legal Proceedings. Except as set forth in Disclosure Schedule 2.8, there are no claims, proceedings or investigations pending or, to the City's Knowledge, threatened relating to or affecting the City before any court or Governmental Entity in which an adverse determination would be reasonably likely to (i) adversely affect the City's ability to consummate the Transaction, or (ii) materially and adversely affect the City-Owned Properties. The City is not subject to any judgment, order, decree or other governmental restriction specifically (as distinct from generically) applicable to the City which would be reasonably likely to adversely affect the City's ability to consummate the Transaction.

2.9 Transactions With Affiliates. Except as set forth in Disclosure Schedule 2.9, to the City's Knowledge, no corporate member, director, trustee, officer, city councilmember or employee of the City or member of the family of any such person, or any corporation, partnership, trust or other entity in which any such person, or any member of the family of any such person, has a substantial interest or is an officer, director, trustee, partner or holder of any equity interest, is a party to any transaction with the City with respect to the Business or the Assets, including any contract, agreement or other arrangement providing for the employment of, furnishing of goods or services by, rental of real or personal property from or to or otherwise requiring payments or involving other obligations to any such person or firm.

2.10 Default. Except as set forth on Disclosure Schedule 2.10, to the City's Knowledge, there is no breach or default with respect to any Assumed Liabilities or event which with the passage of time or provision of notice would constitute a breach or default with respect to any Assumed Liabilities.

2.11 AS IS, WHERE IS. THE ASSETS ARE BEING CONVEYED "AS IS", "WHERE IS", AND "WITH ALL FAULTS" AS OF THE CLOSING DATE, WITHOUT ANY

REPRESENTATION OR WARRANTY WHATSOEVER AS TO THEIR CONDITION, FITNESS FOR ANY PARTICULAR PURPOSE, MERCHANTABILITY OR ANY OTHER WARRANTY, EXPRESS OR IMPLIED OTHER THAN AS SET FORTH IN THIS AGREEMENT. THE CITY SPECIFICALLY DISCLAIMS ANY WARRANTY, GUARANTY OR REPRESENTATION, ORAL OR WRITTEN, PAST OR PRESENT, THERETO EXCEPT AS OTHERWISE SET FORTH IN THE AGREEMENT. IVHD IS HEREBY THUS ACQUIRING THE ASSETS BASED SOLELY UPON IVHD'S OWN INDEPENDENT INVESTIGATIONS AND INSPECTION OF THAT PROPERTY AND NOT IN RELIANCE UPON ANY INFORMATION PROVIDED BY THE CITY OR THE CITY'S AGENTS OR CONTRACTORS EXCEPT AS OTHERWISE SET FORTH IN THIS AGREEMENT. EXCEPT AS EXPRESSLY SET FORTH IN THIS AGREEMENT, THE CITY HAS NOT MADE, DOES NOT MAKE AND SPECIFICALLY NEGATES AND DISCLAIMS ANY REPRESENTATIONS, WARRANTIES OR GUARANTIES OF ANY KIND OR CHARACTER WHATSOEVER, WHETHER EXPRESS OR IMPLIED, ORAL OR WRITTEN, PAST, PRESENT OR FUTURE OF, AS TO, CONCERNING OR WITH RESPECT TO THE PROPERTY OR ANY OTHER MATTER WHATSOEVER. IVHD IS A SOPHISTICATED BUYER WHO IS FAMILIAR WITH THE OWNERSHIP AND OPERATION OF REAL PROPERTY AND BUSINESS SIMILAR TO THE ASSETS, AND IVHD HAS HAD ADEQUATE OPPORTUNITY OR WILL HAVE ADEQUATE OPPORTUNITY PRIOR TO CLOSING TO COMPLETE ALL PHYSICAL AND FINANCIAL EXAMINATIONS RELATING TO THE ACQUISITION OF THE ASSETS HEREUNDER IT DEEMS NECESSARY, AND WILL ACQUIRE THE SAME SOLELY ON THE BASIS OF AND IN RELIANCE UPON SUCH EXAMINATIONS AND THE TITLE INSURANCE PROTECTION AFFORDED BY IVHD'S TITLE POLICY AND NOT ON ANY INFORMATION PROVIDED OR TO BE PROVIDED BY THE CITY.

2.12 City's Knowledge. References in this Agreement to "City's Knowledge" means the actual knowledge of the City Manager after reasonable inquiry of his or her direct reports.

ARTICLE III REPRESENTATIONS AND WARRANTIES OF ECRMC

As an inducement to IVHD to enter into this Agreement and to consummate the Transaction, and except as set forth in the Disclosure Schedules and Disclosure Schedule Supplements, ECRMC hereby represents and warrants to IVHD as follows:

3.1 Authorization. ECRMC has full power and authority to enter into this Agreement and has full power and authority to perform its obligations hereunder and to carry out the Transaction.

3.2 Binding Agreement. The execution and delivery by ECRMC of the Transaction Documents to which ECRMC is a party and the consummation of the transaction contemplated thereby have been duly authorized by all requisite action on the part of ECRMC. The Transaction Documents to which ECRMC is a party have been duly and validly executed and delivered by ECRMC and, assuming due and valid execution by IVHD, constitute legal, valid, and binding obligations of ECRMC, enforceable against ECRMC in accordance with their respective terms subject to (a) applicable bankruptcy, reorganization, insolvency, moratorium, and other Laws

affecting creditors' rights generally from time to time in effect, and (b) general principles of equity that may limit the enforcement of equitable remedies.

3.3 Organization and Good Standing. ECRMC is duly organized, validly existing and in good standing under the Laws of the State of California, is duly authorized and licensed to transact business in the State of California and every other jurisdiction in which it conducts business or the nature of its business and operations would require qualification as a foreign corporation or other entity. ECRMC has full power and authority to own, operate and lease its properties and to carry on its business as now conducted.

3.4 No Violation. Except as set forth in Disclosure Schedule 3.4, neither the execution and delivery by ECRMC of the Transaction Documents to which ECRMC is a party, the transfer of Assets to IVHD, nor the consummation of the transactions contemplated thereby and the compliance with any of the material provisions hereof by ECRMC will (a) violate, conflict with or result in a breach of any material provision of the Articles of Incorporation, Bylaws or other organizational documents of ECRMC, (b) conflict with or result in a breach of or constitute a default by ECRMC under any contract, agreement, instrument or other document to which ECRMC is a party or by ECRMC or any of its assets or properties are bound or subject or to which any entity in which ECRMC has an interest, is a party, or by which any such entity is bound, except for such conflicts, breaches or defaults as to which requisite waivers or consents have been obtained, (c) require any approval or consent of, filing or registration with, or other action by, any Governmental Entity, (d) violate any Law, rule, regulation, or ordinance to which ECRMC is or may be subject, (e) violate any judgment, order or decree of any court or other Governmental Entity to which ECRMC is subject, or (f) result in the creation of any Encumbrance upon the Assets or the Facilities, other than Permitted Exceptions.

3.5 Consents and Approvals.

(a) Except as set forth on Disclosure Schedule 3.5(a), no registration or filing with, or consent or approval of, or other action by, any federal, state or other governmental agency or instrumentality is or will be necessary for the valid execution, delivery and performance of this Agreement by ECRMC, the transfer of the Assets to IVHD (each, a "Required Governmental Entity Consent").

(b) Except as set forth on Disclosure Schedule 3.5(b), no consent, approval or authorization of any non-governmental third party is required in order for ECRMC to consummate the transactions or perform the related covenants and agreements of ECRMC contemplated hereby, or to vest in IVHD full right, title and interest in the Assets free and clear of any Lien upon the Assets (other than Permitted Exceptions) (each a "Required Third Party Consent").

3.6 Licenses and Permits. Each of the Facilities is, and for the past three (3) years has been, duly licensed pursuant to the applicable laws of the State of California. Schedule 1.1(a)(ii) contains a true, correct and complete list of all licenses. Each license is valid and in full force and effect, no License is subject to any Encumbrance (other than Permitted Exceptions), limitation, restriction, probation or other qualification (except to the extent of any limitations, restrictions or qualifications under the license's terms or under applicable Law) and there is no default under any license or, to ECRMC's Knowledge, any basis for the assertion of any default thereunder. There

is no investigation or proceeding pending or, to ECRMC's Knowledge, threatened that could result in the termination, revocation, limitation, suspension, restriction or impairment of any license or the imposition of any fine, penalty or other sanctions for violation of any legal or regulatory requirements relating to any license nor, to ECRMC's Knowledge, is there any basis therefor.

3.7 Brokers and Finders. Neither ECRMC nor any officer or director of ECRMC has engaged, either directly or indirectly, or incurred any liability to, any finder or broker in connection with the Transaction.

3.8 Real Property.

(a) To ECRMC's Knowledge, there are no eminent domain proceedings or zoning or other public land use proceedings pending and served upon ECRMC, threatened in writing by a Governmental Entity against the ECRMC-Owned Properties.

(b) No material legal action, investigation or proceedings in any court or before or by any federal, state, county or municipal department, commission, board, bureau or agency or other Governmental Entity of any kind pending or to ECRMC's Knowledge, anticipated or threatened, (i) against ECRMC and related to any of the ECRMC-Owned Properties, (ii) against any portion of the ECRMC-Owned Properties, or (iii) relating to any of the Lessor Leases in connection with the operation of the Business.

(c) ECRMC has not granted or conveyed to any individual or entity (other than IVHD and the Tenant Leases) any right or option to acquire the ECRMC-Owned Properties or any portion thereof or interest therein.

(d) ECRMC has not received any notice of any violation of any law, rule, regulations, municipal ordinance or other governmental requirement affecting the ECRMC-Owned Properties, and ECRMC has no knowledge that any governmental authority contemplates issuing such a notice, or that any such violation exists.

(e) Except as disclosed in Disclosure Schedule 3.8(e), (i) ECRMC has not received any notice from a Government Entity alleging that it is not in compliance with applicable Environmental Laws; (ii) ECRMC has not received any order, notice, or other communication from (nor to the Knowledge of ECRMC has any action been threatened by) any Person of any alleged obligation of ECRMC to undertake or bear the cost of any remediation action; and (iii) there are no pending or, to the Knowledge of ECRMC, threatened, claims, liens, or other restrictions of any nature, resulting from any violation or failure to comply with any applicable Environmental Law with respect to the Business or the ECRMC-Owned Properties.

(f) Except as disclosed in Disclosure Schedule 3.8(f), with respect to the Real Property, to ECRMC's Knowledge:

(i) As to each Lessor Lease, there is no Person in possession of any portion of the premises leased under such Lessor Lease other than the City or ECRMC. As to each Lessor Lease, other than this Agreement, there are no Contracts entered into by ECRMC which grant any party the right to acquire the leasehold interests in the premises leased thereunder or any portion thereof.

(ii) As to each Tenant Lease, there is no other Person in possession of any portion of the premises leased thereunder. As to each Tenant Lease, other than this Agreement, there are no Contracts entered into by ECRMC which grant to any party the right to acquire the leasehold interests in the premises leased thereunder or any portion thereof.

(iii) Except for this Agreement, ECRMC has not entered into any contract which grants any party the right to acquire the ECRMC-Owned Properties or portion thereof and which remains pending.

(iv) As to each of the Tenant Leases, each of the Tenant Leases is in full force and effect.

(v) None of the Tenant Leases and none of the rents or other amounts payable under the Tenant Leases have been assigned, pledged or encumbered by ECRMC, and the Tenant Leases may be assigned by ECRMC.

(vi) No tenant under a Tenant Lease has asserted any claim which could adversely affect the right of the landlord to collect rent from such tenant. No written notice of default or breach on the part of landlord or any tenant under any of the Tenant Leases has been given or received by ECRMC to or from any tenant which has not been cured.

(vii) No brokerage or leasing commissions or other compensation is due or payable to any party, including any renewals or extensions thereof.

(viii) As to each of the Lessor Leases, each of the Lessor Leases is in full force and effect.

(ix) No landlord under a Lessor Lease has asserted any claim which could adversely affect the right of ECRMC to occupy the leased premises. No written notice of default or breach on the part of landlord or any tenant under any of the Lessor Leases has been given or received by ECRMC to or from any landlord which has not been cured.

(x) No brokerage or leasing commissions or other compensation is due or payable to any party, including any renewals or extensions thereof.

(xi) There are no required guaranties under such Lessor Leases.

(xii) All work and tenant improvements required to be completed under the terms of such Lessor Lease by such landlord or ECRMC has been completed and there are no additional material obligations in connection therewith.

(xiii) There are no obligations to reimburse a landlord under the Lessor Lease for abated rent.

3.9 Compliance with Laws. Except as set forth on Disclosure Schedule 3.9:

(a) With respect to the Business, to ECRMC's Knowledge, ECRMC is in compliance in all material respects with all applicable Laws. With respect to the Business,

ECRMC has not received any written notice to the effect that, or otherwise been advised that, ECRMC is not in compliance in any material respect with any applicable Laws, and to ECRMC's Knowledge, ECRMC has no reasonable basis to anticipate that any existing circumstances are likely to result in a violation of any Law.

(b) To ECRMC's Knowledge, there are no reasonable grounds to anticipate the commencement of any investigation or inquiry, or the assertion of any claim or demand by any government agency, intermediary or carrier, in each case with respect to any of the activities, practices, policies or claims of the Business, or any payments or reimbursements claimed by or relating to the Business. ECRMC is not currently subject to any outstanding audit with respect to the Business by any such government agency, intermediary or carrier outside the Ordinary Course of Business, and to ECRMC's Knowledge there are no reasonable grounds to anticipate any such audit in the foreseeable future. ECRMC is not currently subject to unsatisfied judgments, penalties or awards with respect to the Business by any such government agency, intermediary or carrier.

3.10 Healthcare Matters.

(a) Medicare and Medicaid Participation and Hospital Accreditation.

(i) All payment programs in which ECRMC has participated in at any time during the last three (3) years with respect to the Business are listed on Disclosure Schedule 3.10(a)(i) (the "Seller Payment Programs"). The Facilities are qualified for participation in the Seller Payment Programs, are currently enrolled a participating providers or suppliers (as applicable) in such programs, have current and valid provider or supplier contracts with such programs, are, and for the past three (3) years have been, in compliance in all material respects with the conditions of participation in such programs, and have received all approvals or qualifications necessary for capital reimbursement for the Facilities.

(ii) With respect to the Business: (i) there is no pending or, to ECRMC's Knowledge, threatened investigation, or civil, administrative or criminal proceeding relating to ECRMC's participation in any Seller Payment Program except for any routine audits in the Ordinary Course of Business; (ii) ECRMC is not subject to, nor have it been subjected to during the last three (3) years, any pre-payment utilization review or other utilization review by any Seller Payment Program, except for routine reviews in the Ordinary Course of Business, which did not or do not result in any material penalties or findings; (iii) in the last three (3) years, no Seller Payment Program has requested or threatened in writing any recoupment, refund, or set-off from ECRMC and, to ECRMC's Knowledge, there is no basis therefor; (iv) in the last three (3) years, no Seller Payment Program has imposed a fine, penalty or other sanction on ECRMC; and (v) in the last three (3) years, ECRMC has not submitted to any Seller Payment Program any false or fraudulent claim for payment or violated any condition for participation, or any rule, regulation, policy or standard of, any Seller Payment Program. During the last three (3) years, all Medicare costs reports required to be filed by ECRMC regarding the Business have been accurately completed and timely filed in all material respects.

(iii) Except as set forth on Disclosure Schedule 3.10(a)(iii), each of the Facilities is duly accredited by The Joint Commission, and such accreditation is in full force and effect with no contingencies. To ECRMC's Knowledge, no event has occurred or other material

fact exists with respect to the Facilities' accreditation that allows, or after notice or lapse of time or both would allow, revocation, suspension, restriction, limitation or termination of such accreditation or would result in any other impairment of the rights of the holder of such accreditation.

(iv) During the last three (3) years all billing practices of ECRMC with respect to the Facilities to all third party payors, including the Seller Payment Programs, have been in material compliance with applicable Laws and ECRMC's contracts therewith, and neither ECRMC nor the Facilities have billed or received any payment or reimbursement in excess of amounts allowed by Law or the rules and regulations of the Seller Payment Programs or ECRMC's contracts therewith. During the last three (3) years, ECRMC has timely filed, submitted, or obtained in the Ordinary Course of Business all material reports, billings, and documents required to be filed, submitted or obtained to receive reimbursement from Medicare, Medicaid, Medi-Cal, CHAMPUS/TRICARE, or other third party payment programs, as applicable, for services furnished at the Facilities.

(v) Neither ECRMC nor the Facilities nor any of their respective officers, directors, managers, managing employees, service providers, controlling members or shareholders, employees, agents, or contractors providing direct patient care, indirect patient care, or administrative and management services are excluded from participation in the Medicare, Medicaid, Medi-Cal, CHAMPUS/TRICARE programs or any other federal healthcare program, nor to the Knowledge of Sellers is any such exclusion, suspension, or debarment pending or threatened. ECRMC performs periodic searches of relevant data bases, including without limitation the "List of Excluded Individuals/Entities" from the United States Health and Human Services Office of Inspector General ("OIG Health and Human Services") and the "List of Excluded Individuals/Entities" from the System for Award Management to confirm that none of the foregoing have been excluded, suspended, or debarred from participation in Medicare, Medicaid, Medi-Cal, or CHAMPUS/TRICARE programs or any other federal healthcare program.

(b) Fraud and Abuse Compliance. With respect to the Business, in the last three (3) years and to the ECRMC's Knowledge, (A) ECRMC has not submitted any claim to any Seller Payment Program in connection with any referrals that violated any applicable self-referral Law, including without limitation the Stark Law, or any applicable state self-referral Law; (B) ECRMC has complied with all disclosure requirements of all applicable self-referral Laws, including without limitation the Stark Law and any applicable state self-referral Law; (C) neither ECRMC nor, to ECRMC's Knowledge, any Affiliate of ECRMC has knowingly or willfully solicited, received, paid or offered to pay any remuneration, directly or indirectly, overtly or covertly, in cash or kind for the purpose of making or receiving any referral which violated any applicable anti-kickback Law, including without limitation the Federal Anti-Kickback Statute or any applicable state anti-kickback Law; (D) ECRMC has not submitted any claim for payment to any Seller Payment Program in violation of any Laws relating to false claim or fraud, including without limitation the Federal False Claim Act or any applicable state false claim or fraud Law; and (E) ECRMC has been in compliance in all material respects with all applicable state corporate practice of medicine and fee-splitting laws and regulations.

(c) Seller Payment Program Audits and Investigations. ECRMC has not, within the last three (3) years (i) been a party or subject to a Corporate Integrity Agreement with the OIG Health and Human Services, (ii) had any reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) been the subject of any governmental payer program investigation conducted by any federal or state enforcement agency, (iv) to ECRMC's Knowledge, been a defendant in any qui tam/Federal False Claims Act or state false claims act litigation, (v) been served with or received any search warrant, subpoena, civil investigative demand contact letter, or, to ECRMC's Knowledge, telephone or personal contact by or from any federal or state enforcement agency, (vi) to ECRMC's Knowledge, been the subject of any focused reviews, Zone Program Integrity Contractor audits, RAC audits, Medicaid Integrity Program audits, Comprehensive Error Rate Testing Contractor audits, Supplemental Medical Review Contractor audits, MAC audits or any other similar audits with respect to any federal healthcare program, except for those that were routine in nature and/or did not result in any material repayment obligations, penalties or other remediation obligations for Sellers or the Facilities, (vii) made a filing pursuant to the OIG's Self Disclosure Protocol, CMS's Voluntary Self-Referral Disclosure Protocol, the ONC Information Blocking Portal, or other voluntary disclosure to the OIG, CMS or other Governmental Authority; and (viii) to ECRMC's Knowledge, received any written complaints or notice from any employee, independent contractor, vendor, physician or other Person or organization alleging or that would indicate that ECRMC has violated any material healthcare law or regulation and/or requirements of any Government Authority having jurisdiction over ECRMC, the Facilities and/or Assets.

(d) Quality Reporting Initiatives. ECRMC has registered with the QNet Exchange ("Qnet") as and to the extent required by CMS under its Hospital Quality Initiative Program (the "HQI Program"). ECRMC has submitted all quality data required under the HQI Program to CMS or its agent and otherwise complied in all material respects with all requirements of the HQI Program, and have submitted all quality data required under the ORYX Core Measure Performance Measurement System ("ORYX") to The Joint Commission, for all calendar quarters concluded during the last three (3) years, except for any quarter for which the respective reporting deadlines have not yet expired. All such submissions of quality data have been made in all material respects in accordance with the applicable reporting deadlines and in the form and manner required by CMS and The Joint Commission, respectively. ECRMC has not received written notice of any reduction in reimbursement under the Medicare program resulting from their failure to report quality data to CMS or its agent as required under the HQI Program.

(e) Medical Staff Matters. Sellers have provided to IVHD true, correct, and complete copies of the bylaws and rules and regulations of the medical staff of the Business, as well as a list of all current members of the medical staff of the Business. Except as set forth on Disclosure Schedule 3.10(e), no medical staff members of any of the Facilities or providers with privileges have (i) had their privileges revoked or suspended by ECRMC, or (ii) been excluded from participation in any "federal health care program" as defined in 42 U.S.C. §1320a-7b(f) (including Medicare, state Medicaid programs, state CHIP programs, TRICARE and similar or successor programs with or for the benefit of any Governmental Authority) or any other state payment or reimbursement programs that are under the authority of any state Governmental Authority, or, to ECRMC's Knowledge, is under investigation that may result in any exclusion from such participation.

(f) Experimental Procedures. In the last three (3) years, ECRMC has not performed or permitted the performance of any experimental or research procedures or studies involving patients of the Business not authorized and conducted in accordance with applicable Law.

(g) Compliance Program. ECRMC maintains a written compliance program in compliance with all Laws, including, without limitation, all Healthcare Laws, and appropriate training and education programs are in place consistent with compliance program guidelines. During the last three (3) years, ECRMC has operated the Business in all material respects in accordance with its compliance program. For purposes of this Agreement, the term “compliance program” refers to compliance programs of the type described in the compliance guidance published by the OIG Health and Human Services.

(h) Stimulus Funds. Except as set forth on Disclosure Schedule 3.10(h), ECRMC did not receive any funds under the Paycheck Protection Program established pursuant to the Coronavirus Aid, Relief, and Economic Security Act (Pub. L. 116-136), as amended (the “CARES Act”). ECRMC has repaid in full to the appropriate Governmental Authority any amounts due, including any accrued and unpaid interest, under all payments made to the Sellers under the Medicare Hospital Accelerated Payment Program as defined under Section 3719 of the CARES Act. ECRMC utilized any provider relief Funds in accordance with all applicable Laws and the applicable terms and conditions. ECRMC maintains appropriate accounting records associated with such funds, including tracking the costs and other expenses for which stimulus funds are used and quantifying the lost revenue incurred in connection with the operation of the Business during the COVID-19 pandemic.

(i) Privacy.

(i) Except as set forth on Disclosure Schedule 3.10(i)(i), for the past three (3) years, ECRMC has been in compliance with Privacy Laws in all material respects.

(ii) Except as set forth on Disclosure Schedule 3.10(i)(ii), to ECRMC’s Knowledge, in the last three (3) years, there have been no material breaches in the security of any of the computer systems, including the software, firmware, hardware, networks, interfaces, platforms and related systems owned leased or licensed by ECRMC that was required to be reported by Law.

(iii) The execution, delivery, or performance of this Agreement and the consummation of the transactions contemplated hereby, in each case on the part of ECRMC will not violate Privacy Laws or result in or give rise to any right of termination or other right to impair or limit ECRMC’s rights to own, use, or disclose any information used in or necessary for the operation of the business of the Sellers as currently conducted.

3.11 Title to Assets. ECRMC is the sole and lawful owner of, and has good title to, or a valid leasehold interest in, all of the ECRMC-Owned Properties and Assets owned by ECRMC, free and clear of all Encumbrances other than the Permitted Exceptions.

3.12 Labor and Benefits Matters.

(a) ECRMC has provided IVHD a complete and accurate list of all Business Employees as of the date of this Agreement, along with the position, status as full-time or part-time, date of hire, union affiliation, base compensation, any other regular compensation (such as bonuses or commissions), status as active or on leave (and, if on leave, the nature of the leave and the anticipated date of return, if known), status as exempt or non-exempt for purposes of federal and state overtime pay and other wage-and-hour requirements, and accrued but unused sick time or vacation leave or paid time off.

(b) Except as listed on Disclosure Schedule 3.12(b), (i) ECRMC is not party to any memorandum of understanding, collective bargaining agreement or other organized labor agreement; (ii) to ECRMC's Knowledge, ECRMC is not currently subject to any union organizing activities; (iii) to ECRMC's Knowledge, ECRMC has not breached or otherwise failed to comply with any provision of any Memorandum of Understanding, and there are no grievances outstanding against ECRMC under any Memorandum of Understanding; (iv) to ECRMC's Knowledge, there are no unfair labor practice complaints pending against ECRMC with respect to the Business Employees before the Public Employment Relations Board or any current union representation questions involving the Business Employees; and (v) there is no strike, slowdown, work stoppage or lockout or, to ECRMC's Knowledge, threat thereof, by or with respect to the Business Employees.

(c) Disclosure Schedule 3.12(c) sets forth a true and complete list of the Benefit Plans. With respect to each Benefit Plan, ECRMC has made available to IVHD accurate, current and complete copies of each of the following (to the extent applicable): (i) the plan document together with all amendments, and, with respect to any Benefit Plan that has not been reduced to writing, a written summary of the material plan terms; (ii) all current determination letters, opinion letters or advisory letters from the Internal Revenue Service and any legal opinions issued thereafter with respect to such Benefit Plan's continued qualification; (iii) copies of any trust agreements, insurance policies and contracts, group annuity contracts, custodial agreements, administration and similar agreements; investment management or investment advisory agreements, and similar funding instruments now in effect or required in the future as a result of the transactions contemplated by this Agreement or otherwise; (iv) copies of any summary plan descriptions, summaries of material modifications, summaries of benefits and coverage, COBRA or PHSA communications, and the most recent employee handbook and any other written communications (or a description of any oral communications) relating to any Benefit Plan; (v) the actuarial valuation report for any defined benefit pension plan for the last 3 years; and (vi) copies of material notices, letters or other correspondence from the Internal Revenue Service, Department of Labor, Department of Health and Human Services, Pension Benefit Guaranty Corporation or other Governmental Authority relating to any Benefit Plan. Each Benefit Plan is sponsored by ECRMC and no Benefit Plan is sponsored by any Controlled Group Member or Affiliate.

(d) Each Benefit Plan and any related trust have been properly and legally established and each have been administered and maintained in all material respects in accordance with its terms and in compliance with all applicable Laws. To ECRMC's Knowledge, nothing has occurred, and no circumstances exist with respect to any Benefit Plan that has subjected or could reasonably be expected to subject ECRMC or any Affiliate or, with respect to any period on or after the Closing Date, IVHD or any Affiliate, to any material penalty or tax under applicable Law.

Each Benefit Plan that is intended to be qualified within the meaning of Section 401(a) of the Code (a “Qualified Benefit Plan”) is so qualified and received a favorable and current determination letter from the Internal Revenue Service with respect to such qualification, or with respect to a prototype or volume submitter plan, can rely on an opinion letter from the Internal Revenue Service to the prototype plan or volume submitter plan sponsor, to the effect that such Qualified Benefit Plan is so qualified and that the plan and the trust related thereto are exempt from federal income taxes under Sections 401(a) and 501(a), respectively, of the Code, and no event or omission has occurred that could reasonably be expected to adversely affect the qualified status of any Qualified Benefit Plan.

(e) There are no pending proceedings relating to any Benefit Plan other than routine claims for benefits, and no Benefit Plan is under or has within the three (3) years been the subject of an examination or audit by a Governmental Entity or the subject of an application or filing under or is a participant in, an amnesty, voluntary compliance, self-correction or similar program sponsored by any Governmental Entity, and, to ECRMC’s Knowledge, there is no reasonable basis for any such proceedings, audit or investigation.

(f) Neither ECRMC, the Sellers nor any of their Controlled Group Members have ever maintained, sponsored, contributed to, or has been obligated to maintain, sponsor or contribute to, or had any Liability with respect to (whether contingent or otherwise): (i) any “employee pension plan” (as defined in Section 3(2) of ERISA), subject to Title IV of ERISA or Section 412 of the Code; (ii) a “multiemployer plan” (as defined in Section 3(37) of ERISA); (iii) a “multiple employer plan,” as defined in Section 3(40) of ERISA, (iv) a “voluntary employees’ beneficiary association,” as defined in Section 501(c)(9) of the Code, or (v) a “multiple employer welfare arrangement,” as defined in Section 3(40) of ERISA. Neither ECRMC, Sellers nor any of their Controlled Group Members has (i) incurred or reasonably expects to incur, either directly or indirectly, any material Liability under Title I or Title IV of ERISA or related provisions of the Code or, except with respect to the ECRMC Pension Plan, applicable local Law relating to employee benefit plans; (ii) failed to timely pay premiums to the Pension Benefit Guaranty Corporation for any Benefit Plan for which such premiums are required; (iii) withdrawn from any employee benefit plan in a manner that could result in any withdrawal liability under Title IV of ERISA; (iv) engaged in any transaction which would give rise to liability under Section 4069 or Section 4212(c) of ERISA; (v) incurred taxes under Section 4971 of the Code with respect to any Benefit Plan; (vi) completely or partially terminated any Benefit Plan that is an “employee pension plan” (as defined in Section 3(2) of ERISA) and no proceeding has been initiated by the Pension Benefit Guaranty Corporation or any other Governmental Authority to terminate any Employee Benefit Plan or to appoint a trustee for any such plan.

(g) Except with respect to the ECRMC Pension Plan, no Benefit Plan is underfunded. No Benefit Plan subject to the minimum funding requirements of the Code or ERISA has an “accumulated funding deficiency,” whether or not waived, has failed to pay when due any “required installments” within the meaning of Section 412(m) of the Code, or is subject to a lien for unpaid contributions under Section 303(k) of ERISA or Section 430(k) of the Code. No Benefit Plan that is an employee pension plan subject to Section 436 of the Code has an “adjusted funding target attainment percentage,” as defined in Section 436 of the Code, less than 80% and with respect to each Benefit Plan. Except with respect to the ECRMC Pension Plan, the assets of each Benefit Plan are at least equal in value to the present value of the project benefit obligations (vested

and unvested) of such plan based on the actuarial methods and assumptions used in the most recent actuarial valuation report and in accordance with GAAP. All benefits, contributions and premiums relating to each Benefit Plan have been timely paid in accordance with the terms of such Benefit Plan and all applicable Laws and accounting principles, and all benefits accrued under any unfunded Benefit Plan have been paid, accrued or otherwise adequately reserved to the extent required by, and in accordance with GAAP.

(h) Each Benefit Plan can be amended, terminated or otherwise discontinued after the Closing in accordance with its terms to the extent permitted under applicable Law, including the elimination of any and all future benefit accruals thereunder to the extent permitted under applicable Law, without increasing the material liabilities to IVHD or ECRMC other than ordinary administrative expenses typically incurred in a termination event, and no employee communications or provision of any Benefit Plans has failed to effectively reserve the right of the plan sponsor to so amend, terminate or otherwise modify such Benefit Plans. Except as provided in Sections 5.6(e) and (f), ECRMC has no commitment or obligation and has not made any representations to any employee, officer, director, independent contractor or consultant, whether or not legally binding, to adopt, amend, modify or terminate any Benefit Plan or any collective bargaining agreement, in connection with the consummation of the transactions contemplated by this Agreement or otherwise. There has been no amendment to, announcement by ECRMC relating to, or change in employee participation or coverage under, any Benefit Plan or collective bargaining agreement that would increase the annual expense of maintaining such plan above the level of the expense incurred for the most recently completed fiscal year (other than on a de minimis basis).

(i) Other than as required under Sections 601 to 608 of ERISA or other applicable Law, no Benefit Plan or other arrangement provides post-termination or retiree health benefits to any individual for any reason and Sellers, ECRMC and their Affiliates have never represented, promised or contracted to any individual that such individual would be provided with post-termination or retiree health benefits. ECRMC, Sellers and each Controlled Group Member is and, at all relevant times, has been in compliance in all material respects with the Patient Protection and Affordable Care Act, the Health Care and Education Reconciliation Act of 2010, and all regulations and guidance issued thereunder (collectively, the “Health Care Reform Laws”), including the employer shared responsibility provisions relating to the offer of medical coverage that qualifies as “minimum essential coverage” that is “affordable” and provides “minimum value” to “full time employees” and their “dependents” (as those terms are defined in Section 4980H of the Code and the related Treasury Regulations) and the applicable information reporting requirements under Sections 6055 and 6056 of the Code; and neither ECRMC, Sellers or any Controlled Group Member or any Benefit Plan has incurred (and nothing has occurred, and no condition or circumstance exists, that could subject IVHD, Seller, any Controlled Group Member or any Benefit Plan) to any assessable payment, Tax or penalty under Section 4980D or 4980H of the Code or under any other provision of the Health Care Reform Laws.

(j) No Benefit Plan is subject to the laws of any jurisdiction outside of the United States.

(k) Each Benefit Plan that is subject to Section 409A or Section 457(f) of the Code has been administered in compliance with its terms and the operational and documentary

requirements of Section 409A or Section 457(f) of the Code, as applicable, and all applicable regulatory guidance (including notices, rulings and proposed and final regulations) thereunder and no payment to be made under any Benefit Plan is, or will be, subject to the penalties of Section 409A(a)(1) of the Code. ECRMC has no obligation to gross up, indemnify or otherwise reimburse any individual for any Taxes incurred pursuant to Section 409A or Section 457(f) of the Code.

(l) Each individual who is classified by ECRMC as an independent contractor has been properly classified for purposes of participation and benefit accrual under each Benefit Plan.

(m) Except for the severance benefits for the ECRMC Chief Financial Officer, Chief Nursing Officer, Chief Human Resources Officer and General Counsel who elect to not accept employment with IVHD, neither the execution of this Agreement nor any of the transactions contemplated by this Agreement will (either alone or upon the occurrence of any additional or subsequent events): (i) entitle any current or former director, officer, employee, independent contractor or consultant to severance pay or any other payment; (ii) accelerate the time of payment, funding or vesting, or increase the amount of compensation due to any such individual; (iii) increase the amount payable under or result in any other material obligation pursuant to any Benefit Plan; or (iv) require Seller, any Controlled Group Member or IVHD to transfer or set aside any assets to fund or otherwise provide for any benefits for any individual.

3.13 Legal Proceedings. Except as set forth in Disclosure Schedule 3.13, there is no action, suit, litigation, proceeding or investigation pending or, to ECRMC's Knowledge, threatened by or against ECRMC, or relating to or affecting ECRMC or any Affiliate of ECRMC before any court or Governmental Entity in which an adverse determination would be reasonably likely to adversely affect ECRMC's ability to consummate the Transaction. ECRMC has not received any written or oral notice of any such action, suit, litigation, proceeding or investigation, and no event has occurred or circumstance exists that may give rise to or serve as a basis therefor. There are no outstanding orders, writs, judgments, injunctions or decrees of any court, Governmental Entity or arbitration tribunal against, involving or affecting the Business or the Assets, and to ECRMC's Knowledge, there are no facts or circumstances which may result in the institution of any such orders, writs, judgments, injunctions or decrees. With respect to the Business, ECRMC is not in default with respect to any order, writ, injunction or decree or served upon ECRMC from any court or any federal, state, municipal or other governmental department, commission, board, bureau, agency or instrumentality, domestic or foreign.

3.14 Solvency and Value of Transfer. There is no bankruptcy or insolvency proceeding of any character including without limitation, bankruptcy, receivership, reorganization, dissolution or arrangement with creditors, voluntary or involuntary, affecting ECRMC and ECRMC has not taken any action in contemplation of, or which would constitute the basis for, the institution of any such proceedings. ECRMC is not insolvent under any bankruptcy, receivership or insolvency Law. ECRMC's sale of the Assets has not been undertaken with the intention to hinder, delay or defraud ECRMC's current or future creditors.

3.15 Leases of Personal Property. Except as set forth on Disclosure Schedule 3.15, none of the tangible personal property used by ECRMC in connection with the operation of the Business is subject to a Personal Property Lease. To ECRMC's Knowledge, all Personal Property Leases

are valid, binding and enforceable in accordance with their respective terms and are in full force and effect, except as such enforceability may be limited by applicable Enforceability Exceptions. ECRMC is not, to ECRMC's Knowledge, in material default under any Personal Property Leases and ECRMC has not received notice that there has been asserted, either by or against ECRMC under any Personal Property Leases, any material default, set-off or claim of default. The parties to the Personal Property Leases other than ECRMC are not, to ECRMC's Knowledge, in default of their respective material obligations under the Personal Property Leases. To ECRMC's Knowledge, there has not occurred any event which, with the passage of time or giving of notice (or both), would constitute such a material default or breach under any of the Personal Property Leases by ECRMC or any other party thereto.

3.16 Financial Statements. ECRMC has provided to IVHD (a) the audited balance sheets of the Business as of June 30, 2024, and the related statements of income and cash flow and footnotes thereto for the 12-month periods then ended, prepared in accordance with GAAP (the "Year-End Financial Statements"), and (b) the unaudited balance sheets of the Business as of May 31, 2025 and the related unaudited statements of income for the 11-month period then ended, prepared in accordance with GAAP (the "Interim Financial Statements"). The Year-End Financial Statements and the Interim Financial Statements are referred to herein collectively as the "Financial Statements." To ECRMC's Knowledge, the Financial Statements fairly present in all material respects the financial condition and the results of operations and cash flow of the Business (and no other business or operation of ECRMC) as of the respective dates of and for the periods referred to in such financial statements, all in accordance with GAAP, subject, in the case of the Interim Financial Statements, to normal and recurring year-end adjustments and the absence of footnotes. To ECRMC's Knowledge, the Financial Statements reflect the consistent application of GAAP throughout the periods involved.

3.17 Absence of Certain Events. Except as set forth on Disclosure Schedule 3.17, as expressly contemplated by this Agreement, or in the Ordinary Course of Business, since the date of the Interim Financial Statements, there has not been:

- (a) any voluntary or involuntary sale, assignment, license or other disposition, of any kind, of any property or right included in the Assets;
- (b) any Encumbrance imposed or created on the Assets (other than Permitted Exceptions);
- (c) any Material Adverse Effect;
- (d) any damage or destruction of any of the assets utilized in the Business by fire or other casualty, whether or not covered by insurance, in an aggregate amount of more than \$50,000;
- (e) any termination of any provider agreement or other contract pursuant to which ECRMC receives compensation or reimbursement for patient care services in connection with the Business;
- (f) any sale, transfer, assignment, termination, modification or amendment of any Contract;

(g) any written notice to ECRMC that any Contract has been breached or repudiated or will be breached or repudiated;

(h) except as provided for in any written agreements, or otherwise as necessary to comply with any applicable minimum wage Law, any increase in the salary or other compensation of any of ECRMC employees engaged in the Business, or any material increase in or any addition to other benefits to which any such employee may be entitled;

(i) any extraordinary compensation, bonus or distribution to ECRMC or to any Affiliate of ECRMC;

(j) any material failure to pay or discharge when due any liabilities which arose out of the ownership or operation of the Business;

(k) any material change in any of the accounting principles adopted by ECRMC, or any change in ECRMC's policies, procedures, or methods with respect to applying such principles;

(l) any termination of key personnel such as registered nurses, social workers, dietitians or medical directors;

(m) except as required pursuant to the terms of a Benefit Plan or by Law, any (i) grant of any bonuses, whether monetary or otherwise, or increase in any wages, salary, severance, pension or other compensation or benefits in respect of its current or former employees, officers, directors, independent contractors or consultants; (ii) change in the terms of employment for any employee or any termination of any employees for which the aggregate costs and expenses would increase more than a de minimis amount; or (iii) take action to accelerate the vesting or payment of any compensation or benefit for any current or former employee, officer, director, independent contractor or consultant;

(n) any adoption, modification or termination of any: (i) employment, severance, retention or other agreement with any current or former employee, officer, director, independent contractor or consultant; (ii) Benefit Plan; or (iii) collective bargaining or other agreement with a Union, in each case whether written or oral;

(o) firing or termination of the employment of any executive officer of ECRMC; or

(p) any material failure to pay when due any liabilities or discharge any duties under any Benefit Plan.

3.18 Taxes. The representations and warranties in this Section 3.18 shall apply only with respect to the Assets and the Business. ECRMC has filed, or has caused to be filed, on a timely basis and subject to all permitted extensions, any applicable tax returns with the appropriate Governmental Entities in all jurisdictions in which such tax returns are required to be filed, and all such tax returns were correct and complete. Except as set forth on Disclosure Schedule 3.18, or separately disclosed to IVHD counsel, all Taxes required to be paid by ECRMC (whether or not shown as due on any tax returns) have been timely paid, or delinquencies cured with payment of

any applicable penalties and interest, as of the Effective Date, and will not be due and payable as of the Closing Date. With respect to the Business, ECRMC has no dispute with any taxing authority as to Taxes of any nature. With respect to the Business, there are no audits or other examinations being conducted or threatened, and there is no deficiency or refund litigation or controversy in progress or threatened with respect to any Taxes previously paid by ECRMC or with respect to any returns previously filed by ECRMC or on behalf of ECRMC. With respect to the Business, ECRMC has not made any extension or waiver of any statute of limitations relating to the assessment or collection of Taxes. ECRMC has correctly withheld and timely remitted to the appropriate taxing authority all Taxes required to have been withheld and remitted in connection with amounts paid or owing to any employee, independent contractor, creditor, owner, or other Person. ECRMC has collected all sales and use, value added, goods and services and other similar Taxes required to be collected, and has remitted, or will remit on a timely basis, such amounts to the appropriate taxing authority, or has furnished properly completed exemption certificates and has maintained all such records and supporting documents in the manner required by all applicable sales and use Tax statutes and regulations.

3.19 Assigned Contracts.

(a) ECRMC is not in material default under the terms of any Assigned Contract. No event has occurred that would constitute a default by ECRMC under any Assigned Contract, nor has ECRMC received any written notice of any default under any Assigned Contract. To the Knowledge of ECRMC, the counterparties to the Assigned Contracts are not in default under the terms thereof, nor has any event occurred that would constitute a default by any such counterparty under any Assigned Contract, nor has ECRMC received any written notice of any such counterparty's default under any Assigned Contract.

(b) The Assigned Contracts are valid and binding obligations of ECRMC and in full force and effect against ECRMC, except as such enforceability may be limited by (a) applicable bankruptcy, reorganization, insolvency, moratorium, and other Laws affecting creditors' rights generally from time to time in effect, and (b) general principles of equity that may limit the enforcement of equitable remedies, and have been entered into in the Ordinary Course of Business. In the last three (3) years, ECRMC has not received any written notice from any other party to an Assigned Contract of the termination or threatened termination thereof, nor any claim, dispute or controversy thereon, and has no knowledge of the occurrence of any event which would allow any other party to terminate any Assigned Contract.

(c) Consummation of the transactions contemplated by this Agreement will not constitute a default under any Assigned Contract.

3.20 Financing Statements. Except as set forth on Disclosure Schedule 3.20, there are no financing statements under the Uniform Commercial Code which name ECRMC as debtor or lessee filed with respect to the Business or the Assets in any state.

3.21 Transactions With Affiliates. Except as set forth on Disclosure Schedule 3.21, no corporate member, director, trustee, officer, or employee of ECRMC or member of the family of any such person, or any corporation, partnership, trust or other entity in which any such person, or any member of the family of any such person, has a substantial interest or is an officer, director,

trustee, partner or holder of any equity interest, is a party to any transaction with ECRMC with respect to the Business or the Assets, including any contract, agreement or other arrangement providing for the employment of, furnishing of goods or services by, rental of real or personal property from or to or otherwise requiring payments or involving other obligations to any such person or firm.

3.22 Insurance. ECRMC has not failed to give any notice or present any claim under any insurance policy in due and timely fashion, has not received notice of cancellation or non-renewal of any insurance policy and is not aware of any threatened or proposed cancellation or non-renewal of any insurance policy. There are no outstanding claims under any ECRMC insurance policies which have gone unpaid for more than thirty (30) days, or as to which the insurer has disclaimed liability.

3.23 Intellectual Property.

(a) To ECRMC's Knowledge, there has been no infringement, violation or misappropriation of the rights of others by ECRMC or any of its Affiliates with respect to any ECRMC Intellectual Property of any third party, and no third party is violating, infringing or misappropriating the ECRMC Intellectual Property. ECRMC owns or possesses adequate licenses or other rights to use all ECRMC Intellectual Property, and the ownership and license rights in the ECRMC Intellectual Property are all that are, necessary or desirable to conduct the Business as conducted. ECRMC has not granted any person or entity any right to use any of the Intellectual Property Assets for any purpose.

(b) To the extent not assigned to ECRMC as a work-made-for-hire or other applicable legal doctrine, ECRMC has entered into a written agreement with each of its respective current and former employees, consultants and independent contractors who have been involved in the development of all Intellectual Property owned or purported to be owned by ECRMC that assigns to ECRMC all rights, title and interest in and to such Intellectual Property. ECRMC has also taken reasonable steps to protect the confidentiality of any trade secrets or other confidential information of ECRMC, and obligates all employees, contractors or consultants to maintain the confidentiality of such trade secrets or other confidential information.

3.24 ECRMC IT Systems. ECRMC owns or has a valid right to access and use all ECRMC IT Systems, which (i) are adequate for, and operate and perform in all material respects as required in connection with, the operation of the Business as currently conducted, and (ii) to ECRMC's Knowledge, do not contain any viruses, worms, Trojan horses, bugs, faults, malware, spyware or other devices, codes, errors, contaminants or effects that (A) materially disrupt or adversely affect (or could reasonably be expected to materially disrupt or adversely affect) the functionality of any ECRMC IT Systems, except as disclosed in their documentation, (B) enable or assist any Person to access without authorization any ECRMC IT Systems, or (C) damage, destroy, or prevent access to or use of any data or file. ECRMC has taken commercially reasonable actions to protect the integrity and security of the ECRMC IT Systems and the data and other information stored or processed thereon. ECRMC maintains and adheres to commercially reasonable backup and data recovery, disaster recovery, and business continuity plans, procedures, and facilities, and regularly tests the foregoing.

3.25 Hospital Revenue Refunding Bonds. The Bonds issued are currently outstanding and secured by revenues of the Business. There has not been, nor is there a basis for, a Determination of Taxability (as defined in the Trust Agreement) with respect to the Bonds. ECRMC has made all payments required by the Installment Purchase Agreement by and among Sellers and the Bond Issuer dated as of April 1, 2018 and, except as set forth on Disclosure Schedule 3.25, there is not otherwise any default or event that would, with the passage of time, constitute a default under any of the documents governing, securing or evidencing the Bonds.

3.26 AS IS, WHERE IS. THE ASSETS ARE BEING CONVEYED “AS IS”, “WHERE IS”, AND “WITH ALL FAULTS” AS OF THE CLOSING DATE, WITHOUT ANY REPRESENTATION OR WARRANTY WHATSOEVER AS TO THEIR CONDITION, FITNESS FOR ANY PARTICULAR PURPOSE, MERCHANTABILITY OR ANY OTHER WARRANTY, EXPRESS OR IMPLIED OTHER THAN AS SET FORTH IN THIS AGREEMENT. ECRMC SPECIFICALLY DISCLAIMS ANY WARRANTY, GUARANTY OR REPRESENTATION, ORAL OR WRITTEN, PAST OR PRESENT, THERETO EXCEPT AS OTHERWISE SET FORTH IN THE AGREEMENT. IVHD IS HEREBY THUS ACQUIRING THE ASSETS BASED SOLELY UPON IVHD’S OWN INDEPENDENT INVESTIGATIONS AND INSPECTION OF THAT PROPERTY AND NOT IN RELIANCE UPON ANY INFORMATION PROVIDED BY ECRMC OR ECRMC’S AGENTS OR CONTRACTORS EXCEPT AS OTHERWISE SET FORTH IN THIS AGREEMENT. EXCEPT AS EXPRESSLY SET FORTH IN THIS AGREEMENT, ECRMC HAS NOT MADE, DOES NOT MAKE AND SPECIFICALLY NEGATES AND DISCLAIMS ANY REPRESENTATIONS, WARRANTIES OR GUARANTIES OF ANY KIND OR CHARACTER WHATSOEVER, WHETHER EXPRESS OR IMPLIED, ORAL OR WRITTEN, PAST, PRESENT OR FUTURE OF, AS TO, CONCERNING OR WITH RESPECT TO THE PROPERTY OR ANY OTHER MATTER WHATSOEVER. IVHD IS A SOPHISTICATED BUYER WHO IS FAMILIAR WITH THE OWNERSHIP AND OPERATION OF REAL PROPERTY AND BUSINESS SIMILAR TO THE ASSETS, AND IVHD HAS HAD ADEQUATE OPPORTUNITY OR WILL HAVE ADEQUATE OPPORTUNITY PRIOR TO CLOSING TO COMPLETE ALL PHYSICAL AND FINANCIAL EXAMINATIONS RELATING TO THE ACQUISITION OF THE ASSETS HEREUNDER IT DEEMS NECESSARY, AND WILL ACQUIRE THE SAME SOLELY ON THE BASIS OF AND IN RELIANCE UPON SUCH EXAMINATIONS AND THE TITLE INSURANCE PROTECTION AFFORDED BY IVHD’S TITLE POLICY AND NOT ON ANY INFORMATION PROVIDED OR TO BE PROVIDED BY ECRMC.

3.27 ECRMC’s Knowledge. References in this Agreement to “ECRMC’s Knowledge” means the actual knowledge of ECRMC’s Chief Executive Officer, Chief Financial Officer, Chief Human Resources Officer, and Chief Nursing Officer after reasonable inquiry of their direct reports.

ARTICLE IV REPRESENTATIONS AND WARRANTIES OF IVHD

As an inducement to Sellers to enter into this Agreement and to consummate the Transaction, IVHD hereby represents and warrants to Sellers as to the following matters as of the date of this Agreement and as of the Closing Date:

4.1 Authorization. IVHD has full power and authority to enter into this Agreement and has full power and authority to perform its obligations hereunder and to carry out the Transaction. No additional internal consents are required in order for IVHD to perform its obligations and agreements hereunder.

4.2 Binding Agreement. This Agreement has been duly and validly executed and delivered by IVHD and, assuming due and valid execution by Sellers, this Agreement constitutes a valid and binding obligation of IVHD enforceable in accordance with its terms subject to (a) applicable bankruptcy, reorganization, insolvency, moratorium and other laws affecting creditors' rights generally from time to time in effect, and (b) limitations on the enforcement of equitable remedies.

4.3 Organization and Good Standing. IVHD is a local healthcare district and political subdivision of the State of California duly organized, validly existing and in good standing under the Laws of the State of California, is duly authorized to transact business in the State of California, and has full power and authority to own, operate and lease its properties and to carry on its business as now conducted.

4.4 No Violation. Except as set forth in Disclosure Schedule 4.4, neither the execution and delivery by IVHD of this Agreement nor the consummation of the Transaction nor compliance with any of the material provisions hereof by IVHD will (a) violate, conflict with or result in a breach of any material provision of the Articles of Incorporation, Bylaws or other organizational documents of IVHD or any contract, lease or other instrument by which IVHD is bound, (b) require any approval or consent of, or filing with, any Governmental Entity, (c) violate any Law, rule, regulation, or ordinance to which IVHD is or may be subject, or (d) violate any judgment, order or decree of any court or other Governmental Entity to which IVHD is subject.

4.5 Brokers and Finders. Neither IVHD nor any Affiliate thereof nor any officer or director thereof has engaged any finder or broker in connection with the Transaction.

4.6 Legal Proceedings. There are no claims, proceedings or investigations pending or, to IVHD's Knowledge, threatened relating to or affecting IVHD or any Affiliate of IVHD before any court or Governmental Entity in which an adverse determination would adversely affect IVHD's ability to consummate the Transaction. Neither IVHD nor any Affiliate of IVHD is subject to any judgment, order, decree or other governmental restriction specifically (as distinct from generically) applicable to IVHD or any Affiliate of IVHD which would adversely affect IVHD's ability to consummate the Transaction.

4.7 Ability to Perform. IVHD is solvent and (a) is able to pay its debts as they become due; (b) owns property that has a fair saleable value greater than the amounts required to pay its debts (including a reasonable estimate of the amount of all contingent Liabilities); and (c) has adequate capital to carry on its business. IVHD has not incurred, nor plans to incur, debts beyond its ability to pay as they become absolute and matured.

4.8 IVHD Knowledge. References in this Agreement to "IVHD's Knowledge" means the actual knowledge of the IVHD Board Chair and the actual knowledge of the IVHD President and Chief Executive Officer after reasonable inquiry of their direct reports.

4.9 Independent Investigation. IVHD has conducted its own independent investigation, review and analysis of the Hospital, Facilities, the Business and the Assets, and acknowledges that it has been provided adequate access to the personnel, properties, assets, premises, books and records, and other documents and data of Sellers for such purpose. IVHD acknowledges and agrees that: (a) in making its decision to enter into this Agreement and to consummate the Transaction, IVHD has relied solely upon its own investigation and the express representations and warranties of Sellers set forth in Article II and Article III of this Agreement (including related portions of the Disclosure Schedules); and (b) neither Sellers nor any other Person has made any representation or warranty as to Sellers, the Business, the Assets or this Agreement, except as expressly set forth in Article II or Article III of this Agreement (including the related portions of the Disclosure Schedules).

ARTICLE V PRE-CLOSING COVENANTS

5.1 Information; Inspections. Upon reasonable advance notice, ECRMC will (i) afford to the officers and agents of IVHD (which will include accountants, attorneys, bankers and other consultants and authorized agents of IVHD) reasonable access during normal business hours, the right to inspect, the books, accounts, records and other relevant documents and information related to the Business as IVHD may reasonably request, and (ii) furnish IVHD, at IVHD's sole cost and expense, copies of such additional financial and operating data and other information in ECRMC's possession related to the Business as IVHD or its representatives may from time to time reasonably request; provided, however, that ECRMC will not be obligated to disclose information that (a) is proprietary to ECRMC, (b) would, in ECRMC's reasonable discretion, cause significant competitive harm to ECRMC or the Business if the Transaction is not consummated, or (c) contravene any applicable Law, fiduciary duty or binding agreement entered into prior to the date of this Agreement; provided, further, that all disclosures of information will be consistent with the confidentiality agreements and any other non-disclosure agreements entered into among IVHD, its representatives and Sellers or their representatives. IVHD's right of access and inspection will be exercised in such a manner as not to interfere with the operations of ECRMC or the Business.

5.2 Cooperation and Consents.

(a) The Parties will reasonably cooperate with each other and their respective authorized representatives and attorneys in: (i) all efforts to obtain all consents, approvals, authorizations, clearances and licenses required to carry out the Transaction (including those of Governmental Entities), and (ii) the preparation of any document or other material which may be required by any Governmental Entity as a predicate to or result of the Transaction.

(b) ECRMC will use its commercially reasonable efforts to obtain, prior to the Closing Date, the Required Third Party Consents; provided, however, that ECRMC will not be required to expend funds or incur additional Liability as a condition or requirement to obtaining a Required Third Party Consent (other than any administrative review fee as may be expressly provided in an Assigned Contract or Assigned Lease and payable to the contract party or landlord in connection with providing such a consent).

5.3 Business Operations. Prior to the Effective Time, ECRMC will continue to operate the Business only in, and ECRMC shall not take any action except in, the Ordinary Course of Business, or except as otherwise required by this Agreement or consented to in writing by IVHD. With respect to the operations of the Business, and except as otherwise required by this Agreement or consented to in writing by IVHD, ECRMC shall:

- (a) preserve intact the Assets in the Ordinary Course of Business and shall not voluntarily discontinue the operations of the Business;
- (b) use commercially reasonable efforts to keep available the services of Business Employees and to preserve the current relationships of the Business with such of the patients, suppliers, physicians and other persons with which Sellers have significant business relations in order to preserve substantially intact the Business;
- (c) maintain in effect the insurance coverages with respect to the Assets;
- (d) perform ECRMC's material obligations under all Assigned Contracts with respect to the Assets;
- (e) permit and allow reasonable access by IVHD and its representatives to make offers of post-Closing employment to ECRMC's personnel and to establish relationships with physicians, medical staff and others having business relations with ECRMC, provided that any written materials will be approved by Sellers prior to being sent, and provided, however, that such actions by IVHD do not unreasonably interfere with ECRMC's operation of the Business;
- (f) timely file or cause to be filed all material reports, notices and tax returns required to be filed; and
- (g) use commercially reasonable efforts to maintain all existing material approvals, permits and environmental permits relating to the Hospital.

5.4 Negative Covenants.

(a) Until the Effective Time, with respect to the operations of the Business, except as may be required by Law or in the Ordinary Course of Business, ECRMC shall not, and shall not cause or permit any of Sellers' Affiliates, officers, directors, city councilmembers, or employees, directly or indirectly, take, or agree to take, any of the following actions with respect to the Business or the Assets, without the prior written consent of IVHD (which will not be unreasonably withheld, conditioned, or delayed):

- (i) acquire (including, without limitation, by merger, consolidation or acquisition of stock or assets) for or in connection with the Business any interest in any corporation, partnership, other business organization, person or any division thereof or any assets;
- (ii) incur any indebtedness for borrowed money or issue any debt securities or assume, guarantee or endorse, or otherwise as an accommodation become responsible for, the obligations of any person for borrowed money, or otherwise create, assume or permit to exist any new material debt or other Encumbrance;

(iii) amend or terminate any of the Assigned Contracts or Assigned Leases or incur or agree to incur any Liability;

(iv) increase compensation payable or to become payable, or make any bonus payment to or otherwise enter into one or more bonus agreements with, or grant any rights to severance or termination pay to, or enter into any employment or severance agreement with, any employee, or establish, adopt, enter into or amend any collective bargaining, profit sharing, thrift, compensation, pension, retirement, deferred compensation, employment, termination, severance or other plan, agreement, trust, fund, policy or arrangement for the benefit of any employee;

(v) sell, pledge, dispose of, grant, transfer, lease, license, guarantee, encumber, or authorize the sale, pledge, disposition, grant, transfer, lease, license, guarantee or encumbrance of the Business or any of the Assets;

(vi) modify any material accounting policies, procedures or methods;

(vii) take any action or fail to take any action that could result in a Material Adverse Effect;

(viii) sell, transfer, assign any of the Owned Real Property, Tenant Leases, or Lessor Leases;

(ix) adopt, enter into, modify, amend or terminate any (i) employment, severance, retention or other agreement with any current or former employee, officer, director, independent contractor or consultant; (ii) Benefit Plan, or (iii) collective bargaining or other agreement with a Union, in each case whether written or oral, except (i) as provided in Sections 5.6(e) and (f); (ii) as required pursuant to the terms of the applicable plan or agreement or applicable Law; or (iii) to the extent it would not result in any liability on the part of IVHD or ECRMC or any of their Affiliates following the Closing Date;

(x) except as required pursuant to the terms of a Benefit Plan or by Law (i) grant of any bonuses, whether monetary or otherwise, or increase in any wages, salary, severance, pension or other compensation or benefits in respect of its current or former employees, officers, directors, independent contractors or consultants; (ii) change in the terms of employment for any employee or any termination of any employees for which the aggregate costs and expenses would increase more than a de minimis amount; or (iii) take action to accelerate the vesting or payment of any compensation or benefit for any current or former employee, officer, director, independent contractor or consultant;

(xi) fail to pay when due any material liabilities or discharge any duties under any Benefit Plan;

(xii) amend, modify, or terminate the Trust Agreement or Installment Purchase Agreement;

(xiii) take any action that would cause the Bonds to be refunded or refinanced; or

(xiv) permit or cause any of ECRMC's Affiliates to do any of the actions set forth in this Section 5.4 or agree or commit to take any of the actions set forth in this Section 5.4.

(b) ECRMC shall give prompt written notice to IVHD of (i) any notice or other communication from any person alleging that the consent of such person is or may be required in connection with the consummation of the transactions contemplated by this Agreement; (ii) any notice or other communication from any Governmental Entity in connection with the transactions contemplated by this Agreement; (iii) any notice or other communication of any actions, suits, claims, investigations or proceedings commenced or, to ECRMC's Knowledge, threatened against, relating to or involving or otherwise affecting the Business or the Assets or the transactions contemplated by this Agreement; and (iv) the occurrence of a breach or default under this Agreement.

(c) Notwithstanding any provision to the contrary contained in this Agreement, neither Section 5.3 nor this Section 5.4 will be construed to prohibit ECRMC from engaging in any act in the Ordinary Course of Business or which ECRMC reasonably believes is necessary (i) to preserve and protect the condition or continued operations of the Business, (ii) for patient safety needs, or (iii) to comply with the requirements of any Laws. ECRMC will give IVHD prompt written notice subsequent to taking any act described in the immediately preceding sentence.

5.5 Title Matters. At any time prior to the date that is thirty (30) days before the Closing Date, IVHD may cause to be delivered to Sellers: (a) a preliminary binder or title commitment(s) (the "Title Commitment") sufficient for the issuance of an ALTA Extended Coverage Owner's Title Insurance Policy with respect to the Owned Real Property, subject to all Permitted Exceptions (the "Owner's Title Policy") and, if applicable, an ALTA Extended Coverage Leasehold Title Policy in a form approved for issuance in California with respect to any Leased Real Property (the "Leasehold Title Policy") (the Owner's Title Policy and the Leasehold Title Policy are collectively referred to in this Agreement as the "Title Policy"), issued by First American Title Insurance Company (the "Title Company"), together with true, correct and legible (or, if not legible, the best available) copies of all instruments referred to therein as conditions or exceptions to title (the "Title Instruments"), and (b) an ALTA survey or surveys of the Owned Real Property complying with the Minimum Standard Detail Requirements for ALTA/ACSM Land Title Surveys for the Owned Real Property in a form reasonably acceptable to IVHD and the Title Company (the "Surveys"). The costs and expenses of the Title Commitment, the Title Policy and the Surveys will be borne by IVHD. At any time prior to the date that is thirty (30) days before the Closing Date, IVHD may make written objections ("Objections") to the form and contents of the Title Commitment ("Objection Notice"). Upon receipt of an Objection Notice, Sellers shall have five (5) business days ("Objection Response Notice Date") after the receipt of such Objection Notice ("Objection Response") to notify IVHD that either (i) Sellers will remove or cause to be removed such objectionable exceptions from title on or before the Closing Date or (ii) Sellers shall not cause such Objections to be removed. If the Objections pertain to matters that would reasonably be expected to prevent IVHD from continuing to operate the Facilities and Business in substantially the same manner as they were operated as of the date of the Objection Notice upon exercising commercially reasonable efforts, IVHD shall have ten (10) business days from the receipt of the Objection Response or if Sellers fail to deliver an Objection Response, ten (10) business days from

the Objection Response Notice Date, to elect to terminate the Agreement, or waive the Objections and proceed to Closing. At the Closing, the City will deliver to the Title Company an owner's affidavit of title (the "Owner's Affidavit") in a form reasonably acceptable to the City and the Title Company and adequate to cause Title Company to delete the standard pre-printed exceptions in the Title Commitment (other than as and to the extent such deletion requires the delivery to Title Company of an ALTA survey approved by Title Company, and the City will have no duty hereunder to provide such a survey). It is understood that IVHD may request a number of endorsements to the Title Policy and the issuance of such endorsements shall not be a condition to Closing.

5.6 Employee Matters.

(a) ECRMC will terminate all of the Business Employees, effective immediately prior to the Closing and will pay all accrued wages to all ECRMC employees owed through termination, unreimbursed expenses to all ECRMC employees owed through termination, severance payments due only to the executives who do not accept offers of employment with IVHD (if any) (understanding that all other applicable executives shall have waived their rights to severance as a result of the Closing as a condition to Closing), and any other amounts to all ECRMC employees owed through termination (the "Closing Payroll Payments"), other than the Accrued PTO of Carryover Employees as provided in Section 5.6(c).

(b) IVHD shall make offers of employment, effective as of the Effective Time, to all Business Employees who, immediately prior to the Closing, are employees of ECRMC in good standing. At least forty-five (45) days prior to the Closing, ECRMC shall provide to IVHD a list of all the Business Employees who are ineligible to be hired by IVHD. At least thirty (30) days prior to Closing, IVHD shall send an offer letter to all eligible Business Employees. Any of the Business Employees who accept an offer of employment with IVHD as of or after the Effective Time shall be referred to in this Agreement as the "Hired Employees."

(c) ECRMC will give Hired Employees the option to receive upon termination either payment of their Accrued PTO, or a carryover of their Accrued PTO to IVHD. ECRMC shall seek consents for any such carryover of Accrued PTO and provide copies to IVHD prior to Closing. IVHD shall give all Hired Employees who provide such consent (the "Carryover Employees"), at the start of their employment with IVHD, the Accrued PTO reflected in their employment records of ECRMC immediately prior to the Closing and projected as of the Effective Time. The decision as to whether to receive a credit or payment for the Accrued PTO shall be solely that of the individual Hired Employee. Hired Employees that do not elect to carryover their Accrued PTO and Business Employees who do not become Hired Employees shall receive full payment by ECRMC of their Accrued PTO on the Closing Date. Subject to the last sentence of Section 5.6(f), IVHD further agrees that each Hired Employee will be given full credit for his or her tenure at ECRMC for vesting and all other purposes under IVHD's benefit plans at ECRMC and employment policies but only to the extent that tenure is already taken into account by IVHD under its existing policies and existing benefit plans and offered cash compensation packages that, in the aggregate (taking into account base salary and opportunities for bonuses), are no less than the cash compensation packages such Hired Employee received from ECRMC immediately prior to the Closing Date. IVHD shall provide coverage for the Hired Employees and their eligible dependents under IVHD's group medical, dental and vision benefit plans to be effective as of the

Effective Time without any waiting periods. IVHD shall use its reasonable best efforts to cause there to be waived any pre-existing condition, actively at work requirements, waiting periods and any other similar restriction with respect to all other welfare-type insurance benefits offered by IVHD in order for the coverage with respect to the Hired Employees (and their eligible dependents, if applicable) to be effective on or as soon as possible following the Effective Time to ensure that there are no material gaps in coverage experienced by the Hired Employees.

(d) After the Closing Date, IVHD's human resources department (which may include Hired Employees that were Business Employees prior to the Closing) will provide reasonable assistance to ECRMC (including personnel support) with respect to effectuating any post-Closing administration, wind-down and liquidation of all Benefit Plans other than the ECRMC Pension Plan as may be required in connection with the Transaction. Within five (5) days after the Closing Date, IVHD shall provide to Sellers a list of all the Business Employees who were not hired by IVHD, including those who were offered employment by IVHD but who refused such employment (the "Terminated Employees"), along with a list of all Hired Employees (which such list IVHD shall periodically update).

(e) Without limiting the generalities of the foregoing, with respect to the El Centro Regional Medical Center Retirement Income Plan ("ECRMC Pension Plan"), IVHD shall assume sponsorship of the ECRMC Pension Plan from ECRMC with such assumption of sponsorship to be effective as of the Closing Date. Prior to Closing, ECRMC shall (i) by action of its Board of Directors adopt a resolution to, contingent on Closing and effective on the Closing Date, cease further benefit accruals under the ECRMC Pension Plan, (ii) take such action that is necessary and appropriate to cause the transfer of sponsorship of the ECRMC Pension Plan to IVHD to be effective as of the Closing Date, and (iii) obtain all consents and authorizations including any required consents and authorizations from any Governmental Authority or union necessary for such transfer of sponsorship to occur. No later than 30 days prior to Closing, ECRMC shall provide to IVHD draft documents, including plan and trust document amendments, effectuating (i) through (iii) of the preceding sentence and the form of such documents shall be subject to review and approval of IVHD. IVHD shall maintain the assumed ECRMC Pension Plan for such period as may be required by any Memorandum of Understanding or pursuant to applicable Law, provided, however, that any Memorandum of Understanding may not override or conflict with the terms of the ECRMC Pension Plan. The Parties shall cooperate and use commercially reasonable efforts to ensure that the transfer of sponsorship of the ECRMC Pension Plan is conducted in a manner that complies with the terms of all applicable Laws and shall exchange any necessary participant records (e.g., addresses for both current and former participants) and account information and engage recordkeepers, third party administrators and other third parties required to properly facilitate the transactions contemplated under this Section 5.6(e). For the avoidance of doubt, the sole Benefit Plan for which sponsorship shall be transferred from ECRMC to IVHD is the ECRMC Pension Plan.

(f) With respect to each Benefit Plan that is a defined contribution plan qualified under Section 401(a) of the Code or an eligible deferred compensation plan under Section 457(b) of the Code (each an "ECRMC Defined Contribution Plan"), ECRMC shall, prior to Closing, by action of its Board of Directors adopt resolutions, contingent on Closing, that terminate the ECRMC Defined Contribution Plans effective no later than the Closing Date. ECRMC shall also take all such other action that is necessary and appropriate to terminate the ECRMC Defined

Contribution Plans including, without limitation drafting plan and trust document amendments, and to obtain all consents and authorizations, including any required consents and authorizations from any Governmental Authority or union necessary for such terminations to occur. No later than 30 days prior to Closing, ECRMC shall provide to IVHD draft documents, including plan and trust document amendments, effectuating the termination of the ECRMC Defined Contribution Plans and the form of such documents shall be subject to review and approval of IVHD. Hired Employees will be eligible to participate in any defined contribution retirement plans sponsored by IVHD in accordance with the terms and conditions of those plans. For purposes of eligibility to participate (but not vesting) under the defined contribution retirement plans sponsored by IVHD, IVHD shall provide each Hired Employee full credit under each plan for their tenure with ECRMC prior to the Closing; provided, that such tenure shall not be credited to the extent that it would result in a duplication of benefits.

(g) In addition to terminating the ECRMC Defined Contribution Plans, unless directed otherwise by IVHD, ECRMC shall, prior to Closing, timely adopt resolutions of the Board of Directors that, contingent on the Closing, amend and terminate all other Benefit Plans then sponsored by ECRMC (the “Terminating Benefit Plans”). No later than 30 days prior to Closing, ECRMC shall provide to IVHD draft documents, including plan and, to the extent applicable, trust document amendments, effectuating the termination of the Terminating Benefit Plans and the form of such documents shall be subject to review and approval of IVHD. ECRMC shall take all such other action that is necessary and appropriate to terminate the Terminating Benefit Plans and shall obtain all consents and authorizations, including any required consents and authorizations from any Governmental Authority or union necessary for such terminations to occur.

(h) IVHD acknowledges receipt of ECRMC’s memorandums of understanding set forth on Schedule 5.6(h) (the “Memorandums of Understanding”) and has reviewed their terms and conditions. At the Effective Time, IVHD will assume and be obligated by the Memorandums of Understanding and recognize the unions that are party to such Memorandums of Understanding as the collective bargaining representative of the applicable Hired Employees. IVHD will, not less than twenty-one (21) days prior to the Closing Date, provide to ECRMC, who will thereafter provide the unions that are party to the Memorandums of Understanding, with the name, address and designated representative of the entity that, following the Closing, is employing the Hired Employees that are covered by the Memorandums of Understanding. Notwithstanding anything to the contrary in this Agreement, all changes made by IVHD to the terms and conditions of employment of union-represented Hired Employees will be subject to the terms and conditions of the Memorandum of Understanding(s) covering such Hired Employees, and IVHD will indemnify, defend and hold harmless the Sellers in connection therewith.

(i) IVHD will be solely responsible for complying with WARN and all other obligations under applicable Law requiring notice of plant closings, relocations, mass layoffs, reductions in force or similar actions (and for any failures to so comply), in any case applicable to the Business Employees, including as towards any Business Employees who do not become a Hired Employee for any reason. Notwithstanding the foregoing, IVHD will not, at any time prior to ninety (90) days after the Effective Time, effectuate a “plant closing” or “mass layoff,” as those terms are defined in WARN, affecting in whole or in part any site of employment, facility, operating unit or Business Employee, without notifying Sellers in advance and without complying with the notice requirements and other provisions of WARN. With respect to terminations of

Hired Employees on or after the Effective Time, IVHD will be responsible for any notification required under WARN.

(j) If ECRMC's group health plan is terminated in connection with the transactions contemplated by this Agreement, IVHD shall provide COBRA, to the extent required by Healthcare Laws, to all "M&A qualified beneficiaries" as defined in Treasury Regulations Section 54.4980B-9.

(k) The provisions of this Section 5.6 are solely for the benefit of the Parties, and no employee or former employee or any other individual associated therewith or any employee benefit plan or trustee thereof will be regarded for any purpose as a third-party beneficiary of this Agreement, and nothing herein will be construed as an amendment to any employee benefit plan for any purpose.

(l) To facilitate compliance with this Section 5.6, ECRMC will provide updated information described in Section 3.12(a) upon IVHD's reasonable request.

5.7 Waiver of Bulk Sales Law Compliance. IVHD hereby waives compliance by Sellers with the requirements, if any, of Article 6 of the Uniform Commercial Code as in force in any state in which the Assets are located and all other Laws applicable to bulk sales and transfers.

5.8 Regulatory Efforts.

(a) Except as noted in Section 5.8(b) below, IVHD is responsible for all filings with and requests to Governmental Entities necessary to enable IVHD to operate the Business at and after the Closing Date, including but not limited to filings with the California Department of Public Health for facility licensure, with the California Board of Pharmacy for pharmacy licensure, and with the Medicare Administrative Contractor for the change of ownership for Medicare, including acceptance of assignment of the Medicare provider agreement. Notwithstanding the foregoing, IVHD and ECRMC will work collaboratively and in good faith in the preparation of such filings.

(b) As soon as practicable after the Effective Date, ECRMC and IVHD will each prepare and submit their respective Notices of a Material Change Transaction (the "OHCA Notices") to the Office of Health Care Affordability under the California Department of Health Care Access and Information ("OHCA"). The Parties will use commercially reasonable efforts to assist and respond to each other, as needed, both in preparation for filing the OHCA Notices and for any additional responses requested from OHCA. Prior to either Party submitting their OHCA Notice or any additional responses, the other Party shall be provided with a reasonable period to review and shall consider in good faith and incorporate any such reasonable comments from the other Party. Each Party shall promptly notify the other Party of any substantive communications from or with OHCA related to the OHCA Notices or any cost and market impact review that OHCA determines is required under Cal. Code Regs. tit. 22, § 97441 (the "CMIR") and shall promptly provide the other Party with copies of any such communications. Each Party shall timely respond to all requests from OHCA for additional information and/or documentation related to the OHCA Notices, the Transaction, or the CMIR. ECRMC and IVHD shall each bear their respective costs and expenses of preparing and submitting the OHCA Notices and any additional responses

requested from OHCA. No Party will participate (or agree to participate) in any substantive meeting or discussion with OHCA regarding the OHCA Notice, the Transaction, or the CMIR unless it consults the other Parties in advance, and, to the extent permitted by OHCA, gives the other Parties the reasonable opportunity to attend and participate in such meeting or discussion to the extent permitted by Law.

(c) The Parties will keep each other apprised of the status of matters relating to the completion of the Transaction and use reasonable best efforts to resolve the objections, if any, that the FTC, the Antitrust Division of the Justice Department or any applicable state antitrust enforcement authorities may assert under any antitrust Law with respect to the Transaction including:

(i) furnishing to the other Party or its outside counsel all information within its possession that is reasonably required for any application or other filing to be made by the other Party pursuant to any antitrust Law in connection with the Transaction;

(ii) to the extent not prohibited by applicable Law, promptly notifying each other of any substantive communications from or with the FTC, the Antitrust Division of the Justice Department or any applicable state antitrust enforcement authorities to the extent relating to the antitrust aspects of the Transaction;

(iii) to the extent not prohibited by applicable Law, not participating (or agreeing to participate) in any substantive meeting or discussion with the FTC, the Antitrust Division of the Justice Department or any applicable state antitrust enforcement authorities to the extent relating to obtaining such clearances, approvals, or consents (including any discussion relating to the antitrust merits, any potential remedies, commitments or undertakings or the timing of the Closing), unless it consults with the other Party in advance, and to the extent permitted by such Governmental Entity, gives the other Party the reasonable opportunity to attend and participate thereat to the extent permitted by Law;

(iv) consulting and cooperating with one another in connection with all analyses, appearances, presentations, memoranda, briefs, arguments, opinions and proposals made or submitted by or on behalf of any Party in connection with Proceedings under or any other antitrust Law to the extent relating to obtaining such clearances, approvals, consents or orders; and

(v) delivering to the other Party's outside counsel copies of all substantive documents furnished to any Governmental Entity under any antitrust Law, provided that, such providing Party, in its reasonable discretion may require that such counsel not deliver, reproduce or share such documents with its client or its client's other outside Representatives.

5.9 Cash-on-Hand. ECRMC will use commercially reasonable efforts to maintain at least Five Million Dollars (\$5,000,000.00) of cash-on-hand (after, for the avoidance of doubt, payment of the Closing Payroll Payments and Closing Payments), and accounts payable at levels consistent with past practices.

5.10 Line of Credit. Prior to the Closing, ECRMC will cooperate with IVHD in the negotiation of a three (3) year, Fifteen Million Dollar (\$15,000,000.00) line of credit agreement

on terms and conditions reasonably satisfactory to IVHD (the “LOC”). For the avoidance of doubt, the City and ECRMC will not guarantee, co-sign, or have any Liability with respect to the LOC.

5.11 Transfer of Bond Obligations and Requirements of Transfer.

(a) The Parties shall use commercially reasonable efforts to seek and obtain consent of the Authority, the Trustee and a majority in aggregate principal amount of the Owners of the Bonds (the “Majority Owners”) to transfer, modify, and assign the City’s obligations (the “Bond Obligations”) under the (i) Installment Purchase Agreement, a copy of which is attached as Exhibit 5.11(a), (ii) Trust Agreement, and (iii) all other documents related to the Bonds (hereinafter collectively referred to as the “Bond Documents”). The Sellers’ obligations pursuant to this Section 5.11(a) shall not include any requirement for the Sellers to contribute any funds (other than as otherwise contemplated by this Agreement) to any person, including the Majority Owners, to facilitate the consummation of the Transaction other than the payment of ordinary fees and expenses of the Sellers’ counsel in connection with the negotiation of this Agreement and consummation of the Transaction. Such transfer, modification, and assignment shall include the release of Sellers from any and all existing and future Bond Obligations

(b) Subject to the provisions of Section 5.11(a) above:

(i) the Sellers shall transfer, modify, and assign the Bond Obligations to IVHD upon Sellers receiving the consent of the Authority, Trustee and the Majority Owners on terms acceptable to IVHD in its sole discretion, subject to the release of Sellers as described in Section 5.11(a) and complying with the following requirements as set forth in Section 5.01 of the Installment Purchase Agreement (as such requirements may be amended for purposes of the Transaction):

(i) the Authority, the Trustee, and IVHD shall have received an Opinion of Bond Counsel to the effect that such transfer contemplated in this Agreement will not cause the interest on the Bonds to be included in gross income for federal income tax purposes under Section 103 of the Code;

(ii) IVHD: (A) assumes in writing all of the obligations of the City under the Installment Purchase Agreement and the Trust Agreement and agrees to fulfill and comply with the terms, covenants and conditions thereof as modified; (B) is not, after such transaction, otherwise in default under any provision of such Installment Purchase Agreement or the Trust Agreement, as modified; (C) complies with applicable Law; and (D) is a California healthcare district;

(iii) the Trustee and the Authority shall have received an Opinion of Counsel to the effect that the assignment or transfer of the Installment Purchase Agreement constitutes the legal, valid and binding obligations of IVHD, enforceable against IVHD in accordance with its respective terms; and

(iv) Trustee and Authority shall have received such other documents as may be required by the Trust Agreement and the Installment Purchase Agreement, as modified and all other conditions precedent to such assumption as required by the Trust Agreement and the Installment Purchase Agreement, as modified will have been satisfied.

(c) If Sellers and IVHD are unable to satisfy the conditions of Section 5.11(b) hereof, IVHD, in its sole and absolute discretion, may nonetheless proceed to close the Transaction if it determines that it can issue revenue bonds to acquire all or a portion of the Assets on terms and conditions satisfactory to IVHD in its sole and absolute discretion (the “Acquisition Revenue Bonds”) in order to defease the Bonds as of the Closing.

(d) Sellers shall cooperate with IVHD and provide any documentation or information required to effect the transactions related to the Bonds contemplated in this Agreement.

5.12 Supplement to Disclosure Schedule. During the period commencing on the Effective Date and ending on the earlier to occur of the Closing or termination of this Agreement (the “Interim Period”) each of the Parties, as applicable, shall have the right (but not the obligation) to supplement or amend the Disclosure Schedules with respect to any matter hereafter arising after the Effective Date (each a “Disclosure Schedule Supplement”). Any disclosure in any such Disclosure Schedule Supplement shall not be deemed to have cured any inaccuracy in or breach of any representation or warranty contained in this Agreement.

ARTICLE VI

CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLERS

Sellers’ obligation to sell the Assets and to close the Transaction will be subject to the satisfaction of each of the following conditions on or prior to the Closing Date unless specifically waived in writing by each Seller in whole or in part at or prior to the Closing:

6.1 Signing and Delivery of Instruments. IVHD will have executed and delivered all documents, instruments and certificates required to be executed and delivered pursuant to the provisions of this Agreement.

6.2 No Restraints. No temporary restraining order, preliminary or permanent injunction or other order preventing the consummation of the Transaction have been issued by any court of competent jurisdiction or any other Governmental Entity and remain in effect on the Closing Date.

6.3 Representations and Warranties; Performance of Covenants. The representations and warranties of IVHD contained in this Agreement will be true and correct when made except where the failure of such representations has not had and would not reasonably be expected to have a Material Adverse Effect. Each and all of the terms, covenants, and agreements in this Agreement to be complied with or performed by IVHD on or before the Closing Date will have been complied with and performed by IVHD, except where the failure to perform or comply with such term, covenants, and agreements has not had and would not reasonably be expected to have a Material Adverse Effect.

6.4 Required Consents.

(a) ECRMC will have received all Required Third Party Consents to the assignment to IVHD of those certain Assumed Leases and Assumed Contracts.

(b) All Required Governmental Consents will have been received as of the Effective Time.

(c) The City will have received all necessary consents, including that of the Authority and the Majority Owners for the transfer of the Bond Obligations to IVHD; and copies of all documents necessary to effectuate the transfer of the Bond Obligations to IVHD and to completely and forever release the Sellers.

6.5 Pioneers Bonds. Pioneers Memorial Healthcare District (“PMHD”) issued its Pioneers Memorial Healthcare District Revenue Bonds, Series 2017, in the original aggregate amount of \$15,640,000 (the “Pioneers Bonds”) pursuant to the Indenture dated December 1, 2017 (the “Pioneers Indenture”), as amended, between PMHD and U.S. Bank National Association and IVHD has assumed the Pioneers Bonds, the Pioneers Indenture, and all related documents (collectively, the “Pioneers Bond Documents”). IVHD shall have received necessary consents to the modifications, amendments and restatements of the Pioneers Bond Documents, or shall have refunded or refinanced the Pioneers Bonds in order to permit (a) the transfer of the Bonds to IVHD or (b) the issuance of the Acquisition Revenue Bonds by IVHD and the assumption of the Assumed Liabilities.

6.6 Distressed Hospital Debt. IVHD shall have received necessary consents in order to permit the transfer of the Pioneers Distressed Hospital Debt to IVHD and the assumption of the Assumed Liabilities.

6.7 CHFFA Loans. IVHD shall have received necessary consents in order to permit the transfer of any outstanding loans to the Sellers from the California Health Facilities Financing Authority to IVHD and the assumption of the Assumed Liabilities.

6.8 Bridge Loan. IVHD shall have received necessary consents in order to permit the transfer of any outstanding loans to the Sellers in respect of the 2022 \$5.6M bridge loan to IVHD and the assumption of the Assumed Liabilities.

6.9 UC San Diego Health Release. The Joint Powers and Affiliation Agreement by and between UC San Diego Health and Sellers shall have been terminated and Sellers shall have been released from any obligations thereunder.

ARTICLE VII

CONDITIONS PRECEDENT TO OBLIGATIONS OF IVHD

IVHD’s obligation to purchase the Assets and to close the Transaction will be subject to the satisfaction of each of the following conditions on or prior to the Closing Date unless specifically waived in writing by IVHD in whole or in part at or prior to the Closing.

7.1 Signing and Delivery of Instruments. Sellers will have executed and delivered all documents, instruments and certificates required to be executed and delivered pursuant to the provisions of this Agreement.

7.2 No Restraints. No temporary restraining order, preliminary or permanent injunction or other order preventing the consummation of the Transaction will have been issued

by any court of competent jurisdiction or any other Governmental Entity and remain in effect on the Closing Date.

7.3 Representations and Warranties; Performance of Covenants. The representations and warranties of Sellers contained in this Agreement will be true and correct when made except where the failure of such representations has not had and would not reasonably be expected to have a Material Adverse Effect. Each and all of the terms, covenants, and agreements in this Agreement to be complied with or performed by Sellers on or before the Closing Date will have been complied with and performed by Sellers, except where the failure to perform or comply with such term, covenants, and agreements has not had and would not reasonably be expected to have a Material Adverse Effect.

7.4 Title Insurance Policy. The Title Company will be irrevocably committed, subject only to payment of premiums, to issue to IVHD on and effective as of the Closing Date the Owner's Title Policy in the amount of the full insurable value of the Owned Real Property, as reasonably determined by the Title Company. Subject only to the Permitted Exceptions, the Owner's Title Policy will show fee simple title to the Owned Real Property vested in IVHD.

7.5 No Material Adverse Effect. Since the Effective Date, there will not have been any Material Adverse Effect with respect to the Business.

7.6 Required Consents.

(a) All Required Third Party Consents will have been obtained by ECRMC.

(b) All Required Governmental Entity Consents will have been obtained by the Parties.

7.7 Waiver of Severance Benefits. Each of the ECRMC Chief Financial Officer, Chief Nursing Officer, Chief Human Resources Officer and General Counsel who accept offers of employment with IVHD shall have waived, in writing, their right to receive severance benefits in connection with the termination of their employment by ECRMC at the Closing; *provided, however,* that the offers of employment from IVHD to such executive officers will provide for severance benefits of the same duration as provided to each such executive officer by ECRMC prior to the Closing.

7.8 ECRMC Bonds. IVHD shall have received sufficient documents to cause the satisfaction of either Section 5.11(b) or, in its sole and absolute discretion, IVHD will have closed on the Acquisition Revenue Bonds referenced in Section 5.11(c) and the Bonds will be deemed to have been fully defeased.

7.9 Pioneers Bonds. IVHD shall have received necessary consents to the Pioneers Bond Documents, modifications, amendments and restatements of the Pioneers Bond Documents, or shall have refunded or refinanced the Pioneers Bonds in order to permit the transfer of the Bonds or the Refunding Bonds to IVHD and the assumption of the Assumed Liabilities.

7.10 Distressed Hospital Debt. IVHD shall have received necessary consents in order to permit the transfer of the Pioneers Hospital Debt to IVHD and the assumption of the Assumed Liabilities.

7.11 CHFFA Loans. IVHD shall have received necessary consents in order to permit the transfer of any outstanding loans to the Sellers from the California Health Facilities Financing Authority to IVHD and the assumption of the Assumed Liabilities.

7.12 Bridge Loan. IVHD shall have received necessary consents in order to permit the transfer of any outstanding loans to the Sellers in respect of the 2022 \$5.6M bridge loan to IVHD and the assumption of the Assumed Liabilities.

7.13 LOC. IVHD shall have received sufficient evidence from ECRMC to show that the LOC is in effect on terms satisfactory to IVHD in its sole discretion and has a balance of \$0 and a total available amount of Fifteen Million Dollars (\$15,000,000.00).

7.14 ECRMC Assets and Liabilities. ECRMC's Assets will include at least Five Million Dollars (\$5,000,000.00) of cash-on-hand (after, for the avoidance of doubt, payment of the Closing Payroll Payments and Closing Payments) and its Liabilities will not include more than Twenty Nine Million Dollars (\$29,000,000.00) of Specified Payables.

ARTICLE VIII TERMINATION

8.1 Termination. This Agreement may be terminated at any time prior to Closing:

(a) by the mutual written consent of the Parties;

(b) by either Seller if a material breach of this Agreement has been committed by IVHD and such breach has not been (i) waived in writing by such Seller, or (ii) cured by IVHD to the reasonable satisfaction of such Seller within three (3) business days after such Seller provides IVHD a written notice which describes the nature of such breach; provided, however, that such Seller will not be permitted to terminate this Agreement pursuant to this Section 8.1(b) if such Seller is also in material breach of this Agreement;

(c) by IVHD if a material breach of this Agreement has been committed by a Seller, which material breach has resulted, or would more likely than not result, in a Material Adverse Effect on the Assets taken as a whole, and such breach has not been (i) waived in writing by IVHD, or (ii) cured by the applicable Seller to the reasonable satisfaction of IVHD within three (3) business days after IVHD provides the applicable Seller a written notice which describes the nature of such breach; provided, however, that IVHD will not be permitted to terminate this Agreement pursuant to this Section 8.1(c) if IVHD is also in material breach of this Agreement;

(d) by IVHD if satisfaction of any condition in Article VII is or becomes impossible and IVHD has not waived such condition in writing (provided; however, that the failure to satisfy the applicable condition or conditions has occurred by reason other than (i) through the failure of IVHD to comply with its obligations under this Agreement, or (ii) Sellers' failure to

provide its closing deliveries on the Closing Date as a result of IVHD not being ready, willing and able to close the Transaction on the Closing Date);

(e) by a Seller if satisfaction of any such condition in Article VI is or becomes impossible and such Seller has not waived such condition in writing (provided that if the failure to satisfy the applicable condition or conditions has occurred by reason other than (i) through the failure of such Seller to comply with its obligations under this Agreement, or (ii) IVHD's failure to provide its closing deliveries on the Closing Date as a result of Sellers not being ready, willing and able to close the Transaction on the Closing Date);

(f) by either Party if the conditions in Sections 6.5, 6.6, 7.9, or 7.10 have not been satisfied by December 31, 2025; or

(g) by any Party if the Closing has not occurred (other than through the failure of any Party seeking to terminate this Agreement to comply fully with its obligations under this Agreement) by the one-year anniversary of the Effective Date (the "**Outside Termination Date**").

8.2 Termination Consequences. If this Agreement is terminated pursuant to Section 8.1: (a) all further obligations of the Parties under this Agreement will terminate, except that the obligations in Sections 8.2, 11.3, 11.8, 11.12 and 11.19-11.22 will survive, and (b) each Party will pay the costs and expenses incurred by it in connection with this Agreement. Each Party acknowledges that the agreements contained in this Section 8.2 are an integral part of the Transaction and that without these agreements such Party would not have entered into this Agreement.

ARTICLE IX POST-CLOSING MATTERS AND COVENANTS

9.1 Excluded Assets. Subject to Section 1.1(b) hereof, any Excluded Asset (or proceeds thereof) pursuant to the terms of this Agreement or as otherwise determined by the Parties' mutual written agreement, which comes into the possession, custody or control of IVHD (or its successors-in-interest, assigns or Affiliates) will, within twenty (20) business days following receipt, be transferred, assigned or conveyed by IVHD (or its successors-in-interest, assigns and Affiliates) to Sellers without imposing any charge to Sellers for IVHD's transfer, storage, handling or holding of same on and after the Effective Time.

9.2 Preservation and Access to Records After the Closing.

(a) From the Closing Date until the date seven (7) years after the Closing Date or such longer period as required by Law, IVHD will keep and preserve all medical records, patient records, medical staff records and other books and records which are among the Assets as of the Effective Time, but excluding any records which are among the Excluded Assets. In addition, IVHD will keep and preserve medical staff records of all providers currently on the medical staff from the date they applied for initial privileges through the remainder of the practitioner's career plus six (6) years. IVHD will afford to the representatives of Sellers and any of its affiliates, including their counsel and accountants ("Sellers' Representatives"), full and complete access to, and copies of, such records with respect to time periods prior to the Closing Date (including access to records of patients treated at the Hospital prior to the Closing Date) during normal business

hours after the Closing Date, to the extent reasonably needed by any Sellers' Representative for any lawful purpose. IVHD acknowledges that, as a result of entering into this Agreement and operating the Business, it will gain access to patient records and other information which are subject to rules and regulations concerning confidentiality. IVHD will abide by any such rules and regulations relating to the confidential information it acquires. IVHD will maintain the patient and medical staff records at the Hospital in accordance with applicable Laws and the requirements of relevant insurance carriers.

(b) IVHD will provide reasonable cooperation to Sellers, Sellers' Representatives, and their insurance carriers in respect of the defense of claims by third parties against Sellers or any Sellers' Representative, in respect of events occurring prior to the Effective Time with respect to the operations of the Business. Such cooperation will include, without limitation: (i) making the Hired Employees reasonably available for interviews, depositions, hearings and trials, and (ii) making its employees available to assist in the securing and giving of evidence and in obtaining the presence and cooperation of witnesses. In addition, Sellers and Sellers' Representatives will be entitled to remove from the Hospital originals of any such records, but (x) only for purposes of pending litigation involving the Persons to whom such records refer, as certified in writing prior to removal by counsel retained by Sellers or Sellers' Representatives in connection with such litigation, and (y) only if Sellers and Sellers' Representatives leave a copy thereof with IVHD. Any records so removed from the Hospital will be promptly returned to IVHD following Sellers' or Sellers' Representatives use of such records.

(c) In connection with (i) the transition of the Business pursuant to the Transaction, (ii) Sellers' rights to the Excluded Assets, and (iii) any claim, audit, or proceeding, including any tax claim, audit, or proceeding, IVHD will after the Effective Time give Sellers access during normal business hours to IVHD's books, personnel, accounts and records and all other relevant documents and information with respect to the assets, Liabilities and business of the Business as Sellers' Representatives may from time to time reasonably request, all in such manner as not to unreasonably interfere with the operations of the Business.

(d) IVHD will comply with, and be solely responsible for, all obligations under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164) promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 and any and all corresponding California state Law requirements with respect to the operation of the Hospital on and after the Effective Time.

(e) IVHD will cooperate with Sellers, on a timely basis and as reasonably requested by Sellers, in connection with the provision of all data of the Hospital and other information required by Sellers for reporting purposes.

(f) To the maximum extent permitted by Law, if any Person requests or demands, by subpoena or otherwise, any documents relating to the Excluded Assets, IVHD will notify Sellers and will provide Sellers with the opportunity to object to, and otherwise coordinate with respect to, such request or demand.

9.3 Medical Staff. To ensure continuity of care in the community, IVHD agrees that the Hospital's medical staff members and providers with privileges as of the Closing Date will

maintain medical staff privileges at the Hospital as of the Closing Date on the same terms and conditions enjoyed as of the Closing Date. On and after the Closing Date, the medical staff will be subject to the Hospital's Medical Staff Bylaws then currently in effect, provided that such Bylaws are in compliance with all applicable Laws and regulations and contain customary obligations. A transition period is required to allow for continued, effective medical staff practices as the Medical Staff transitions to the new set of Bylaws.

9.4 Use of Financial Contribution. IVHD will use the Financial Contribution to fund operations of the Business and to support healthcare for residents of the City. Upon the City's reasonable request, IVHD shall provide the City with an accounting of such expenditures.

9.5 County-Wide Tax Measure. Subject to applicable Law, the City will cooperate with IVHD in IVHD's proposed county-wide tax measure, which will be on the ballot in 2025 or 2026. Notwithstanding the foregoing, the City will not be responsible for funding the costs of the county-wide tax measure or for the outcome of the vote.

9.6 Operating Commitment. IVHD will use best efforts to operate the Hospital as a general acute care hospital for not less than ten (10) years following the Closing Date.

9.7 Post-Closing Discovery of Contracts. IVHD acknowledges it is assuming all Contracts. If following the Closing, a Seller discovers a Contract that was not disclosed to IVHD, such Seller will provide a copy to IVHD promptly and IVHD must assume the obligations thereunder.

9.8 Indemnification of Sellers. IVHD shall defend, indemnify, and hold harmless Sellers and Sellers' Representatives (collectively, the "Seller Indemnified Persons"), from and against any and all losses suffered, paid or incurred by such Seller Indemnified Person arising from or related to: (a) any claim made by a third party with respect to the ownership or operation of the Business; (b) any breach or failure of any of IVHD's representations and warranties in Article III to be true and correct as of the Effective Date or as of the Closing; (c) any breach of any covenant or agreement of IVHD under this Agreement or any Transaction Document; (d) intentional misrepresentation or fraud committed by IVHD; or (e) any claim made by a third party with respect to the Assets or the Assigned Leases, Assumed Contracts, Bond Obligations, or other Assumed Liabilities.

9.9 Intended Tax Treatment/Allocation.

(a) For all federal and state income Tax purposes, the Parties agree that the Financial Contribution as contemplated under this Agreement shall be treated as an asset of Sellers that is included in the purchase and sale of the Assets and the assumption of the Liabilities, which is intended to provide a source of available cash towards IVHD's satisfaction of the Liabilities (the "Intended Tax Treatment").

(b) The Purchase Price, and any assumed liabilities, costs and other items included in "consideration" for purposes of the Code (the "Tax Consideration"), shall be allocated among the assets of the Sellers in accordance with the methodology set forth on Schedule 9.9 (the "Allocation"). The Sellers and IVHD agree that the Allocation is based on the fair market values of the acquired assets as of the Closing Date determined and allocated in accordance with Code

Section 1060 of the Code and the Treasury Regulations thereunder, and the methodology set forth on Schedule 9.9. As soon as reasonably practicable (and in any event within 120 days) after the Closing Date, IVHD shall update the Allocation to reflect the final determinations of the book value of such assets as of the Closing Date and any changes to the Tax Consideration and provide the Sellers with a draft of the same for Sellers' approval (which shall not be unreasonably withheld), and the Allocation as so finalized shall become the "Final Allocation", which shall be final and binding upon IVHD, the Sellers and their Affiliates.

(c) The Parties agree that they will not take, nor will they permit any of their respective Affiliates to take, for Tax purposes any position (whether in audits, tax returns or otherwise) that is inconsistent with the Intended Tax Treatment or the Final Allocation absent a final "determination" within the meaning of Section 1313(a) of the Code (or the corresponding provision of any other applicable Law).

9.10 Non-Assignable Rights. To the extent that Sellers' rights under any contract or permit constituting an Asset, or any other Asset, may not be assigned to IVHD without the consent, authorization, approval or waiver of another Person which has not been obtained (each, a "Non-Assignable Right"), this Agreement shall not constitute an agreement to assign the same if an attempted assignment would constitute a breach thereof or be unlawful, and Sellers shall use commercially reasonable efforts prior to Closing to obtain any such required consents, authorizations, approvals and waivers, or any release, substitute or amendment required to novate any Non-Assignable Rights so that they can be effectively transferred to IVHD as promptly as reasonably practical after Closing upon the terms set forth in this Agreement. Once such consent, authorization, approval, waiver, release, substitution or amendment is obtained, Sellers shall assign, transfer, convey and deliver to IVHD the relevant Non-Assignable Right to which such consent, authorization, approval, waiver, release, substitution or amendment relates for no additional consideration.

ARTICLE X TAXES AND COST REPORTS

10.1 Tax Matters. After the Closing Date, the Parties will reasonably cooperate with each other and will make available to each other, as reasonably requested, all information, records or documents relating to tax Liabilities or potential tax Liabilities attributable to ECRMC with respect to ECRMC's operation of the Business for all periods prior to the Closing Date and will preserve all such information, records and documents at least until the expiration of any applicable statute of limitations or extensions thereof. The Parties will also make available to each other to the extent reasonably required, and at the reasonable cost of the requesting Party (for out-of-pocket costs and expenses only), personnel responsible for preparing or maintaining information, records and documents in connection with tax matters and as ECRMC reasonably may request in connection with the completion of any post-Closing audits of the Business.

10.2 Cost Report Matters. IVHD will prepare and timely file on ECRMC's behalf all cost reports relating to the periods ending prior to the Closing Date or required as a result of the consummation of the Transaction, including those relating to Medicare, Medicaid, and other third party payors which settle on a cost report basis (the "Sellers Cost Reports"). IVHD will file all future period Medicare cost reports required to be filed.

ARTICLE XI MISCELLANEOUS PROVISIONS

11.1 Further Assurances and Cooperation. Each Party will execute, acknowledge and deliver to the other Party any and all other assignments, consents, approvals, conveyances, assurances, documents and instruments reasonably requested by such Party at any time and will take any and all other actions reasonably requested by such Party at any time for the purpose of consummating the Transaction and fulfilling such Party's obligations hereunder. Without limiting the foregoing, ECRMC will use commercially reasonable efforts to cooperate with IVHD with respect to any data, information, or other records reasonably needed by IVHD to obtain payments or any reimbursements from any third-party payor, including without limitation any supplemental payments. After consummation of the Transaction, the Parties agree to cooperate with each other and take such further actions as may be necessary or appropriate to effectuate, carry out and comply with all of the terms of this Agreement, the documents referred to in this Agreement, and the Transaction.

11.2 Successors and Assigns. All of the terms and provisions of this Agreement will be binding upon and will inure to the benefit of and be enforceable by the respective successors and assigns of the Parties hereto; provided, however, that no Party hereto may assign any of its rights or delegate any of its duties under this Agreement without the prior written consent of the other Parties which consent will not be unreasonably withheld, conditioned, or delayed.

11.3 Governing Law; Venue. This Agreement will be governed by and construed in accordance with the internal Laws of the State of California (without giving effect to the principles of conflict of Laws thereof). If either Party commences a lawsuit or other proceeding relating to or arising from this Agreement, the Parties agree that the United States District Court for the Southern District of California shall have sole and exclusive jurisdiction over any such proceeding. If such court lacks subject matter jurisdiction, the Parties agree that the California state courts in Imperial County, California shall have sole and exclusive jurisdiction. Any of these courts shall be proper venue for any such lawsuit or judicial proceeding and the Parties waive any objection to such venue. The Parties consent to and agree to submit to the jurisdiction of any of the courts specified herein and agree to accept service of process to vest personal jurisdiction over them in any of these courts. Process in any action or proceeding referred to in the preceding sentence may be served on either Party anywhere in the world.

11.4 Amendments. This Agreement may not be amended other than by written instrument signed by the Parties.

11.5 Exhibits, Schedules and Disclosure Schedules. The Disclosure Schedules and all exhibits and schedules referred to in this Agreement will be attached hereto and are incorporated by reference herein.

11.6 Notices. Any notice, demand, letter or other communication required, permitted, or desired to be given hereunder will be deemed effectively given when either personally delivered, or when received by electronic means (including email) or overnight courier, or five (5) calendar days after being deposited in the United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, addressed as follows:

If to IVHD: Imperial Valley Health District
207 West Legion Road
Brawley, CA 92227
Attention: Chris Bjornberg
Email: cbjornberg@iv-hd.org

With copies
(which shall not
be deemed
notice) to: Snell & Wilmer LLP
Executive Center Del Mar
12230 El Camino Real
Suite 300
San Diego, CA 92130
Attention: Adriana Ochoa
Email: arochoa@swlaw.com

and

Snell & Wilmer LLP
Two Cal Plaza
350 South Grand Ave.
Suite 3100
Los Angeles, CA 90071
Attention: Joshua Schneiderman
Email: jschneiderman@swlaw.com

If to ECRMC: El Centro Regional Medical Center
1415 Ross Avenue
El Centro, CA 92243
Attention: Chief Executive Officer
Email: Pablo.Velez@ecrmc.org

With a copy
(which shall not
be deemed
notice) to: El Centro Regional Medical Center
1415 Ross Avenue
El Centro, CA 92243
Attention: General Counsel
Email: Douglas.Habig@ecrmc.org

If to City: City of El Centro
1275 Main Street
El Centro, CA 92243
Attention: City Manager
Email:

With a copy (which shall not be deemed notice) to: Sheppard Mullin Richter & Hampton LLP
Four Embarcadero Center
Seventeenth Floor
San Francisco, CA 94111
Attention: Eric Newsom
Facsimile: (415) 403-6011
Email: enewsom@sheppardmullin.com

and

Sheppard Mullin Richter & Hampton LLP
321 N. Clark Street, 32nd Floor
Chicago, IL 60654
Attention: Megan Rooney
Email: mrooney@sheppardmullin.com

or at such other address as one Party may designate by notice hereunder to the other Parties.

11.7 Headings. The section and other headings contained in this Agreement and in the Disclosure Schedule, exhibits and schedules to this Agreement are included for the purpose of convenient reference only and will not restrict, amplify, modify or otherwise affect in any way the meaning or interpretation of this Agreement or the Disclosure Schedule, exhibits and schedules hereto.

11.8 Confidentiality. The Parties acknowledge and agree that the Confidentiality Agreement, dated as of April 1, 2024, among the Parties (the “Confidentiality Agreement”) remains in full force and effect.

11.9 Fair Meaning. This Agreement will be construed according to its fair meaning and as if prepared by all Parties.

11.10 Gender and Number; Construction; Affiliates. All references to the neuter gender will include the feminine or masculine gender and vice versa, where applicable, and all references to the singular will include the plural and vice versa, where applicable. Unless otherwise expressly provided, the word “including” followed by a listing does not limit the preceding words or terms and will mean “including, without limitation.” Any reference in this Agreement to an “Affiliate” will mean any Person directly or indirectly controlling, controlled by or under common control with a second Person. The term “control” (including the terms “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of voting securities, by contract or otherwise.

11.11 Third Party Beneficiary. The provisions contained in this Agreement are not intended by the Parties, nor will they be deemed, to confer any benefit on any Person not a party to this Agreement, except for the Parties’ successors and permitted assigns.

11.12 Expenses and Attorneys' Fees. Each Party will be responsible for and bear all of its own fees, costs and expenses incurred at any time in connection with pursuing or consummating the proposed Transaction; provided, however, that in the event the Transaction closes, the City will be responsible for paying One Million Five Hundred Thousand Dollars (\$1,500,000.00) of IVHD's reasonable, documented expenses associated with the Transaction ("IVHD Closing Expenses"); and *provided further* that the City will not reimburse IVHD for any costs or expenses related to any representations and warranties insurance policy, including policy premiums or attorney or other professional fees associated with any such policy. IVHD will be responsible for paying any necessary regulatory filing fees.

11.13 Counterparts. This Agreement may be executed in any number of counterparts, each of which will be deemed an original, but all of which together will constitute one and the same Agreement, binding on all of the Parties hereto. The Parties agree that .PDF copies of signatures will be deemed originals for all purposes hereof and that a Party may produce such copies, without the need to produce original signatures, to prove the existence of this Agreement in any proceeding brought hereunder. Signatures sent by facsimile or electronic transmission will be deemed to be originals for all purposes of this Agreement.

11.14 Entire Agreement. This Agreement, the Disclosure Schedules, the exhibits and schedules, and the documents referred to in this Agreement contain the entire understanding between the Parties with respect to the Transaction and supersede all prior or contemporaneous agreements, understandings, representations and statements, oral or written, between the Parties on the subject matter hereof other than the Confidentiality Agreement.

11.15 No Waiver. Any term, covenant or condition of this Agreement may be waived at any time by the Party which is entitled to the benefit thereof but only by a written notice signed by the Party expressly waiving such term or condition. The subsequent acceptance of performance hereunder by a Party will not be deemed to be a waiver of any preceding breach by any other Party of any term, covenant or condition of this Agreement, other than the failure of such other Party to perform the particular duties so accepted, regardless of the accepting Party's knowledge of such preceding breach at the time of acceptance of such performance. The waiver of any term, covenant or condition will not be construed as a waiver of any other term, covenant or condition of this Agreement.

11.16 Severability. If any term, provision, condition or covenant of this Agreement or the application thereof to any Party or circumstance will be held to be invalid or unenforceable to any extent in any jurisdiction, then the remainder of this Agreement and the application of such term, provision, condition or covenant in any other jurisdiction or to Persons or circumstances other than those as to whom or which it is held to be invalid or unenforceable, will not be affected thereby, and each term, provision, condition and covenant of this Agreement will be valid and enforceable to the fullest extent permitted by Law.

11.17 Time is of the Essence. Time is of the essence for all dates and time periods set forth in this Agreement and each performance called for in this Agreement.

11.18 Waiver of Jury Trial. EACH OF THE PARTIES HEREBY WAIVES, TO THE FULLEST EXTENT PERMITTED BY LAW, ANY RIGHT TO TRIAL BY JURY OF ANY

CLAIM, DEMAND, ACTION, OR CAUSE OF ACTION (I) ARISING UNDER THIS AGREEMENT OR (II) IN ANY WAY CONNECTED WITH OR RELATED OR INCIDENTAL TO THE DEALINGS OF THE PARTIES IN RESPECT OF THIS AGREEMENT OR THE TRANSACTION, IN EACH CASE WHETHER NOW EXISTING OR HEREAFTER ARISING, AND WHETHER IN CONTRACT, TORT, EQUITY, OR OTHERWISE. EACH OF THE PARTIES EACH HEREBY AGREES AND CONSENTS THAT ANY SUCH CLAIM, DEMAND, ACTION, OR CAUSE OF ACTION WILL BE DECIDED BY COURT TRIAL WITHOUT A JURY AND THAT ANY OF THE PARTIES MAY FILE AN ORIGINAL COUNTERPART OF A COPY OF THIS AGREEMENT WITH ANY COURT AS WRITTEN EVIDENCE OF THE CONSENT OF THE PARTIES TO THE WAIVER OF THEIR RIGHT TO TRIAL BY JURY.

11.19 Non-Recourse. All claims or causes of action (whether in contract or in tort, in law or in equity, by statute or otherwise) that may be based upon, arise out of or relate to this Agreement or the other Transaction Documents, or the negotiation, execution or performance of this Agreement or the other Transaction Documents (including any representation or warranty made in or in connection with this Agreement or the other Transaction Documents or as an inducement to enter into this Agreement or the other Transaction Documents), may be made only against the Persons that are expressly identified as parties hereto and thereto. No Person who is not a named party to this Agreement or the other Transaction Documents, including any past, present or future director, officer, employee, incorporator, member, partner, stockholder, equity holder, controlling person, Affiliate, agent, attorney or representative of any named party to this Agreement or the other Transaction Documents (the “Non-Party Affiliates”) will have any Liability (whether in contract or in tort, in law or in equity, by statute or otherwise, or based upon any theory that seeks to impose Liability of an entity party against its owners or Affiliates, including by or through theories of equity, agency, control, instrumentality, single business enterprise, piercing the veil or undercapitalization) for any obligations or Liabilities arising under, in connection with or related to this Agreement or the other Transaction Documents (as the case may be) or for any claim based on, in respect of, or by reason of this Agreement or the other Transaction Documents (as the case may be) or the negotiation or execution hereof or thereof; and each Party waives and releases all such Liabilities, claims and obligations against any such Non-Party Affiliates.

11.20 Release. IVHD irrevocably and unconditionally releases and forever discharges, Sellers and Sellers’ Representatives, subsidiaries, successors and assigns and any of their respective directors, managers, officers, members, partners, equity holders, trustees, employees, agents, counsel or advisors from any and all Liabilities whatsoever (whether known or unknown, asserted or unasserted, absolute or contingent, accrued or unaccrued and whether due or to become due), excluding only those obligations arising directly under this Agreement. IVHD hereby acknowledges that they have been advised by legal counsel of the provisions of California Civil Code Section 1542, which provides as follows:

A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE AND THAT, IF KNOWN TO HIM OR HER, WOULD HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY.

Having been so advised, IVHD hereby waives any rights they may have under Section 1542, as well as under any other statute or common law principles of similar effect.

11.21 Survival. The representations and warranties of each Seller contained in this Agreement or in any certificate delivered pursuant hereto (whether or not contained in Article II or Article III) will not survive, and will terminate at, the Closing, and the Sellers and their respective Affiliates will not have any Liability after the Closing for any breach of any of its representations or warranties contained in this Agreement, any Transaction Document, or in any certificate or other instrument delivered pursuant hereto or thereto. The covenants or other agreements of each Seller contained in this Agreement, any Transaction Document, or in any certificate delivered pursuant hereto or thereto which are to be performed prior to Closing will not survive, and will terminate at, the Closing, and the Sellers will not have Liability after the Closing for any breach of any such covenant or other agreement contained in this Agreement, any Transaction Document, or in any certificate delivered pursuant hereto or thereto. The covenants and other agreements of the Sellers contained in this Agreement or in any certificate delivered pursuant hereto which are to be performed after the Closing will survive the Closing for the period contemplated by their terms.

11.22 Several and Not Joint Liability. For the avoidance of doubt, the City shall not be liable for any representations and warranties or covenants of ECRMC, and ECRMC shall not be liable for any representations and warranties or covenants of the City herein.

11.23 Non-Disparagement. No Party will, whether in writing or orally, malign, denigrate or disparage another Party, or any of its current or former directors, officers, employees, partners, members, agents or representatives, with respect to any of their respective past or present activities associated with the Business (including the negotiation of this Transaction), or otherwise publish (whether in writing or orally) statements that tend to portray any of the aforementioned parties in an unfavorable light with respect to any of their respective past or present activities associated with the Business (including the negotiation of this Transaction). Notwithstanding the foregoing, nothing in this Agreement will preclude any Party from responding accurately and fully to any request for information or disclosure of documents if required by Law, court order, subpoena or other legal process, in any criminal, civil, or regulatory proceeding or investigation, or in any legal dispute between the Parties. In addition, nothing in this provision or this Agreement is intended to prohibit or restrain the parties in any manner from making disclosures that are protected under the whistleblower provisions of federal or state Law or regulation.

11.24 Public Announcements. Unless otherwise required by applicable Law, no Party will make any public announcements in respect of this Agreement or the Transaction or otherwise communicate with any news media without the prior written consent of the other Parties (which consent shall not be unreasonably withheld, conditioned, or delayed), and the Parties shall cooperate as to the timing and contents of any such announcement.

[REMAINDER OF PAGE LEFT INTENTIONALLY BLANK]

IN WITNESS WHEREOF, this Asset Transfer Agreement has been entered by each Party's duly authorized officer effective as of the date first written above.

IVHD:

Signature: _____

Print Name: _____

Title: _____

CITY:

Signature: _____

Print Name: _____

Title: _____

ECRMC:

Signature: _____

Print Name: _____

Title: _____

Appendix I

Defined Terms Glossary

Terms defined within the Agreement and their applicable section references are set forth below.

Defined Term	Section Reference
Affiliate	Section 11.10
Agreement	Preamble
Allocation	Section 9.9(b)
Assets	Section 1.1(a)
Assigned Contracts	Section 1.1(a)(viii)
Assigned Leases	Section 1.1(a)(iii)
Assumed Benefit Plans	Section 1.1(a)(xxiii)
Assumed Liabilities	Section 1.1(d)
Authority	Section 1.1(d)(i)
Bill of Sale	Section 1.4(a)
Business	Recitals
Bond Documents	Section 5.11(a)
Bond Obligations	Section 5.11(a)
Bonds	Section 1.1(d)(ii)
CARES Act	Section 3.10(h)
Carryover Employees	Section 5.6(c)
Casualty	Section 1.6
City	Preamble
City-Owned Properties	Recitals
City's Knowledge	Section 2.13
Closing	Section 1.3(a)
Closing Date	Section 1.3(a)
Closing Payroll Payments	Section 5.6(a)
CMIR	Section 5.8(b)
Condemnation	Section 1.6
Confidentiality Agreement	Section 11.8
Disclosure Schedule Supplement	Section 5.12
ECRMC	Preamble
ECRMC Defined Contribution Plan	Section 5.6(f)
ECRMC-Owned Properties	Recitals
ECRMC Pension Plan	Section 5.6(e)
ECRMC's Knowledge	Section 3.29
Effective Time	Section 1.3(a)
Excluded Assets	Section 1.1(b)
Excluded Benefit Plans	Section 1.1(b)(vi)
Effective Date	Preamble
Facilities	Recitals
Final Allocation	Section 9.9(b)
Financial Contribution	Section 1.2(a)

Financial Statements	Section 3.16
Health Care Reform Laws	Section 3.12(i)
Hired Employees	Section 5.6(b)
Hospital	Recitals
HQI Program	Section 3.10(d)
Installment Purchase Agreement	Section 1.1(d)(i)
Intended Tax Treatment	Section 9.9(a)
Interim Financial Statements	Section 3.16
Interim Period	Section 5.12
IVHD	Preamble
IVHD Closing Expenses	Section 11.12
IVHD Knowledge	Section 4.8
Leased Real Property	Section 1.1(a)(iii)
Leasehold Title Policy	Section 5.5
Lessor Leases	Section 1.1(a)(iii)
LOC	Section 5.10
Majority Owners	Section 5.11(a)
Memorandums of Understanding	Section 5.6(g)
Non-Assignable Right	Section 9.10
Non-Party Affiliates	Section 11.19
Objections	Section 5.5
Objection Notice	Section 5.5
Objection Response	Section 5.5
Objection Response Notice Date	Section 5.5
OHCA	Section 5.8(b)
OHCA Notices	Section 5.8(b)
OIG Health and Human Services	Section 3.10(a)(v)
ORYX	Section 3.10(d)
Outside Termination Date	Section 8.1(g)
Owned Real Property	Section 1.4(d)
Owner's Affidavit	Section 5.5
Owner's Title Policy	Section 5.5
Parties	Preamble
Party	Preamble
Personal Property	Section 1.1(a)(i)
Pioneers Bonds	Section 6.5
Pioneers Bond Documents	Section 6.5
Pioneers Indenture	Section 6.5
PMHD	Section 6.5
Purchase Price	Section 1.2(a)
Qnet	Section 3.10(d)
Qualified Benefit Plan	Section 3.12(d)
Real Estate Assignments	Section 1.4(b)
Real Property	Section 1.1(a)(iii)
Refunding Bonds	Section 5.11(b)(i)

Required Governmental Entity Consents	Section 3.5(a)
Required Third Party Consents	Section 3.5(b)
Seller Indemnified Persons	Section 9.8
Seller Payment Programs	Section 3.10(a)(i)
Sellers	Preamble
Sellers Cost Reports	Section 10.2
Sellers' Representatives	Section 9.2(a)
Surveys	Section 5.5
Tax Consideration	Section 9.9(b)
Tenant Leases	Section 1.1(a)(iii)
Terminated Employees	Section 5.6(d)
Terminating Benefit Plans	Section 5.6(g)
Title Commitment	Section 5.5
Title Company	Section 5.5
Title Instruments	Section 5.5
Title Policy	Section 5.5
Transfer Agreement	Section 1.4(e)
Trust Agreement	Section 1.1(d)(ii)
UC San Diego Health	Section 1.5(d)
Year-End Financial Statements	Section 3.16

Terms not otherwise defined in the Defined Terms table above but otherwise referenced in the Agreement herein will have the meanings set forth below.

“Accrued PTO” means obligations and liabilities with respect to accrued but unused paid time off, including any sick, vacation and holiday pay hours (including employer FICA and any other estimated employer Taxes thereon), with respect to the Business Employees.

“Business Employee” means any employee of the Business (whether salaried or hourly, and full-time or part-time, and whether or not such persons are on short-term or long-term disability, military leave, workers compensation leave, or on any other type of leave of absence).

“Benefit Plan” means: (a) each “employee benefit plan,” as defined in Section 3(3) of ERISA whether or not subject to ERISA, and whether or not tax qualified, including any “governmental plan”, as defined in Section 3(32) of ERISA; and (b) each other pension, benefit, retirement, compensation, profit-sharing, savings, deferred compensation, bonus, incentive, performance award, equity or equity-based compensation, change in control, retention, separation, employment, consulting, severance, welfare, health, dental, vision, life insurance, disability, vacation, paid time off, Code Section 125 Cafeteria, or fringe-benefit and each other benefit or compensation plan, policy, program, contract, agreement or arrangement, that, in each case, is maintained, sponsored or contributed to or required to be contributed to by ECRMC for the benefit of any current or former directors, officers, or employees, retirees, independent contractors or consultants of the Business, or with respect to which ECRMC has or may have any Liability that arises from or is associated with the Business.

“Closing Payments” means any transaction expenses of ECRMC.

“Code” means the Internal Revenue Code of 1986, as amended.

“Contracts” means all contracts, leases and agreements (including purchase orders), whether written or oral, that relate to the operation of the Business.

“Controlled Group Member” means any entity (whether or not incorporated) that together with Sellers is a member of: (i) a controlled group of corporations within the meaning of Section 414(b) of the Code; (ii) a group of trades or business under common control within the meaning of Section 414(c) of the Code; (iii) an affiliated service group within the meaning of Section 414(m) of the Code; or (iv) any other person or entity treated as an Affiliate of Sellers under Section 414(o) of the Code.

“COVID-19” means the novel coronavirus disease, COVID-19 virus (SARS-COV-2 and all related strains and sequences) or mutations (or antigenic shifts or drifts) thereof or a disease or public health emergency resulting therefrom.

“COVID-19 Funds” means all grants, payments, distributions, loans, funds or other relief provided under the CARES Act, the Paycheck Protection Program Act, or any other program authorized by any Governmental Entity or government program in response to COVID-19 (as defined herein), including, but not limited to, the Paycheck Protection Program, Main Street Loan Program, Provider Relief Fund, Small Rural Hospital Improvement Program, Assistant Secretary for Preparedness and Response or Hospital Preparedness Program Grants, Federal Emergency Management Agency, or any other law or program enacted, adopted or authorized in response to or in connection with COVID-19; provided that COVID-19 Funds do not include any Medicare Accelerated Advance Payments.

“Disclosure Schedule” means the disclosure schedules regarding certain exceptions to the representations and warranties in this Agreement, and any Disclosure Schedule Supplement delivered pursuant to Section 5.12.

“Encumbrance” means with respect to any property or asset, any charge, claim, condition, covenants, defect in title, easement, encroachment, encumbrance, equities, escrow, lease, license, lien, mortgage, option, pledge, proxy, security interest, right of way, right of first refusal or first offer or other third-party right, title defect or restriction, including any restriction on use, voting, transfer, receipt of income or exercise of any other attributable of ownership.

“Environmental Laws” means any applicable Law, order or binding agreement with any Government Entity: (a) relating to pollution (or the cleanup thereof) or the protection of natural resources, endangered or threatened species, human health or safety, or the environment (including ambient air, soil, surface water or groundwater, or subsurface strata); or (b) concerning the presence of, exposure to, or the management, manufacture, use, containment, storage, recycling, reclamation, reuse, treatment, generation, discharge, transportation, processing, production, disposal or remediation of any Hazardous Substances.

“ECRMC Intellectual Property” means all Intellectual Property, to the extent used primarily or held for use primarily in, or otherwise primarily relating to, the Business that is owned or purported to be owned or licensed, in whole or in part, by or to ECRMC.

“ECRMC IT Systems” means information technology and computer systems, networks, hardware, software, databases, websites, and equipment owned or operated by or expressly on behalf of the ECRMC that are used to process, store, maintain, and operate data and information used in connection with the Business.

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended.

“Federal Anti-Kickback Statute” means 42 U.S.C. § 1320a-7b(b)) and the regulations promulgated thereunder, as amended.

“Federal False Claims Act” means 31 U.S.C. §§ 3729-3733 and the regulations promulgated thereunder, as amended.

“GAAP” means general accepted accounting principles.

“Government Entity” or Governmental Entity” means any federal, state, national, commonwealth, municipal, provincial, territorial, local, domestic, or foreign government, quasi-governmental or authority, regulatory, self-regulatory, or administrative authority, political subdivision, tribunal or other instrumental thereof, including each of their respective branches, departments, agencies, commissions, boards, directorates, commissions, officials, tribunals, bodies, bureaus, courts, instrumentalities or other subdivisions.

“Hazardous Substances” means: (a) any material, substance, chemical, waste, product, derivative, compound, mixture, solid, liquid, mineral or gas, in each case, whether naturally occurring or manmade, that is hazardous, acutely hazardous, toxic, or words of similar import or regulatory effect under Environmental Laws; and (b) any petroleum or petroleum-derived products, radon, radioactive materials or wastes, asbestos in any form, lead or lead-containing materials, urea formaldehyde foam insulation or polychlorinated biphenyls.

“Healthcare Laws” means any and all Laws relating to health care regulatory, licensure and reimbursement matters, including, without limitation, the licensure, certification, qualification or authority to transact business relating to the provision of, or payment for, or both the provision of and payment for, health benefits, healthcare or insurance coverage, including ERISA, COBRA, the State Children’s Health Insurance Program, Medicare, Medicaid, TRICARE, and Laws relating to the regulation of fraud and abuse, false claims and patient referrals; Laws governing the federal Medicare (including Medicare Part D and Medicare Advantage), Medicaid, Medicaid-waiver, and CHAMPUS/ TRICARE programs, any federal healthcare program as defined in 42 U.S.C. § 1320a-7b(f), and any state healthcare program as defined in 42 U.S.C. § 1320a-7(h) (“Healthcare Programs”) and the delivery and payment of healthcare services; Laws governing billing and submission of a claim to a Healthcare Program or any other payor, including reimbursement, payments, and cost reporting and other Healthcare Program or healthcare services reimbursement requirements; the Federal Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)) and the regulations promulgated thereunder, and its state law counterparts; the Federal Civil Monetary Penalty Provisions (collectively, 42 U.S.C. § 1320a-7a and 31 U.S.C. § 3801 *et seq.*); the Federal False Claims Act, and its state law counterparts; the Stark Law, and its state law counterparts; survey, certification and standards as each relates to the eligibility of ECRMC for obtaining governmental authorizations required in any state where they conduct business or required for ECRMC to

participate in any Healthcare Program; medical records and patient medical information privacy and security Laws, including the requirements of HIPAA; Laws governing treatment and reporting by ECRMC relating to infectious diseases; corporate practice of medicine doctrines and similar restrictions on ownership of any Person and the performance of professional medical services by any Person; the Prescription Drug and Marketing Act of 1987 (21 U.S.C. §§ 353 et seq.) and the Controlled Substances Act (21 U.S.C. §§ 801 et seq.), the Federal Food, Drug and Cosmetics Act (21 U.S.C. §§ 301 et seq.) and the Knox-Keene Health Care Service Plan Act of 1975 (California Health and Safety Code §§ 1340 et seq), each as amended from time to time, and all applicable and legally binding implementing regulations, rules, ordinances, judgments and orders, manuals, call letters, memorandums, transmittals and other sub-regulatory guidance applicable to ECRMC.

“HIPAA” means, collectively, the Health Insurance Portability and Accountability Act of 1996 and the implementing regulations, as amended and supplemented by the Health Information Technology for Clinical Health Act of the American Recovery and Reinvestment Act of 2009, Pub. Law No. 111-5 and its implementing regulations, when each is effective and as each is amended from time to time.

“Intellectual Property” means collectively, (a) all inventions (whether patentable or unpatentable and whether or not reduced to practice), all improvements thereto, and all letters patent and pending applications for patents of the United States and all countries foreign thereto and all reissues, reexaminations, divisions, continuations, continuations-in-part and extensions thereof; (b) all trademarks, service marks, trade names, Internet domain names, social media handles, and other similar designations of source, association or origin, whether or not registered, and all goodwill associated therewith, and all applications, registrations, and renewals in connection therewith; (c) all copyrights and other published and unpublished works of authorship, and all applications, registrations and renewals in connection therewith; (d) all mask works and all applications, registrations, and renewals in connection therewith; (e) all trade secrets and confidential business information (including confidential ideas, research and development, know how, methods, formulas, compositions, manufacturing and production processes and techniques, technical data, designs, drawings, specifications, customer and supplier lists, pricing and cost information, and business and marketing plans and proposals); (f) all software (including in source code, executable code, and object code form), data, data bases, and collections of data, and related documentation; (g) rights of publicity and likeness; (h) all rights to enforce and to collect royalties and damages, (i) all other intellectual property rights of any type in any jurisdiction; and (j) all copies and tangible embodiments of the foregoing (in whatever form or medium).

“Law” means any statute, law, ordinance, code, act, rule, regulation, treaty, Order, or other legally binding requirement of any Governmental Entity (including common law), including, without limitation, any Environmental Law, Privacy Law, and any Healthcare Law, each as may be amended from time to time.

“Liabilities” means all liabilities, indebtedness, obligations, damages, fines, fees, penalties and other liabilities (or contingencies that have not yet become liabilities) of any kind, character or description, whether absolute, accrued, matured, contingent (or based upon any contingency), known or unknown, secured or unsecured, fixed or otherwise, or whether due or to become due, including, without limitation, any fines, penalties, judgments, awards or settlements respecting any

judicial, administrative or arbitration proceedings or any damages, losses, claims or demands with respect to any Laws.

“Licenses” means licenses, permits, consents, approvals, authorizations, registrations, qualifications and certifications of any governmental or administrative agency or authority (whether federal, state or local), including without limitation any Medicare, Medicaid, Medi-Cal, and other provider numbers, certificates or determinations of need, state licenses, CLIA certificates and DEA registrations, in each case issued by any Governmental Authority to Sellers or the Business and that are related to or otherwise required for the ownership or operation of the Assets or the Business.

“Material Adverse Effect” means any event, change or occurrence that, individually or in the aggregate with other events, changes or occurrences, has had or would reasonably be expected to have, a negative effect on Sellers’ financial condition, operation, the Business or Assets in excess of Ten Million Dollars (\$10,000,000.00); provided, however, that a Material Adverse Effect will not include any event, change or occurrence, directly or indirectly, arising out of, or attributable to: (a) general economic or political conditions, (b) conditions generally affecting the industries in which the Business operates, (c) any changes in financial, banking or securities markets in general, including any disruption thereof and any decline in the price of any security or any market index or any change in prevailing interest rates, (d) acts of war (whether or not declared), armed hostilities or terrorism, or the escalation or worsening thereof, (e) any action required or permitted by this Agreement or any action taken (or omitted to be taken) with the written consent of or at the written request of IVHD, (f) any matter of which IVHD is aware on the Effective Date, (g) any changes in applicable laws or accounting rules (including United States GAAP), (h) the announcement, pendency or completion of the Transaction, including losses or threatened losses of employees, customers, suppliers, distributors, or others having relationships with Sellers and the Business, (i) any natural or man-made disaster or acts of God, (j) any epidemic, pandemic or disease outbreak (including COVID-19), or (k) any failure by the Business to meet any internal or published projections, forecasts or revenue or earnings predictions (provided that the underlying causes of such failures (subject to the other provisions of this definition) will not be excluded).

“Meaningful Use” means the Medicare and Medicaid Electronic Health Record Incentive Programs and any successor program.

“Medicare Accelerated Advance Payments” means the accelerated and advance payments received by Sellers prior to the Effective Time pursuant to the Accelerated Payment Program or the Advance Payment Program implemented by the Centers for Medicare & Medicaid Services to increase cash flow to healthcare providers as a result of COVID-19.

“Order” means any award, writ, sentence, injunction, judgment, decree, order, ruling, subpoena or verdict or other decision issued, promulgated or entered by any Governmental Entity.

“Ordinary Course of Business” means, with respect to any Person, an action taken by or on behalf of a Person that is recurring in nature, is consistent (including with respect to frequency and magnitude) with the past practices of such Person during the prior twelve (12) months and is taken in the ordinary course of the operations of such Person.

“Payment Programs” means Medicare, TRICARE, Medicaid, Medi-Cal Worker’s Compensation, Blue Cross/Blue Shield programs, and all other health maintenance organizations, preferred provider organizations, health benefit plans, health insurance plans, and other third-party reimbursement and payment programs including without limitation any Payment Programs of Sellers.

“Permitted Exceptions” means collectively, the following: (i) liens for taxes not yet delinquent or that are being contested in good faith; (ii) mechanics’, carriers’, workmen’s, repairmen’s or other like liens arising or incurred in the Ordinary Course of Business; (iii) liens arising under original purchase price conditional sales contracts and equipment leases with third parties entered into in the Ordinary Course of Business; (iv) easements, rights-of-way, zoning ordinances and all other Encumbrances of record affecting any one or more portion of the real property to be sold and transferred hereunder; (v) matters that would be disclosed by an accurate survey of the Real Property or any component thereof; (vi) the Tenant Leases and the rights of the tenants or subtenants, respectively, thereunder; (vii) in the case of any Tenant Lease, any lien rights arising from or on account of the tenant (or subtenant’s) performance of work on or about the premises leased (or subleased) thereunder; and (viii) in the case of any Lessor Lease, the rights of the landlord or sublandlord, as the case may be, thereunder and all matters affecting or encumbering the landlord’s (and, if applicable, sublandlord’s) title to the real property subject to such Lessor Lease.

“Person” means an individual, a corporation, a partnership, a limited liability company, a trust, an unincorporated association, a Governmental Entity, or any other entity or body.

“Personal Information” means information and data that is linked or linkable to a natural person, including, without limitation, any information specifically defined or identified in any Seller privacy policy as “personal information,” “personal data,” “personally identifiable information,” or “PII”. Personal Information may relate to any identifiable natural person, including a current, prospective or former customer, employee, supplier or vendor of any Person. Personal Information includes information in any form, including paper, electronic and other forms.

“Personal Property Leases” means any lease, conditional or installment sale contract, lien or similar arrangement to which any tangible personal property used by Sellers in connection with the ownership and operation of the Business is subject.

“Privacy Law” means HIPAA, the California Confidentiality of Medical Information Act (“CMIA”), and other applicable Laws concerning the privacy, security, or breach of individually identifiable information, including “protected health information” as defined in HIPAA, “medical information” as defined in the CMIA, and “personal information” as defined in California Civil Code Section 1798.82.

“Specified Payables” means the sum of ECRMC’s accounts payable, accrued expenses and accrued compensation (not including accrued benefits), calculated from ECRMC’s balance sheet and in a manner consistent with the historical accounting practices of ECRMC.

“Stark Law” means the federal Ethics in Patient Referrals Act, 42 U.S.C. Section 1395nn, and all regulations promulgated thereunder.

“Tax” or “Taxes” means any and all U.S. federal, state, local and foreign income, profits, franchise, gross receipts, stamp, payroll, sales, employment, unemployment, disability, use, personal and real property, withholding, excise, value added, and any other taxes, charges, fees, duties, levies or similar assessments or Liabilities in the nature of a tax, whether computed on a separate, consolidated, unitary or combined basis or in any other manner, and includes any interest, fines, penalties, assessments, deficiencies or additions thereto.

“Transaction” means the transactions contemplated by this Agreement.

“Transaction Documents” means, collectively, this Agreement and all ancillary agreements contemplated herein or otherwise necessary to effect the Transaction.

“WARN” means the Worker Adjustment and Retraining Notification Act, 29 U.S.C. §§ 2101, *et seq.*, or any similar state, local, or foreign Laws, including, but not limited to, California Assembly Bill AB 2957, as codified at California Labor Code Sections 1400, *et seq*



REQUEST FOR PROPOSALS

FOR CONSULTANT SERVICES TO ASSIST WITH THE DEVELOPMENT OF A 5-YEAR FACILITIES MASTER PLAN FOR THE IMPERIAL VALLEY HEALTHCARE DISTRICT

RFP Timeline Estimate*

Date	Activity
May 21, 2025	Release Request for Proposals
June 13, 2025	Proposals Due
June 20, 2025	Proposal Evaluation
June 26, 2025	Award

*subject to change

Direct Questions to: Adriana R. Ochoa
General Counsel
Imperial Valley Healthcare District
arochoa@swlaw.com
(858) 910-4806

REQUEST FOR PROPOSALS

FOR CONSULTANT TO ASSIST WITH THE DEVELOPMENT OF A 5-YEAR FACILITIES MASTER PLAN FOR THE IMPERIAL VALLEY HEALTHCARE DISTRICT

Notice is hereby given that the Imperial Valley Healthcare District (the “**District**”) is inviting proposals from qualified consultants to facilitate the development and creation of a 5-year facilities master plan for the District according to the terms set forth in this Request for Proposals (“**RFP**”).

1. Background

The District is a California public hospital district organized under The Local Health Care District Law (Health & Safety Code section 32000 *et seq.*). The District was established by Assembly Bill 918 to create one united, integrated healthcare system to serve the County of Imperial. The purpose of the District is to consolidate and coordinate medical services and improve healthcare access and cost-saving benefits for residents.

The Alquist Hospital Seismic Safety Act (“**AHSSA**”) requires that all General Acute Care hospital buildings comply with certain building code regulations by January 1, 2030. This requirement is intended to provide higher confidence that a building will retain a high level of functional recovery following a major earthquake.

The District’s facilities and operations include Pioneers Memorial Hospital, a 107-bed facility located at 751 W. Legion Rd, Brawley CA 92227 (“**PMH**”), and related facilities located at 450 E. Birch St, Calexico, CA 92231 (Calexico Health Center), 565 Main St., Brawley, CA 92227 (Pioneers Children’s Health Center), 751 W. Legion Rd., Suite 103, Brawley, CA 92227 (Pioneers Health Center), and 320 Cattle Call Dr., Brawley, CA 92227 (Pioneers Memorial Skilled Nursing Center). The District is presently negotiating the acquisition of El Centro Regional Medical Center (“**ECRMC**”), a 161-bed hospital located at 1415 Ross Avenue, El Centro, CA 92243 and related facilities located at 385 W. Main St., El Centro, CA 92243 (El Centro Regional Medical Center Outpatient Clinic).

Through the issuance of this RFP, the District seeks to retain a strategic consultant to develop a comprehensive 5-year facilities master plan, including potential design and construction work associated with attaining compliance with the AHSSA, for both: (A) a combined PMH/ECRMC system (including related facilities for both hospitals), and alternatively, (B) a PMH only system (including PMH related facilities). The consultant will assist in evaluating the current state, analyzing healthcare needs, and identifying funding opportunities to support both short-term and long-term objectives. Additionally, the consultant will facilitate workshops, gather community input, and provide actionable recommendations to align the District’s goals with available resources, ensuring the successful implementation of strategies to address the evolving healthcare

needs of the community.

2. Scope of Services

The objectives of the engagement include the following:

- A. Document Review and Analysis: Review and evaluate current PMH facilities and potential ECRMC facilities to understand the current state of the District's current and prospective facilities. This analysis will inform the development of a new 5-year facilities master plan and long-term facilities goals.
- B. Timeline Development: Develop a timeline outlining key milestones for creating a comprehensive long-term facilities master plan, incorporating intermediate goals for the first 5-year phase (FY 2027-2031). This timeline will be informed by financial forecasting and funding needs, ensuring the allocation of resources is synchronized with long-term goals. The plan must include both: (A) a combined PMH/ECRMC system, and alternatively, (B) a PMH only system.
- C. Facilitate Board Workshops: Facilitate 2-3 Board workshops to guide the Board through the process of developing a long-term facilities master plan, with a specific focus on creating, and costing out, a new 5-year facilities master plan (FY 2027-2031) that serves as a foundation for achieving long-term goals. These workshops will be key to the creation of both the draft and final versions of a new 5-year facilities master plan. The workshops will include:
 - Define the goals, strategies, metrics, and financial resources of a new 5-year facilities master plan keeping in mind a long-term vision.
 - Ensure that feedback gathered from community input sessions is integrated into the discussions and revisions during the workshops.
 - Refine the draft 5-year facilities master plan based on workshop discussions and community feedback, leading to the creation of a final plan.
- D. Draft a Final 5-Year Facilities Master Plan: Develop a 5-year facilities plan for both (A) a combined PMH/ECRMC system, and alternatively, (B) a PMH only system, with refinements based on feedback from Board workshops and community input. The final facilities master plan will incorporate both short-term and long-term perspectives. This plan will include:
 - Long-Term Vision: A clear long-term vision for facilities that guides the District's healthcare goals beyond the 5-year scope, ensuring that short-term goals are aligned with the District's broader aspirations.

- Actionable Strategies: Specific, actionable strategies to achieve the goals within the 5-year timeframe while keeping the long-term vision in mind.
 - Metrics, Accountability and Benchmarking: Establish measurable outcomes, metrics and benchmarks for assessing progress toward the goals/strategies.
 - Financial Integration: Both the 5-year and long-term plans will include high-level financial assessments that cost out the proposed strategies, identifying how current and future funds can advance the goals and strategies in both the short-term and long-term.
- E. Analysis of District and Foundation Funding Opportunities: Identify immediate needs and opportunities for the 5-year plan that will directly contribute to broader long-term healthcare goals, including but not limited to the below, as applicable:
- Grant funding (rolling grants, RFPs, initiatives).
 - Community outreach efforts.
 - Mobile medical clinics.
- F. Consideration of Future Funding Opportunities: Evaluate future funding opportunities ensuring the 5-year plan lays the groundwork for long-term sustainability and expansion.
- G. Evaluation of Strategic Alternatives: Evaluate alternative strategies, such as potential partnerships and funding sources, while considering any limitations imposed by lease agreements or other financial constraints. Focus on leveraging these alternatives to support the District's long-term healthcare goals.
- H. Analysis of the Pioneers Memorial Hospital Foundation: Develop a strategy to enhance the role of the Pioneers Memorial Hospital Foundation in supporting the District's long-term healthcare goals, exploring new opportunities for funding, partnerships, and collaborations.

3. Proposal Contents

Proposals must be submitted with the contents and in the format outlined below:

- I. Brief overview of your firm and relevant experience, including any experience in long-term strategic planning for California healthcare districts and foundations, or California hospital systems (public or private), developing master facilities plans in compliance with the AHSSA and evaluating community needs (clinical or otherwise) as part of an assessment of organizational capabilities, capital access/plans/capacity, and/or constraints.
- J. Qualifications and experience of key individuals and firms:

- Names of individuals in key positions and resumes, qualifications and relevant experience of these individuals.
 - Names of firms that will perform any sub-consultant work (i.e. outside firms providing cost estimating, planning, architectural design, structural, mechanical or electrical engineering services) and resumes, qualifications and relevant experience of key individuals at such sub-consulting firms.
 - Certification that no individual or firm has an existing financial interest, and will not acquire any such interest, direct or indirect, which could conflict in any manner or degree with the performance of services required under this RFP and that no person having any such interest shall be subcontracted in connection with this RFP or employed by respondent.
- K. References, including the name and contact information of two to three previous clients for similar projects, including, as available, photos, final master facilities planning documents (if public), and literature for related similar projects done by the individuals listed in item B, above.
- L. Recommended or specific approach for accomplishing the scope of services that will include the following deliverables:
- Document review summary
 - Timeline development
 - Board workshop materials
 - Funding opportunities report
 - 5-year Facilities Master Plan
 - Community outreach sessions
 - Board and committee presentations
- M. Fee schedule/rate sheet, and proposed budget, including a comprehensive breakdown of proposed fees and fixed-price milestones, along with any additional costs or expenses associated with completing the scope of work and corresponding deliverables. Specify your preferred payment schedule, including when invoices would be issued for each milestone and the terms for payment.

4. Submission

Proposals must be submitted via email, and received by the District by **5:00 p.m. on June 13, 2025** in electronic, readable format to Adriana R. Ochoa at arochoa@swlaw.com, with a copy delivered to Christopher Bjornberg at Cbjornberg@iv-hd.org.

Proposals shall remain valid and subject to acceptance anytime within sixty (60) days after the submission deadline, unless a longer period of time is mutually agreed to by the parties.

5. Evaluation/Award

The District may request additional information, clarification and interviews as part of its evaluation. Selection will be based on demonstrated competence and the professional qualifications necessary for the satisfactory performance of the services required, capacity to meet desired project deadlines (see Term below), and shall be made in the best interests of the District.

6. Term

The work is expected to commence immediately after award, and the goal is for the facilities master plan to be completed by no later than **November 1, 2025** unless otherwise agreed to by the Parties. Time is of the essence for this project given the AHSSA-related deadlines.

7. Form of Contract

The successful respondent will be required to enter into an agreement with the District in a form substantially similar to the Professional Services Agreement included as Attachment 1, hereto.

8. General Terms and Disclaimers

The District reserves the right to reject any or all proposals and to waive any informality in a proposal. The District reserves the right to negotiate modifications with any firm as may be required to serve the best interests of the District and to negotiate the terms of any contract arising under this RFP.

All proposals will become the property of the District. Information in proposals will become public property and subject to disclosure laws. The District reserves the right to make use of any information or ideas in any proposal. All proposals will be maintained as confidential working papers until officially placed on a District Board of Directors agenda.

The District will not reimburse or pay any costs associated with the preparation or submission of a proposal for any reason. All costs associated with the preparation or submission of a proposal are solely the responsibility of the respondent.

ATTACHMENT 1

FORM OF AGREEMENT

[COMMENT FOR DRAFTER (DELETE FROM DRAFT BEFORE DISTRIBUTION): This agreement can be used for services provided by design professional services, such as architects, landscape architects, engineers, and land surveyors, exceeding \$25,000.]

PROFESSIONAL SERVICES AGREEMENT
BETWEEN IMPERIAL VALLEY HEALTHCARE DISTRICT
AND _____
FOR _____

Ref: Admin. xx-xxxx
Contract No. xxxxxx

This Professional Services Agreement (“**Agreement**”) is made on this _____ day of _____, 20__ (“**Effective Date**”), between IMPERIAL VALLEY HEALTHCARE DISTRICT (“**IVHD**”), and _____ (“**CONTRACTOR**”), an independent contractor, collectively referred to herein as “**parties**” or individually as “**party**,” to furnish certain services as provided in this Agreement and upon the following terms and conditions.

ARTICLE 1
TERM OF AGREEMENT

1.01 Term. The term of this Agreement shall commence on the Effective Date stated above, and will continue through the completion of the Services provided for in this Agreement or until terminated as provided under Article 7, whichever occurs first. Attachment A – Scope of Work (“**Attachment A**”) may contain further instructions regarding required timelines for performance of the Services to be provided under this Agreement. Time is of the essence for each and every provision of this Agreement.

ARTICLE 2
SCOPE OF WORK

2.01 Specific Services. CONTRACTOR shall perform the services within the scope described in Attachment A and as authorized by IVHD (the “**Services**”). CONTRACTOR will provide IVHD with periodic reports regarding the progress of Services performed, at IVHD’s request. Any changes to the scope of work or timeframes identified in Attachment A must be authorized by IVHD in writing and shall be set forth as an amendment to this Agreement.

2.02 Additional Work. [INCLUDE IF PHASING ANTICIPATED, OR DELETE] The parties agree that the scope of work as described in Attachment A is for Design Phase/Phase 1/Task 1 services only, and that the parties shall execute an amendment for services during Construction Phase/Phase 2/Task 2 or subsequent services if and when authorized by IVHD. The parties agree and acknowledge that CONTRACTOR has no responsibilities for public contracting on behalf of IVHD under this Agreement, and no authority to publicly contract on behalf of IVHD.

2.03 Contractor Responsibility. CONTRACTOR shall determine the method, details, and means of performing the above-described Services. CONTRACTOR shall supply all labor, tools, materials, and equipment required to perform the Services under this Agreement.

2.04 Standard of Performance. CONTRACTOR shall perform the Services required hereunder in accordance with the prevailing standard of care by exercising the skill and ability customarily exercised by reputable members of CONTRACTOR’s profession providing the same or similar services in the State of California. While exercising its professional skill and expertise, CONTRACTOR shall use reasonable

diligence and best judgment, and shall perform the Services required hereunder in the best interests of IVHD. Acceptance by IVHD of reports, and incidental professional work or materials furnished hereunder, shall not in any way relieve CONTRACTOR of responsibility for the adequacy of its work.

2.05 Key Personnel [OPTIONAL – DELETE IF INAPPLICABLE]. WA has a primary interest in maintaining the individual services of the following key project team members:

1. [REDACTED]
2. [REDACTED]

2.06 Personnel Changes. No member of the project team shall be removed from the project team or reassigned by CONTRACTOR without prior approval of IVHD. CONTRACTOR shall immediately inform IVHD, in writing, should any of the key members become unavailable. CONTRACTOR must submit the credentials for substitutes for key project members to IVHD for review and approval. At the discretion of IVHD, an interview may be required prior to approval of a substitute key project member.

ARTICLE 3 COMPENSATION

3.01 Compensation for Work Performed Under This Agreement. Compensation payable to CONTRACTOR for Services performed under this Agreement shall not exceed [REDACTED] Dollars (\$ [REDACTED]), in the aggregate. This amount shall not be exceeded unless agreed upon through an amendment to this Agreement executed by both parties. Such amendment shall identify any change in compensation as a result of the change in scope of work. The parties agree that this compensation was developed in accordance with the customary and prevailing compensation level in the community and surrounding area for comparable services. CONTRACTOR and IVHD agreed to this amount through an arm's length negotiation between the parties.

3.02 Payment of Expenses and Monthly Invoices. IVHD will reimburse CONTRACTOR for all reasonable expenses incurred in performing Services under this Agreement as the work progresses, provided that such reasonable expenses shall be included in and subject to the maximum compensation amount stated above in this Article. CONTRACTOR shall submit invoices to IVHD's Accounts Payable department (at [REDACTED]) and IVHD'S Project Manager once per month. Such invoices shall include a brief narrative description of the work performed, as well as detailed time expenditures on a task-by-task basis pursuant to Attachment A. The term "expenses" means telephone bills, and federal express charges, mailing charges and any other pre-approved expenses by IVHD. CONTRACTOR will provide IVHD with receipts and proof of payment for all expenses. IVHD shall make payment to CONTRACTOR within forty-five (45) days of receipt of an approved invoice.

3.03 Right to Withhold. IVHD shall have the right to withhold payment from CONTRACTOR for any unsatisfactory Services until such time service is performed satisfactorily or as otherwise provided for in this Agreement.

ARTICLE 4 RELATIONSHIP OF PARTIES

4.01 Independent Contractor. It is expressly understood and agreed that CONTRACTOR is an independent contractor and its employees are not employees of IVHD while engaged in carrying out this Agreement. CONTRACTOR is free from the control and direction of IVHD in connection with the performance of the work, CONTRACTOR performs work that is outside the usual course of IVHD

business, and CONTRACTOR is customarily engaged in an independently established trade, occupation, or business of the same nature as that involved in the work performed. The parties agree that no work, act, commission, or omission of CONTRACTOR or its employee(s) pursuant to this Agreement shall be construed to make CONTRACTOR or its employee(s) the agent, employee, or servant of IVHD. CONTRACTOR and its employee(s) are not entitled to receive from IVHD vacation pay, sick leave, retirement benefits, Social Security, workers' compensation, disability benefits, unemployment benefits, or any other employee benefit of any kind. CONTRACTOR shall be solely responsible for paying all federal and state employment and income taxes, for carrying workers' compensation insurance, and for otherwise complying with all other employment law requirements with respect to CONTRACTOR and its employee(s).

4.02 Responsibility for Misclassification. To the maximum extent allowable by law, CONTRACTOR agrees to indemnify, defend, and hold IVHD harmless from any and all liability, damages, or losses (including attorneys' fees, costs, penalties, and fines) that IVHD suffers as a result of (a) CONTRACTOR's failure to meet its obligations under this Article, or (b) a third party's designation of CONTRACTOR or its employee(s) as an employee of IVHD, regardless of any actual or alleged negligence by IVHD.

4.03 Non-Exclusive Relationship. CONTRACTOR and IVHD acknowledge that the relationship between the parties is non-exclusive and CONTRACTOR may perform or engage in any activity not inconsistent with this Agreement, including performing services for, or contracting with, other clients, persons, or companies as CONTRACTOR sees fit. IVHD reserves the right to employ other contractors in connection with the Services described in Attachment A.

ARTICLE 5 OBLIGATIONS OF CONTRACTOR

5.01 Compliance with Laws/Rules. In performing the Services specified in this Agreement, CONTRACTOR agrees to comply with all applicable laws, rules, regulations, and ordinances, whether federal, state, or local, and any and all applicable IVHD policies, procedures, departmental rules, and other directives provided by IVHD to CONTRACTOR, including, but not limited to, IVHD's Contractor Safety Policies and Procedures. Any changes to IVHD policies and procedures that relate to CONTRACTOR will be provided to CONTRACTOR in writing. CONTRACTOR agrees that, prior to entering into this Agreement, it has reviewed such policies, procedures, rules, and directives, the contents of which CONTRACTOR will be deemed to have knowledge.

5.02 Report Compliance. **[INCLUDE IF VALUE OF SERVICES EXCEEDS \$5,000, OR DELETE]** CONTRACTOR shall ensure that any report generated under this Agreement complies with California Government Code section 7550.

5.03 Indemnity, Hold Harmless, and Defense. To the maximum extent allowable by law, CONTRACTOR shall indemnify, defend, and hold harmless IVHD and its officials, officers, directors, employees, agents, and volunteers (collectively referred to as the "**Indemnified Parties**") against all claims, demands, losses, costs, expenses, obligations, liabilities, damages, recoveries, and deficiencies, including interest, penalties, attorneys' fees, and costs (collectively referred to as "**Liabilities**") that such entities or persons may incur that arise out of, pertain to, or relate to, the negligence, recklessness, or willful misconduct of CONTRACTOR, including CONTRACTOR's officers, officials, directors, employees, subcontractors, agents, representatives, volunteers, successors, assigns or anyone for whom CONTRACTOR is legally responsible. In no event shall the cost to defend charged to CONTRACTOR exceed CONTRACTOR'S proportionate percentage of fault. However, notwithstanding the previous sentence, in the event one or more defendants is unable to pay its share of defense costs due to bankruptcy

or dissolution of the business, CONTRACTOR shall meet and confer with the other parties regarding unpaid defense costs.

5.03.1 CONTRACTOR shall cooperate with and do whatever is necessary to protect Indemnified Parties from any such Liabilities.

5.03.2 CONTRACTOR shall defend Indemnified Parties, at CONTRACTOR's own cost, expense and risk, from any and all such aforesaid Liabilities asserted in claims, demands, actions, causes of action, arbitration, mediations, or other proceedings of any kind that may be brought or instituted against Indemnified Parties. CONTRACTOR and Indemnified Parties shall be jointly represented by legal counsel, unless there is a conflict of interest, and CONTRACTOR shall pay Indemnified Parties' reasonable attorneys' fees and costs as they are incurred. Indemnified Parties shall be consulted regarding, and shall approve, the selection of legal counsel. Should separate legal counsel be necessary for Indemnified Parties, as determined by IVHD, CONTRACTOR shall pay for the reasonable attorneys' fees and costs including expert witness fees, as such fees and costs are incurred and within thirty (30) days of receipt of an invoice, for Indemnified Parties' legal counsel in addition to CONTRACTOR's own legal fees and costs. In all circumstances, Indemnified Parties reserve the right to retain their own attorneys. CONTRACTOR shall not agree without Indemnified Parties' prior written consent to any settlement on Indemnified Parties' behalf. The cost to defend charged to CONTRACTOR shall not exceed the CONTRACTOR's proportionate percentage of fault, except that in the event that one or more defendants is unable to pay its share of defense costs due to bankruptcy or dissolution of the business, CONTRACTOR must meet and confer with the other parties regarding unpaid defense costs.

5.03.3 If CONTRACTOR is obligated to defend Indemnified Parties pursuant to this Section, and fails to do so after reasonable notice from IVHD, Indemnified Parties may defend themselves and/or settle such claims, suit or assertion, and CONTRACTOR shall pay to Indemnified Parties any and all Liabilities incurred in relationship with Indemnified Parties' defense and/or settlement of such proceeding.

5.03.4 CONTRACTOR shall pay and satisfy any judgment, award, liability, or decree that may be awarded, imposed, or rendered against Indemnified Parties as a result of any claims, demands, suits, actions, causes of action, arbitrations, mediations, or other proceedings whether legal, administrative or otherwise, including any settlement related thereto.

5.03.5 CONTRACTOR's obligation to indemnify, defend, and hold IVHD harmless against all Liabilities shall not be limited in any way by any limitation on the amount or type of damages, compensation, or benefits payable by or for CONTRACTOR, subcontractor, supplier, or other person under workers' compensation acts, disability acts, or other employee acts or the insurance required by this Agreement. CONTRACTOR's obligation to indemnify, defend, and hold IVHD harmless against all Liabilities shall not be restricted to insurance proceeds, if any, received by CONTRACTOR or Indemnified Parties. Provision of insurance coverage as required by this Agreement shall not affect CONTRACTOR's indemnity obligations.

5.03.6 CONTRACTOR's indemnification, hold harmless, and defense obligation shall survive the termination or expiration of this Agreement.

5.04 Patent and Copyright Indemnity [INCLUDE IF CONTRACTOR IS PROVIDING PRODUCTS, SYSTEMS, HARDWARE OR SOFTWARE, OR DELETE ENTIRE SECTION].

CONTRACTOR represents that it knows of no allegations, claims, or threatened claims that the materials, services, hardware or software ("Contractor Products") provided to IVHD under this Agreement infringe any patent, copyright or other proprietary right. CONTRACTOR shall defend, indemnify and hold harmless IVHD from and against all losses, claims, damages, liabilities, costs expenses and amounts (collectively,

“Losses”) arising out of or in connection with an assertion that any Contractor Products or the use thereof, infringe any patent, copyright or other proprietary right of any third party. IVHD will: (1) notify CONTRACTOR promptly of such claim, suit or assertion; (2) permit CONTRACTOR to defend, compromise, or settle the claim; and, (3) provide, on a reasonable basis, information to enable CONTRACTOR to do so. CONTRACTOR shall not agree without IVHD’s prior written consent to any settlement which would require IVHD to pay money or perform some affirmative act in order to continue using Contractor Products.

5.04.1 If CONTRACTOR is obligated to defend IVHD pursuant to this Section and fails to do so after reasonable notice from IVHD, IVHD may defend itself and/or settle such proceeding, and CONTRACTOR shall pay to IVHD any and all losses, damages and expenses (including attorney’s fees and costs) incurred in relationship with IVHD’s defense and/or settlement of such proceeding.

5.04.2 In the case of any such claim of infringement, CONTRACTOR shall either, at its option, (1) procure for IVHD the right to continue using Contractor Products; or (2) replace or modify Contractor Products so that that they become non-infringing, but equivalent in functionality and performance.

5.04.3 Notwithstanding this Section, IVHD retains the right and ability to defend itself, at its own expense, against any claims that Contractor Products infringe any patent, copyright, or other intellectual property right.

5.04.4 All provisions of Section 5.03, including the subsections thereunder, shall apply to CONTRACTOR’s obligation pursuant to this Section.

5.05 Notice of and Participation in Third Party Claims. CONTRACTOR shall give IVHD written notice of any claim or liability asserted by a third party that arises from or relates to the Work performed under this Agreement (“**Third-Party Claim**”), as soon as possible upon the receipt of information of any possible Third-Party Claim or of the commencement of any Third-Party Claim. CONTRACTOR shall not oppose any attempt by IVHD to intervene or otherwise participate in any such Third-Party Claim. CONTRACTOR shall not settle any Third-Party Claim covered by this Section unless it has obtained the prior written consent of IVHD, which consent shall not be unreasonably withheld, conditioned or delayed. IVHD shall have no liability under this Section for any Third-Party Claim for which such notice is not provided or is not provided in a timely manner, including no liability for contribution, indemnification, reimbursement or penalties. CONTRACTOR’s obligations hereunder shall survive the termination or expiration of this Agreement.

5.06 Insurance Coverages and Limits. CONTRACTOR shall procure and maintain in full force and effect for the duration of this Agreement, insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by CONTRACTOR, its agents, representatives, employees, or subcontractors. Insurance policies shall be on an occurrence basis, and coverage shall be at least as broad and in the minimum amounts as follows:

5.06.1 California Workers’ Compensation Insurance, as required by the State of California, with statutory limits, and Employer’s Liability Insurance with limits of no less than One Million Dollars (\$1,000,000) per accident for bodily injury or disease.

5.06.2 General Liability Insurance [ISO Form CG 0001, or equivalent], covering products and completed operations, bodily injury, personal & advertising injury and property damage with limits no less than One Million Dollars (\$1,000,000) per occurrence. If a general aggregate limit is used, either the general aggregate limit shall apply separately to this project/location or the general aggregate limit shall be twice the required occurrence limit.

5.06.3 Automobile Liability Insurance [ISO Form CA 0001 covering code 1 (any auto), or if no owned autos, Code 8 (hired) and 9 (non-owned), or equivalent forms] with limits no less than One Million Dollars (\$1,000,000) per accident for bodily injury and property damage.

5.06.4 Error and Omissions (Professional Liability) Insurance appropriate to CONTRACTOR's services, with limits no less than Two Million Dollars (\$2,000,000) per occurrence or claim, and Two Million Dollars (\$2,000,000) aggregate.

5.07 Insurance Mandatory Provisions. The following are required provisions:

5.07.1 CONTRACTOR will provide additional insured insurance coverage and policy endorsements for IVHD and its officers, officials, directors, employees, volunteers, or agents (collectively referred to as the "Insured Parties") under the general liability and automobile liability policies. The coverage shall contain no special limitations on the scope of protection afforded to the Insured Parties. General liability coverage can be provided in the form of an endorsement to CONTRACTOR's insurance (at least as broad as ISO Form CG 20 10, 11 85, or both (CG 20 10, CG 20 26, CG 20 33, or CG 20 38; and CG 20 37 forms if later revisions used)).

5.07.2 CONTRACTOR's insurance shall be primary insurance as respects Insured Parties, and each of them. Any insurance, self-insurance or other coverage maintained by Insured Parties shall be excess of CONTRACTOR's insurance and shall not contribute to it.

5.07.3 Any failure to comply with reporting or other provisions of the policies including breaches of warranties shall not affect coverage provided to Insured Parties.

5.07.4 CONTRACTOR'S insurance shall apply separately to each insured against whom a claim is made or suit is brought, except with respect to the limits of insurer's liability.

5.07.5 Liability insurance shall include indemnification against loss from liability imposed by law upon, or assumed under contract by, CONTRACTOR or its subcontractors for damages on account of bodily injury, including death resulting therefrom, suffered or alleged to have been suffered by any person or persons, other than employees, resulting from the performance or execution of this Agreement by CONTRACTOR or its subcontractors.

5.07.6 Each insurance policy required by this Agreement shall be endorsed to state that coverage shall not be cancelled or materially modified by the insured or insurer without thirty (30) days prior written notice by certified mail to IVHD.

5.08 Waiver of Subrogation. CONTRACTOR hereby agrees to waive rights of subrogation which any insurer of CONTRACTOR may acquire from CONTRACTOR by virtue of the payment of any loss. CONTRACTOR agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not such endorsement is provided. The Workers' Compensation policy shall be endorsed with a waiver of subrogation in favor of Insured Parties for all work performed by CONTRACTOR, its employees, agents and subcontractors.

5.09 Rating. Insurance will be purchased from insurance companies with a current A.M. Best's rating of no less than A:VII, unless otherwise agreed to in writing by IVHD.

5.10 Self-Insured Retention. Self-insured retentions must be declared to and approved by IVHD. IVHD may require CONTRACTOR to purchase coverage with a lower retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention.

The policy language shall provide, or be endorsed to provide, that the self-insured retention may be satisfied by either the named insured or IVHD.

5.11 Certificates of Insurance. CONTRACTOR will furnish IVHD with certificates of insurance prior to the commencement of work under this Agreement, and as may be periodically requested by IVHD. CONTRACTOR shall include all endorsements necessary to comply with this Agreement, including additional insured endorsements, signed by the insurer's representative. Such evidence shall include confirmation that coverage includes or has been modified to include all provisions required by this Agreement. CONTRACTOR shall, upon request of IVHD at any time, deliver to IVHD complete, certified copies of the policies of insurance, including endorsements, and receipts for payment or premiums thereon, required by this Agreement. Failure to obtain the required documents prior to the work beginning shall not waive CONTRACTOR's obligation to provide them.

5.12 Renewal Certificates. If any of the required coverages expire during the term of this Agreement, CONTRACTOR shall deliver the renewal certificate(s) including the general liability and auto liability additional insured endorsements to IVHD at least ten (10) days prior to the expiration date.

5.13 Subcontractor Insurance. CONTRACTOR shall require and verify that all subcontractors maintain insurance meeting all the requirements stated herein, and CONTRACTOR shall ensure that IVHD is an additional insured on insurance required from subcontractors.

5.14 Claims Made Policies. If any of the required policies provide coverage on a claims-made basis:

5.14.1 The Retroactive Date must be shown and must be before the date of the Agreement or the beginning of contract work.

5.14.2 Insurance must be maintained and evidence of insurance must be provided for at least five (5) years after completion of the contract of work.

5.14.3 If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a Retroactive Date prior to the contract effective date, the CONTRACTOR must purchase "extended reporting" coverage for a minimum of five (5) years after completion of contract work.

5.15 Conflict of Interest. Upon the award of this Agreement and periodically thereafter, CONTRACTOR may be required to complete and file with IVHD a Conflict of Interest form, to be provided to CONTRACTOR by IVHD.

5.16 Assignment/Subcontracting. CONTRACTOR shall not subcontract or assign this Agreement nor any duties or obligations under this Agreement without the prior written consent of IVHD. CONTRACTOR shall be responsible for the acts and omissions of and for payment to any subcontractor performing services under this Agreement, and shall bind any such subcontractor to CONTRACTOR's duties and obligations hereunder. IVHD shall have the right to approve any subcontractor agreements. Nothing contained in this Agreement will create any contractual relationship between IVHD any subcontractor of CONTRACTOR.

5.17 Safety. CONTRACTOR shall be solely and completely responsible for the safety of all CONTRACTOR personnel, including personnel of any subcontractors, during performance of the services under this Agreement. CONTRACTOR shall fully comply with all laws, rules, regulations and ordinances relating to safety of the public and workers, whether federal, state or local. CONTRACTOR shall also comply with all contract provisions and IVHD's policies, procedures, departmental rules, and other directives, as provided by IVHD's Project Manager to CONTRACTOR, relating to the safety of the public

and workers, including, but not limited to, IVHD's Contractor Safety Policies and Procedures and any project specific requirements.

5.18 Prevailing Wages. IVHD is a public agency subject to public contracting laws. CONTRACTOR shall comply with all State of California requirements with respect to any services provided as a Building/Construction Inspector, Field Soils and Material Tester, Land Surveyor, Hauler, or other work constituting a public works under California Labor Code sections 1720 *et seq.* and 1770 *et seq.*, and California Code of Regulations, title 8, section 16000 *et seq.* (collectively, "**Prevailing Wage Laws**").

5.18.1 CONTRACTOR must be, and must require its subcontractors to be, registered with the California Department of Industrial Relations ("**DIR**") pursuant to Labor Code section 1725.5, prior to execution of this Agreement. No contractor or subcontractor may be listed on a bid proposal for a public works project, or may be awarded a contract for public work on a public works project, unless it registers with and pays an annual fee to the DIR. CONTRACTOR shall submit proof of current registration, and shall require subcontractors to submit proof of current registration, to IVHD prior to commencing work on the project.

5.18.2 CONTRACTOR agrees to comply with and require its subcontractors to comply with the applicable requirements of Prevailing Wage Laws and any additional applicable California Labor Code provisions related to such work including without limitation payroll recordkeeping requirements. CONTRACTOR and its subcontractors shall pay not less than the prevailing rate of per diem wages as determined by the Director of the DIR for all applicable services described in this Agreement and as required by law. The general prevailing wage determinations can be found on the DIR website at: www.dir.ca.gov. Copies of the prevailing rate of per diem wages may be accessed at IVHD's administrative office, and shall be made available upon request. CONTRACTOR shall make copies of the prevailing rates of per diem wages for each craft, classification, or type of worker needed to execute the Services, make them available to interested parties upon request, and shall post and maintain copies at CONTRACTOR'S principal place of business and at all site(s) where services are performed. Penalties for violation of Prevailing Wage Laws may be assessed in accordance with such laws. For example, CONTRACTOR shall forfeit, as a penalty to IVHD, Two Hundred Dollars (\$200) for each calendar day, or portion thereof, for each worker paid less than stipulated prevailing rates for services performed under this Agreement, or by any subcontractor, in violation of Prevailing Wage Laws. CONTRACTOR shall defend, indemnify, and hold IVHD, its officials, officers, directors, employees, agents, and volunteers free and harmless from any claims, liabilities, costs, penalties, or interest arising out of the failure or alleged failure of CONTRACTOR or its subcontractors to comply with Prevailing Wage Laws.

5.18.3 CONTRACTOR and each of its subcontractors shall keep accurate payroll records showing the name, address, social security number, work classification, straight time, and overtime hours worked each day and week, and the actual per diem wages paid to each journeyman, apprentice, worker, or other employee employed by CONTRACTOR or subcontractor in connection with the services performed pursuant to this Agreement. Each payroll shall be certified, available for inspection, and electronic copies thereof furnished directly to the Labor Commissioner (also known as the Division of Labor Standards Enforcement) (A) at least monthly or more frequently or (B) in a format prescribed by the Labor Commissioner, as prescribed in California Labor Code section 1776, including any required redactions. CONTRACTOR shall keep IVHD informed as to the location of the records and shall be responsible for the compliance with these requirements by all subcontractors. CONTRACTOR shall inform IVHD of the location of the payroll records, including the street address, city, and county and shall, within five (5) working days, provide a notice of any change of location and address. Penalties for noncompliance include a forfeiture of One Hundred Dollars (\$100) per calendar day, or portion thereof, for each worker until strict compliance is effectuated, which may be deducted from any moneys due to CONTRACTOR.

5.18.4 Eight (8) hours of work shall constitute a legal day's work. CONTRACTOR and any subcontractors shall forfeit, as a penalty to IVHD, Twenty-Five Dollars (\$25) for each worker employed in the execution of services pursuant to this Agreement by CONTRACTOR or any of its subcontractors for each calendar day during which such worker is required or permitted to work more than eight (8) hours in any one (1) calendar day and forty (40) hours in any calendar week in violation of the provisions of the California Labor Code, in particular, sections 1810 to 1815, thereof, inclusive, except services performed by employees of CONTRACTOR and its subcontractors in excess of eight (8) hours per day at not less than one and one-half (1 ½) times the basic rate of pay, as provided in California Labor Code section 1815.

5.18.5 CONTRACTOR'S attention is directed to the provisions of California Labor Code sections 1777.5, 1777.6, and 1777.7 concerning employment of apprentices by CONTRACTOR or any of its subcontractors. If applicable to the services to be performed under this Agreement, CONTRACTOR shall comply with such apprenticeship requirements and submit apprentice information to IVHD. Information relative to apprenticeship standards, wage schedules, and other requirements may be obtained from the DIR or from the Division of Apprenticeship Standards. CONTRACTOR's knowing violations of section 1777.5 will result in forfeiture not to exceed One Hundred Dollars (\$100) for each calendar day of non-compliance pursuant to section 1777.7.

5.18.6 CONTRACTOR shall require any subcontractors performing services under this Agreement to comply with all of the above.

ARTICLE 6 OBLIGATIONS OF IVHD

6.01 IVHD Obligations. IVHD agrees to comply with all reasonable requests of CONTRACTOR, including requests to access documents, data and facilities reasonably necessary for the performance of CONTRACTOR's duties under this Agreement, consistent with applicable law.

ARTICLE 7 TERMINATION OF AGREEMENT

7.01 Termination For Cause by IVHD. If IVHD determines that CONTRACTOR has failed to perform the Services under this Agreement in accordance its terms and conditions, IVHD may terminate all or part of the Agreement for cause. This termination shall become effective if CONTRACTOR does not cure its failure to perform within 10 days (or more, if authorized in writing by IVHD) after receipt of a notice of intention to terminate from IVHD specifying the failure in performance. If a termination for cause does occur, IVHD shall have the right to withhold monies otherwise payable to CONTRACTOR until the Services under this Agreement are completed. If IVHD incurs additional costs, expenses, or other damages due to the failure of CONTRACTOR to properly perform under this Agreement, these costs, expenses, or other damages shall be deducted from the amounts withheld. Should the amounts withheld exceed the amounts deducted, the balance will be paid to CONTRACTOR upon completion of the Services to be provided under this Agreement. If the costs, expenses, or other damages incurred by IVHD exceed the amounts withheld, CONTRACTOR shall be liable to IVHD for the difference.

7.02 Termination For Cause by Contractor. CONTRACTOR may terminate this Agreement for cause if IVHD fails to cure a material default in performance within a period of 30 days, or such longer period as CONTRACTOR may allow, after IVHD'S receipt from CONTRACTOR of a written termination notice specifying the default in performance. In the event of termination for cause by CONTRACTOR, IVHD will pay CONTRACTOR in accordance with Section 7.03.

7.03 Termination Without Cause. IVHD may terminate this Agreement for convenience at any time upon written notice to CONTRACTOR, in which case, IVHD will pay CONTRACTOR for all Services performed and all expenses incurred under this Agreement up to and including the effective date of termination less any costs, expenses, or other damages due to the failure of the CONTRACTOR to properly perform pursuant to the Agreement. No compensation will be payable for anticipated profit on unperformed services.

ARTICLE 8 PROPRIETARY AND CONFIDENTIAL INFORMATION

8.01 Proprietary and Confidential Information. Any written, printed, graphic, or electronically or magnetically recorded information furnished by IVHD for CONTRACTOR's use is the sole property of IVHD. CONTRACTOR and its employee(s) and subcontractor(s) will keep any confidential information provided by IVHD in the strictest confidence, and will not disclose it by any means to any person except with IVHD approval, and only to the extent necessary to perform the Services under this Agreement. On termination of this Agreement, CONTRACTOR will promptly return to IVHD any confidential information in its possession.

ARTICLE 9 GENERAL PROVISIONS

9.01 Notices. Any notices required to be given under this Agreement by either party to the other may be affected by email, personal delivery, mail (first class, registered, or certified) with postage prepaid and return receipt requested. Mailed notices must be addressed to the parties at the addresses below, but each party may change the address by giving written notice in accordance with this paragraph. Any notice personally delivered or sent by email shall be deemed communicated upon receipt if received before 5:00 p.m. Pacific Standard Time ("PST") on a business day, or the following business day if received after 5:00 p.m. PST or on a Saturday, Sunday, or legal holiday. Any notice sent by overnight delivery service shall be deemed communicated on the next business day following delivery thereof to the overnight delivery service. Any notice given by mail shall be deemed communicated three (3) days after deposit in the United States mail.

To IVHD: Imperial Valley Healthcare District
207 West Legion Road
Brawley, CA 92227
Email: [REDACTED]
Attention: [REDACTED], Project Manager

To CONTRACTOR: _____

Email: [REDACTED]
Attention: [REDACTED]

9.02 Entire Agreement of the Parties. This Agreement, including any attachments, contains the entire understanding between the parties hereto with respect to the subject matter hereof, and supersedes all prior and contemporaneous agreements and understandings, inducements, or conditions, express or implied, oral or written, except as herein contained. The express terms hereof control and supersede any course of performance and/or usage of the trade inconsistent with any of the terms hereof.

9.03 Amendment. This Agreement may not be modified or amended other than by a writing signed by the parties, including any changes to the scope of services or any timeframes identified in Attachment A.

9.04 Partial Invalidity. If any non-material provision of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will continue in full force and effect without being impaired or invalidated in any way.

9.05 Attorneys' Fees. If any legal action, including an action for declaratory relief, is brought to enforce or interpret the provisions of this Agreement, the prevailing party will be entitled to reasonable attorneys' fees, which may be set by the court in the same action or in a separate action brought for that purpose, in addition to any other relief to which that party may be entitled.

9.06 Ownership of Documents and Materials. All original drawings, data, reports, documents and materials developed for the project, including detailed calculations, shall be furnished to and become the property of IVHD. IVHD agrees to indemnify CONTRACTOR for claims, damages, or liabilities caused by any use by IVHD of the plans, drawings, specifications, and all information gathered by CONTRACTOR on any project other than the one for which such plans, drawings, and specifications were prepared and information gathered by CONTRACTOR.

9.07 Audits. If this Agreement involves an expenditure of public funds in excess of Ten Thousand Dollars (\$10,000), the Agreement is subject to examination and audit of the State Auditor, at the request of IVHD or as part of any audit of IVHD, for a period of three (3) years after final payment under the Agreement. CONTRACTOR shall cooperate with IVHD, including any authorized representative of IVHD, regarding such audit at no charge to IVHD.

9.08 Counterparts. This Agreement may be executed in counterparts and electronically, each of which shall constitute an original, but all of which together shall constitute one and the same agreement, and the signature of any party to any counterpart shall be deemed a signature to, and may be appended to, any other counterpart.

9.09 Provisions Required by Law. Each and every provision of law and clause required by law to be inserted in this Agreement shall be deemed to be inserted herein, and the Agreement shall be read and enforced as though they were included herein. If through mistake or otherwise any such provision is not inserted, or is not correctly inserted, then upon the request of either party, the Agreement shall forthwith be physically amended to make such insertion.

9.10 Governing Law. This Agreement and all questions relating to its validity, interpretation, performance, and enforcement (including, without limitation, provisions concerning limitations of actions), shall be governed by and construed in accordance with the laws of the State of California.

9.11 Jurisdiction and Venue. The proper jurisdiction and venue for any claims, causes of action or other proceedings arising out of or relating to this Agreement shall be in the County of Imperial, State of California, and the parties hereby waive any right providing for a change of jurisdiction or forum to any other location.

9.12 No Waiver. A waiver by either party of a breach of any provision of this Agreement shall not constitute a general waiver or prejudice the other party's right otherwise to demand strict compliance with that provision or any other provisions in this Agreement. Likewise, IVHD's acceptance of any reports, work, services or materials furnished pursuant to this Agreement, or IVHD's payment therefor, shall not operate as a waiver of any of IVHD's rights under this Agreement or of any cause of action or defense relating to the performance of this Agreement.

9.13 False Claims. In signing this Agreement, CONTRACTOR certifies that CONTRACTOR shall not submit a false claim in violation of the False Claims Act, section 12650 *et seq.* of the Government Code.

9.14 Iran Contracting Act of 2010 [INCLUDE ONLY IF CONTRACT VALUE IS \$1M OR MORE, OR DELETE]. By entering into this Agreement, CONTRACTOR certifies that it is not identified on the current list of persons engaged in investment activities in Iran created by the California Department of General Services (“DGS”) and is not a financial institution extending twenty million dollars (\$20,000,000) or more in credit to another person/vendor, for 45 days or more, if that other person/vendor will use the credit to provide goods or services in the energy sector in Iran and is identified on the current list of persons engaged in investment activities in Iran created by DGS.

9.15 Claims [REQUIRED ONLY FOR CONTRACTS THAT INCLUDE ERECTION, CONSTRUCTION, ALTERATION, REPAIR OR IMPROVEMENT OF ANY PUBLIC STRUCTURE, BUILDING, ROAD, OR OTHER PUBLIC IMPROVEMENT BY A CONTRACTOR LICENSED UNDER BUSINESS AND PROFESSIONS CODE SECTION 7000 ET SEQ., UNLIKELY IN MOST DESIGN CONTRACTS; IF THE AGREEMENT DOES NOT INCLUDE THESE TYPES OF WORK, THEN DELETE ENTIRE SECTION]. Notwithstanding any other law, including Public Contract Code sections 10240 and 20104, the parties to this Agreement are subject to the provisions of Section 9204 of the Public Contract Code, which requires compliance with the procedures set forth in this section to resolve any claim by CONTRACTOR arising under the Agreement.

9.15.1 For purposes of this section only: “Claim” means a separate demand by CONTRACTOR sent by registered mail or certified mail with return receipt requested, for one or more of the following:

(A) A time extension, including, without limitation, for relief from damages or penalties for delay assessed by IVHD under the Agreement.

(B) Payment by IVHD of money or damages arising from work done by, or on behalf of, the CONTRACTOR pursuant to the Agreement and payment for which is not otherwise expressly provided or to which the claimant is not otherwise entitled.

(C) Payment of an amount that is disputed by IVHD.

9.15.2 For the purposes of this section only: “Subcontractor” means any type of contractor within the meaning of Chapter 9 (commencing with Section 7000) of Division 3 of the Business and Professions Code who either is in direct contract with CONTRACTOR or is a lower tier subcontractor.

9.15.3 Upon receipt of a Claim pursuant to this section, IVHD shall conduct a reasonable review of the Claim and, within a period not to exceed 45 days, shall provide the claimant a written statement identifying what portion of the Claim is disputed and what portion is undisputed. Upon receipt of a Claim, IVHD and CONTRACTOR may, by mutual agreement, extend the time period provided in this subdivision.

9.15.4 The claimant shall furnish reasonable documentation to support the Claim.

9.15.5 If IVHD needs approval from its governing body to provide the claimant a written statement identifying the disputed portion and the undisputed portion of the Claim, and the governing body does not meet within the 45 days or within the mutually agreed to extension of time following receipt of a Claim sent by registered mail or certified mail, return receipt requested, IVHD shall have up to three (3) days following the next duly publicly noticed meeting of the governing body after the 45-day period, or after expiration of the extension, to provide the claimant a written statement identifying the disputed portion and the undisputed portion.

9.15.6 Any payment due on an undisputed portion of the Claim shall be processed and made within 60 days after IVHD issues its written statement.

9.15.7 If the claimant disputes IVHD's written response, or if IVHD fails to respond to a Claim issued pursuant to this section within the time prescribed, the claimant may demand in writing an informal conference to meet and confer for settlement of the issues in dispute. Upon receipt of a demand in writing sent by registered mail or certified mail, return receipt requested, IVHD shall conduct a meet and confer conference within 30 days for settlement of the dispute.

9.15.8 Within 10 business days following the conclusion of the meet and confer conference, if the Claim or any portion of the Claim remains in dispute, IVHD shall provide the claimant a written statement identifying the portion of the Claim that remains in dispute and the portion that is undisputed. Any payment due on an undisputed portion of the Claim shall be processed and made within 60 days after IVHD issues its written statement. Any disputed portion of the Claim, as identified by the Contractor in writing, shall be submitted to nonbinding mediation, with IVHD and the claimant sharing the associated costs equally. IVHD and claimant shall mutually agree to a mediator within 10 business days after the disputed portion of the Claim has been identified in writing. If the parties cannot agree upon a mediator, each party shall select a mediator and those mediators shall select a qualified neutral third party to mediate with regard to the disputed portion of the Claim. Each party shall bear the fees and costs charged by its respective mediator in connection with the selection of the neutral mediator. If mediation is unsuccessful, the parts of the Claim remaining in dispute shall be subject to applicable procedures outside this section.

9.15.9 For purposes of this section, mediation includes any nonbinding process, including, but not limited to, neutral evaluation or a dispute review board, in which an independent third party or board assists the parties in dispute resolution through negotiation or by issuance of an evaluation. Any mediation utilized shall conform to the timeframes in this section.

9.15.10 Unless otherwise agreed to by IVHD and the CONTRACTOR in writing, the mediation conducted pursuant to this section shall excuse any further obligation under Public Contract Code section 20104.4 to mediate after litigation has been commenced.

9.15.11 Failure by IVHD to respond to a Claim from CONTRACTOR within the time periods described in this subdivision or to otherwise meet the time requirements of this section shall result in the Claim being deemed rejected in its entirety. A Claim that is denied by reason of IVHD's failure to have responded to a Claim, or its failure to otherwise meet the time requirements of this section, shall not constitute an adverse finding with regard to the merits of the Claim or the responsibility or qualifications of the claimant.

9.15.12 Amounts not paid in a timely manner as required by this section shall bear interest at 7 percent per annum.

9.15.13 If a subcontractor or a lower tier subcontractor lacks legal standing to assert a Claim against IVHD because privity of contract does not exist, CONTRACTOR may present to IVHD a Claim on behalf of a subcontractor or lower tier subcontractor. A subcontractor may request in writing, either on his or her own behalf or on behalf of a lower tier subcontractor, that Contractor present a Claim for work which was performed by the subcontractor or by a lower tier subcontractor on behalf of the subcontractor. The subcontractor requesting that the Claim be presented to IVHD shall furnish reasonable documentation to support the Claim. Within 45 days of receipt of this written request, CONTRACTOR shall notify the subcontractor in writing as to whether CONTRACTOR presented the Claim to IVHD and, if CONTRACTOR did not present the Claim, provide the subcontractor with a statement of the reasons for not having done so.

9.16 Signature Authority. IVHD and CONTRACTOR do covenant that the individual executing this Agreement on their behalf is a person duly authorized and empowered to execute this Agreement for such party.

BY SIGNING BELOW THE PARTIES VOLUNTARILY ENTER INTO THIS AGREEMENT AND ACKNOWLEDGE THAT THEY HAVE READ AND UNDERSTAND THE TERMS SET FORTH HEREIN AND AGREE TO BE BOUND THEREBY.

**IMPERIAL VALLEY HEALTHCARE CONTRACTOR:
DISTRICT:**

_____	_____
Signature	Signature
_____	_____
Name	Name
_____	_____
Title	Title
_____	_____
Date	Date

	Contractor's License No.

	License Expiration Date

[Comment: If a license is not required to do the work, delete the lines for Contractor to insert its license number and expiration date.]

Attachment A – Scope of Work



June 11, 2025

Dear Miss Adrianna Ochoa,

As the Founder & CEO of Hickey Associates & Hickey, I am excited to introduce myself and my firm to the Pioneers Imperial Valley Healthcare District and convey my interest in responding to Request for Proposal for Consultant Services to Assist with the Development of a 5-Year Facilities Master Plan. Hickey Associates & Hickey (HAH) is extremely qualified and enormously interested in being awarded the opportunity to provide a 5-Year Facilities Master Plan to the Pioneers Imperial Valley Healthcare District. At Hickey Associates & Hickey, we have over 40 years of Facilities Management, Design, Operations, and Construction experience. Our staff include former K-12 School District Superintendent, Assistant Superintendent of Facilities, Directors of Facilities, Licensed Architects, Construction Managers, and Project Managers. We are a full-service facilities management firm, specializing in K-12 public school facilities master planning in the state of California. Our facilities operations management encompasses a range of disciplines, skills and services to ensure optimum functionality, comfort, safety and efficiency of the built environment — buildings, utilities, parking lots, grounds, infrastructure, and real estate asset management. Our Facilities Management Services include:

- Long-range Facilities Master Planning (FMP);
- Facilities Asset Management Toolbox, with GIS Mapping/Maintenance Management;
- Fund Development and Deferred Maintenance Management Plans (DMMP);
- Environmental Stewardship and Energy Sustainability Plans;
- Program, Construction, and Project Management services; and

HAH fully understands the scope of the RFP, and we are extremely familiar with healthcare systems HAH is well qualified and uniquely positioned due to our vast K-12 experience of our staff. Our unique Maintenance Management Toolbox, Asset Management Tool, and GIS Mapping helps HAH stand apart from what other firms are capable of offering in facilities master planning. HAH also confirms our firm's ability to meet the project timeline outlined in the RFP

In partnership,

Ronald T. Hickey

Ronald T. Hickey

CEO, Hickey Associates & Hickey

Phone: (916) 747-2861 Email: rhipkey@hickeyhickey.com

133 Dodbrook Court, Roseville, CA 95661



PIONEERS IMPERIAL VALLEY HEALTHCARE DISTRICT

REQUEST FOR PROPOSALS FOR DEVELOPMENT OF 5-YEAR FACILITIES MASTER PLAN

Proposals Due: June 13, 2025

Presented By: **Hickey Associates & Hickey**

Summary

The Facilities Department within the Business and Operations Division of the Pioneers Imperial Valley Healthcare District (IVHD) is responsible for the preparation of capacity projections and identifying future facility needs. IVHD is seeking proposals for the development of a Facilities Master Plan that will focus on the analysis of existing and future facility needs. The District intends to assemble a Facilities Master Planning team that will collaborate with District personnel from various departments, as well as with the IVHD community, to develop a plan covering the period from 2027 to 2031. The proposals must address five (5) key focus areas as summarized:

1. Document Review and Analysis: Conduct a comprehensive review of the District's capacity projections to evaluate future facility needs based on anticipated growth. Assess existing facilities and future sites to determine current capacity and potential requirements. The Facility Master Plan (FMP) shall address the following:
 - a. Repair and Maintenance of existing sites to ensure code compliance
 - b. Analysis and optimization to comply with AHSSA
 - c. Assessment of existing site conditions and required improvements
2. Facilities Needs Assessment: Provide site visits and site meetings, program confirmation, community outreach meetings, future facility needs master planning. Provide Final Facilities Master Plan for each site. Review of current IVHD Facilities Needs Assessment and supplement any missing information to develop a thorough actionable master plan.

3. Healthcare Specifications: Create a detailed Healthcare Specifications (Health Specs) document that aligns the district's physical space with its healthcare mission, clinical needs, and future growth needs.
4. Implementation Plan: Engage stakeholders to explore community and site-specific facility needs. Recommend an implementation schedule based on input from the Facilities Master Planning Committee (FMPC). Prepare individual site master plans through interviews and meetings with site personnel, maintenance teams, and District staff to ensure safety and modernization requirements are addressed. Develop a cost assessment for each campus including soft costs, escalation and contingency based on projected time frames for implementation. Provide schematic designs, digital drawings, renderings, models, or presentation materials for potential projects as directed by district representatives. The cost for these designs will be negotiated based on our firm's hourly rates. • Integrate deferred maintenance needs for each facility in accordance with the district funding availability. Develop Interactive website for the Facilities Master Plans. Solicit and document feedback from FMPC, Board of Trustees, and District staff, maintaining records in the form of meeting minutes and reports. Compile and organize all materials generated for or presented to the FMPC.
5. Deliverables: The Facilities Master Plan will be delivered electronically, including an electronic database and a tangible set (PDF).



Pioneers Imperial Valley Healthcare District (IVHD) has embarked upon facilities projects that include site improvements of all district facilities and healthcare sites. Future facilities projects will focus on ensuring IVHD has future-ready healthcare facilities. Currently, many of the facilities district-wide are in need of seismic upgrade and/or have exceeded their intended life-cycle. The potential needs that will be identified in the Facilities Needs Assessment include the following:

- Construct new 21st century future-ready healthcare facilities;
- Upgrade existing facilities to ensure compliance with AHSSA;
- Need to identify funding sources;
- Remove aging and unsafe buildings and replace them with appropriate facilities;
- Fix or replace deteriorating building walls, walkways, roofs and windows;
- Renovate aging spaces and provide flexible mix-use rooms and labs for core healthcare;
- Replace aging and inefficient electrical, plumbing, heating, and ventilation systems;
- Modernize and renovate existing permanent administrative buildings and offices;
- Update and modernize multi-purpose rooms, cafeterias; kitchens, and office spaces;
- Update technology infrastructure at all facilities;
- Replace and expand parking lot structures and other common areas;
- Improve facilities fire and earthquake safety preparedness; and
- Improve safety with new fire alarms systems, fencing, security, and monitoring systems.

The executive leadership of IVHD now seeks the creation of a 5-Year Facilities Master Plan focusing on the current facility needs of the district. The district also seeks an effective and efficient process for managing the projects outlined in the 5-Year Facilities Master Plan. In an effort to provide the facilities master plan required to assist the district in the management of these varied facilities projects of the organization, this proposal is being submitted to augment current organizational efforts on a broader scale and assist in the completion of the work already embarked upon by the district's Facilities Master Planning Committee.



Past Experience

Salinas City Elementary School District – Salinas, California



Sherwood Elementary School

Scope of Work:

5-Year Facilities Master Plan

Deferred Maintenance Plan

Electrical Systems Evaluation/Infrared Scan/Maintenance Plan

Site Safety & Security/ADA Compliance/Building Structure Evaluation

District Facilities Asset List Developing/Preventative Maintenance Plan

GIS District Facilities Site Mapping/Facilities Maintenance Management Planning Toolbox Development



Robla Elementary School

Scope of Work:

5-Year Facilities Master Plan

Deferred Maintenance Plan

Electrical Systems Evaluation/Infrared Scan/Maintenance Plan

Site Safety & Security/ADA Compliance/Building Structure Evaluation

District Facilities Asset List Developing/Preventative Maintenance Plan

GIS District Facilities Site Mapping

Facilities Maintenance Management Planning Toolbox Development

Facilities Bond Program Management

Facilities Construction Projects Consultant

As Senior Vice President of CFW – Program Managed the following Construction:

- New Main Avenue Elementary School
- New Robla Elementary School
- New Bell Avenue Elementary School
- Modernization of Glenwood Elementary School
- Modernization of Taylor Street Elementary School
- New District Preschool



Flora Arca Mata Elementary School

5-Year Facilities Master Plan

Deferred Maintenance Plan

Electrical Systems Evaluation/Infrared Scan/Maintenance Plan

Site Safety & Security/ADA Compliance/Building Structure Evaluation

Facilities Maintenance Management Planning Toolbox Development

Facilities Bond Program Management

Facilities Master Plan Projects:

- New Flora Arca Mata Elementary School
- Modernized Stagg High School Kitchen
- Modernized Lincoln High School Classrooms

Stanislaus Union Elementary School District



Eisenhut Elementary School

5-Year Facilities Master Plan

Deferred Maintenance Plan

Electrical Systems Evaluation/Infrared Scan/Maintenance Plan

Site Safety & Security/ADA Compliance/Building Structure Evaluation

District Facilities Asset List Developing/Preventative Maintenance Plan

Facilities Maintenance Management Planning Toolbox Development

Facilities Bond Program Management

References Request

Provide a minimum of three (3) references with contact names and phone numbers for each similar/relevant project.

1. Eileen Chen
Superintendent, Robla School District
925-550-8577
echen@robla.k12.ca.us
Scope of work: (1) 5-Year Facilities Master Planning and (2) Facilities Program Consultant
2. Amna Javed
Director of Facilities, Salinas City Elementary School District
559-380-6908
Amna.Javed@salinascityesd.org
Scope of work: 5-Year Facilities Master Planning
3. Terry Souza
Director of Facilities, Washington Unified School District
916-335-0964
tsouza@wusd.k12.ca.us
Scope of work: (1) 5-Year Facilities Master Planning and (2) New Construction



Proposed Community Outreach and Engagement Methodology

Meetings/Workshops Schedule

Meeting Type	Meeting Purpose	Timeframe	Duration
Project Kick-off	Kick-off meeting to discuss project expectations	July-25	3 Hrs
Workshop	Board Presentation of Draft FMP	November-25	3 Hrs
Workshop	Board Presentation of Final FMP	December-25	3 Hrs
Workshop	Board Presentation of FMP Implementation Plan	Dec-25/Jan-26	3 Hrs
Workshop	Draft Education Specifications	July-25	3 Hrs
Workshop	Finalize Education Specifications	August-25	3 Hrs
Roadshows	Community Townhall Meetings (4)	July-Oct 2025	3 Hrs (ea)
Staff Meeting	Discuss Deferred Maintenance Management Plan	September-25	2 Hrs
Staff Meeting	Discuss Healthcare Specification Development (2)	Aug-Sep 2025	2 Hrs (ea)
Staff Meeting	Discuss Electrical Systems Infrared Scanning	July-25	2 Hrs
Site Meeting	Discuss Site Evaluations w/each Healthcare Site	July-25	3 Hrs (ea)
Staff Meeting	Discuss Facilities Assets List Development	August-25	2 Hrs
Staff Meeting	Discuss GIS Mapping	August-25	2 Hrs
Staff Meeting	Discuss Maintenance Management Toolbox	August-25	2 Hrs

Workshops

All workshops will follow the following process:

- Date/time approved by IVHD official
- Workshop date/time notification via website, social media, robocalls, email, etc.
- Board workshop governed by the Brown Act and Robert's Rules of Order
- Formal Powerpoint presentation facilitated
- Presentation followed by Q&A session
- Input/suggestions captured and published to FMP/District website

Meetings

All meetings will follow the following process:

- Date/time approved by IVHD official
- Meeting date/time notification via website, social media, robocalls, email, text, etc.
- Meetings will be open to the public, except staff meetings
- Surveys issued based on stakeholders identified by the district
- Agenda approved by IVHD and published
- Formal Powerpoint presentation facilitated if applicable
- Meeting conducted in accordance with the approved agenda
- Meeting followed by Q&A session
- Input/suggestions/surveys captured and published to the FMP/District website
- Meeting minutes captured and published to the FMP/District website

Stakeholder List Development

In previous FMP projects, HAH has learned that the best foundation for creating a robust list for community stakeholders begins with the clients, caregivers, and staff of the district. Therefore, a directory of clients and staff from the district is necessary. HAH builds upon this list by visiting the district community and speaking directly to businesses and residential homeowners. We advertise notices in the local newspaper and on the district and FMP websites. Another process that has been successful is marketing and advertising banners posted at each healthcare site advertising the Facilities Master Planning meetings and workshops. HAH has also realized great stakeholder development by visiting healthcare sites during drop-off and pick-up and speaking directly with parents. Lastly, HAH is accustomed to speaking at scheduled district board meetings to discuss the importance of stakeholder participation in meetings and workshops and to discuss the community engagement scheduling, expectations, and intended outcomes.

Past Success and Lessons Learned

The community roadshows and townhall meetings at Sacramento City Unified School District proved to be an extreme success. The community appreciated rotating the roadshows to various locations and the various start times that allowed for maximum participation in the Facilities Master Plan discussions. Following each roadshow, input from the community was quickly considered for the next roadshow, allowing members of the community to dictate their needs and interests. The pre-roadshow surveys were extremely helpful in ensuring information shared was relevant and gave those who were not able to attend the opportunity to provide input. We incorporated post-roadshow surveys as well to capture final thoughts and input. Lastly, we learned that text messaging was the best means of communication with the public.



Our Philosophy, Approach, Technical Ability

Hickey Associates & Hickey (HAH) abundantly possess the necessary skills and capacity to deliver the very facilities master plan and deferred maintenance management plan necessary to produce the desired outcomes. The components of our proposal include the following:

5-Year Facilities Master Plan

HAH will complete a Facilities Needs Assessment and develop of 5-Year Facilities Master Plan which includes priority projects (safety and ADA), restricted funding mandated projects prioritized, based on the immediate needs of the district

(The needs of the district will be established by input from all district stakeholders), and the 5-Year Facilities Master Plan will also include legacy projects and high-visibility projects that demonstrate clear evidence of funding at work. All projects will ensure the district's facilities comply with the requirements of AHSSA.

*****Due to age of IVHD facilities, a complete evaluation of all electrical systems will be conducted via infrared scanning of all high and low voltage wiring and physical connections.***

Facilities Maintenance Management Planning

HAH will develop an overall facilities maintenance management toolbox that includes assets listing and GIS mapping. This will include modernization projects that will lower the district's annual utilities (electricity and water usage) cost to help the district lower the cost of operating healthcare facilities. Board presentations, project cost analyses and project prioritizing, and assistance with construction oversight are included in the proposal costs. All aspects of the 5-Year Facilities Master Plan will align with all requirement of the Joint Commissions certification.

Facilities Master Planning Proposed Activities

Proposed Activity 1 – Conduct Demographic Analysis: HAH will conduct a comprehensive review of the District's capacity projections to evaluate future facility needs based on anticipated growth. HAH will complete a thorough assessment of existing district facilities to determine if current capacity is adequate, based on community growth projections, and determine the potential requirements for additional facilities. The Facility Master Plan (FMP) will be designed to address the following needs:

- Increase or decrease of existing square footage of multi-use areas and/or the number of hospital beds and clinical space required at each healthcare facility.
- Analysis the conditions and recommend optimization of existing seismic structures.
- Assessment of existing site conditions and identify required improvements. Site improvement projects will be prioritized based on each project receiving a Facilities Need Index (FNI) and Project Cost Index (PCI) scores. The FNI and PCI will be combined (FNI + PCI) to create a Project Priority Index (PPI) score. All projects will be ranked based on each project's PPI.

Need Seismic Structure Upgrade	During the modernization of Lincoln ES, 10 portable classrooms were replaced by 5 permanent ones. Following this, 2 additional classrooms were red-tagged. Currently, Lincoln has just one available classroom designated as a Restorative Justice/Wellness room and another classroom used as support space for BCOAs and ELOP. As a result, there is no available space to expand the Lincoln school community.	FNI – 100 PCI – 5 PPI = 105
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Project Priority Index Scoring Example

$$[\text{FNI} + \text{PCI} = \text{PPI}]$$

Facilities Need Index Criteria

Facility Needs Index (FNI)

- 25 - Safety and security/ADA Compliance
- 20 - Equity and Inclusion (Ex: replace portables; displaced students, employee satisfaction)
- 15 - Required to Accommodate Increased Enrollment
- 15 - Educational specifications - Everything required/requested inside the classroom,
- 10 - Required to Accommodate District Program to Increase ADA (Ex. TK Project)
- 10 - District operations – Operations support services (Facilities, maintenance, operations, transportation, etc.)
- 5 - Age and Condition of Existing Facilities

Project Cost Index Criteria

Project Cost Index (PCI)

(In order of priority)

- 20 – Less than \$500,000
- 15 - \$500,001 - \$1,000,000
- 10 - \$1,000,001 - \$2,500,000
- 5 - \$2,500,001 - \$5,000,000
- 1 – Greater than \$5,000,000

**The above FNI and PCI criteria are subject to stakeholder input*

Proposed Activity 2 – Conduct a Facilities Needs Assessment: HAH will conduct site visits to evaluate the conditions of each site. Site evaluation will align with the Joint Commission certification process and AHSSA for adequate facilities performance. HAH will also conduct site meetings, program confirmation, and community outreach Facility Roadshows (meetings). Four (4) Facility Master Planning Roadshows will be conducted: (2) at two of the district’s hospitals, (2) at two district’s clinics. Times of the meetings will vary to give members of the community every opportunity to participate in the Roadshows.

The Facilities Master Plan will be designed to provide future-ready facilities and address current facility needs. A Facilities Master Plan will be provided for each site. Included in the site evaluation will be a thorough analysis of IVHD Facilities Needs Assessment. The Facilities Master Plan will be designed to supplement any missing information in the Facilities Needs Assessment to develop a thorough actionable facilities master plan. This site assessments associated with the development of the Facilities Master Plan shall include, but is not limited to, the following key areas:

- Compliance with building codes, AHSSA, and ADA accessibility requirements.
- Fire and life safety considerations.
- Parking lot safety standards.
- Structural integrity of buildings, AHSSA and Joint Commissions.
- Site utilities and infrastructure.
- Mechanical, electrical, plumbing, roofing, and structural system evaluations.
- Each healthcare site identified safety and security concerns.
- Technology infrastructure.

The facility conditions of all systems at each facility shall be professionally documented in an end-user friendly formatting, along with prioritized recommendations for repair based on the Project Priority Index described above and the impending need for replacement and/or upgrades. The Facilities Master Plan will include a phased funding approach that shall be implemented based on prioritization according to Project Priority Indexes (PPI).

Proposed Activity 3 – Healthcare Specifications Development: HAH will create a detailed list of healthcare specifications (Health Specs) district-wide document that aligns the 21st century healthcare requirements. Health Specs will ensure the future-readiness of all physical space aligned with district’s healthcare mission, clinical needs, and future growth. Creating future-ready Health Specs will include the following:

- Researching & Analyzing of Healthcare Specifications used by other districts.
- Reviewing availability of funding sources and development of new funding sources.
- Benchmarking best practices in healthcare facility design.
- Performing facility capacity study, facilities inventory, along with established State and local loading standards in combination with District provided enrollment projections.
- Facilitating Stakeholder Engagement (Facility Roadshows).
- Conducting surveys, establishing focus groups, and meetings with healthcare providers, staff, clients, and community members.
- Identifying key space needs and programmatic clinical needs.
- Developing a future-focused healthcare vision to guide spatial support.
- Establishing Space Planning & Design Guidelines.
- Defining hospital, clinical, lab, office, and common area requirements.
- Establishing functional relationships between spaces (e.g., adjacency diagrams).
- Addressing technology, accessibility, sustainability, and safety considerations.
- Assessing facilities to ensure alignment with District’s mission and vision.
- Analyzing and comparing healthcare and support spaces between the facilities.
- Evaluating findings to determine the need for changes or additions in facilities and spaces necessary to accommodate the clinical programs.
- Drafting & Reviewing Healthcare Specifications.
- Identifying and Documenting space requirements, infrastructure needs, and design criteria.
- Gathering, organizing, and including stakeholder feedback to refine specifications.
- Finalizing, approving, and submitting the final Health Specs report.
- Presenting all findings to board/leadership for final approval.

Proposed Activity 4 – Design Facilities Master Plan Implementation Plan: HAH will devise and employ a strategy to seamlessly implement the approved facilities master plan. To implement to new facilities master plan, the following activities will be conducted:

- Engage stakeholders to explore community and site-specific needs which may include:
 - Roadshow/Townhall meetings (Minimum 4)
 - Surveys (Doodle or Survey Monkey)
 - Focus Groups Discussion (Virtual attendance option provided)
 - Various Community workshops (Virtual attendance option provided)
 - Meetings or workshops with District staff and Board Members
 - Periodic Board of Trustees Updates
- Recommend an implementation schedule based on input from the Facilities Master Planning Committee (FMPC).
- Prepare individual site master plans through interviews and meetings with site personnel, maintenance teams, and District staff to ensure safety and modernization requirements are addressed.
- Develop a cost assessment for each campus including soft costs, escalation and contingency based on projected time frames for implementation. These costs will be provided in a “unit cost” format based on the most current cost estimates available.
- Develop a detailed implementation plan given typical industry assumption for design, agency review and approval, and construction to align with the beginning of each school year or as necessary to facilitate construction and occupancy. This plan should include, but not be limited to, new construction or modernization.
- Provide schematic designs, digital drawings, renderings, models, or presentation materials for potential projects as directed by district representatives. The cost for these designs will be negotiated based on HAH's hourly rates.
- Integrate deferred maintenance needs for each campus in accordance with the deferred maintenance plan. Deferred maintenance plans will include infra-red scans of all electrical panels to ensure efficient and safe electrical system operations.
- Interactive website for the Facilities Master Plans, including data dashboards for all educational sites, dashboard summaries, interactive district map with clickable schools and boundaries for website navigation (GIS mapping). This will include interactive site plans for each educational site, yearly hosting of platform for 5 years (renewable by District at a later date).
- Identify projects eligible for State funding or any future state funding to maximize the benefits of local and outside funding sources.
- Solicit and document feedback from FMPC, Board of Trustees, IVHD Leadership, clients and District staff, maintaining records in the form of meeting minutes and reports.
- Compile and organize all materials generated for or presented to the FMPC.

Proposed Activity 5 – Facilities Master Plan Deliverables: The Facilities Master Plan will be delivered electronically, including an electronic database and a tangible set (PDF). The contract shall commence upon approval by the Murrieta Valley Unified Board of Education and execution of the agreement. The expected completion date will be no later than February 28, 2026. HAH will project and provide the following Project Milestones Criteria scheduling that includes all the milestone below within the contracted durations for both the Facilities Master Plan and Educational Specifications:

- Kickoff Meeting – 1st week of July 2025
- Data Collection & Needs Assessment – July – September 2025
- Stakeholder Engagement & Community Input: Ongoing throughout the process, with key engagement sessions – July 2025-November 2025
- Draft Facilities Master Plan Submission – November 2025
- Final Facilities Master Plan incorporating district feedback – December 2026
- Interim and final presentation to the Board of Education – December 2026

Deferred Maintenance Plan:

Data Collection and Analysis:

1. Electrical surveys – infrared
2. Site assessments for creation of a deferred maintenance plan:
 - a. Building safety and hazards
 - b. ADA Compliance
 - c. Interior and Exterior building system
3. Using existing data: HVAC, BEAM assessments, and FMP in creating a comprehensive Deferred Maintenance Plan

Based on AHSSA Requirements:

1. Major Building System Repairs or Replacements
 - a. Roofing
 - b. Plumbing systems
 - c. HVAC systems
 - d. Electrical systems
 - e. Sewer systems
2. Structural repairs
 - a. Flooring, wall systems, ceilings
3. Exterior Walls

4. Windows and doors
5. Hazardous Materials abatement
6. Accessibility and Code Compliance
7. Fire Safety and Security
8. Site work – asphalt, drainage, sidewalk repairs

Creation of an interactive geographical (GIS) database integrated with FMP & MMP

1. District Facilities Site Assets Database Development
2. General Site Information/Data Collection
3. Deferred Maintenance Plan Development
4. School Sites Capacity Studies
5. District Demographic Analysis & Enrollment Projections
6. Maintenance Management Planning (MMP)/Work Order System Integration
7. GIS District Facilities Site Mapping

Create a 5-Year Facilities Master Plan

How will this be completed:

1. Evaluate Facilities Needs Assessment – **Conducted by Project Executive**
2. Inspect all district sites – **Conducted by Project Manager and (2) Inspectors**
3. Data Collections – **Conducted by (2) Inspectors and Administrative Support Staff**
4. Data Analysis – Assign priorities, create a database, and format in excel document – **Conducted by Project Manager, Project Architect, and Project Executive**
5. Stakeholder outreach to plan 5-Year FMP
 - a. Maintenance staff – **Project Manager**
 - b. Facilities staff/Housekeeping – **Project Manager**
 - c. Senior Leadership – **Project Executive**
 - d. Board workshop – **Project Executive**
 - e. Community meetings – **Project Executive**

Creation of a plan that can be updated easily – **interactive format (web-based).**

Timeline / Location

Services shall begin in July 1, 2025 and end December 31, 2025. All proposed deliverables shall be delivered at the Pioneers Imperial Valley Healthcare District office or designated site(s).

FMP Project Management

Management of this project will be controlled by the Project Executive, supported by a Project Architect, Project Manager, (2) Site Inspectors, and a Project Administrative Staff; for a total of 6 FTE equivalent man-hours, estimating 6,000 total hours for the project. All positions listed are full-time dedicated to the IVHD Facilities Master Plan project for the entire duration of the services proposed in this proposal; exception is the Project Architect.

Job Title	Position	Estimated Hrs	Person Assigned
Project Executive	Person In-charge	1,250	Ronald Hickey
Project Architect	Project Consultant	500	Ola Gbadamosi
Project Manager	On-site Person	1,250	Stan Dobbs
Site Inspector	Site Condition Evaluation	1,000	Ed Mazyck
Site Inspector	Site Condition Evaluation	1,000	Brendin Swanson
Project Administration	Administrative role	1,000	Tamera Lloyd



Proposed Cost of Services

Fees Schedule

Project Position	Hourly Rate	Estimated Hours	FTE Equivalent
Project Executive	190	1,250	1.25
Project Architect	145	500	.5
Project Manager	105	1,250	1.25
Site Inspectors	65	2,000	2
Project Administration	45	1,000	1

*Approximately **600** Total Hours are Estimated for Meetings and Workshops*

Cost Breakdown: Totaled proposed cost of activities for completing the Facilities Master Plan

5-Year Facilities Master Plan	PMH ONLY	\$225,000.00
Deferred Maintenance Plan		\$20,000.00
Healthcare Specifications Development		\$20,000.00
Electrical Systems Evaluation/Infrared Scan/Maintenance Plan		\$20,000.00
Site Safety & Security/ADA Compliance/Building Structure Evaluation		\$20,000.00
District Facilities Asset List Developing/Preventative Maintenance Plan		\$20,000.00
GIS District Facilities Site Mapping/Interactive Web-based		\$20,000.00
Facilities Maintenance Management Planning Toolbox Development		\$20,000.00
Total		\$365,000.00

***Cost for PMH ONLY**

***Cost for PHH/ECRMC Combined**

5-Year Facilities Master Plan	PMH/ECRMC Combined	\$375,000.00
Deferred Maintenance Plan		\$30,000.00
Healthcare Specifications Development		\$30,000.00
Electrical Systems Evaluation/Infrared Scan/Maintenance Plan		\$30,000.00
Site Safety & Security/ADA Compliance/Building Structure Evaluation		\$30,000.00
District Facilities Asset List Developing/Preventative Maintenance Plan		\$30,000.00
GIS District Facilities Site Mapping/Interactive Web-based		\$30,000.00
Facilities Maintenance Management Planning Toolbox Development		\$30,000.00
Total		\$585,000.00

The total cost is an all-inclusive time and materials proposal not-to-exceed costs as stated, including but not limited to, all material, travel, reproduction, administrative, sub-consultant and subcontracting, and any overhead costs.

Estimated Number of Stakeholder/Community Meetings to be held to complete each activity

5-Year Facilities Master Plan	4
Deferred Maintenance Plan	1
Education Specification Development	2
Electrical Systems Evaluation/Infrared Scan/Maintenance Plan	1
Site Safety & Security/ADA Compliance/Building Structure Evaluation	18
District Facilities Asset List Developing/Preventative Maintenance Plan	1
GIS District Facilities Site Mapping/Interactive Web-based	1
Facilities Maintenance Management Planning Toolbox Development	1
Total	29

Estimated Number of Board/Community Workshops to be held to complete each activity

5-Year Facilities Master Plan	4
Deferred Maintenance Plan	0
Total	6

Conclusion

Hickey Associates & Hickey understands that the Pioneers Imperial Valley Healthcare District currently has great operational processes, and the designing of new best practices to further the efficient and effective management of all operational processes of the facilities organization would simply be an enhancement. At HAH we believe an organization is only as good as the processes utilized to guide operations management. We look forward to discussing the concepts in this proposal, creating great operational processes on your behalf, and impacting your organization's continued success. Thank you for the opportunity to submit this proposal for your review and consideration.

We look forward to a productive professional working relationship with the Pioneers Imperial Valley Healthcare District Executive Staff.

Respectfully,

Ronald T. Hickey

Ronald T. Hickey, Chief Executive Officer

PROPOSAL APPROVAL SIGNATURE

I agree with the terms listed in the aforementioned proposal.

Signature: _____ Date: _____

Jose Contreras
Director of Facilities, Maintenance and Operations
Pioneers Imperial Valley Healthcare District

Innovation Born from Our Land. For Our People.

Cover Letter

June 10, 2025

Imperial Valley Healthcare District Board of Directors
202 North 8th Street
El Centro, CA 92243

Dear Esteemed Board Members,

It is with deep commitment and strategic foresight that I submit this proposal on behalf of Ale Najera LLC and the Surgical Access Network (SAN) to support Imperial Valley Healthcare District in designing and executing a future-facing, equity-rooted 5-Year Facilities Master Plan.

Our engagement is not just architectural—it is foundational. Our plan leverages over a decade of global leadership in surgical access, telehealth, and system-wide transformation to help Imperial Valley lead the state in rural health excellence. This is more than a plan—it is a mission to build systems where dignity, precision, and access are non-negotiable.

Imperial Valley's healthcare system is ready for autonomy—with infrastructure that reflects its people, and systems accountable to them. Our proposal enables the District to own its future, with surgical precision, economic growth, and community-rooted collaboration. No longer dependent. Always advancing.

My leadership has been presented on the floors of WHO Europe, informed by executive education from MIT, Harvard, and Stanford, and shaped by real-world delivery in complex environments. I bring the strategy, the team, passion, excellence, and the vision to help Imperial Valley Healthcare District not only fulfill regulatory expectations but exceed them—building a sustainable, human-centered ecosystem of care. Built for Dignity. Powered by Innovation. Rooted in Community.

We Offer:

- **Culturally anchored, high-trust facilitation** across Imperial Valley's multilingual, rural, and cross-border communities—rooted in lived experience and guided by diplomatic neutrality.
 - **Next-generation ROI modeling** that justifies every dollar—leveraging public and philanthropic capital while tracking long-term cost avoidance, health equity return, and economic revitalization.
 - **AI-integrated infrastructure strategy** preparing Imperial Valley for the future of healthcare:
 - Predictive analytics and demand forecasting
 - Robotic surgical readiness and tele-surgical frameworks
 - HIPAA-compliant, interoperable patient data systems
 - **Global-Local Alignment** with WHO Emergency Preparedness standards, **Rady Children's Health (RCH)** innovation pipelines, and international hospital partnerships across Romania, India, and Baja California.
 - **Decentralized Care Blueprints** including mobile clinics, community health coach pipelines, bilingual provider systems, and modular emergency zones for underserved and high-risk areas.
 - **Global Recognition & Awards Positioning:**
 - Strategic alignment for **UN SDG Health Innovation Awards, WHO Collaborating Center designation, and Global Health 50/50 Impact Index**
 - Positioning Imperial Valley as a **global leader in rural health equity and resilience**
 - **Be the Voice of the Voiceless:**
 - **Advocacy for pediatric, maternal, mental health, and cancer care**—ensuring no community member suffers in silence due to distance, language, or income
 - **Mental Health for All:** Community-rooted, destigmatized support across lifespan—from childhood trauma to elder care—centered in respect, healing, and dignity
-

Strategic Priorities: Driving Imperial Valley's Healthcare Transformation with Precision and Authority

Under the leadership of Alejandra Nájera, this engagement will move Imperial Valley's healthcare system from fragmented to formidable—delivering measurable impact through decisive, innovative, and sustainable action.

Our priorities are clear, uncompromising, and tailored to solve current challenges while unlocking future opportunities:

Optimize Patient-Centered Care with Cultural Competence and Operational Excellence

- Implement bilingual, respectful care models that rebuild community trust and reduce access barriers.
- Deploy telehealth, mobile clinics, and community health coaching to reach every corner of the region efficiently.
- Redesign workflows and physical spaces focused on patient outcomes, not legacy protocols.

Strengthen Workforce Capacity and Retention

- Build resilient training and residency pipelines rooted in local talent.
- Leverage partnerships with top academic and global health institutions to elevate clinical expertise.
- Institute wellness and trauma-informed practices that reduce burnout and secure staff longevity.

Integrate PMH and ECRMC into a Cohesive, Data-Driven Network

- Enable real-time, secure data sharing and operational alignment across facilities.
- Apply AI-enabled predictive analytics and GIS tools to improve emergency response and resource allocation.
- Establish a joint innovation council to drive continuous improvement and policy advancement.

Accelerate Economic Growth through Strategic Healthcare Development

- Position Imperial Valley as a regional healthcare hub that creates jobs, fosters small business growth, and attracts investment.
- Activate community engagement models that establish residents as active stakeholders in health governance.
- Ensure transparent and consistent communication to maintain and deepen public trust.

Deploy Scalable, Advanced Technologies to Expand Access and Preparedness

- Lead tele-surgical and tele-hospital initiatives that bring specialty care to underserved areas safely and efficiently.
- Develop modular infrastructure adaptable to demographic shifts and emergent needs.
- Align all technology deployments with WHO emergency preparedness standards, setting a national benchmark.

This is not a theoretical exercise. This is a strategic roadmap with authority, precision, and clarity—designed for execution and measurable outcomes.

Alejandra Nájera brings the leadership, expertise, and systems-level thinking to deliver this transformation with discipline, transparency, and unwavering focus.

Imperial Valley Healthcare District will not only meet today's demands—it will own the future of rural healthcare innovation.

Strategic Global Partnership Reference

To underscore our unwavering commitment to evidence-based and globally informed healthcare strategies, we respectfully invite the Imperial Valley Healthcare District Board of Directors to review two critical resources that frame the foundation of our proposal:

- The comprehensive White Paper authored and presented by Alejandra Nájera at the World Health Organization (WHO) Symposium in Denmark, April 2025, entitled “Looking to the Future: Modelling and Optimizing the Health and Care Workforce.” This document articulates advanced methodologies in healthcare workforce optimization and system resilience, which directly inform the strategic framework embedded within our proposal.
[WHO Symposium on Health Workforce Optimization — April 2025](#)
- The Surgical Access Network (SAN) overview, illustrating our organizational structure, vision, and strategic priorities tailored to transform rural healthcare access in Imperial Valley.
[Surgical Access Network \(SAN\) Overview](#)

By integrating these globally benchmarked insights and organizational frameworks, our proposal embodies a locally grounded yet internationally recognized approach—ensuring Imperial Valley's leadership in innovative, resilient, and equitable healthcare delivery.

Imperial Valley Healthcare District

Ten-Year Retrospective & Future Strategy

Prepared by Ale Najera LLC

Hospitals Included:

- Pioneer Memorial Hospital (PMH)
- El Centro Regional Medical Center (ECRMC)

Vision: Build the strongest rural healthcare system in the Western United States—anchored in trust, technology, and community strength.

10-Year Retrospective + 10-Year ROI Summary

Pioneer Memorial Hospital (PMH) & El Centro Regional Medical Center (ECRMC)

Pioneer Memorial Hospital (PMH)

Current State (2023–2025):

- Deferred maintenance impacting surgical capacity and reliability
- Emergency department overuse leading to bottlenecks
- Bilingual staff shortages affecting patient satisfaction and retention

Future State under Ale Najera LLC:

- Modernized surgical suites and outpatient diagnostics reduce ER usage by 30%
- Mobile clinics and telehealth deployed regionwide
- Bilingual patient navigators and training rotations for staff retention

10-Year ROI Projections: These figures reflect not just cost savings, but a reinvestment engine designed to drive workforce development, small business growth, and healthcare job creation throughout Imperial Valley.

Metric	Current	With Ale Najera LLC
ER Cost Savings	High	30% reduction = \$30M saved
Outpatient Revenue	Under-utilized	+\$45M via new services
Philanthropic Grants	Modest	+\$20M via new partnerships

Total Estimated ROI: \$95M

El Centro Regional Medical Center (ECRMC)

Current State (Jan 2023–Nov 2024):

- November 2024: \$4.2M operating loss, −49.4% margin
- January 2023: \$20.1M net loss, −22.5% operating margin
- 6–26 days of cash-on-hand, financial instability

Future State under Ale Najera LLC:

- Pediatric specialty hub with high-efficiency modular emergency infrastructure
- School-based telehealth units
- AI-driven staffing and resource allocation

10-Year ROI Projections: These figures reflect not just cost savings, but a reinvestment engine designed to drive workforce development, small business growth, and healthcare job creation throughout Imperial Valley.

Metric	Current	With Ale Najera LLC
ER Cost Reduction	High	35% savings = \$60M
Specialty Revenue	Limited	+\$50M from expanded services

Grants & DSH

Existing +\$25M via innovation

Total Estimated ROI: \$135M

Integrated System ROI: From Fragmented to Formidable

System ROI Opportunities:

- Joint IT/admin efficiency: 10–15% savings = \$40M
- Philanthropic/state grants: +\$30M
- Healthcare corridor & innovation zone: +\$50M

Combined 10-Year System ROI: ~\$350M

A. Document Review and Analysis

Ale Najera LLC will conduct a comprehensive 10-year retrospective of both PMH and ECRMC board agendas, budgets, and operational data. This analysis will identify infrastructure gaps, missed opportunities, and duplications in care delivery—forming a diagnostic baseline to inform an actionable 5-year plan and long-term facilities strategy.

B. Timeline Development

We will co-develop a phased, financially informed master timeline that accounts for infrastructure buildouts, staffing projections, and capital improvements. It will present both:

- An integrated PMH/ECRMC system vision
 - A standalone PMH strategy, ensuring flexibility and readiness across multiple planning scenarios.
-

C. Facilitate Board Workshops

Ale Najera LLC will facilitate high-impact, solution-focused workshops, including strategic planning, cost modeling, and vision alignment. Each session will:

- Define measurable goals and strategies
- Integrate community feedback

- Refine and align drafts with Board priorities
These sessions will empower board members with clarity and confidence in decision-making.
-

D. Draft a Final 5-Year Facilities Master Plan

We will deliver two actionable plans: one for a unified system, and one PMH-only, both integrating:

- A long-term vision that repositions Imperial Valley as a healthcare innovation zone
 - Tactical 5-year actions with built-in metrics and accountability
 - Integrated financial scenarios to model sustainability, risk, and ROI
-

E. Analysis of District and Foundation Funding Opportunities

Ale Najera LLC will map active funding opportunities—from federal rural health grants to local foundation assets—and design pathways to leverage them. We will prioritize funding linked to equity-based outcomes and capital expansion (e.g., mobile clinics, outreach programs).

F. Consideration of Future Funding Opportunities

We will future-proof the 5-year plan by embedding sustainable capital strategies, including bond alignment, philanthropic partnerships, and emerging public health investments—ensuring enduring funding pipelines beyond 2031.

G. Evaluation of Strategic Alternatives

Our team will assess legal, financial, and operational alternatives to deliver scalable health impact. This includes:

- Asset-sharing and public-private partnerships
 - Lease constraints and mitigation strategies
 - Advisory on co-location and cross-border collaboration (Baja/CA)
-

H. Analysis of the Pioneers Memorial Hospital Foundation

We will re-envision the Foundation’s role as a catalytic force in long-term transformation—recommending donor activation strategies, community investment initiatives, and transparent fundraising platforms to extend its reach and relevance.

L. Recommended Approach for Accomplishing the Scope of Services

Ale Najera LLC present a clear, decisive approach that reflects deep experience in healthcare transformation, public trust facilitation, and systems-level planning.

Deliverables & Methodology Overview

Deliverable	Approach Summary
Document Review Summary	Conduct retrospective 10-year analysis of PMH & ECRMC board agendas, budget data, and regional health indicators to ground planning in real context. Summarize insights and prepare solutions-focused report.
Timeline Development	Co-create detailed implementation roadmap with milestones tied to funding cycles, workforce expansion, and capital improvements.
Board Workshop Materials	Deliver a custom leadership education series tailored to rural equity, WHO-aligned transformation,US Healthcare System Aligned and sustainable innovation. Includes facilitation guides and US/Global policy briefs.
Funding Opportunities Report	Identify and prioritize relevant federal/state grants, philanthropic channels, and public-private investment pathways. Model ROI scenarios and leverage potential.
5-Year Facilities Master Plan	Design a modular, equity-rooted capital plan. Includes phased growth models, integrated service delivery, risk mitigation, and GIS-backed infrastructure planning.

Community Outreach Sessions	Lead bilingual patient-centered forums across Imperial Valley communities. Build local advisory input to align with the region’s cultural, social, and economic landscape.
Board & Committee Presentations	Deliver results-driven presentations at all key governance checkpoints. Includes briefing decks, ROI analysis, and implementation advisories.

M. Fee Schedule / Rate Sheet and Proposed Budget

This budget reflects the full scope of strategic transformation, leadership, and expert services provided by Ale Najera LLC over a five-year period. It honors the value delivered—locally and globally—with direct alignment to ROI, regulatory excellence, and public trust.

Total Proposed Budget: \$5,000,000 (5-Year Engagement)

Fixed-Price Milestone Structure

Deliverable	Description	Fee (USD)
Document Review & Retrospective Strategy	10-Year review of PMH/ECRMC + initial report	\$500,000
Timeline Development & Strategic Phasing	Implementation roadmap across all systems	\$500,000
Board Workshop Series	Facilitation, governance alignment, education	\$750,000
Funding Opportunities Report	Grant discovery, ROI modeling, investment plan	\$750,000

Facilities Master Plan (5-Year)	Planning, spatial integration, clinical design	\$1,000,000
Community Outreach Series	Bilingual engagement, advisory formation	\$250,000
Board & Committee Presentations	Full delivery of all board-facing content	\$500,000
Additional Scope Reserved (Pilot, R&D, Contingency)	Support for tele-surgery, rapid tech expansion	\$750,000

Payment Terms

- **Initial Retainer:** \$500,000 upon contract execution
- **Milestone-Based Invoicing:** Invoices issued **at the initiation** of each milestone
- **Net Terms:** Net 30 from date of invoice
- **Adjustments:** Scope enhancements or add-ons billed separately upon mutual agreement

Additional Support Expenses (Estimated)

- **Travel and Translation Services:** \$100,000
Includes local travel, community engagement, and essential bilingual support for effective stakeholder communication.
- **International Travel & Government Advocacy:** \$75,000
Dedicated to representing Imperial Valley Healthcare District at global symposia, engaging with government ministries, and fostering strategic partnerships with international healthcare leaders to elevate the district's profile and secure collaborative opportunities.
- **Legal and Grant Consulting:** \$150,000
Partnered expert counsel to navigate regulatory compliance and maximize funding opportunities.

- **Optional Services – GIS & Tele-Surgery Pilot Blueprinting: \$200,000**
Advanced technical planning to support scalable telehealth and data-driven infrastructure innovation.
-

Risk Mitigation

Ale Najera LLC, under the direction of Alejandra Nájera, engages a distinguished legal counsel with specialized expertise in healthcare law, corporate governance, and regulatory compliance to provide comprehensive legal oversight throughout the engagement. This counsel ensures full protection of Ale Najera LLC and Ms. Nájera against potential liabilities, contractual disputes, and fiduciary risks.

The risk management strategy employed by Ale Najera LLC is designed to systematically identify, assess, and mitigate risks in a proactive manner, including but not limited to:

- **Financial Risk:** Implementation of stringent financial controls, milestone-based payment structures, and transparent accounting practices to mitigate budgetary overruns and optimize capital allocation.
- **Regulatory Compliance Risk:** Ongoing monitoring and adherence to applicable federal, state, and international laws and regulations—including HIPAA, CMS requirements, and WHO standards—to ensure full compliance and timely adaptation to legal and policy changes.
- **Operational Risk:** Phased deployment of services with continuous performance evaluation and adaptive management to minimize disruptions and maintain clinical and operational integrity.
- **Human Capital Risk:** Strategic workforce development initiatives, inclusive of culturally competent training and wellness programs, designed to minimize turnover and maintain workforce stability.
- **Technology Risk:** Adoption of HIPAA-compliant, interoperable health information systems with rigorous vendor due diligence, testing protocols, and cybersecurity safeguards to protect data integrity and confidentiality.
- **Governance Risk:** Establishment of clear governance frameworks with defined roles, responsibilities, and escalation procedures to promote transparency, accountability, and efficient resolution of issues.

Ale Najera LLC expressly disclaims any liability arising from unforeseeable external factors beyond its control, while committing to a diligent and collaborative approach to risk management. This comprehensive risk mitigation framework, underpinned by legal expertise and global best practices, positions Imperial Valley Healthcare District to effectively manage complexity, safeguard stakeholder interests, and uphold the highest standards of healthcare delivery.

Closing Statement

This proposal embodies not only what is required—but what is possible. It is dignified, strategic, and grounded in the confidence that Imperial Valley can be a national model for what inclusive, resilient, proactive patient-centered-care healthcare looks like.

We begin now—with a shared mandate to deliver care that's excellent, equitable, and locally led. The time for Imperial Valley to own its healthcare future is now.

Alejandra Nájera

President, Surgical Access Network

Founder, Ale Najera LLC

contact@alenajera.com

www.alenajera.com

Personal: alejandramnajera@gmail.com

Submitted by: Ale Najera LLC & Surgical Access Network (Ale Najera LLC)

**SECOND AMENDMENT TO
STANDARD INDUSTRIAL/COMMERCIAL SINGLE-TENANT LEASE – NET WITH
TYSON MEDICAL INC.**

This Second Amendment to Standard Industrial/Commercial Single-Tenant Lease - Net (“**Second Amendment**”) is made and entered into as of June 26, 2025 (“**Effective Date**”), by and between **HEFFERNAN MEMORIAL HEALTHCARE DISTRICT** (“**Lessor**”), and **TYSON MEDICAL INC.**, a California corporation, dba All Valley Urgent Care (“**Lessee**”). Lessor and Lessee are sometimes referred to in this Second Amendment individually as a “**Party**” and collectively as the “**Parties**”.

RECITALS

A. The Parties entered into that certain Standard Industrial/Commercial Single-Tenant Lease - Net dated April 4, 2022 (“**Original Lease**”), as amended by that certain First Amendment to Addendum to Lease effective as of January 4, 2024 (“**First Amendment**” and, together with the Original Lease, “**Lease**”), for the premises commonly known as 400 Mary Avenue, Calexico, California 92231 (“**Premises**”).

B. The Parties desire to acknowledge the Delivery Date, amend the Base Rent Abatement for the Premises, and amend the permitted use of the South Side (as defined below).

C. The Parties now desire to modify the Lease further on the terms set forth herein. Capitalized terms used but not defined in this Second Amendment shall have the meanings given in the Lease.

AGREEMENT

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Lessor and Lessee hereby agree as follows:

1. Recitals. The above recitals are hereby confirmed as true and correct and are reaffirmed herein.
2. Delivery Date. The Parties acknowledge and agree that the Delivery Date was February 1, 2025. The Parties further acknowledge and agree that, in accordance with the Lease, and to confirm the Expiration Date, the Original Term shall expire on January 31, 2030.
3. Paragraph 53 Base Rent Amendment shall be amended to add the following language:

The Base Rent abatement for the portion of the Premises located on the north side of the building (“**North Side**”), comprising approximately 2,469 square feet **and depicted on Exhibit A** shall expire June 30, 2025. Commencing July 1, 2025, and continuing thereafter until adjusted in accordance with this Second Amendment, Lessee shall pay Base Rent for the North Side in the amount of Two Thousand

Signature Page to Second Amendment to Standard Industrial/Commercial Single-Tenant Lease -
Net

Eight Hundred Sixty-Eight and 50/100 Dollars (\$2,868.50) per month, which amount shall be payable in accordance with the terms of the Lease.

The Parties acknowledge that Lessee was provided access and Lessee began occupying that portion of the Premises located on the south side of the building (“**South Side**”), comprising approximately 4,632 square feet and depicted on **Exhibit A**, on June 10, 2025. Provided that Lessee is not then in default under the Lease and subject to Lessee’s continued compliance therewith, Base Rent for the South Side shall be abated for a five-month period commencing June 10, 2025 and ending November 10, 2025 (the “**South Side Abatement Period**”). If Lessee defaults under the Lease during the South Side Abatement Period and such default remains uncured after any applicable notice and cure period, all Base Rent previously abated shall immediately become due and payable as Rent, in addition to any other remedies available to Lessor.

Effective November 11, 2025, Lessee shall commence payment of the full Base Rent for the entire Premises in the amount of Eight Thousand Two Hundred Fifty Dollars (\$8,250.00) per month, prorated for the partial month of November 2025, and thereafter in full on the first (1st) day of each calendar month, subject to the scheduled Fixed Rental Adjustments previously agreed to by the Parties in Paragraph 54 of the Lease. Accordingly, on February 1, 2026, the monthly Base Rent shall increase to \$8,752.43.

4. South Side Use. The permitted use of the South Side shall be strictly limited to a facility for specialty healthcare services, a pharmacy and an urgent care facility (“**South Side Use**”). Notwithstanding the foregoing, the South Side Use shall not include any use related to providing medical or healthcare services otherwise offered by Lessor or any affiliate of Lessor (“**Prohibited South Side Use**”). Lessee shall immediately discontinue any such Prohibited South Side Use upon receipt of written notice from Lessor of any violation.

5. Good-Faith Negotiation. The Parties acknowledge that, prior to executing this Second Amendment, they mutually expressed their intent to modify the definition of the Premises under the terms of the Lease to possibly relocate Lessor to a different facility location. Pursuant to this Paragraph 5, the Parties memorialize and reaffirm their commitment to negotiate any such modifications in good faith. Nothing herein obligates either Party to reach a definitive agreement, but each shall use commercially reasonable, good-faith efforts to do so.

6. Other Provisions In Effect. All other provisions of the Lease not modified hereby shall remain in full force and effect. In the event of any conflicts or inconsistencies between the provisions hereof and those of the Lease, the provisions of this Second Amendment shall control.

7. Certification as to Original Lease. Tenant certifies that (a) the Lease is in full force and effect and has not been amended, except as previously stated in the Recitals above; (b) Tenant has no current actual knowledge of any uncured defaults on the part of Tenant or Landlord under the Lease; (c) except as set forth in this Second Amendment there are no outstanding obligations by Landlord to Tenant related to any tenant improvements to the Premises, including but not limited to any tenant improvement allowances; and (d) except as contemplated under this Second

Amendment, there are no outstanding or unpaid broker or leasing commissions relating to the Lease.

8. Counterparts. This Second Amendment may be executed in a number of counterparts, each of which will be deemed an original, but all of which together will constitute but one and the same instrument. The delivery of an executed copy of this Second Amendment by electronic transmission in electronic format (for example, “pdf” or “tif”) or by electronic means (for example, DocuSign or Adobe Sign) will have the same force and effect as the delivery of a signed original. This Second Amendment shall not be binding unless and until all Parties hereto have executed this Second Amendment.

9. Authority. The Parties executing this Second Amendment each represent and warrant to the other that they are duly authorized to do so on behalf of the Party on whose behalf they have signed and that no further consents or approvals are required in order for such person to duly bind the entity on whose behalf such individual has executed this Second Amendment; and that this Second Amendment is valid and shall be binding upon and enforceable against Landlord and Tenant and their respective successors and assigns and shall inure to the benefit of Landlord and Tenant, and their respective successors and assigns.

IN WITNESS WHEREOF, Lessor and Lessee have executed this Second Amendment as of the Effective Date.

LESSOR:

**IMPERIAL VALLEY HEALTHCARE
DISTRICT**, as successor agency to the
HEFFERNAN MEMORIAL HEALTHCARE
DISTRICT

By: _____
Name: _____
Its: _____

LESSEE:

TYSON MEDICAL INC.,
a California corporation, dba All Valley
Urgent Care

By: _____
Name: _____
Its: _____

EXHIBIT A

Depiction of North Side

[to be inserted]

Exhibit A

EXHIBIT B

Depiction of South Side

[to be inserted]

Exhibit B

IMPERIAL VALLEY HEALTHCARE DISTRICT

SOCIAL MEDIA POLICY

PURPOSE

The District may use social media for a variety of official reasons, including communication, collaboration and transparency. Individuals may also use social media for personal reasons. The purpose of this policy is to help distinguish between official and personal use and to ensure appropriate use of social media that comports with applicable laws, including those concerning privacy, confidentiality, harassment, free speech and government transparency.

SCOPE

This policy applies to District employees, consultants and public officials, including:

- Anyone managing or posting in an official capacity on a District-sponsored social media account.
- Employees using social media at any time and their affiliation is identified, or is known, or presumed.
- Public officials using social media in an official capacity.

This policy shall in no way restrict the rights of employees, public officials or other individuals to speak about matters of public concern in their personal capacities. This policy shall not prevent or discourage employees from discussing or disclosing their working conditions.

DEFINITIONS

“Confidential Information” means the District’s information and physical material not generally known or available outside the District and information and physical material entrusted to the District in confidence by third parties. Examples include, but are not limited to: PII, PEI, PHI, patient and member records, personnel records, financial information, proprietary information, privileged information, District-developed intellectual property, and information about the District’s affiliates, doctors, vendors or suppliers. For the purposes of this policy, Confidential Information includes information that may qualify as a public record or be subject to disclosure under other laws, but which is not permitted to be used or disclosed on social media.

“District” means the Imperial Valley Healthcare District.

“Patient Identifiable Information (PII)” means any individually identifiable information regarding a patient of the District collected, received, created, transmitted, or maintained in connection with his/her status as a patient. PII includes, but is not limited to: information about a patient’s physical or mental health, rare diseases or medical conditions, the receipt of health care, or payment for that care; patient records, pictures, photographs, audiotapes or other images of the patient, name, address, Social Security Number, account number, security code, information from or about

transactions, driver's license number, financial or credit account numbers, phone numbers, ISP and Internet domain addresses, and other personal identifiers.

"Protected Employee Information (PEI)" means information collected, received, created, transmitted, or maintained by the District in connection with a person's status as an employee, including but not limited to: Social Security number, address, telephone number, driver's license number, information about an employee's physical or mental health, emergency contact information, insurance information, disciplinary actions against employees, and complaints filed by employees or against employees.

"Protected Health Information (PHI)" means PII (oral, written or electronic) about a patient's physical or mental health, the receipt of health care, or payment for that care. PHI includes individually identifiable member/patient payment, insurance information, or demographic information as defined by HIPPA.

"Public official" means an official with the power and authority to speak on behalf of the District, including Board Members and officers.

"Social media" means an online service open and accessible to the public for the sharing of ideas and information through virtual networks and communities. Social media includes, without limitation: Instagram, Facebook, LinkedIn, X (fka Twitter), Reddit, Yelp, YouTube, TikTok, social networks, blogs, wikis and consumer review networks.

POLICY

Confidential Information

The District has a legal obligation to protect patient privacy and to prevent the disclosure of PHI, including on social media. Employees may not disclose, under any circumstances, any patient information, including PHI, whether on District-sponsored social media or on social media accessed or utilized by an employee for purely personal reasons. Disclosure of such information may violate not only the patient's privacy but also state and federal laws.

The District has an interest in protecting its Confidential Information from disclosure to third parties. Employees may not disclose any Confidential Information at any time, whether through District-sponsored social media or on social media accessed or utilized by an employee for purely personal reasons.

District employees have a privacy interest in their PEI. Accordingly, social media cannot be used to disclose PEI, although nothing prevents employees from discussing or disclosing their own wages, personnel information or working conditions.

All such prohibited disclosures of Confidential Information include indirect and indirect disclosure on social media. For example, even if neither the District, patient or employee are named, references to information about the District, context, location, patient or employee may allow the reader or viewer to identify them. Such inadvertent disclosure, although not intentional, is a violation of this policy and may be a violation of law.

Restrictions on Social Media Use

Social media must not be used for any unlawful purpose. All social media use must comply with applicable laws, including:

- The Health Insurance Portability and Accountability Act (HIPAA) and similar laws that protect the confidentiality of patient information.
- Trade secret and copyright laws which prohibit the unauthorized use and disclosure of such materials.
- Laws that prohibit harassment, discrimination, threats of violence and retaliation. Such inappropriate use of social media, even if carried out on a personal account and in an individual capacity, may still constitute a workplace violation.
- Laws that prohibit defamation—generally a false and unprivileged statement that causes injury.
- District-sponsored social media and other official social media use is subject to transparency laws such as the Public Records Act and Brown Act, which prohibits a majority of Board Members from using a social media platform to discuss District business amongst themselves.

In addition to unlawful use, certain disruptive social media use is prohibited by the District. The District depends on the public trust to achieve its mission of improving healthcare access and outcomes across Imperial County. Social media use that is detrimental to the mission and functions of the District, that undermines respect or public confidence in the District, or that undermines the goals and mission of the District is prohibited. As such, the District's name must not be used on a social media page or account that also contains sexually suggestive, violent or otherwise offensive content.

Although District employees enjoy certain rights and freedoms to comment on and to express their views about matters of public concern, they may still be subject to disciplinary and/or legal action if their comments are unlawful or unduly disrupt the District's business as outlined above.

Official vs. Personal Use

Social media use that exercises official duties or District business must only be on a District-sponsored account created for that purpose and clearly designated as such. Such "official" social media use may include: announcements about District activities, programs and meetings; requests for feedback on the District's business; and descriptions of actions undertaken on behalf of the District.

Personal social media must not be used for official duties or District business. Instead, personal accounts should remain personal in both appearance and function. For example, when using social media for personal reasons, employees and public officials must not: use the District logo or their official title; say or suggest that the views and opinions expressed are those of the District; or make official announcements. Employees and public officials with "mixed use" social media—meaning

the account includes posts made in both a personal and official capacity—risk having all such communications designated as “state action” and a “public record” which can give rise to unintended liability.

Public Comment

The District has discretion, on a case-by-case basis, to enable public comment on some or all of its social media. In the event comments are enabled, individual members of the public may not be blocked or their comments hidden or deleted simply because they are unfavorable. When comments are allowed on District-sponsored social media, the following disclaimer must be included: “We do not discriminate against any views, but reserve the right to remove any of the following: threats of violence, obscenities, lewd or harassing content, solicitations, confidential information and any other posts that violate the law.” Comments can only be restricted in accordance with applicable law and after consultation with legal counsel.

Best Practices for Social Media Use

Persons subject to this policy are expected to adhere to the following best practices when using social media:

- To identify and help distinguish private speech, public officials and employees should add a disclaimer to personal accounts and posts, such as: “This is the personal page of [official / employee's name]” and/or “The views expressed are strictly my own.”
- Use caution to ensure statements are accurate and not misleading. Ensure opinions are clearly expressed as such, and not as the view of the District, its directors, officers, members, employees, patients or affiliates.
- If you make an error or misstatement, promptly correct it. Ignoring mistakes or errors can cause more harm than admitting to the mistake and fixing it.
- Never post about patients. Even if you don’t think the patient is identifiable, they may be to family and others who could be humiliated and emotionally distressed by such comments.
- Attribute quotes, only quote short excerpts of other people’s material, and try to link to others’ work.
- The use of social media is not a substitute for addressing workplace complaints with Human Resources or your supervisor according to District policy. Social media is not monitored by the District with the same frequency or by individuals who may be qualified to process or respond to workplace complaints. For instance, complaints of harassment or unsafe working conditions must also be reported to appropriate District personnel to ensure a prompt response and safe working environment.
- Only use social media on behalf of the District when you have been expressly authorized.
- When using social media on behalf of the District, always be polite and courteous. Think

before you respond to criticisms, and do not let haste cause problems.

- Do not restrict or delete public comment on District-sponsored social media without first consulting with legal counsel.
- District Board Members must not respond directly to any communication on social media regarding a matter that is within the subject matter jurisdiction of the District that is made, posted, or shared by any other District Board Member.

Enforcement

Violations of this policy may result in discipline up to and including termination of employment or contractual obligations, as applicable.

PROCEDURE

Creating and Managing District Social Media

No-one is permitted to create or use a District-sponsored social media account without first obtaining written permission from the Chief Executive Officer, including as to whether or not public comment will be enabled for each account. The settings on all District-sponsored social media accounts shall comport with District policies concerning records retention and public participation and shall include any required disclaimers. Account usernames and passwords will be maintained by the District's Director of Marketing (or equivalent position as determined by the Chief Executive Officer), and must not be shared, except that the Director of Information Technology shall maintain a copy of the most recent account usernames and passwords as a backup.

Training

Employees and public officials must review and acknowledge this policy upon commencement of their employment or membership with the District, as applicable.

Consultants responsible for using or managing District social media will be required to comply with this policy and provided a copy prior to commencing those services.

REFERENCES

- *Garnier v. O'Connor-Ratcliff* (2025) 136 F.4th 1181.
- *City of San Jose v. Superior Court* (2017) 2 Cal.5th 608.
- *Hernandez v. City of Phoenix* (2022) 43 F.4th 966.

IMPERIAL VALLEY HEALTHCARE DISTRICT

BOARD MEETING DATE: June 26, 2025

SUBJECT:

Authorize the execution of the Joint Powers Authority Agreement, the Application for Certificate of Consent to Self-Insure as a Public Agency Employer Self-Insurer and the Resolution to effectuate such application for Imperial Valley Healthcare District ("IVHD").

BACKGROUND:

BETA Risk Management Authority, which has provided Pioneers Memorial Healthcare District's workers' compensation coverage for several years, is overseen by the Department of Industrial Relations as a self-insured entity and holds a master Certificate of Consent to Self-Insure. Because Imperial Valley Healthcare District is now conducting business under a new tax identification number, it is necessary that IVHD apply for an affiliate Certificate of Consent to Self-Insure to be filed under BETA's master certificate.

KEY ISSUES: PMHD completed the same process at the inception of BETA coverage with workers' compensation but it cannot be rolled over to the new entity.

CLASSIFICATION: Workers' Compensation Insurance

RESPONSIBLE ADMINISTRATOR: Carly Loper, CFO

DATE SUBMITTED TO LEGAL: 6-19-25 **REVIEWED BY LEGAL:** ☒ Yes ☐ No

FIRST OR SECOND SUBMITTAL: ☒ 1st ☐ 2nd

RECOMMENDED ACTION:

Authorize the execution of the Joint Powers Authority Agreement, the Application for Certificate of Consent to Self-Insure as a Public Agency Employer Self-Insurer and the Resolution to effectuate such application for Imperial Valley Healthcare District ("IVHD"), as outlined.

**BETA HEALTHCARE GROUP
RISK MANAGEMENT AUTHORITY**



***JOINT POWERS
AUTHORITY AGREEMENT***

Revised July 14, 2023

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BETA HEALTHCARE GROUP RISK MANAGEMENT AUTHORITY JOINT POWERS AUTHORITY AGREEMENT

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**BETA HEALTHCARE GROUP
RISK MANAGEMENT
AUTHORITY
JOINT POWERS AUTHORITY AGREEMENT**

Revised July 14, 2023

THIS AMENDED BETA HEALTHCARE GROUP RISK MANAGEMENT AUTHORITY JOINT POWERS AUTHORITY AGREEMENT (this "Agreement") is entered into pursuant to the provision of Title 1, Division 7, Chapter 5, Article 1 (Sections 6500, et seq.) of the California Government Code, relating to joint exercise of powers between the local healthcare districts, counties, other political subdivisions and qualified non-profits which operate hospitals, clinics, medical foundations and other health-related facilities and/or provide related healthcare services, and which have signed this Agreement, and those that may sign hereafter, for the purpose of operating and administering Group Self-Insurance Programs and/or insurance purchasing programs for professional liability, workers' compensation and/or providing other coverage or services for those healthcare districts and those counties, other political subdivisions and qualified non-profits which own and operate hospitals, clinics, medical foundations and other health-related facilities and/or provide related healthcare services. This Agreement is effective as of the date first set forth above. Capitalized terms used but not defined herein have the meaning set forth in Article I.

General Recitals

WHEREAS, it is to the mutual benefit and in the best public interest of the parties to this Agreement to join together to enter into this Agreement for the purposes set forth herein;

WHEREAS, the development, organization and implementation of the Group Self-Insurance Programs and/or other insurance purchasing programs are of such magnitude that it is necessary for the parties to join together through this Agreement in order to accomplish the purposes herein set forth;

WHEREAS, the parties have determined that there is a need by district hospitals, county hospitals, qualified non-profits, government-owned hospitals, clinics and other health-related facilities for Group Self-Insurance Programs and/or insurance purchasing programs for healthcare entity liability, workers' compensation and other coverages;

WHEREAS, such Group Self-Insurance Programs and/or insurance purchasing programs can adequately serve the needs of all the parties;

WHEREAS, The Government Code of the State of California authorizes joint exercise by two or more public agencies of any power common to them;

WHEREAS, it is the desire of the parties signing this Agreement to jointly provide for Group Self-Insurance Programs and/or insurance purchasing programs for healthcare entity liability, workers' compensation and other coverages for their mutual advantage;

WHEREAS, the different Group Self-Insurance Programs and/or group insurance purchasing programs offered under BETARMA shall be structured as separate lines of business with distinct rates, services, coverage contracts, administrative structures, excess and/or reinsurance structures, retentions, if applicable, and actuarial services;

WHEREAS, the State of California Senate and Assembly voted to approve Senate Bill No. 2004 in 1998, the Governor approved the Bill and the Secretary of State Chaptered the law effective January 1, 1999, as part of pursuant to Government Code Section 6527, BETARMA may include as Members any non-profit corporation which provides healthcare services where the BETA Council makes specified findings at a public meeting;

WHEREAS, the State of California Senate and Assembly voted to approve Assembly Bill No. 2078 in

2002, the Governor approved the Bill and the Secretary of State Chaptered the law effective September 20, 2002, as part of pursuant to Government Code Section 6527, BETARMA may include as Members for Group Self-Insurance for workers' compensation risks any non-profit corporation which provides healthcare services similar to services provided by a healthcare district;

WHEREAS, Government Code Section 990.8 provides that two or more local entities may, by a joint powers agreement, provide insurance for any purpose by any one or more of the methods specified in Government Code Section 990.4;

WHEREAS, each of the parties to this Agreement desires to join together with the other parties for the purpose of pooling certain self-insured claims and losses, administering claims, providing Risk Management and loss prevention programs and transferring risk between and among the parties, as permitted under this Agreement, section 6 of the California Constitution and as provided in Government Code Section 990.8, and/or jointly purchasing excess insurance, reinsurance and/or administrative services in connection with self-insurance and/or insurance programs for said parties;

WHEREAS, the parties desire to grow the membership of BETARMA and enhance its productivity and ancillary revenues, and the potential to do so exists through a variety of marketing efforts and service opportunities, it has been determined by the parties that there is value in offering Risk Management consulting services, claims consulting services and/or third-party claims administration services to non-Members, as well as to administer other joint powers authorities.

NOW, THEREFORE, for and in consideration of the mutual advantages to be derived, and in consideration of the execution of this Agreement by healthcare districts, counties, other political subdivisions and qualified non-profits which operate hospitals, clinics, medical foundations and other health-related facilities and/or provide related healthcare services, each of the parties hereto does hereby agree as follows:

I.

DEFINITIONS AND GENERAL PROVISIONS

1. "Administrator" shall mean the contractor or consultant retained, or staff employed by the BETA Council to administer the Group Self-Insurance Programs and/or other insurance purchasing programs.
2. "Agreement" shall have the meaning set forth in the first paragraph of this agreement.
3. "Authority" shall mean BETA Healthcare Group Risk Management Authority, a California joint powers authority.
4. "BETARMA" shall mean the Authority.
5. "BETA Council" shall mean the board of directors of BETARMA, consisting of representatives of Members, who are charged with the responsibility of governing BETARMA and its programs.
6. "Certificate of Coverage" shall mean the document issued to each Member evidencing its participation in one or more of the Group Self-Insurance Programs.
7. "Chief Executive Officer" shall mean the manager of the day-to-day affairs of BETARMA, appointed by the BETA Council.
8. "County" shall mean any political subdivision denoted as such by law.
9. "Coverage Contract" shall mean a contract of group self-insurance through Risk Sharing, risk transfer and Risk Management, which defines the terms and conditions and the extent of BETARMA's coverage of a Member's liability.
10. "Fiscal Year" shall mean that period of time commencing January 1 of each year and ending on the following December 31.

11. "Funds" shall mean, unless the context otherwise specifies, all monies paid into BETARMA or any of its Group Self-Insurance Programs, including any earnings thereon or any other sums coming to BETARMA from any source.
12. "Governmental Entity" shall mean any political subdivision or non-profit corporation operating a health facility, or any non-profit corporation which is considered a local government agency for the purposes of pooling self-insurance claims or losses as stated in California Government Code Section 6527 and empowered to execute this Agreement under the laws of the State of California.
13. "Group Self-Insurance" shall refer to the concept of a group of individuals or organizations who collectively manage risks by setting aside a pool of money to be used when a loss occurs.
14. "Group Self-Insurance Program(s)" shall mean a self-insuring plan of group Risk Sharing, risk transfer and Risk Management created for the benefit of the Members that provides for the defense and payment of claims, Risk Management and program administration by Risk Sharing and the maintenance of reserve Funds and Fund Balance, and which ordinarily provides for the transfer of risks from a Member to BETARMA. The Group Self-Insurance Programs may be provided with or without a Member deductible and/or in excess of a Member's self-insured retention ("SIR"). The Authority anticipates there will be multiple Group Self-Insurance Programs with separate coverages, limits and rates.
15. "Member" shall mean any Governmental Entity that is a signatory to the JPAA and has current coverage through BETARMA or one of its affiliated programs, provided, however, that this definition shall not be construed to prevent BETARMA from extending coverage to any subsidiary, or wholly owned or affiliated entity, upon terms and conditions approved by BETARMA. A Governmental Entity with claims-made coverage which has purchased an extended reporting period or tail coverage, but no longer purchases a current coverage contract from BETARMA, shall be deemed a former Member and not a current Member. BETARMA is also a Member of BETARMA with all the rights and obligations of other Members except that, while it is entitled to vote as a Member, it may not have an elected representative on the BETA Council.
16. "Occupied Beds" shall mean the daily average number of beds, cribs and bassinets used for patients during the coverage period.
17. "Reserves" shall mean Funds, including but not limited to incurred but not reported claims reserves, not yet committed to the payment of a covered claim but held for the payment of claims.
18. "Reserve and Distribution Policy" shall have the meaning set forth in Article XV, Section 12.
19. "Risk Management" shall mean the process of identifying, evaluating, reducing, transferring, sharing, financing and eliminating risk. "Risk Management" includes various elements of patient safety, insurance, law, administration, technology, accounting and general business to effectively manage hazards and losses to which Members and non-Members may be exposed.
20. "Risk Sharing" shall mean any common fund or pool of monies: (1) which is composed of cash, investments permitted by Government Code Sections 53601, et seq., or other assets; (2) to which two or more Members have agreed to contribute in accordance with the terms of a Certificate of Coverage and a Coverage Contract in which participation is voluntary; (3) from which claim and defense expenses of any contributor to that common fund shall be paid to claimants by BETARMA on a Member's behalf; (4) from which administrative costs to operate and manage the Fund and activities related to the purpose of the Fund shall be paid; and (5) which operates in accordance with this joint powers agreement.
21. "SIR" has the meaning set forth in Section 14 above.

II.
PURPOSES AND TERM

1. Purposes. The purposes of BETARMA are to provide and administer Group Self-Insurance Programs and/or insurance purchasing programs and services to its Members, as well as Risk Management consulting services, claims consulting services and third-party claims administration services to its Members and non-Members; to secure appropriate excess insurance and/or treaty or facultative reinsurance; to provide Members with the mechanisms to accumulate, administer and invest Funds to self-insure or insure as a group various exposures up to specified, predetermined limits of coverage; and to effect cost savings to Members in the administration of such Group Self-Insurance Programs and/or insurance purchasing programs as may be established by BETARMA in order to reduce the cost of healthcare to the patient-consumer.
2. Term. This Agreement shall become effective as of the date hereof and shall continue in full force and effect until it is terminated and BETARMA is dissolved, as provided herein. It is the intent of the parties hereto that the separate public agency created under this Agreement have an indefinite life and shall continue to exist so long as necessary to carry out the purposes of this Agreement, including the orderly wind-up of the affairs of BETARMA. It is the further intent of the parties that the withdrawal or termination of any Member from any Group Self-Insurance Program, insurance purchasing program and/or other program of BETARMA, or from BETARMA itself, shall not terminate such program or this Agreement as to the remaining Members therein nor relieve any Member or former Member from any obligations it may have under this Agreement, except as expressly provided in Article XXIII.

III.
CREATION OF AUTHORITY

Pursuant to Sections 6500, et seq. of the Government Code, there has been created a public entity, separate and apart from the parties hereto, known as BETA Healthcare Group Risk Management Authority. Pursuant to Government Code Section 6508.1, the debts, liabilities and obligations of BETARMA shall not constitute debts, liabilities or obligations of any party to this Agreement. No party to this Agreement shall have any right, title or interest in the assets of BETARMA or in any contributions, consideration, or property paid or donated by a party to BETARMA, or any of its programs, except as expressly provided in this Agreement.

IV.
ORGANIZATION & ADMINISTRATION

1. Responsibility. The overall responsibility for administration of Group Self-Insurance Programs, insurance purchasing programs or any other BETARMA program or activity of BETARMA shall be vested in the BETA Council.
2. Agents. Each Member hereby appoints the BETA Council and its delegates or designees to act as its agents in executing all contracts, reports, waivers, agreements and service contracts and to make and arrange for the defense, settlement and payment of claims and all other things required for the proper and orderly operation of BETARMA.
3. Bylaws. BETARMA shall be governed pursuant to this Agreement and the Bylaws. Amendments to the Bylaws may be proposed by any Member or BETA Council director. A copy of the proposed amendment and the reasons therefor shall be presented to the BETA Council, if not proposed by the BETA Council. All proposed amendments shall be approved by a two-thirds vote of the BETA Council. Upon its approval, the amendment shall be disseminated to all Members. The effective date of any amendment shall be July 1st following adoption, unless otherwise stated in the amendment. Each party to this Agreement agrees to comply with and be bound by the provisions of the said Bylaws and further agrees that all Group Self-Insurance Programs, insurance purchasing programs and BETARMA shall be operated pursuant to this Agreement and the said Bylaws. In the event of any conflict between the Bylaws and this Agreement, this Agreement shall prevail.

4. BETA Council. The governing body of BETARMA shall be known as the BETA Council. Upon approval by the Members of this amended Agreement, the BETA Council shall continue in office and shall be responsible for overseeing the organization and operation of BETARMA and all of its programs, as provided herein. The BETA Council shall establish such policies and guidelines as may be necessary to carry out any BETARMA program. The organization and structure of the BETA Council shall be established in the Bylaws, as they may be amended as provided therein.

V. **POWERS OF AUTHORITY**

1. Common Powers. BETARMA shall have the following common powers and is hereby authorized to perform all acts necessary for the exercise of said common powers:
 - A. To make and enter into Risk Management services and consulting contracts for Members and non-Members, as well as contracts of insurance and self-insurance for its Members providing for risk pooling or sharing, whether or not subject to regulation under the Insurance Code, to the extent and in the manner permitted under Government Code Sections 990, 990.4, 990.8 and 6508, or any other provision of law;
 - B. To hire employees and contract with consultants, independent contractors and legal counsel;
 - C. To invest and reinvest money in the treasury of BETARMA pursuant to Government Code Sections 53601, et seq.;
 - D. To incur debts, liabilities or obligations;
 - E. To acquire, hold, lease or dispose of real or personal property;
 - F. To sue and be sued in its own name;
 - G. To establish and operate Group Self-Insurance Programs and/or insurance purchasing programs designed to reduce the operating costs and/or improve patient safety for the Members;
 - H. To purchase excess insurance and/or reinsurance on behalf of Members and/or BETARMA; and
 - I. To exercise all powers necessary and proper to carry out the terms and provisions of this Agreement, or otherwise authorized by law.
2. Restrictions on Powers. Said powers shall be exercised pursuant to the terms hereof, subject to the restrictions, if applicable to BETARMA, upon the manner of exercising the powers set forth in the Local Health Care District Law (Division 23 of the Health & Safety Code).

VI. **MEMBERS**

1. Eligibility. The benefits of participation in BETARMA shall be available, pursuant to Section 6527 of the California Government Code, to non-profit corporations which provide healthcare services that may be provided by a healthcare district upon the following terms and conditions:
 - A. The BETA Council makes findings at a public meeting that: (1) the participation of the non-profit corporation in BETARMA will be substantially related to and in furtherance of the governmental purposes of BETARMA; and (2) the healthcare district and other local governmental entity Members in BETARMA will maintain control over the activities of BETARMA through the governance, management or ownership of BETARMA;
 - B. A reserve account or accounts has been established and maintained by the Members sufficient to operate BETARMA on an actuarially sound basis;

- C. The aggregate payments made on behalf of the Members under this Agreement shall not exceed the amounts available to BETARMA; and
 - D. A public meeting shall be held prior to any dissolution or termination of any enterprise of BETARMA operating under this section to consider the disposition, division or distribution of any assets acquired as a result of the joint exercise of powers under this section.
2. Participation of Members. Members may participate in one or all of the Group Self-Insurance Programs, insurance purchasing programs and/or other joint purchasing programs. Each such program shall maintain appropriate records to account for its operating results of the respective Members based on contributions, claims and other related revenues and expenses.

VII. **MEETINGS OF THE MEMBERS**

1. Members' Meetings. There shall be an annual meeting of Members for the purpose of electing directors on the BETA Council and to transact any other BETARMA business. The annual election of BETA Council members may be commenced in advance of the annual meeting using a ballot pre-approved by the BETA Council which may be distributed to Members via mail, in person and/or electronically. Completed ballots may be submitted to BETARMA at or in advance of the annual meeting. The election will not be final until results are announced at the annual meeting. The annual meeting, and any additional meetings, shall be held at the call of the Chair. Twenty percent (20%) of the Members may also call a meeting of Members. Each Member may be represented at meetings by its chief executive officer, or his or her designee, only. If a designee is to represent the Member, written notice from the Member's Chief Executive Officer or Board of Directors shall be provided to BETARMA.
2. Minutes. The Secretary of BETARMA shall cause minutes of regular, adjourned regular and special meetings of the Members to be maintained upon approval by the BETA Council. The Secretary, with the BETA Council's approval, may delegate this task to the Administrator.
3. Quorum. Twenty-five percent (25%) of the Members shall constitute a quorum to transact business at any meeting of the Members. A vote of the majority of a quorum present at a meeting shall be sufficient to constitute action by the Members, except as otherwise specifically set forth in this Agreement or in the Bylaws.
4. Written Consent. The Members may approve certain matters by written consent in lieu of a meeting, which shall be governed by the Bylaws.

VIII. **BETA COUNCIL**

1. Number. BETARMA shall be governed by the BETA Council, which is hereby established and which shall be composed of a minimum of seven (7) elected directors and a maximum of twenty-one (21) directors – each of whom represents a Member of BETARMA – plus one non-elected director who is the Chief Executive Officer of BETARMA. The BETA Council is responsible for maintaining a balanced representation from its political subdivision and non-profit members who must be representatives of the Members. Directors shall be elected by the Members in accordance with the Bylaws of BETARMA. As required by California Government Code Section 6527(a)(2), a majority of the elected BETA Council members shall be from public subdivisions, including counties and healthcare districts, so that public subdivision Members maintain control over the governance of BETARMA.
2. Term. Each elected director on the BETA Council shall serve four (4) years. The terms of office shall be staggered yearly over four years so one or more terms expire each year, and one or more new terms commence each year. A director may be re-elected and may serve successive terms. Each elected BETA Council director shall have one (1) vote.
3. Vacancies. Vacancies on the BETA Council shall be filled as provided in the Bylaws.

IX.
POWERS OF THE BETA COUNCIL

1. Review of Executive Committee. The BETA Council may review all acts of the Executive Committee and shall have the power to modify and/or override any decision or action of the Executive Committee upon a majority vote of the entire BETA Council.
2. Budget. The BETA Council shall review, modify, if necessary, and approve the annual operating budget of BETARMA prepared by the Committee assigned this responsibility as defined in the Bylaws.
3. Financials. The BETA Council shall receive and review periodic accountings of all Funds under this Agreement.
4. Conduct of Business. The BETA Council shall have the power to conduct, on behalf of BETARMA, all business of BETARMA, including that assigned to the Executive Committee, which BETARMA may conduct under the provisions hereof and pursuant to law.
5. Contracts. The BETA Council shall have the authority to enter into contracts and to incur usual and necessary expenses for the accomplishment of its functions, to appoint and assign staff personnel, and to employ or contract for professional or consulting services to carry out and effect the functions of BETARMA. Based on its policies and actions, the BETA Council may delegate to management appropriate authority to carry out these functions.
6. Miscellaneous Powers. The BETA Council shall have such other powers and shall perform such other functions as provided for in this Agreement.

X.
MEETINGS OF THE BETA COUNCIL

1. Meetings. The BETA Council shall provide for its regular, adjourned regular and special meetings upon call of the Chair, Vice Chair, the Executive Committee, a majority of the directors on the BETA Council or Chief Executive Officer of BETARMA, provided, however, that it shall hold at least four (4) regular meetings annually, as set forth in the Bylaws.
2. Minutes. The Secretary of BETARMA shall cause minutes of regular, adjourned regular and special meetings to be maintained upon approval by the BETA Council. The Secretary, with the BETA Council's approval, may delegate this task to the Administrator.
3. Quorum. A majority of the elected directors of the BETA Council shall constitute a quorum for the transaction of business, except that less than a quorum may adjourn from time to time. A vote of the majority of a quorum present at a meeting shall be sufficient to constitute action by the BETA Council, except as otherwise specifically set forth in this Agreement or in the Bylaws.

XI.
EXECUTIVE COMMITTEE

1. Number. The Executive Committee shall consist of the BETA Council Chair, BETA Council Vice Chair, BETA Council Secretary, BETA Council Treasurer-Auditor and Chairs of the Underwriting, Claims and Governance Committees. The BETA Council Chair shall be the Chair of the Executive Committee.
2. Vacancies. Vacancies on the Executive Committee shall be filled as provided in the Bylaws.

XII.
POWERS OF THE EXECUTIVE COMMITTEE

The BETA Council may delegate to the Executive Committee such powers as the BETA Council deems appropriate.

XIII.
MEETINGS OF THE EXECUTIVE COMMITTEE

1. Meetings, Minutes, Quorum. The Bylaws shall govern the calling of meetings, recording of minutes, establishment of a quorum, and filling of vacancies, among other things.
2. Reports. The Committee shall make periodic reports to the BETA Council, advising the BETA Council of its decisions, recommendations and activities.

XIV.
OFFICERS OF BETARMA

1. Chair, Vice Chair, Secretary and Treasurer-Auditor. The BETA Council shall elect from the BETA Council a Chair, Vice Chair, Secretary and Treasurer-Auditor of BETARMA for terms of not less than one (1) nor more than four (4) years, as provided in the Bylaws, each to hold office until a successor is elected. In the event an officer so elected ceases to be a Member of the BETA Council, the resulting vacancy in the office shall be filled at the next regular meeting of the BETA Council held after such vacancy occurs. The Executive Committee may appoint an interim officer pending action by the BETA Council. In the absence or inability of the Chair to act, the Vice Chair shall act as Chair. The Chair, or in his or her absence the Vice Chair, shall preside at and conduct all meetings of the BETA Council and shall chair the Executive Committee.
2. Other Officers. The BETA Council may appoint other officers as may be necessary to carry out the purposes of this Agreement.

XV.
CONTRIBUTIONS AND OPERATIONS

1. Contributions. The parties agree that each Member shall make payment of contributions for coverage under the applicable programs and the operations of BETARMA. The amount of such contribution for each Member shall be determined based upon the coverage and programs selected by, and underwriting factors applicable for, each Member and any rating amendments that are made a part of a Member's Coverage Contracts. It is agreed that there must be a timely and orderly method of determining and paying such contributions. The BETA Council is therefore authorized and directed to establish the base rates of contribution for all Members. Members acknowledge that the base rates established by the BETA Council for coverage under the Group Self-Insurance Programs may reflect changes in coverage, exposures, excess insurance and/or reinsurance premiums and administrative costs, as well as the past or projected experience of the Members, as a group, and the judgment of the Administrator. Such rates will not necessarily reflect the experience of an individual Member during any specific period of participation. Consequently, there can be no assurance that current or former Members will benefit equally from changes in the Group Self-Insurance Programs (including, but not limited to, changes in eligibility for credits, dividends or enlargements of coverage grants), nor that the burdens will be equally shared. The timely payment of all contributions, deductibles, penalties and/or other fees to BETARMA shall be a condition precedent to the continuation of participation by each Member in the Group Self-Insurance Programs and BETARMA and eligibility to receive various Member benefits, including but not limited to dividends. A Member has no title or interest in the Member's or other Members' contributions or any type of dividend, whether equitable or otherwise, except as expressly provided in this Agreement.
2. Annual Nature of Contributions. Participation in the Group Self-Insurance Programs, except initial participation which may be less than one year, shall be for one year at a time commencing for most members on July 1 and ending June 30 (the contract period), subject to termination at any time upon either the Group Self-Insurance Programs or Member giving proper notice as provided in the Coverage Contract accepted by a Member. Participation may be renewed for additional contract periods by submitting to BETARMA such information as the Administrator may require or may specify in an application for coverage or Coverage Contract, and by remitting to BETARMA, upon such payment schedule as BETARMA shall specify, the Member's contribution for the following year. BETARMA may elect to non-renew a Member as specified in the Coverage Contract.

3. Computation and Notice of Rates.
 - A. The base rates to be used in calculating contributions for each Member for participation in the Group Self-Insurance Programs shall be determined by the BETA Council not less than sixty (60) days prior to the commencement of the coverage year and communicated to all current Members as soon as practicable thereafter.
 - B. The Administrator, in consultation with the Actuary, shall determine the rates to be submitted to the BETA Council for review and approval. Rate computations may take into account factors including, but not limited to, the total number of Occupied Beds, outpatient visits, inpatient visits, physicians on the medical staff, surgeries and employees, and Member payroll, as well as reinsurance premiums, administrative costs and loss experience of the individual Member and of all Members. The Administrator and/or the BETA Council may also consider industry trends and other factors and methods commonly used by insurers in rate setting. Individual Members may pay a rate that is greater or less than the base rates established by the BETA Council if the Administrator determines that changes in loss experience or the Member's risk profile warrant a rate adjustment.
4. Loss Prevention and Risk Management. Members agree to follow the loss prevention and Risk Management recommendations of the Administrator and to abide by all conditions, requirements, rules and regulations regarding loss prevention and Risk Management which may be promulgated by the BETA Council.
5. Right to Inspect. As provided in the Coverage Contracts, each Member agrees that the BETA Council, Administrator or any of their respective agents, servants, employees or attorneys shall be permitted at any reasonable time to inspect Member's property and operations and to examine Member's books, documents and records as necessary in the proper operation of the Group Self-Insurance Programs or BETARMA.
6. Audit. The BETA Council shall obtain an annual audit of the financial affairs of the Group Self-Insurance Programs and BETARMA by a certified public accountant at the end of each fiscal year in accordance with generally accepted auditing principles. Copies of the annual audit report shall be delivered to each Member. The costs to audit BETARMA, as a whole, shall be charged to each Group Self-Insurance Program, as appropriate, in management's determination.
7. Management Audits. The BETA Council shall arrange for periodic audits of each Group Self- Insurance Program by a qualified consultant. Such audit(s) may consider one or more of the following areas: underwriting, claims and/or investment management, administrative procedures and practices, claims reserving and such other activities as may be determined by the BETA Council. The BETA Council is also empowered to retain an independent actuary in connection with such audits.
8. Binding Nature. Any Governmental Entity which makes application for participation in a Group Self-Insurance Program or any other BETARMA program and is accepted as a Member and signs this Agreement shall thereupon become a party to this Agreement and shall be bound by all the terms and conditions hereof, provided, however, that any Governmental Entity may be refused admission to BETARMA or any of its programs in the sole absolute and unreviewable discretion of the Administrator and/or BETA Council.
9. Deposit of Funds. Members shall pay contributions into the Group Self-Insurance Programs and other BETARMA programs. The contributions and income therefrom shall be accumulated to pay the administrative costs of BETARMA and claims against Members together with allocated costs, up to a specified amount to be determined from time to time by the BETA Council. Members may also pay contributions for participation in group insurance purchasing and/or other programs to BETARMA, which shall be administered by the BETA Council pursuant to the provisions of those programs, this Agreement and the Bylaws. Each Group Self-Insurance Program shall receive and account for Funds separately, but Funds may be commingled at financial institutions and with investment managers. Funds received by BETARMA shall be deposited and invested in accordance with the laws of the State of

California pertaining to the investment of excess funds of healthcare districts.

10. Contributions by Members. Without in any way limiting the powers otherwise provided for in this Agreement, the Bylaws or by statute, BETARMA shall have the power and authority to receive, accept and utilize the services of personnel offered by any Member or its representatives or agents; to receive, accept and utilize property, real or personal, from any Member or its agents or representatives; and to receive, accept, expend and disburse Funds by contract or otherwise, for purposes consistent with the provisions of this Agreement, which Funds may be provided by any Member, its agents or representatives. BETARMA shall account and disburse Funds for each Group Self-Insurance Program separately.
11. Excess Insurance and Reinsurance. BETARMA shall obtain or cause to be obtained such excess insurance and/or reinsurance as may be necessary and prudent in the judgment of the BETA Council. The expense of such excess insurance or reinsurance shall be paid from the Funds of BETARMA. If, because of financial, administrative and/or program design reasons, obtaining excess insurance and/or reinsurance with or in conjunction with other entities affiliated with BETARMA is in the best interests of BETARMA and/or its Members, then such joint marketing, presentation and/or analysis of data and purchasing of excess insurance and/or reinsurance is authorized by BETARMA. BETARMA will maintain sufficient excess insurance and reinsurance necessary for each Group Self-Insurance Program, even if this requires separate insurance coverage.
12. Determination of Reserves and Distribution of Surplus. Based upon input from the Actuary, the BETA Council shall, from time to time, adopt a policy determining how reserves will be calculated and whether and how any surplus will be distributed to Members of each Group Self-Insurance Program (a "Reserve and Distribution Policy").

XVI.

CLAIMS ADMINISTRATION, RISK MANAGEMENT SERVICES & PAYMENT OF EXPENSES OF THE GROUP SELF-INSURANCE PROGRAMS

1. General. The principal purpose for the establishment and administration of the Group Self-Insurance Programs is to provide for the orderly presentment, examination, investigation, defense and/or settlement of certain identified claims made against the Members. It is agreed and understood that BETARMA shall use the sums contributed by all the Members in connection with each Group Self-Insurance Program to pay such claims and related expenses for all the Members and BETARMA's administrative costs.
2. Entities with Self-Insured Retentions or Captives. BETARMA may offer excess coverage, claims administration services and/or Risk Management consulting services to entities that maintain SIR or captive insurance programs. Such entities may elect not to retain BETARMA to provide claims administration services or may access BETARMA's claims administration services differently than described in this section. In such instances, the entire scope of claims administration services and responsibilities will be addressed in the Coverage Contract issued to the Member and/or a separate third-party claims administration agreement.
3. Presentment of Claims. The services and benefits to be provided under the Group Self-Insurance Programs shall be paid by or furnished to or for the benefit of a Member with respect to a particular incident or claim only if BETARMA is notified as required by the Coverage Contract.
 - A. Upon presentation of a claim to BETARMA under a Group Self-Insurance Program, the following accounting procedures shall be followed in connection with such claim:
 - i. The claim shall be evaluated as to probable loss exposure and defense costs based upon information known at the time of presentation.
 - ii. The sum so determined shall be established as a Reserve following presentation of the claim. Such reserved sum shall be held for the administration and payment of such claim, and for no other purpose.

- iii. The Reserves shall be adjusted from time to time based upon the most recently available information related to such claims.
 - iv. Claims for each Group Self-Insurance Program shall be maintained and administered separately.
 - B. At each regularly scheduled BETA Council meeting, the Administrator shall advise the BETA Council regarding the current status of claims against Members that meet the reporting criteria approved by the BETA Council.
- 4. Investigation and Defense. Except as provided in Article XVI Section 2 above, the Administrator will investigate, or cause to be investigated, all such claims referred to in the foregoing paragraphs and will attempt to adjust or settle such claims, in accordance with the authority delegated to the Administrator by the BETA Council and the Member involved. Each party to this Agreement hereby delegates such authority, subject only to the terms and conditions of the Group Self-Insurance Programs in which the Member participates. As required by, and subject to, the provisions of the Coverage Contracts, BETARMA, through designated defense counsel, will provide legal defense of claims against Members. The Member agrees to cooperate fully with BETARMA in such matters and to provide and make available all information and personnel as may be reasonably required in the opinion of the Administrator to fully investigate and defend the claim.
- 5. Payment of Claims. For claim payments in excess of the authority delegated to the Administrator, the Administrator shall pay claims as directed by the BETA Council at regularly scheduled or special meetings. It is understood that the BETA Council and Administrator shall use their discretion in making judgments and assumptions as to the actual value of any claim and setting such Reserves based on such judgments.
- 6. Installment Payment of Judgments. The Administrator is authorized to seek authority for periodic payment of judgments as authorized by law.

XVII.

TERMINATION OR WITHDRAWAL OF A MEMBER

- 1. Withdrawal of a Member. A Member may terminate its participation in a Group Self-Insurance Program, or in other BETARMA programs, or from all programs of BETARMA and from BETARMA itself, by giving at least thirty (30) calendar days' written notice of withdrawal, unless otherwise provided in the Coverage Contracts, insurance policies, Certificates of Coverage or other contracts issued by or through BETARMA directly or indirectly. A withdrawing Member shall remain liable for any unpaid amounts due BETARMA including but not limited to contributions (including late payment fees) and/or claim deductible amounts which shall have accrued or will accrue under any Coverage Contract, insurance policy, Certificate of Coverage or other contracts and for any liability it may have to BETARMA itself through the effective date of termination. Upon its voluntary withdrawal or its termination as a Member in BETARMA, a former Member becomes ineligible to participate in any other BETARMA program, except that the rights of a Member after termination shall be limited to those benefits, such as the defense and indemnity of claims covered under Coverage Contracts issued by BETARMA which have accrued as of the date of termination as determined by the provisions of the Coverage Contracts or other evidence of coverage and/or insurance issued to the Member. A withdrawing or terminating Member shall have no other rights in any assets of BETARMA or any BETARMA program, whether denominated as Fund balance, equity, surplus, dividends, credits, contributions or otherwise, unless the circumstances described in Article XXIII apply to such withdrawal.
- 2. Involuntary Termination. A Member may be terminated by BETARMA from any BETARMA program, or from BETARMA itself,
 - A. Pursuant to the non-renewal terms of any Coverage Contracts or insurance policies issued by or on behalf of BETARMA; or

B. With or without cause, upon a two-thirds vote of the directors on the BETA Council.

3. Adjustment. Whether termination is voluntary or involuntary, a Member shall remain liable for any unpaid contributions, late payment fees and/or deductible amounts which shall have accrued prior to withdrawal or termination of its participation in a Group Self-Insurance Program, or any other BETARMA program, or BETARMA itself or deductible amounts which accrue after withdrawal or termination. Adjustment for amounts of contributions due to the Group Self-Insurance Program upon termination shall be made within thirty (30) calendar days of the time at which cancellation is effective.
4. No Continued Liability. Except as provided in Paragraph XVII, Sections 1 and 3, after a Member withdraws or terminates, such withdrawing party shall not be subject to assessment to maintain the solvency of any Group Self-Insurance Program or other program of BETARMA.

XVIII. ADMINISTRATOR

1. Appointment of Administrator. The BETA Council shall appoint or employ an experienced and qualified Administrator to administer BETARMA, including the Group Self-Insurance Programs. Such Administrator may be a person, association, partnership, corporation, contracted or employed staff or any other form of entity.
2. Duties of Administrator. The Administrator shall have all such duties and authorities as may be delegated to it by the BETA Council. If the Administrator is not the employed staff of BETARMA, the BETA Council shall enter into a service agreement or establish policies and procedures which shall specify all of the duties and obligations of the Administrator.

XIX. DEPOSITORIES

1. Designation of Depositories. The BETA Council shall appoint one or more institutions qualified under the laws of California to act as a depository for the Funds of BETARMA.
2. Duties. In accordance with policy guidelines established by the BETA Council, the BETA Council and its Treasurer-Auditor shall be responsible for depositing and investing all Funds of the Group Self-Insurance Programs and such other Funds of BETARMA as the BETA Council may direct. The BETA Council may appoint one or more investment managers and may delegate investment decisions to such firms, subject to BETARMA's Investment Policy. Custody of all Funds shall be maintained by one or more lawful depositories out of which expenses, claims and settlements on behalf of the Group Self-Insurance Programs may be paid as directed by the Administrator. The Treasurer-Auditor, with the BETA Council's approval, may delegate the above tasks to the Administrator.
3. Terms and Conditions. Depositories shall be paid such reasonable compensation as shall be agreed upon from time to time by BETA Council, pursuant to a written contract establishing terms and conditions under which services will be provided. Said compensation shall be an expense of each Group Self-Insurance Program and BETARMA.

XX. ACCOUNTS AND RECORDS

1. Annual Budget. The BETA Council shall annually adopt an operating budget for BETARMA.
2. Funds and Accounts. The Treasurer-Auditor of BETARMA shall establish and maintain, and shall cause each Depository to establish and maintain, such Funds and accounts as required by the BETA Council and as required by good accounting practice. Books and records of BETARMA in the hands of the Treasurer-Auditor shall be open to any inspection at all reasonable times by the BETA Council and as otherwise required by law. The Treasurer-Auditor, with the BETA Council's approval, may delegate the above tasks to the Administrator.

3. Bond. A bond in the amount determined adequate by the BETA Council may be required of any officers and personnel authorized to disburse Funds of BETARMA. Such bond shall be paid for by BETARMA.

XXI. ACTUARY

1. Appointment. The BETA Council shall retain one or more Actuaries.
2. Duties. The Actuary shall have all duties as may be delegated to it by the BETA Council in a written contract between the Actuary and the Administrator. It is contemplated that the duties of the Actuary may include but not necessarily be limited to the following:
 - A. Recommend base rates;
 - B. Review and comment on rating practices;
 - C. Complete an annual claims Reserve review;
 - D. Provide input on new lines of coverage;
 - E. Provide input on risk retention and reinsurance; and
 - F. Provide input on market conditions, trends and financial assumptions.
3. Payment. The professional fee and reimbursement of reasonable expenses paid to the Actuary for its services shall be an expense of the Group Self-Insurance Programs, except as to any actuarial services provided for insurance programs of BETARMA. The professional fee may be based on a flat sum, an hourly rate or another method as the parties may specify. Unless otherwise specified in the contract, the professional fee shall be full payment by BETARMA for discharge of the Actuary's duties.
4. Termination. The contract between BETARMA and the Actuary may be terminated by either party on thirty (30) days' written notice to the other party of such termination, in which event the Actuary shall be paid for all services rendered by it up until the effective date of such termination but shall not be paid for any work it may do thereafter except as otherwise specifically agreed. Upon termination, the Actuary shall return all books, records, files and other items pertaining to the Group Self-Insurance Programs and any other program of BETARMA, or its Members, to BETARMA or its designee promptly upon request by the BETA Council or the Administrator.

XXII. LEGAL COUNSEL

1. Appointment. The BETA Council shall appoint an attorney for BETARMA to serve as General Counsel, whose services may be made available to the Group Self-Insurance Programs upon request by the BETA Council or Administrator. The BETA Council or Administrator may retain Special Counsel as needed.
2. Payment. The professional fees of General and any Special Counsel for services rendered to BETARMA shall be based on a retainer, an hourly rate or other method as the parties may specify. The professional fees shall include all normal overhead expenses of General and Special Counsel except items such as duplication of copies, long-distance telephone calls, hotels, motels, travel or other items not incidental to normal office overhead.
3. Termination. The contract between BETARMA and General Counsel may be terminated by either party on thirty (30) days' written notice to the other party of such termination, in which event General Counsel shall be paid for all services rendered by it up until the effective date of such termination but shall not be paid for any work it may do thereafter except as otherwise specifically agreed. Upon termination, General Counsel shall return all books, records, files and other items pertaining to a Group Self-

Insurance Program and any other program of BETARMA, or its Members, to BETARMA or its designee, promptly upon request by the BETA Council or the Administrator.

XXIII. **AMENDMENT AND TERMINATION**

1. Amendment.
 - A. Members may amend this Agreement at any time by an instrument in writing approved by a majority vote of the BETA Council and executed by a majority of the Members, provided, however, that no amendment shall retroactively reduce the benefits which any Member is entitled to receive under any Coverage Contract for any coverage year in which a Member was a fully qualified Member in the Group Self-Insurance Programs, without the Member's written consent.
 - B. Upon approval as above by the BETA Council, and upon execution of any amendment by a majority of the Members, the said amendment shall immediately be effective and binding upon all Members. Any Member that has failed to sign the amendment shall have the option of withdrawing from BETARMA on the first day of the month following the month in which a majority of the Members have completed approval of the amendment or remaining in BETARMA and being bound by such amendment.
2. Termination by Agreement. Members may terminate a Group Self-Insurance Program, or any insurance program of BETARMA, or BETARMA without a successor program or entity effective as of the end of the then-current coverage year, by an instrument in writing approved by a majority vote of the BETA Council and executed by a majority of the Members, provided, however, if a Group Self-Insurance Program or any insurance program of BETARMA or BETARMA shall be so terminated, such termination shall not reduce or terminate the rights, benefits and obligations of any Member as to any claim theretofore presented.
3. Termination by Withdrawals. If, at any time, by reason of withdrawals or terminations of Members, the Actuary shall advise and the BETA Council concurs that a Group Self-Insurance Program or any insurance program of BETARMA is no longer economically feasible or actuarially sound, then such program or programs shall be terminated and dissolved by the BETA Council.
4. Disposition of Funds upon Termination. Upon termination of a Group Self-Insurance Program or any other program of BETARMA, BETARMA shall retain in a liquidation Fund such sums up to the entire amount held by BETARMA for the benefit of the Members in such program as the BETA Council deems sufficient to pay the remaining obligations of the Group Self-Insurance Program or other program. In the alternative, BETARMA may insure or reinsure all outstanding liabilities of Members in such program. Any Funds remaining after termination of the Group Self-Insurance Program or other program of BETARMA, after adequate provision for all liabilities and claims hereunder, shall be distributed to Members and former Members in the same proportion as each Member's (or former Member's) net contributions paid by that Member, reduced by the amount of losses and allocated claims expenses paid on behalf of that Member, bear to net contributions paid by all Members, reduced by the total losses and allocated claims expenses paid on behalf of all Members from the inception of the Group Self-Insurance Program or other program of BETARMA to its termination. If BETARMA insures or reinsures all outstanding liabilities of Members, any Funds remaining in excess of amounts necessary to pay the cost of such insurance or reinsurance shall be distributed to Members in accordance with this Section, not later than twelve (12) months after payment of the final insurance or reinsurance premium. If BETARMA elects to liquidate the liabilities by means of a liquidation Fund, any excess Funds shall be distributed not later than twenty-five (25) years following the date of termination of the Group Self-Insurance Program or any other program of BETARMA. The BETA Council shall determine such distribution within six (6) months after disposal of the last pending claim or loss covered by the program being terminated.
5. Termination of BETARMA. BETARMA itself may be terminated and dissolved in the same manner and subject to the same conditions as any Group Self-Insurance Program or other program may be

terminated, provided that, in addition, the Treasurer-Auditor shall disburse any Funds in the treasury not held by a Depository as directed by the BETA Council. The BETA Council is vested with all powers of BETARMA for the purpose of winding up and dissolving the business affairs of BETARMA.

XXIV.

CLAIMS, LITIGATION OR JUDGMENTS AGAINST BETARMA

1. Defense of Claims. As to any claim or action against BETARMA which is based on or arises out of an occurrence involving a BETA Council Member or officer or employee of BETARMA during the course and in the scope of such duties, who is also a director, officer or employee of a Member, such claim or action against BETARMA will be defended by BETARMA to the extent authorized by law. Such claims or actions shall not be considered claims or actions against such Member solely as a result of employment by BETARMA.
2. Claims and Judgments against BETARMA. Claims and judgments against BETARMA, its agents, the BETA Council Members, officers or employees, shall be paid from, or charged to, the appropriate coverages or self-insured Funds BETARMA has established and/or purchased against such claims, judgments or losses.
3. Arbitration. All disputes concerning, arising out of or relating to this Agreement shall be submitted to binding arbitration, unless all parties to the dispute agree in writing to a different procedure than outlined in this section.
 - A. Governing Law and Waiver of Right to Jury Trial. The arbitration will be governed by the California Arbitration Act, Sections 1280, et seq. of the Code of Civil Procedure. BETARMA and each Member waive the right to court remedies, including a jury trial.
 - B. Rules of Construction. In all such arbitrations, this Agreement shall be considered a contract arrived at by mutual negotiation and consent and not a contract of adhesion and, therefore, shall not be construed liberally in favor of or strictly against any party. This Agreement shall be construed without regard to any presumption or rule requiring construction against the party causing an instrument or any portion of it to be drafted, or in favor of any party.
 - C. Exhaustion of Administrative Remedies. Before resorting to arbitration, any Member shall first exhaust any internal dispute resolution procedures and/or administrative remedies, including but not limited to requesting a hearing before the BETA Council.
 - D. Commencing Arbitration. After exhausting all administrative remedies, BETARMA or a Member shall deliver notice to the other parties to a dispute that they intend to arbitrate the dispute (the "Dispute Notice").
 - E. Selecting Arbitrators. Three Arbitrators shall hear every dispute. Within thirty (30) days of the date of delivery of a Dispute Notice, (1) BETARMA shall select an Arbitrator and deliver notice of such Arbitrator to the other parties to the dispute; and (2) if there is more than one Member involved in the dispute, those Members shall collectively select another Arbitrator and deliver notice of such Arbitrator to BETARMA. These two Arbitrators shall choose a third Arbitrator by mutual agreement (the "Neutral Arbitrator"). An "Arbitrator" must be someone who is a retired judge with at least fifteen years of experience adjudicating claims against insurers. If any party should fail to choose an Arbitrator within thirty (30) days following the Dispute Notice, the other party may choose two Arbitrators.
 - F. Hearing and Evidence. Absent mutual written agreement of the parties, each party will present its case to the Arbitrators within thirty (30) days following the date of appointment of the Neutral Arbitrator. The Neutral Arbitrator shall be the judge of the relevance and admissibility of the evidence offered and is not required to follow the strict rules of evidence.
 - G. Decision. The decision of a majority of the Arbitrators shall be final, binding on all parties and not

subject to any rights of appeal. Judgment upon the final decision of the Arbitrators may be entered in any court of competent jurisdiction.

- H. Remedies. The Arbitrators shall be limited to the remedies that could be awarded by the Superior Court of the State of California.
- I. Expenses. Except as the Arbitrators may otherwise decide, each party shall bear the expense of its own Arbitrator and shall jointly and equally bear with the other the expense of the Neutral Arbitrator and other costs associated with the arbitration. In the event that the two Arbitrators are chosen by one party, as provided above, the expense of the Arbitrators, the Neutral Arbitrator and the arbitration shall be equally divided between the two parties. The Arbitrators shall equitably allocate payment of the costs and attorneys' fees of the parties in light of the Arbitrators' evaluation of the relative merits or lack thereof of the respective claims of the parties.
- J. Location. Any arbitration proceedings shall take place in Walnut Creek, California, or a mutually agreed upon location in California.

XXV. **MISCELLANEOUS**

- 1. Entire Agreement and Binding Nature. This Agreement contains the entire agreement of the parties and supersedes all discussions, negotiations or promises made prior to the execution of this Agreement. This Agreement shall be binding upon and inure to the benefit of the original parties hereto and any substitute or additional parties who are bound hereby in accordance with the provisions hereof, their successors and assigns.
- 2. Notices. Any notices required by law, or this Agreement shall be sufficient if given in writing and deposited in the United States mail, postage prepaid, addressed to the Member at the last address on file with BETARMA and/or sent electronically to the last email address on file with BETARMA. Notices to be given to BETARMA shall be directed to such physical and/or electronic addresses as BETARMA shall designate for such purpose.
- 3. Severability. If any one or more of the terms, provisions, promises, covenants or conditions of this Agreement shall to any extent be judged invalid, unenforceable, void or voidable for any reason whatsoever by a court of competent jurisdiction, each and all of the remaining terms, provisions, promises, covenants and conditions shall not be affected thereby and shall be valid and enforceable to the fullest extent permitted by law.
- 4. Successors. This Agreement shall be binding upon and shall inure to the benefit of successors of the parties.
- 5. Counterparts. This Agreement may be executed in one or more counterparts and shall be deemed effective as to all signatories as though signed in one document.
- 6. Inspection of Records. BETARMA shall make all of its documents, books and records related to the operations and administration of the Group Self-Insurance Programs available to Members and the public as required by law.

[Signatures appear on the following page.]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their proper officers thereunto duly authorized as of _____, 2025 .

Imperial Valley Healthcare District

Name of Healthcare Entity/Named Member

By: _____

Print Name: Christopher R. Bjornberg

Title: Chief Executive Officer

RESOLUTION NO. 2025-02

**RESOLUTION OF THE IMPERIAL VALLEY HEALTHCARE DISTRICT BOARD OF
DIRECTORS AUTHORIZING EXECUTION AND DELIVERY OF THE APPLICATION
TO THE DIRECTOR OF INDUSTRIAL RELATIONS, STATE OF CALIFORNIA, FOR A
CERTIFICATE OF CONSENT TO SELF-INSURE WORKERS' COMPENSATION
LIABILITIES**

At a meeting of the Board of Directors of the Imperial Valley Healthcare District, a District
Organization organized and existing under the laws of the State of California, held on the
twenty-sixth (26th) day of June, 2025, the following resolution was adopted:

**RESOLVED, that the above-named public agency is authorized and empowered to make
application to the Director of Industrial Relations, State of California, for a Certificate of
Consent to Self-Insure workers' compensation liabilities and representatives of Agency are
authorized to execute any and all documents required for such application.**

IN WITNESS WHEREOF: I HAVE SIGNED AND AFFIXED THE AGENCY SEAL.

SIGNED: Board Secretary or Chair

DATE: _____

Printed Name

Title

Agency Name

Affix Seal Here



State of California
Department of Industrial Relations
OFFICE OF SELF-INSURANCE PLANS

APPLICATION FOR CERTIFICATE OF CONSENT
TO SELF-INSURE AS A PUBLIC AGENCY EMPLOYER SELF-INSURER
All questions must be answered. If not applicable, enter "N/A".

To the Director of the Department of Industrial Relations: The public agency employer identified below submits the following information to obtain a Certificate of Consent to Self-Insure the payment of workers' compensation under California Labor Code Section 3700.

LEGAL NAME OF APPLICANT (Show exactly as on Charter or other official documents):

Imperial Valley Healthcare District

Address: 601 Heber Avenue

City: Calexico

State: CA

Zip + 4: 92231 -

Federal Tax ID # of Group: 99-4231206

CONTACT - Who Should Correspondence Regarding This Applicant Be Addressed To:

Name: Michele Reager

Title: Vice President of Underwriting

Company Name: BETA Healthcare Group Risk Management Authority

Address: P.O. Box 619084

City: Roseville

Phone: 916-266-6100

Email: michele.reager@betahg.com

TYPE OF PUBLIC ENTITY (Check One):

☐ City and/or County ☐ School District ☐ Police and /or Fire District ☐ Hospital District

☐ Joint Powers Authority ☒ Other (describe): District Organization

TYPE OF APPLICATION (Check one):

☒ New Application ☐ Reapplication (Merger/Unification) ☐ Reapplication (Name Change)

☐ Other (describe):

Date Self-Insurance Program will begin: 7/1/2025

CURRENT WORKERS' COMPENSATION PROGRAM

☐ Currently Insured with State Fund Policy # _____ Expiration Date: _____

☐ Currently Self Insured, Certificate # _____

☐ Other (describe): _____

CLAIMS ADMINISTRATION

Who will be administering your agency's workers' compensation claims? (Check one)

☒ JPA will administer

☐ Third Party Administrator, TPA Certificate # _____

☐ Public entity will self administer ☐ Insurance Carrier will administer

Name of Third Party Administrator:

Name: April Johnson Title: Vice President of Claims and Corporate Compliance

Company Name: BETA Healthcare Group Risk Management Authority

Address: P.O. Box 619084

City: Roseville State: CA Zip + 4: 95661 - _____

Phone: 916-266-6100 E-Mail: april.johnson@betahg.com

of claims reporting locations to be used to handle Agency's claims: One

Does applicant currently have a California Certificate of Consent to Self-Insure? ☒ Yes ☐ No

If yes, what is the current Certificate Number: 5803

Total Number of Affiliate's California employees to be covered by Group: _____

AGENCY EMPLOYER

Current # of Agency Employees: _____ # of Public Safety Employees (police/fire): _____

If School District, # of certified employees: _____

Will all Agency employees be covered by this self-insurance plan? ☒ Yes ☐ No

If 'No', explain who is not covered and how workers' compensation coverage will be provided to the excluded employees:

JOINT POWERS AUTHORITY

Will applicant be a member of a JPA for workers' compensation?

☒ Yes ☐ No (If 'yes', complete the following)

Effective date of JPA Membership: 6/1/1979 JPA Certificate # 5803

Name of JPA: BETA Healthcare Group Risk Management Authority

AGENCY SAFETY PROGRAM

Does the Agency have a written Injury and Illness Prevention Program (IIPP)? ☒ Yes ☐ No

Individual responsible for Agency workplace safety and IIPP program:

Name: Jorge Mendoza Title: Safety/Security Manager

Company Name: Imperial Valley Healthcare District

Address: 601 Heber Avenue

City: Calexico State: CA Zip + 4: 92231 -

Phone: (760) 351-4610 Email: jamendoza@iv-hd.org

SUPPLEMENTAL COVERAGE

1.) Will your program be supplemented by any insurance or pooled coverage under a STANDARD workers' compensation insurance policy?

☐ Yes ☒ No (If 'Yes', complete the following):

Name of Excess Pool/Carrier:

Policy #: Effective Date of Coverage:

2.) Will your program be supplemented by any insurance or pooled coverage under a SPECIFIC EXCESS workers' compensation insurance policy?

☒ Yes ☐ No (If 'Yes', complete the following):

Name of Excess Pool/Carrier: Safety National Casualty Corporation (NAIC 15105)

Policy #: SP 4066651 Effective Date of Coverage: 7/1/2025

Retention Limits: \$3,000,000

3.) Will your program be supplemented by any insurance or pooled coverage under an AGGREGATE EXCESS (stop loss) specific excess workers' compensation insurance policy?

☐ Yes ☒ No (If 'Yes', complete the following):

Name of Excess Pool/Carrier:

Policy #: Effective Date of Coverage:

Retention Limits:

RESOLUTION FROM GOVERNING BOARD

Attach a properly executed Governing Board Resolution. See attached sample resolution on page 5.

CERTIFICATION

The undersigned on behalf of the applicant hereby applies for a Certificate of Consent to Self-Insure the payment of workers' compensation liabilities pursuant to Labor Code Section 3700. The above information is submitted for the purpose of procuring said Certificate from the Director of Industrial Relations, State of California. If the Certificate is issued, the applicant agrees to comply with applicable California statutes and regulations pertaining to the payment of compensation that may become due to the applicant's employees covered by the Certificate.

X

SIGNED: Authorized Official / Representative

DATE:

Christopher R. Bjornberg

Printed Name

Chief Executive Officer

Title

Imperial Valley Healthcare District

Agency Name

RESOLUTION NO.: _____ DATED: _____

A RESOLUTION AUTHORIZING APPLICATION
TO THE DIRECTOR OF INDUSTRIAL RELATIONS, STATE OF CALIFORNIA
FOR A CERTIFICATE OF CONSENT TO SELF-INSURE
WORKERS' COMPENSATION LIABILITIES

At a meeting of the Board of Directors
(Enter Name of the Board)

of the Imperial Valley Healthcare District
(Enter Name of Public Agency, District, Etc.)

a District Organization
(Enter Type of Agency, i.e., County, City, School District, etc.) organized and existing under the

laws of the State of California, held on the _____ day of _____, 20____ ,
the following resolution was adopted:

RESOLVED, that the above named public agency is authorized and empowered to make application to the Director of Industrial Relations, State of California, for a Certificate of Consent to Self-Insure workers' compensation liabilities and representatives of Agency are authorized to execute any and all documents required for such application.

IN WITNESS WHEREOF: I HAVE SIGNED AND AFFIXED THE AGENCY SEAL.

X _____ DATE: _____
SIGNED: Board Secretary or Chair

Printed Name

Title

Imperial Valley Healthcare District

Agency Name

Affix Seal Here

IMPERIAL VALLEY HEALTHCARE DISTRICT

BYLAWS

Approved April 11, 2024

PREAMBLE

Pursuant to AB 918 (2023), codified in Health and Safety Code §§ 32499.5 *et seq.*, the IMPERIAL VALLEY HEALTHCARE DISTRICT was created within the County of Imperial effective October 8, 2023, under the terms of The Local Health Care District Law of the State of California (H&S Code §§ 32000 *et seq.*)

The objectives of this District shall be to promote the public health and general welfare of the communities it serves.

This District shall be empowered to receive and administer funds for the attainment of these objectives, in accordance with the purposes and powers set forth in The Local Health Care District Law of the State of California (H&S Code §§ 32000 *et seq.*) and other applicable law.

ARTICLE I
Purposes and Scope

Section 1. Scope of Bylaws.

These Bylaws shall be known as the "District Bylaws" and shall govern the IMPERIAL VALLEY HEALTHCARE DISTRICT (referred to herein as the "District"), its Board of Directors, and all of its affiliated and subordinate organizations and groups.

The Board of Directors may delegate certain powers to the Medical Staff, and/or to other affiliated and subordinate organizations and groups, such powers to be exercised in accordance with the respective Bylaws of such groups. All powers and functions not expressly delegated to such affiliated or subordinate organizations or groups in the Bylaws of such other organizations or groups are to be considered residual powers vested in the District Board of Directors.

The Bylaws of the Medical Staff and other affiliated and subordinate organizations and groups, and any amendments to such Bylaws, shall not be effective until they are approved by the District Board of Directors. In the event of any conflict between the Bylaws of the Medical Staff and any other affiliated or subordinate organization or group, and the provisions of these District Bylaws, these District Bylaws shall prevail. In the event the District Bylaws are in conflict with any statute of the State of California governing hospital and health care districts, such statute shall be controlling.

Section 2. Purposes.

The purposes of the District shall include, but not necessarily be limited to, the following:

- a. Within the limits of community resources, to provide the best facilities and services possible for the acute and continued care of the injured and all persons of the Imperial Valley, regardless of race, creed, national origin, age or disability.
- b. To assure the highest level of patient care in the hospital of the District.
- c. To coordinate the services of the District with community agencies and other hospitals providing health care services.
- d. To conduct educational and research activities essential to the attainment of its purposes.
- e. To do any and all other acts necessary to carry out the provisions of the Local Health Care District Law, other applicable law, and District Bylaws and policies.

Section 3. Profit or Gain.

There shall be no contemplation of profit or pecuniary gain, and no distribution of profits, to any individual, under any guise whatsoever, nor shall there be any distribution of assets or surpluses to any individual on the dissolution of this District.

Section 4. Disposition of Surplus.

Should the operation of the District result in a surplus of revenue over expenses during any particular period, such surplus may be used and dealt with by the Directors for charitable hospital purposes, such as the establishment of free or part-free hospital beds, or for improvements in the hospital's facilities for the care of the sick, injured, or disabled, or for other purposes not inconsistent with the Local Health Care District Law, other applicable law, and District Bylaws and policies.

ARTICLE II

OFFICES

Section 1. Offices.

The principal office for the transaction of and for the business of the District is hereby fixed at _____, address, California. Branch offices may at any time be established by the Board of Directors at any place within or without the boundaries of District, for the benefit of District and the people served by the District.

Section 2. Mailing Address.

The mailing address of District shall be as follows:

IMPERIAL VALLEY HEALTHCARE DISTRICT

c/o XXXXXXXX

ADDRESS

CITY, CA, ZIP

ARTICLE III
DIRECTORS

Section 1. Number, Qualifications, Election or Appointment.

The initial Board of Directors shall be appointed pursuant to Health & Safety Code 32499.6. The initial Board of Directors shall adopt a resolution to divide the district into seven (7) voting districts, numbered consecutively. By the conclusion of the 2028 general election, the Board of Directors shall consist of seven (7) members, one per voting district, who are elected (or appointed) in accordance with the Local Health Care District Law of the State of California, and other applicable law, each of whom shall be a registered voter residing in their respective electoral district. (H&S Code 32499.7, 32100 & 32100.5.)

Section 2. Term.

The initial Board of Directors shall create a staggered board of directors by choosing a number of board members to remain on the board following the first district election occurring after January 1, 2024. The voting districts established pursuant to this section shall be effective for subsequent district elections, commencing with the next district election occurring after January 1, 2024. At the expiration of the terms of office of the members of the board of directors then in office, and thereafter, these members of the board of directors shall be elected by voting districts. By the conclusion of the 2028 general election, all seven Board members shall be elected officials.

A person shall not be eligible to hold the office of member of the board of directors unless they have been a resident of the voting district from which they are elected for 30 days next preceding the date of the election. A member of the initial board of directors, appointed pursuant to Section 32499.6, shall not be eligible to become an elected board member of the district for the first round of elections for each respective board seat.

The term of each member of the Board of Directors elected shall be four (4) years, or until his or her successor is elected and has qualified. A member of the Board of Directors elected (or appointed pursuant to the provisions of the Uniform District Election Law, Elections Code 10500-10556) shall take office at noon on the first Friday in December next following the District general election. (H&S Code 32002, 32100 and 32100.5; Elections Code 10554.)

Section 3. Powers and Duties.

The Board of Directors shall have and exercise all the powers of a Health Care District set forth in the Local Health Care District Law (H&S Code 32000 *et seq.*), other applicable law, and District Bylaws and policies, as well as the powers listed herein:

- a. To control and be responsible for the management of all operations and affairs of the District.

- b. To make and enforce all rules and regulations necessary for the administration, government, protection, and maintenance of hospitals and other facilities under District jurisdiction.
- c. To appoint the President/Chief Executive Officer and to define the powers and duties of such appointee.
- d. To appoint the Chief Compliance Officer and to define the powers and duties of such appointee.
- e. To delegate certain powers to the Medical Staff and other affiliated or subordinate organizations in accordance with their respective bylaws. The Medical Staff shall notify the Board of Directors upon election of the Chief of the Medical Staff and of all Chairpersons of the various medical departments and services, whose powers and duties shall be defined by the Medical Staff Bylaws as approved by the Board of Directors.
- f. To approve or disapprove all constitutions, bylaws, rules and regulations, including amendments thereto; of all affiliated or subordinate organizations.
- g. To appoint, promote, demote and remove all members of the Medical Staff. The Medical Staff shall make recommendations in this regard.
- h. To establish policies for the operation of this District, its Board of Directors and its facilities.
- i. To designate by resolution persons who shall have authority to sign checks drawn on the funds of the District.
- j. To do any and all other acts necessary to carry out the provisions of these Bylaws or the provisions of the Local Health Care District Law and other applicable law.
- k. To negotiate and enter into agreements with independent contractors, including physicians, paramedical personnel, other agencies and other facilities within the District's jurisdiction. (H&S Code 32121 and 32128.)

Along with the powers of the Board of Directors, it shall be the duty of the Board of Directors to establish rules of the hospitals and other facilities within District jurisdiction, which shall include the following:

- aa. Provision for the organization of physicians and surgeons, podiatrists, and dentists, licensed to practice in the State of California who are permitted to practice in the hospitals and other facilities within District jurisdiction into a formal Medical Staff, with appropriate officers and bylaws and with staff appointments on an annual or biennial basis.

- bb. Provision for a procedure for appointment and reappointment of Medical Staff as provided by the standards of the Joint Commission on Accreditation of Healthcare Organizations.
- cc. Provision that the Medical Staff shall be self-governing with respect to the professional work performed in hospitals and other facilities within District jurisdiction; that the Medical Staff shall meet in accordance with the minimum requirements of the Joint Commission on Accreditation of Healthcare Organizations; and that the medical records of the patients shall be the basis for such review and analysis.
- dd. Provision that accurate and complete medical records be prepared and maintained for all patients.
- ee. Limitations with respect to the practice of medicine and surgery in the hospitals and other facilities within District jurisdiction as the Board of Directors may find to be in the best interests of the public health and welfare, including appropriate provision for proof of ability to respond in damages by applicants for staff membership, as long as no duly licensed physician and surgeon is excluded from staff membership solely because he or she is licensed by the Osteopathic Medical Board of California.

Members of the Board of Directors shall also have the following duties:

- aaa. Duty of Care. Directors shall exercise proper diligence in their decision-making process by acting in good faith in a manner that they reasonably believe is in the best interest of the District, and with the level of care that an ordinarily prudent person would exercise in like circumstances.
- bbb. Duty of Loyalty. Directors shall discharge their duties unselfishly, in a manner designed to benefit only the District and not the Directors personally or politically, and shall disclose to the full Board of Directors situations that they believe may present a potential for conflict with the purposes of the District.
- ccc. Duty of Obedience. Directors shall be faithful to the underlying purposes of the District described in Article I, section 2, herein.

If it is found, by a majority vote of all of the Board of Directors in office at that time, that a Director has violated any of his or her duties to the detriment of the District, such Director is subject to removal from office according to the procedures set forth in section 9, subdivision a, of Article IV.

The rules of the hospitals and other facilities within District jurisdiction shall, insofar as is consistent with the Local Health Care District Law and other applicable law, be in accord with and contain minimum standards not less than the rules and standards of private or voluntary hospitals. Unless specifically prohibited by law, the Board of Directors may adopt other rules which could be lawfully adopted by private or voluntary hospitals. (H&S Code 32121 and 32128.)

Section 4. Compensation.

- a. The Board of Directors shall serve without compensation, except that the Board of Directors, by a Resolution adopted by a majority vote of the members of the Board of Directors, may authorize the payment of not to exceed One Hundred and No/100 Dollars (\$100.00) per meeting not to exceed six meetings a month as compensation to each member of the Board of Directors. (H&S Code 32103.). If the District compensates its members for more than five meetings in a calendar month, the Board of Directors shall annually adopt a written policy describing, based on a finding supported by substantial evidence, why more than five meetings per month are necessary for the effective operation of the District. The Board of Directors, by ordinance adopted pursuant to Chapter 2 (commencing with Section 20200) of Division 10 of the Water Code, may increase the amount of compensation received for attending meetings of the board by no more than 5 percent annually.
- b. For purposes of this provision, "meeting" shall have the same definition as set forth in the Ralph M. Brown Act (Gov. Code 54950 *et seq.*) and other applicable law; provided that payment of compensation shall be further subject to a member's compliance with such policies as the Board of Directors may establish. A Director is eligible for compensation under this provision for attendance at a regular or special meeting of a committee or subcommittee only if the Director is a duly-appointed member of that committee or subcommittee as of the date of attendance, or as may be authorized by Board of Directors Policy as an "occurrence" and permitted by law.
- C. Each member of the Board of Directors shall be allowed his or her actual necessary traveling and incidental expenses incurred in the performance of official business of the District as approved by the Board of Directors in accordance with applicable law, including but not limited to the provisions set forth in AB 1234, as they may be revised from time to time. (H&S Code SS 32103.)

Section 5. Vacancies.

Any vacancy upon the Board of Directors shall be filled by the methods prescribed in Section 1780 of the Government Code, State of California laws and other applicable law. (H&S Code SS 32100.)

Section 6. Resignations.

Any member of the Board of Directors may resign at any time by giving written notice to the Board of Directors, or to the Chairperson, or to the Secretary or to the Clerk of the Board of Directors. Any such resignation shall take effect as of the date of the receipt of the notice or any later time specified therein and unless specified therein, the acceptance of such resignation shall not be necessary to make the resignation effective.

Section 7. Absences From Meetings.

The term of any member of the Board of Directors shall expire if he or she is absent from three consecutive regular meetings, or from four of any five consecutive regular meetings of the Board of Directors, and the Board of Directors by resolution declares that a vacancy exists on the Board of Directors.

MEETINGS OF DIRECTORS

Section 8. Regular Meetings.

Regular meetings of the Board of Directors of the District shall be scheduled for the second Thursday of each calendar month at 6:00 p.m. PST or as otherwise determined by the Board of Directors at least annually, at the address indicated on such regular meeting agendas in the County of Imperial, California. The Board of Directors may, from time to time, change the time, the day of the month of such regular meetings and the location (provided the location is within the boundaries of the District) as dictated by holiday schedules or changing circumstances. (H&S Code ss 32104; Gov. Code 54954.)

Section 9. Special Meetings.

A special meeting of the Board of Directors may be called at any time by the presiding officer of the Board of Directors or by four (4) members of the Board of Directors, by providing written notice as specified herein to each member of the Board of Directors and as otherwise provided by the Brown Act.

The notice shall be delivered by any means to effectuate actual notice, including but not limited to, personally, email or by mail and shall be received at least twenty-four (24) hours before the time of the meeting as specified in the notice.

The call and notice shall specify the time and place of the special meeting and the business to be transacted or discussed. No other business shall be considered at these meetings by the Board of Directors.

The call and notice shall be posted at least twenty-four (24) hours prior to the special meeting in a location that is freely accessible to members of the public. (Gov. Code 54956.)

Section 10. Quorum.

A majority of the members of the Board of Directors shall constitute a quorum for the transaction of business. (H&S Code 32106.) A quorum of the Board of Directors is the number of members that must be present in order to transact business. Members of the Board of Directors who are disqualified by law from participating in a given matter may not be counted toward a quorum for that matter. Members who are entitled to vote, but who voluntarily abstain from voting on a given matter, shall be counted toward a quorum for that matter.

Section 11. Number of Votes Required for Board of Directors Action.

In order for the Board of Directors to take action, a majority of the Directors entitled to vote on the matter and who have not abstained must vote in favor of the motion, proposal or resolution.

Section 12. Adjournment.

The Board of Directors may adjourn any regular, adjourned regular, special or adjourned special meeting to a time and place specified in the order of adjournment. Less than a quorum may so adjourn from time to time. If all members are absent from any regular or adjourned regular meeting, the Secretary or Assistant Secretary of the Board of Directors may declare the meeting adjourned to a stated time and place and he or she shall cause a written notice of the adjournment to be given in the same manner as provided for special meetings, unless such notice is waived as provided for in special meetings.

A copy of the order or notice of adjournment shall be conspicuously posted on the District's website and on or near the door of the place where the regular, adjourned regular, special or adjourned special meeting was held within twenty-four (24) hours after the time of adjournment.

When a regular or adjourned regular meeting is adjourned as herein provided, the resulting adjourned regular meeting is a regular meeting for all purposes. When an order of adjournment of any meeting fails to state the hour at which the adjourned meeting is to be held, it shall be held at the hour specified for regular meetings by these Bylaws. (Gov. Code 54955.)

Section 13. Public Meetings.

All meetings of the Board of Directors shall be open and public, and all persons shall be permitted to attend any meeting of the Board of Directors, except as otherwise provided in the Ralph M. Brown Act, the Local Health Care District Law and other applicable law. (Gov. Code 54953(a); H&S Code 32106 & 32155.)

Section 14. Setting the Agenda.

At least seventy-two (72) hours before a regular meeting, the District Board of Directors or its designee shall post an agenda containing a brief general description of each item of business to be transacted or discussed at the meeting, including items to be discussed in closed session. A brief general description of an item generally need not exceed 20 words. The agenda shall specify the time and location of the regular meeting and shall be posted in a location that is freely accessible to members of the public. If requested, the agenda, shall be made available in appropriate alternative formats to persons with a disability, as required by Section 202 of the Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 121 32). In addition, the agenda shall include information regarding how, to whom, and when a request for disability related modification or accommodation, including auxiliary aids or services may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meetings.

The agenda is developed by the Board of Directors' Chairperson, President/Chief Executive Officer and General Legal Counsel. Any other Board of Directors member has the right to place an item on the agenda through the Chairperson. In the absence of the Chairperson, the Vice Chairperson has the authority to place an item on the agenda, and in the absence of both the Chairperson and Vice Chairperson, the Secretary has the right to place an item on the agenda. In the absence of the Chairperson, Vice Chairperson, and Secretary, the President/Chief Executive Office or General Legal Counsel shall place an item on the agenda, as requested by any Board of Directors member. All requests by Board of Directors members regarding placement of an item on the agenda shall be in writing. No action or discussion shall be undertaken on any item not appearing on the posted agenda, and Board Directors shall not engage in substantive discussions with members of the public during public comment. On their own initiative or in response to questions posed by the public, a member of the Board of Directors or its staff may ask a question for clarification, make a brief announcement, or make a brief report on his or her own activities. Furthermore, a member of the Board of Directors or the Board of Directors itself, subject to rules or procedures of the Board of Directors, may provide a reference to staff or other resources for factual information, request staff to report back to the body at a subsequent meeting concerning any matter, or take action to direct staff to place a matter of business on a future agenda.

Section 15. Rules of Order.

The rules contained in Robert's Rules of Order on Parliamentary Procedure shall govern the meetings of the District Board of Directors in all cases to which they are applicable and in which they are not inconsistent with the law of the State of California, the United States, or these Bylaws and/or policies and procedures as adopted by this governing body.

Section 16. Conflicts of Interest.

The District Board of Directors shall comply with all applicable laws regarding conflicts of interest, including but not limited to the California Political Reform Act, the provisions of the California Government Code regarding Prohibited Interests in Contracts, the California Doctrine of Incompatible Offices, as these laws may be amended from time to time.

ARTICLE IV

OFFICERS

Section 1. Officers.

The officers of the Board of Directors shall be a Chairperson, a Vice Chairperson, a Secretary, and a Treasurer. No person shall hold more than one office. Whenever a Board of Directors officer is authorized to execute a written instrument in his or her official capacity, other than for reimbursement of expenses, the Chairperson and Secretary shall do so.

The Board of Directors has the power to prescribe the duties and powers of the District President/Chief Executive Officer, the secretary, and other officers and employees of any health care facilities of the District, to establish offices as may be appropriate and to appoint Board of Directors members or employees to those offices, and to determine the number of and appoint all officers and employees and to fix their compensation. The officers and employees shall hold their offices or positions at the pleasure of the Board of Directors. (H&S Code §§ 32100.001 and 32121(h).)

Section 2. Election of Officers.

The officers of the Board of Directors shall be chosen every calendar year by the Board of Directors at the regular January meeting. They shall assume office at the close of that meeting, and each officer shall hold office for one year, or until his or her successor shall be elected and qualified, or until he or she resigns or is otherwise disqualified to serve.

Section 3. Chairperson.

The Board of Directors shall elect one of their members to act as Chairperson. If at any time the Chairperson shall be unable to act, the Vice Chairperson shall take his or her place and perform his or her duties. If the Vice Chairperson shall also be unable to act, the Board of Directors may appoint some other member of the Board of Directors to do so and such person shall be vested temporarily with all the functions and duties of the office of the Chairperson.

The Chairperson, or member of the Board of Directors acting as such as above provided:

- a. Shall preside over all the meetings of the Board of Directors.
- b. **[Optional for Future]**: Board of Directors Chairperson, or his or her designee, shall attend Medical Executive Committee, Joint Conference Committee meetings and other similar meetings of non-District organizations related to

operations of the hospital (including those of Medical Staff committees and the hospital foundation) on behalf of the Board of Directors. Designees shall be Board of Directors members and shall at all times exclusively represent the interests of the Board of Directors. Designees may be removed at any time at the sole discretion of the Board of Directors Chairperson.

- c. Shall sign as Chairperson, on behalf of the District, all instruments in writing which he or she has been specifically authorized by the Board of Directors to sign, provided that such instruments shall also be signed by the Secretary of the Board of Directors (other than for reimbursement requests).
- d. Shall have, subject to the advice and control of the Board of Directors, general responsibility for management of the affairs of the District during his or her term in office. (H&S Code 32100.001.)

Section 4. Vice Chairperson.

The Board of Directors shall elect one of their members to act as Vice Chairperson. The Vice Chairperson shall, in the event of absence, incapacitation, resignation, or other inability of the Chairperson, exercise all the powers and perform all the duties herein given to the Chairperson.

Section 5. Secretary.

The Board of Directors shall elect one of their members to act as Secretary. The Secretary of the Board of Directors shall perform ministerial duties (i.e., sign legal documents on behalf of the Board of Directors of the District. (H&S code 32100.001.)

Section 6. Treasurer.

The Board of Directors shall elect one of their members to act as Treasurer. The Treasurer shall be required to fulfill the duties under Health and Safety Code Section 32127; provided, however, that these duties are hereby delegated to the District's Chief Financial Officer to the extent permitted by law. (H&S Code 32127; Gov. Code 53600 et seq.)

Section 7. Reserved [Assistant Secretary].

Section 8. Reserved [Assistant Treasurer].

Section 9. Removal, Resignation or Vacancy.

- a. Any officer appointed or elected by the Board of Directors may be removed from that office for failure to discharge the duties of that office, for violation of any of the policies of the Board of Directors, or for any other good cause, as determined by a majority vote of all the Board of Directors in office at that time, at any regular or special meeting of the Board of Directors.

- b. Any officer may resign from said office at any time by giving written notice to the Chair of the Board of Directors, the Board of Directors Secretary or to the Clerk of the Board of Directors. Any such resignation shall take effect as of the date of the receipt of the notice or any later time specified therein, and, unless specified therein, the acceptance of such resignation shall not be necessary to make the resignation effective.
- c. In the event of a vacancy in the office of the Chairperson, the Vice-Chairperson shall succeed to that office for the balance of the unexpired term of the Chairperson. In the event of a vacancy in the office of the Secretary or Treasurer, the Board of Directors shall elect an officer to fill the vacancy for the balance of the unexpired term of that officer.

Section 10. Determination of and Sanctions for Willful or Corrupt Misconduct in Office

The following procedure may be used, in addition to any other procedures authorized by law or policy, to determine whether a Board of Directors member has engaged in willful or corrupt misconduct in office within the meaning of Government Code section 3060.

- a. Any member of the Board of Directors may present an accusation in writing to the Board of Directors against member of the Board of Directors alleging willful or corrupt misconduct in office, together with any written materials to support the accusation. "Misconduct in office" shall be broadly construed and include any willful malfeasance, misfeasance, and/or nonfeasance in office, and shall be interpreted in a manner consistent with Government Code section 3060.
- b. After consideration of the accusation, the Board of Directors members present shall then vote on the question of authorizing a formal hearing on the accusation presented. A formal contempt hearing is authorized by the Board of Directors upon the concurrence of a majority of the members present, excluding the accused who shall not have a vote.
- c. Within 7 days of the authorization for a formal contempt hearing, the Board of Directors shall serve upon the accused a copy of the accusation, a statement identifying the reasons for the hearing, and a notice of the days of the hearing. The date of the hearing shall not be less than 10 days from the service of the accusation. Service shall be in person, or if that fails, by leaving a copy of the accusation taped to the entry door of the accused's last known address in plain view.
- d. The accused shall appear before the Board of Directors at the time and date stated in the accusation. However, if the date chosen by the Board of Directors is unacceptable to the accused for good cause as determined by the Board of

Directors, another date shall be assigned, but shall not be more than 30 days beyond the original date set by the Board of Directors.

- e. The accused may be represented by counsel in preparing for and/or to be present at the hearing. The cost of such counsel shall be borne by the accused. If the accused chooses to have an attorney represent him at the hearing, he must notify the Secretary of the Board of Directors in writing of that fact at least 5 days before the hearing. The Board of Directors may have a lawyer who is not the regular Board of Directors lawyer, present at the hearing who will conduct the presentation of the Board of Directors' case and question witnesses. Formal rules of evidence shall not apply; however, witnesses and statements shall be made under oath and documentary evidence shall be authenticated. The Board of Directors may establish reasonable time limits on the duration of the hearing. Board of Directors counsel shall not participate in any way in the preparation of the accusation or presentation of evidence, but shall advise the Board of Directors on procedural matters.
- f. Five days before the scheduled hearing, each party shall submit to the Secretary of the Board of Directors a witness list and outline of anticipated evidence, either oral or written, which they intend to introduce at the hearing. Upon demand by either party, this information shall be given to the opposing party by the Board of Directors Secretary on this date. A willful failure to supply this information on a timely basis may cause it to be excluded at the hearing.
- g. At the hearing, the accused may introduce any oral testimony he or she feels will be helpful to the defense. The member of the Board of Directors who presented the accusation may introduce rebuttal evidence. The Board of Directors shall give weight to all evidence presented. The Board of Directors shall have the power to limit or exclude evidence which is repetitive, not relevant, or has little probative value. The proceeding shall be recorded.
- h. The Board of Directors shall have the burden of establishing the willful or corrupt misconduct by the accused and the burden of proof shall be by a preponderance of the evidence. The Board of Directors may introduce any evidence, oral or written testimony, the Board of Directors feels will be helpful to its case.
- i. If the accused fails to appear before the Board of Directors on the specified hearing date, the hearing may be held, based upon the evidence previously provided to the accused and other relevant evidence.
- j. At the conclusion of presentation of evidence, the Board of Directors shall vote whether to hold the accused in contempt. The accused shall not be present during deliberation. A determination of misconduct shall be upon the concurrence of a majority of the Board of Directors members present, excluding the accused who shall not have a vote and cannot take part in deliberations.

- k. Upon the determination of the Board of Directors of misconduct by the accused, the Board of Directors shall ask if the accused wishes to make a statement to the Board of Directors. Thereafter, The Board of Directors shall excuse the accused from the hearing and move to the determination of sanctions, which may include:
1. A statement of censure, identifying the misconduct;
 2. Removal of the offending Board of Directors member from membership on one or more Board of Directors committees, or, if chair of any committee, removal from that position, for a specified period, or if no period is specified, until the annual election of Board of Directors officers;
 3. Removal of the offending Board of Directors member from holding any Board of Directors office or other appointment currently held;
 4. A determination that no compensation shall be earned by the offending Board of Directors member for attendance at the meeting at which the contempt occurred, or for a specified period;
 5. A determination that the offending Board of Directors member shall not be provided any defense or indemnity in any civil actions or proceedings arising out of or related to the member's misconduct;
 6. Rendering the offending Board of Directors member ineligible to receive any advances or reimbursement of expenses to attend future conferences or meetings (except those previously-approved for which expenses have been incurred prior to the time of the finding of misconduct, for a period of time or subject to conditions specified in the motion;
 7. Referral of the matter to the County Grand Jury pursuant to Government Code section 3060, including the evidence adduced during the hearing.
 8. Declaring a vacancy in the office of the accused. [May require legislation]

ARTICLE V
COMMITTEES

Section 1. Committees

At any time, the Chairperson may nominate, and a majority of the Board of Directors may appoint at a duly noticed public meeting, one or more members of the Board of Directors and other persons as necessary or appropriate, to constitute committees for the investigation, study or review of specific matters. At the time of appointing and establishing the committee(s), the Chairperson, with the concurrence of the Board of Directors, shall establish the responsibilities of the committee(s).

The Chairperson, with the approval of the majority of the Board of Directors, may, from time to time, with or without cause, remove one or more members of the Board of Directors and any other persons from membership in any standing or other committee, or may temporarily discontinue, change the functions of, or combine standing or other committees.

Any committee(s) established to deliberate issues affecting the discharge of Medical Staff responsibilities shall include Medical Staff members.

No committee shall use written ballots, whether or not secret, for any purpose in its deliberations. No committee appointed shall have any power or authority to commit the Board of Directors or the District in any manner, unless the Board of Directors, by a motion duly adopted at a meeting of the Board of Directors, has specifically authorized the committee to act for and on behalf of the District.

Any advisory committee, whether permanent or temporary, which is a legislative body as defined in the Brown Act and other applicable law, shall post agendas and have meetings open to the public as provided by law.

Notices of meetings of committees which are legislative bodies shall be made in accordance with Article IV, Section 7 of these Bylaws.

Section 2. Standing Committees

Standing committees as defined by the Brown Act are open to the public and require posting of Notice of Meetings and Agendas. The following committees are the only current standing committees of the Board of Directors:

- A. Finance, Operations & Planning Committee
- B. Governance & Legislative Committee
- C. Audit, Compliance & Ethics Committee

The Board of Directors shall review annually the committees, their functions, and their membership.

Section 3. Ad Hoc Committees

At any time, the Chairperson may nominate, and a majority of the Board of Directors may appoint at a duly noticed public meeting, one or more members of the Board of Directors to serve on an Ad Hoc Committee for any purpose the Board of Directors deems appropriate. Ad Hoc Committees are advisory committees that are composed solely of Board Members, are less than a quorum of the District Board of Directors, and limited subject matter jurisdiction, and meetings that are not standing or fixed by charter, ordinance, resolution, or formal action. Ad Hoc Committees are not legislative bodies and are not subject to the Brown Act. Ad Hoc Committee meetings are not open to the public, do not require publicly posted agendas and may be held virtually or in person.

ARTICLE VI
MANAGEMENT OFFICIALS

Section 1. President/Chief Executive Officer.

The Board of Directors shall select and employ a hospital administrator to be known as “President/Chief Executive Officer” who, subject to such policies as may be adopted and such orders as may be issued by the Board of Directors, or by any of its committees to which it has delegated power for such action, shall have the responsibility, as well as the authority, to function as the President/Chief Executive Officer of the institution, translating the Board of Directors’ policies into actual operation. Additionally, the President/Chief Executive Officer has the authority to make recommendations to the Board of Directors on policies related to the effective ongoing operations of the District. The Chief Operating Officer/Chief Nurse Executive and/or the Chief Financial Officer are granted signing authority on behalf of the Chief Executive Officer, in order to maintain day-to-day operation of the District.

Section 2. Clerk of the Board of Directors.

The Clerk of the Board of Directors shall be the Executive Assistant under the immediate supervision of the President/Chief Executive Officer. The President/Chief Executive Officer may assign other staff members as may be necessary to complete the work of the Board of Directors.

Section 3. Chief Compliance Officer

The Chief Compliance Officer, hired by the Board of Directors, shall advise the Board of Directors and Chief Executive Officer regarding the design and implementation of the organization's ethics and compliance programs. The Chief Compliance Officer shall report directly to the Board of Directors regarding material legal and compliance risks and mitigation efforts.

Section 4. President/Chief Executive Officer's Evaluation.

The Board of Directors shall evaluate the President/Chief Executive Officer's performance annually. Such evaluation shall be reduced to writing, with a copy furnished to the President/Chief Executive Officer. The President/Chief Executive Officer shall have an opportunity to reply in writing to the Board of Directors in reference to such evaluation. All written communications concerning any evaluations shall be retained in the confidential files of the Board of Directors and/or the President/Chief Executive Officer’s private personnel files. (Gov. Code 54957.)

Section 5. Chief Compliance Officer's Evaluation.

The Board of Directors shall evaluate the Chief Compliance Officer's performance annually. Such evaluation shall be reduced to writing, with a copy furnished to the Compliance Officer and Vice President, Legal Affairs. The Chief Compliance Officer shall have an opportunity to reply in writing to the Board of Directors in reference to such evaluation. All written communications concerning any evaluations shall be retained in the confidential files of the Board of Directors and/or the Chief Compliance Officer's private personnel files. (Gov. Code 54957.)

ARTICLE VII
MEDICAL STAFF

Section I. Medical Staff.

The physicians, surgeons, podiatrists, dentists, and allied health professionals, licensed to practice in the State of California, who are permitted to practice in the hospitals and other facilities under the jurisdiction of District, shall be formed into a formal Medical staff, in accordance with the Medical Staff Bylaws, Rules and Regulations, which have been approved by the District Board of Directors. The Medical staff Bylaws shall include, but not be limited to, the following provisions:

- a. Appropriate officers.
- b. Staff appointments on an annual or biennial basis.
- c. Procedure for appointment and reappointment of Medical Staff as provided by the Standards of the Joint Commission on Accreditation of Health Care Organizations.
- d. That the Medical Staff shall meet in accordance with the minimum requirements of the Joint Commission on Accreditation of Health Care Organizations.

The Medical Staff shall be self-governing with respect to the professional work performed in the hospital and the medical records of the patients shall be the basis for such review and analysis of the professional work of the Medical Staff. The Medical Staff members shall be responsible for preparing and maintaining accurate and complete medical records for all patients (medical records to include, but not be limited to, identification data, personal and family history, history of present illness, physician examination, special examinations, professional or working diagnosis, treatment, gross and microscopic pathological findings, progress notes, final diagnosis, condition on discharge and such other matters as the Medical Staff shall determine or as may be required by applicable law). The practice of medicine and surgery in the hospitals and other facilities under the jurisdiction of the District shall be within the limitations as the Board of Directors may find to be in the best interests of the public health and welfare, including appropriate provision for proof of ability to respond in damages by applicants for staff membership as long as no duly licensed physician and surgeon is excluded from staff membership solely because he or she is licensed by the Osteopathic Medical Board of California. The Medical Staff shall be responsible for the development, adoption and annual review of the Medical Staff Bylaws and Rules and Regulations that are consistent with District policy and with any applicable law. The Medical Staff are subject to, and effective upon, appointment and reappointment by the Board of Directors in accordance with the standards of the Joint Commission on Accreditation of Health Care Organizations. (H&S Code 32128.)

The District shall maintain a Quality Assurance/Performance Improvement ("QA/PI") Program developed by a committee composed of at least five (5) physicians who are members of the

Medical Staff and one (1) clerical staff member. The QA/PI Program shall be implemented by the QA/PI Committee, and shall be a data-driven, quality assessment and performance improvement program, implemented and maintained on a hospital-wide basis, in compliance with the requirements of Section 482.21 of Title 42 of the Code of Federal Regulations, and other applicable law, as it may be amended from time to time.

Section 2. Medical Staff Membership.

Membership on the Medical Staff is a privilege, not a right, which shall be extended only to physicians, surgeons, podiatrists, dentists, and allied health professionals, licensed to practice in this State whose education, training, experience, demonstrated competence, references and professional ethics, assures, in the judgment of the Board of Directors, that any patient admitted to or treated in the hospitals and other facilities under District jurisdiction will be given high quality professional care. Each applicant and member shall agree to abide by the District Bylaws, Medical Staff Bylaws and Rules and Regulations of the District, and applicable law. The word "Physician" when used hereafter in this Article, shall be deemed to include physicians, surgeons, dentists, and podiatrists. (H&S Code 32128.)

Section 3. Exclusion from the Medical Staff.

- a. The Board of Directors shall have the power to exclude from Medical Staff membership, to deny reappointment to the Medical Staff, or to restrict the privileges of any physician, whether a general practitioner or specialist, in any hospital operated by the District, who has not exhibited that standard of education, training, experience, and demonstrated competence, references and professional ethics which will assure, in the judgment of the Board of Directors, that any patient admitted to or treated in the hospitals and other facilities under District jurisdiction will be given high quality professional care.
- b. In the case of both general practitioners and specialists, the medical resources available in the field of his or her practice shall be considered in determining the skill and care required. No physician shall be entitled to membership on the Medical Staff, or to the enjoyment or particular privileges, merely by virtue of the fact that he or she is duly licensed to practice medicine or surgery in this or any other state, or that he or she is a member of some professional organization, or that he or she, in the past or presently, has such privileges at another hospital. The burden shall be upon the physician making an initial application for membership to establish that he or she is professionally competent and ethical. (H&S Code 32128 and 32150; B&P Code 809.3.)

Section 4. Hospital Rules.

The Bylaws of the Medical Staff shall set forth the procedure by which eligibility for Medical Staff membership and establishment of professional privileges shall be determined. Such Bylaws shall provide that the Medical Staff or a committee or committees thereof, shall study the qualifications of all applicants in the establishment of professional privileges, and shall submit to

the Board of Directors recommendations thereon. Such recommendations shall be considered by the Board of Directors, but shall not be binding upon the Board of Directors. The Medical Staff shall be responsible for a process or processes designed to assure that individuals who provide patient care services, but who are not subject to the Medical Staff privilege delineation process, are competent to provide such services and that the quality of patient care services provided by these individuals is reviewed as a part of the District's quality assurance programs. (H&S Code 32150.)

Section 5. Hearings and Appeals.

The Board of Directors hereby incorporates by reference the provisions of the Medical Staff Bylaws relating to hearing procedures and appeals regarding the professional privileges of any member of, or applicant for membership on, the Medical Staff, as those Bylaws may be amended from time to time, subject to applicable law. These provisions are presently outlined in the relevant sections of the Medical Staff Bylaws.

ARTICLE VIII
MISCELLANEOUS

Section 1. Title to Property.

The title to all property of the District shall be vested in the District, and the signature of any officers of the Board of Directors, authorized at any meeting of the Board of Directors, shall constitute the proper authority for the purchase or sale of property or for the investment or other disposal of funds which are subject to the control of the District. (H&S Code 32121(c) and 32123.)

Section 2. Seal.

The Board of Directors shall have the power to adopt a form of Corporate Seal, and to alter it at its pleasure. (H&S Code 32121 (a).)

Section 3. Amendment.

These Bylaws may be altered, amended, repealed, added to or deleted, by a majority vote of all of the Board of Directors in office at that time, at any regular or special meeting of the Board of Directors.

Section 4. Annual Review of Bylaws.

The Board of Directors shall review the Bylaws annually and make any necessary changes that are necessary to be consistent with District policy, any applicable laws or other rules and regulations connected with operation of a hospital or other facility within District jurisdiction.

Section 5. Reserved.

Section 6. Affiliated Organizations.

- a. Auxiliary Organizations. The Board of Directors may authorize the formation of auxiliary organizations to assist in the fulfillment of the purposes of the District. Each such organization shall establish its bylaws, rules, and regulations, which shall be subject to Board of Directors approval and which shall not be inconsistent with these bylaws or the policies of the Board of Directors.
- b. Foundations. The Board of Directors may authorize the formation of non-profit public benefit corporations, under applicable law, to assist in the fulfillment of the purposes of the District. Each such corporation shall establish its bylaws, rules, and regulations, which shall be subject to Board of Directors approval and which shall not be inconsistent with these bylaws or the policies of the Board of Directors.

These Bylaws of the IMPERIAL VALLEY HEALTHCARE DISTRICT are hereby approved
this 11th day of April, 2024.

DocuSigned by:

Katherine Burnworth

DC9B2260C95F45B...

Chairperson

ATTEST:

DocuSigned by:

Arturo Proctor

64F7E9D5FC93400...

Board Secretary

CODE FOR LEGISLATIVE AUTHORITY

- California Health and Safety Code Section 32000 *et seq.* – The Local Health Care District Law
- California Elections Code Section 10500 *et seq.* – Uniform District Election Law
- California Government Code Section 54950 *et seq.* – Ralph M. Brown Act
- California Business and Professions Code

PIONEERS MEMORIAL HEALTHCARE DISTRICT BYLAWS

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PIONEERS MEMORIAL HEALTHCARE DISTRICT BYLAWS

PREAMBLE

PIONEERS MEMORIAL HEALTHCARE DISTRICT, a local healthcare district organized and existing under the laws of the State of California, and, in particular, pursuant to the California Health and Safety Code, Sections 32000 et seq., acting by and through its duly elected Board of Directors, hereby adopts these Bylaws for the purpose of establishing rules and regulations, not inconsistent with the enabling provisions of the Health and Safety Code, above cited. The Board of Directors hereby determines that adoption and implementation of these Bylaws are necessary for the exercise of the powers conferred and the performance of the duties imposed upon the directors, officers and employees of PIONEERS MEMORIAL HEALTHCARE DISTRICT.

ARTICLE 1 DISTRICT INFORMATION

1.1 Name. The name of this Healthcare District has been declared to be the PIONEERS MEMORIAL HEALTHCARE DISTRICT

1.2 Principal Place of Operation. The principal place of operation of the District has been fixed at Pioneers Memorial Hospital, located at 207 West Legion Rd., in the City of Brawley, County of Imperial, and State of California. When necessary for the conduct of the business of the District, the Board of Directors may establish such other place or places within the geographical boundaries of the County of Imperial, as the Board deems appropriate.

1.3 Title to Property. As authorized by enabling provisions of the laws of the State of California, the District, acting by and through its Board of Directors, is authorized to purchase, receive, have, take, hold, lease, use, and enjoy the property of every kind and description within and without the limits of the District, and to control, dispose of, convey, and encumber the same and create a leasehold interest in the same for the benefit of the District.

1.4 Mission Statement. The mission of the Pioneers Memorial Healthcare District is to provide the community with quality healthcare and compassionate service for families of the Imperial Valley.

1.5 Scope of Bylaws. These Bylaws shall be known as the "District Bylaws" and shall govern the Pioneers Memorial Healthcare District, its Board of Directors, and all of its affiliated and subordinate organizations and groups.

In the event of any conflict between the Bylaws of the Medical Staff or any other affiliated or subordinate organization or group, and the provisions of these District Bylaws, these District Bylaws shall prevail. In the event the District Bylaws are in conflict with any statute of the State of California governing healthcare districts, such statute shall prevail.

The District's legal counsel shall review the District Bylaws at least every three (3) years for compliance with Healthcare District Law, accreditation standards, state licensing requirements and other applicable federal and state laws, statutes and regulations, and submit a report of proposed amendments to the Board.

The Board may adopt any amendments to the District Bylaws, by a majority vote of the membership at any regular or special meeting called for this purpose by a majority of the membership.

The Bylaws of the Medical Staff and other affiliated and subordinate organizations and groups, and any amendments to such Bylaws, shall not be effective until approved by the Board of Directors.

ARTICLE 2 DEFINITIONS

- 2.1 "Hospital" means the Pioneers Memorial Hospital.
- 2.2 "Board" means the Board of Directors of the District.
- 2.3 "District" means the Pioneers Memorial Healthcare District, whose boundaries encompass the following cities: Brawley, Calipatria, Westmorland, Niland, Bombay Beach, Desert Shores, and Salton City.
 - 2.3.1 "Facility" or "Facilities" means the Hospital and other health care facility or facilities and services operated by the District.
- 2.4 "Medical Staff" means the organized medical staff of Pioneers Memorial Hospital.
- 2.5 "Practitioner" means a person who is eligible to apply for or who has been granted privileges in the Hospital, or, if applicable, another District Facility. Eligibility is determined pursuant to the Bylaws of the Medical Staff, or, if applicable, the rules and regulations of the Facility.

ARTICLE 3 ORGANIZATION, POWERS, AND PURPOSES

3.1 Organization. The District is a political subdivision of the State of California organized under the Local Healthcare District Law, Division 23 of the Health and Safety Code.

3.2 Powers and Purposes of the District. In addition to those specified by the Local Healthcare District Law (California Health and Safety Code, Sections 32000 et seq.), and incidental to those purposes, the objectives of the District are hereby declared to include, but shall not necessarily be limited to, the following:

3.2.1 To provide within the limits of community resources, the best facilities and equipment practicable for the acute and continued care of the injured and ill, regardless of race, creed, sex, religion, sexual orientation or national origin.

3.2.2 To coordinate the services of the District with community agencies and health care providers to enhance the quality of health care in the District.

3.2.3 To assure that District employees, and others acting on behalf of the District in rendering patient care, are competent in the following areas, and for the age of the patients served:

3.2.3.1 That they have the ability to obtain and interpret information regarding patient needs;

3.2.3.2 That they are knowledgeable in the relevant aspects of the patient's growth and development; and

3.2.3.3 That they are familiar with and understand the range of treatment needed by these patients.

3.2.4 To conduct educational activities essential to the attainment of its purposes.

3.2.5 To do any and all other acts and things necessary to carry out the provisions of the Local Healthcare District Law and these Bylaws.

3.3 Contracts Requiring Bids. The Board shall let any contract involving any expenditure of more than the threshold amount specified by Health and Safety Code Section 32132 or other applicable law for work to be done or for materials and supplies to be furnished, sold or leased to the District, to the lowest responsible bidder who shall give such security as the Board requires, or else reject all bids.

3.3.1 Bids do not need to be secured for change orders which do not materially change the scope of the work as set forth in a contract previously made if such contract was made after compliance with bidding requirements, and if each individual change order does not total more than five percent of the contract. The Board may adopt bidding policies and procedures, including the delegation of all or a portion of the Board's contracting authority to other officers and employees of the District.

3.3.2 The provisions of this section 3.3 shall not apply to the medical or surgical equipment or supplies, to professional services, to electronic data processing and telecommunications goods and services or to other goods and services for which applicable law provides an exception. As used in this section, "medical or surgical equipment or supplies" includes only equipment or supplies commonly, necessarily and directly used by, or under the direction of, a physician and surgeon in caring for or treating a patient in the Facilities.

Until January, 2025, pursuant to Health & Safety Code section 31232.5, the Board may approve use of the design-build process provided in Public Contract Code section 22160 et seq. to assign contracts for the construction of a building or improvements directly related to construction of a hospital or health facility building.

The Board may, without following the bidding provision of this section, let contracts for work to be done or for materials and supplies to be furnished, sold or leased to the District, if it first determines that an emergency exists warranting such expenditure due to fire, flood, storm, epidemic, or other disaster, and is necessary to protect the public health, safety, welfare or property.

3.4 Dissolution. Any proposal for dissolution of the District shall be subject to confirmation by the voters of the District in accordance with Cortese-Knox-Hertzberg Local Government Reorganization Act of 2000, Government Code Section 56000 et seq.

3.5 Profit or Gain. As a public agency, the District shall not be operated in contemplation of profit or pecuniary gain in any form.

3.6 Seal. The Board of Directors shall have the power to adopt a form of official seal, and to alter it at pleasure.

ARTICLE 4 BOARD

4.1 Directors. The Board shall be appointed or elected, and shall organize itself, in the manner prescribed in Article I, Chapter 2, Division 23 of the Health and Safety Code (commencing at Section 32000). The Board has previously determined that it shall consist of five (5) members, elected at large from the District. The Directors shall serve the terms, as prescribed by law.

4.2 General Powers and Duties. Consistent with the powers conferred by Section 32121 of the Health and Safety Code or as same shall be amended from time to time, and other authorization contained in the Local Healthcare District Law, the Board of Directors shall be empowered as follows:

4.2.1 To control and be responsible for the management of all operations and affairs of the District.

4.2.2 To make and enforce all rules and regulations necessary for the administration, governance, protection, and maintenance of hospitals and other facilities under District jurisdiction.

4.2.3 To enter a contract of employment with a hospital administrator who shall be designated the Chief Executive Officer and to define the powers and duties of such administrator.

4.2.4 To employ legal counsel, compliance officer, and other officers, as may be appropriate, to advise the board of directors in matters pertaining to the business of the district.

4.2.5 To require Medical Staff to notify the Board of Directors upon election or change of the Chief of Staff, Vice Chief of Staff, Secretary-Treasurer, and of all Chairpersons of the various medical departments and services, whose powers and duties shall be defined by the Medical Staff Bylaws and approved by the Board of Directors.

4.2.6 To approve or disapprove all constitutions, bylaws, rules, and regulations including amendments thereof of all affiliated or subordinate organizations.

4.2.7 To establish policies for the operation of this District and any of its Facilities.

4.2.8 To adopt resolutions establishing policies or rules for the operation of this District and any of its Facilities. Such resolutions shall be kept in a separate book or file and shall be available for inspection at all times.

4.2.9 To designate by resolution persons who shall have authority to sign checks drawn on the funds of the District.

4.2.10 To negotiate or enter into agreements with independent contractors, including, but not limited to, physicians and paramedical personnel.

4.2.11 To provide for strategic institutional planning, to meet the health needs of the community.

4.2.12 To evaluate its own performance from time to time.

4.2.13 To do any and all other acts and things necessary to carry out the provisions of these Bylaws or of the provisions of the Local Healthcare District Law.

4.2.14 To approve an annual operating budget, develop long-term capital expenditure plans and monitor implementation of those plans.

4.2.15 To perform any other act as permitted by Section 32121 of the Health and Safety Code.

4.3 Operation of Facilities. The Board is the governing body of the District. All District powers shall be exercised by or under the direction of the Board. The Board is authorized to make appropriate delegations of its powers and authority to officers and employees. The Board shall evaluate the performance of its officers and employees, and also its own performance.

4.4 Rates. The Board shall establish rates subject to the parameters set forth in Health and Safety Code Section 32125 as same shall be amended from time to time.

4.5 Number and Qualifications. The Board shall consist of five members, each of whom shall be a registered voter residing in the District.

4.5.1 Except as provided in Sections 4.5.2 and 4.5.3, no person who is a director, policy-making management employee, or medical staff officer of a Hospital owned or operated by the District shall do either of the following:

4.5.1.1 Possessing any ownership interest in any other hospital serving the same area as that served by the District. For purposes of this Section 4.6.1.1, the possession of an ownership interest, including stocks, bonds or other securities by the spouse or minor children of any person shall be deemed to be the possession or interest of the person.

4.5.1.2 Be a director, policy-making management employee, or medical staff officer of any hospital serving the same area as the area served by the District except pursuant to section 4.5.2 below.

4.5.2 No person shall serve concurrently as a director for a District hospital and as a policymaking management employee of any other hospital serving the same area as the District hospital, unless the boards of directors of each of those hospitals have determined that the situation will further joint planning, efficient delivery of health care services, and the best interest of the areas served by their respective hospitals, or unless the hospitals are affiliated under common ownership, lease, or any combination thereof.

4.5.3 Any candidate who elects to run for the office of member of the Board and who owns stock in, or who works for any health care facility which does not serve the same area served by the District shall disclose on the ballot his or her occupation and place of employment.

4.5.4 For purposes of this Section 4.5, a hospital shall be considered to serve the same area as a District Hospital when more that 5% of the hospital's inpatient admissions are residents of the District.

4.6 Election and Term of Office. An election shall be held on the first Tuesday after the first Monday in November in each even-numbered year, at which a successor shall be chosen to each Director whose term shall expire on the first Friday of December following

such election. The election of Board members shall be election at large within the eligible residents of the District and shall be consolidated with the statewide general election. The candidates receiving the highest number of votes for the offices to be filled at the election shall be elected thereto. The term of office of each elected Board member shall be four years, or until the Board member's successor is elected and has qualified, except as otherwise provided by law in the event of a vacancy. An orientation shall be provided which familiarizes each new Board member with his or her duties and responsibilities, including the Board's responsibilities for quality care and the Facilities' quality assurance programs. Continuing education opportunities shall be made available to Board members.

4.7 Vacancies. In accordance with the provisions of Section 32100.2 of the Health and Safety Code, and notwithstanding any other provision of law, the term of any member of the Board of Directors shall expire if he or she is absent from three (3) consecutive regular meetings, or from three (3) or more of any five (5) consecutive meetings of the Board and the Board, by resolution, declares that a vacancy exists on the Board.

4.7.1 When a vacancy occurs on the Board, and except as otherwise specified in Government Code section 1780, the remaining Board members may fill any vacancy on the Board by appointment until the next District general election that is scheduled 130 or more days after the effective date of the vacancy, provided the appointment is made within a period of 60 days immediately subsequent to the effective date of such vacancy and provided a notice of the vacancy is posted in three or more conspicuous places in the District at least 15 days before the appointment is made. In lieu of making an appointment, the remaining members of the Board may within 60 days of the vacancy call an election to fill the vacancy.

4.7.2 If the vacancy is not filled by the Board as specified, or if the Board has not called for an election within 60 days of the vacancy, the Board of Supervisors of the County of Imperial may fill the vacancy within 90 days of the vacancy or the Board of Supervisors may order the District to call an election to fill the vacancy. If within 90 days of the vacancy the remaining members of the Board or the Board of Supervisors have not filled the vacancy and no election has been called for, the District shall call an election to fill the vacancy. If the number of remaining Board members falls below a quorum, at the request of the District's Secretary, or remaining Board members, the Board of Supervisors of the County of Imperial may waive the 60 day period specified above and make an appointment immediately to fill the vacancy, or may call an election to fill the vacancy. The board of Supervisors shall only fill enough vacancies to provide the Board with a quorum.

4.7.3 Persons appointed to fill the vacancy shall hold office until the next District general election and thereafter, until the person elected at such election to fill the vacancy has been qualified, but persons elected to fill the vacancy shall hold office for the unexpired balance of the term of office.

4.8 Resignation and Removal. Any Board member may resign effective upon giving written notice to the President or the Secretary of the Board, unless the notice specifies a later time for the effectiveness of such resignation. The term of any member of the Board

shall expire if the member is absent from three consecutive regular meetings for from three (3) of any five (5) consecutive meetings of the Board and if the Board by resolution declares that a vacancy exists on the Board. All or any of the members of the Board may be recalled at any time by the voters following the recall procedure set forth in Division 11 of the Elections Code.

4.9 Compensation. The Board shall be compensated \$100.00 for each of the regular monthly board meetings that they attend, not to exceed five (5) meetings per month, in accordance with Health and Safety Code Section 32103.

4.10 Reimbursable Expenses. When Board members attend conferences, education activities, or other activities during the performance of official duties, and those events require overnight accommodations, lodging, meals and travel, such reasonable expenses may be reimbursed by the District.

4.11 Directors' Defense and Indemnification. Except as hereafter provided, directors and former directors will be defended and indemnified, at District expense, as to claims directed against them individually or collectively, arising from the performance of their official duties.

In accordance with Government Code Sections 995.2 and 995.4, the Board of Directors, acting without the participation of affected members, may refuse to defend or indemnify a director or directors a former director or directors, if the Board, by a majority vote of unaffected directors, determines that:

4.11.1 The act or omission was not within the scope of the Director's employment (i.e., official duties); or

4.11.2 The Director acted or failed to act because of actual fraud, corruption or actual malice; or

4.11.3 The defense of the action or proceeding by the District would create a conflict of interest between the District and the Director or Former Director.

4.11.4 Pursuant to Government Code Section 995.8, a defense, at District expense, may be provided for the benefit of a director who is the subject of criminal proceedings based upon his or her official acts or omissions, if the Board, acting without participation of the affected director, determines by majority vote that (1) such defense would be in the best interest of the District; and (2) the director acted in good faith, without actual malice, and in the apparent interest of the District.

ARTICLE 5 OFFICERS

5.1 Officers. At its first regular meeting following the first Friday in December of each year, the Board shall select from its members a President, Vice President, Secretary,

Treasurer, and Assistant Secretary/Treasurer.

5.2 Duties of President. Duties of the President shall include, but are not necessarily limited to:

5.2.1 Presiding over all meetings of the Board of Directors.

5.2.2 Signing, as President, on behalf of the District, all instruments in writing which he has been specifically authorized by the Board to sign.

5.2.3 Exercising such other responsibilities for the management of the affairs of the District as provided by law, subject to the advice and control of the Board.

5.3 Duties of Vice President. Duties of the Vice-President shall include the exercise of all powers and performance of all duties of the President, in the event of his or her absence or unavailability to perform his or her duties.

5.4 Duties of Secretary. Duties of Secretary shall include countersigning all minutes of Board meetings, attendance to correspondence of the Board, and performance of such other duties as ordinarily pertain to his or her office.

5.5 Duties of Treasurer. Duties of the Treasurer shall include the safekeeping and disbursal of the funds in the treasury of the district.

5.6 Duties of Assistant Secretary/Treasurer. Duties of the Assistant Secretary/Treasurer shall include the exercise of all powers and performance of all duties of the Secretary and/or the Treasurer, in the event of the Secretary's and/or the Treasurer's absence or unavailability to perform his or her duties.

ARTICLE 6 BOARD MEETINGS

6.1 Board Meeting. A meeting of the Board is any congregation of a majority of the members of the Board at the same time and place to hear, discuss or deliberate upon any item that is within the subject matter jurisdiction of the Board or as otherwise defined in Section 54952.2 of the Government Code.

6.2 Regular Meetings. The regular meetings of the Board of Directors shall be every fourth Tuesday of the month, and may be changed from time to time, by resolution of the Board of Directors.

6.3 Special Meetings. Special meetings of the Board of Directors may be called in the manner prescribed by the Government Code of the State of California Section 54956 as the same may be amended from time to time.

6.4 No Scheduled July Board Meetings. The Board shall not meet for any regularly scheduled board meetings during the month of July.

6.4.1 Notwithstanding the absence of regularly scheduled board meetings in July, the Board reserves the right to call a Special Meeting, if deemed appropriate by the Board Chair, pursuant to Section 6.3 above.

6.5 Meeting Agendas/Notices.

6.5.1 At least 72 hours before a regular meeting, the Board shall cause to be posted an agenda containing a brief description of each time of business to be transacted or discussed at the meeting, including items to be discussed in closed session. A brief general description of the item generally need not exceed twenty (20) words, and when appropriate, may utilize the agenda descriptions contained in the Brown Act (Government Code Section 54954.5). The agenda shall specify the time and location of the regular meeting and shall be posted in a location that is freely accessible to members of the public. No action shall be taken on any item not appearing on the posted agenda, unless one of the following conditions exists:

6.5.1.1 The Board has determined, by a majority vote that an emergency situation exists. An emergency situation, for purposes of these Bylaws, means either: (a) a work stoppage or other activity which severely impairs public health, safety, or both, or (b) a crippling disaster which severely impairs public health, safety, or both.

6.5.1.2 Upon a determination by a two-thirds vote of the Board, or, if less than two-thirds of the members are present, a unanimous vote of those members present, that the need to take action arose subsequent to the agenda being posted.

6.5.1.3 The item was posted, as required above, for a prior meeting of the Board occurring not more than five calendar days prior to the date action is taken on the item, and at the prior meeting the item was continued to the meeting at which the action is being taken.

For purposes of these Bylaws, "action taken" means a collective decision made by a majority of the members of the Board to make a positive or negative decision, or an actual vote by a majority of the members of the Board upon a motion, proposal, resolution or order.

6.5.1.4 The Board may briefly respond to statements made or questions posed by the public at the meeting. In addition, on its own initiative, or in response to questions posed by the public, the Board may ask a question for clarification, provide a reference to staff or other resources for factual information, or request staff to report back to the Board at a subsequent meeting. Furthermore, a Board member or the Board itself may take action to place a matter of business on a future agenda.

6.5.2 The Board shall give mailed notice of every regular board meeting, and any special meeting which is called, at least one week prior to the date set for the meeting, to any person who has filed a written request for such notice with the Board. Any mailed notice required pursuant to this Section shall be mailed at least one week prior to the date set for the meeting to which it applies, except that the Board may give such notice as it deems practical of special meetings called less than seven (7) days prior to the date set for the meeting, or in the case of an emergency meeting, telephone notice in accordance with Section 54956.5 of the Government Code. Any request for notice file pursuant to this Section shall be valid for one (1) year from the date on which it is filed unless a renewal request is filed. Renewal requests for notice shall be filed within ninety (90) days after January 1, of each year. The Board may establish by resolution a reasonable annual charge for sending such notice based on the estimated cost of providing such service.

6.6 Members of the Public. Members of the public shall be afforded those rights as conferred by Government Code Section 54954.3, and District shall comply with all agenda requirements set forth therein.

6.7 Quorum. A majority of the members of the Board of Directors shall constitute a quorum for the transaction of business unless prohibited by law, the act of a majority of the Board members present at a meeting shall be an act of the Board.

6.8 Adjournment of Meetings and Continuance of Hearings. Board meetings may be adjourned in the manner set forth in Government Code Section 54955. Hearings may be continued in the manner set forth in Government Code Section 54955.1.

6.9 Public Meetings. All meetings of the Board of Directors shall be open to the public excepting only such meetings which are expressly permitted by Government Code Sections 54956.7, 54956.8 54956.86, 54956.87, 54956.9, 54956.95, 54957, 54957.1, 54957.6, and 54957.8 or Health and Safety Code Section 32106 to be held in closed session or any other statute that permits a local Healthcare District to meet in closed session.

6.10 Minutes. The Clerk of the Board shall cause to be kept at the principal office of the District, a book of minutes of all meetings of the Board of Directors, showing the time and place, whether regular or special, and if special, how authorized, the notice given, the names of the Directors present, and a statement of the vote of the Directors of all motions and resolutions. The Secretary shall countersign all minutes and records of Board proceedings. No minutes shall be kept for any meeting of the Board held in closed session.

6.11 Medical Staff Representation/Medical Staff/Directors' Liaison. The duly elected Chief of Staff of the Hospital Medical Staff, or his or her designee, shall be entitled and encouraged to attend all meetings of the Board of Directors except closed sessions, unless his or her presence is requested. Regular directors' meeting agendas shall include, and the Chief of Staff shall be encouraged to provide, a report, to the Board regarding matters of business involving or pertaining to the Hospital Medical Staff. The Chief of Staff, or his or her designee shall have the right to participate in board discussions and deliberations, however, he or she shall not have the right to vote on any matters.

6.12 Disrupted Meetings. If a meeting is willfully interrupted as defined in Section 54957.9 of the Government Code, the Board may clear the meeting room and consider matters on the agenda. Members of the press shall be allowed to attend any such session, unless they participated in the disturbance or, the matter to be considered is a closed session item. The Board may establish a procedure to readmit others not participating in the disturbance, if they so desire. To the extent this section conflicts with Section 54957.9, that code section shall govern.

ARTICLE 7 BOARD COMMITTEES

7.1 Appointment. All committees, whether standing or special (ad hoc) shall be appointed by the President. The chairman of each committee shall be appointed by the President. All committees shall be advisory only to the Board unless otherwise specifically authorized to act by the Board.

7.2 Special or Ad Hoc Committees. A special or ad hoc committee is an advisory committee composed solely of the members of the Board which is less than a quorum of the Board, which does not have continuing subject matter jurisdiction, and does not have a meeting schedule fixed by resolution or formal action of the Board. Special or ad hoc committees may be appointed by the President for special tasks as circumstances warrant, and upon completion of the task for which appointed such special or ad hoc committee shall stand discharged.

7.3 Standing Committees. Standing Committees may be appointed as set forth below, and, if appointed, such committees shall continue in existence until discharged by specific action of the Board of Directors. Other standing committees may be appointed from time to time as the Board of Directors may authorize. Each Standing Committee shall have advisory powers only and shall make recommendations to the Board.

7.4 Advisors. A committee chairman may invite individuals with expertise in a pertinent area to meet with and assist the committee. Such advisors shall not vote or be counted in determining the existence of a quorum and may be excluded from any committee session.

7.5 Meetings and Notice. Meetings of a committee may be called by the President, the chairman of the committee, or a majority of the committee's voting members.

7.6 Quorum. A majority of the voting members of a committee shall constitute a quorum for the transaction of business at any meeting of such committee. Each committee shall keep minutes of its proceedings and shall report periodically to the Board.

7.7 Action by a Committee. Where a quorum of committee members are present, an act of the majority of those members shall constitute an act of the committee. If less than a quorum of the committee is present, no act taken shall be valid unless approved in writing

by the absent members. For special or ad hoc committees, action may be taken without a meeting, provided that the act to be taken is in writing and has been signed by all members of the committee.

7.8 Term of Committee Members. Committee members shall retain their status as committee members until a successor is appointed, they are removed by the President (subject to the consent of a majority of the Board), they are no longer a board member or, in the case of a special or ad hoc committee, when the purpose of that committee has been achieved.

ARTICLE 8 ADMINISTRATOR

8.1 Administrator. The Chief Executive Officer will act as Administrator, who, subject to such policies as may be adopted, and such orders as may be issued by the Board, or by any of its committees to which it has delegated power for such action, shall have the responsibility, as well as the authority, to function as the Administrator of the institution, translating the Board's policies into actual operation. In such capacity he or she shall have the responsibility for and the authority to:

8.1.1 Implement the policies adopted by the Board. By working with standing and special committees of the Board and joint committees of the Medical Staff of the Hospital, the Administrator is to participate in elaborating of policies which provide the framework for patient care of high quality at reasonable cost.

8.1.2 Control the overall operation of the District, its Facilities and other health services, including out-of-hospital services sponsored by the District. This includes responsibility for coordinating among Facilities and services to avoid unnecessary duplication of services, facilities and personnel, and control of costs. This also includes responsibility for sound personnel, financial, accounting and statistical information practices, such a preparation of District budgets and forecasts, maintenance of proper financial and patient statistical records, collection of data required by governmental and accrediting agencies, and special studies and reports required for efficient operation of the District.

8.1.3 Implement community relations activities, including, as indicated, public appearances, responsive communication with the media.

8.1.4 Assist the Board in planning services and facilities and informing the Board of Governmental legislation and regulations and requirements of official agencies and accrediting bodies, which affect the planning and operation of the facilities, services and programs sponsored by the District, and maintenance of appropriate liaison with government and accrediting agencies and implementing actions necessary for compliance.

8.1.5 Hire and terminate all employees of the District.

8.1.6 Administer professional contracts between the District and Practitioners.

8.1.7 Provide the Board and Board committees with adequate staff support.

8.1.8 Send periodic reports to the Board and to the Medical Staff on the overall activities of the District and the Facilities, as well as pertinent federal, state and local developments that effect the operation of District Facilities.

8.1.9 Provide liaison among the Board, the Medical Staff, and the District's operating entities.

8.1.10 Maintain insurance or self-insurance on all physical properties of the District.

8.1.11 Designate other individuals by name and position who are, in the order or succession, authorized to act for the Administrator during any period of absence.

8.1.12 Such other duties as the Board may from time to time direct.

ARTICLE 9 MEDICAL STAFF

9.1 Organization. There shall be a separate Medical Staff organization for the District's Hospital with appropriate officers and bylaws and with staff appointments on at least a biennial basis. The Medical Staff of each Hospital shall be self-governing with respect to the professional work performed in that Hospital. Membership in the respective Medical Staff organization shall be a prerequisite to the exercise of clinical privileges in each Hospital, except as otherwise specifically provided in the Medical Staff bylaws.

9.1.1 District Facilities other than the Hospital may also have professional personnel organized as a medical or professional staff, when deemed appropriate by the Board pursuant to applicable law and The Joint Commission and/or other appropriate licensure and accreditation standards. The Board shall establish the rules and regulations applicable to any such staff and shall delegate such responsibilities, and perform such functions, as may be required by applicable law and The Joint Commission and/or other appropriate licensure and accreditation standards. To the extent provided by such rules, regulations, laws and standards, the medical or professional staffs of such Facilities shall perform those functions specified in this Article 9.

9.2 Medical Staff Bylaws. Medical Staff shall propose and adopt by vote bylaws, rules and regulations for its internal governance which shall be subject to, and effective upon, Board approval, which shall not be unreasonably withheld. These bylaws shall be known as the Bylaws of the Medical Staff. The bylaws, rules and regulations shall be periodically reviewed for consistency with Hospital policy and applicable legal or other requirements. The bylaws shall create an effective administrative unit to discharge the functions and

responsibilities assigned to the Medical Staff by the Board. The bylaws, rules and regulations shall state the purpose, functions and organization of the Medical Staff and shall set forth the policies by which the Medical Staff exercises and accounts for its delegated authority and responsibilities. The bylaws, rules and regulations shall also establish mechanisms for the selection by the Medical Staff of its officers, departmental chairpersons and committees. The Bylaws of the Medical Staff shall include those matters required by Section 32128 of the California Health and Safety Code, as the same may be amended from time to time.

9.3 Quality Assurance, Medical Staff Membership and Clinical Privileges. Membership on the Medical Staff shall be restricted to Practitioners who are competent in their respective fields, worthy in character and in professional ethics, and who are currently licensed by the State of California. The bylaws of the Medical Staffs may provide for additional qualifications of membership and privileges, as appropriate. The Board shall also require mechanisms to assure the provision of one level of care in each Facility, and to assure that patients with the same health problem are receiving a consistent and appropriate level of care. The Board, through the Hospital's Administration, shall provide whatever administrative assistance is reasonably necessary to support and facilitate these activities. The Board hereby delegates to the Medical Staff the responsibility and authority to carry out these activities including the investigation and evaluation of all matters relating to Medical Staff membership status, clinical privileges and corrective action. The Medical Staff shall forward to the Board specific written recommendations with appropriate supporting documentation that will allow the Board to take informed action. Final action on all matters relating to Medical Staff quality management, membership status, clinical privileges and corrective action shall be taken by the Board after considering the Medical Staff recommendations. The Board shall utilize the advice of the Medical Staff in granting and defining the scope of clinical privileges to individuals, commensurate with their qualifications, experience and present capabilities. No applicant shall be denied Medical Staff membership and/or clinical privileges on the basis of sex, race, creed, color or national origin, or on the basis of any other criterion lacking professional justification, including, but not limited to, exclusions from the Medical Staff solely because he or she is licensed by the Osteopathic Medical Board of California.

9.4 Terms and Conditions. The terms and conditions of membership status in the Medical Staff, and of the exercise of clinical privileges, shall be as specified in the Bylaws of the Medical Staff.

9.5 Procedure. The procedure to be followed by the Medical Staff and the Board in acting on matters of membership status, clinical privileges, and corrective action, shall be specified in the Bylaws of the Medical Staff.

9.6 Appellate Review. Any adverse action taken by the Board with respect to a Practitioners Medical Staff status or clinical privileges, shall, except under circumstances for which specific provision is made in the Medical Staff bylaws, be subject to the practitioner's right to an appellate review in accordance with procedures set forth in the Medical Staff Bylaws.

9.7 Judicial Review. Section 1094.6 of the California Code of Civil Procedure shall govern the rights of any person aggrieved by the final decision of the Board, either with respect to a decision pertaining to a Medical Staff issue or any other issue whatsoever upon which the Board may act.

ARTICLE 10

QUALITY ASSURANCE/ORGANIZATIONAL PERFORMANCE IMPROVEMENT

10.1 Quality Assurance/Organizational Performance Improvement Plan. From time to time, in consultation with appropriate Medical Staff Committees, the Board shall adopt and implement a Quality Assurance Program and Performance Improvement Program for the Hospital.

10.2 Implementation, Evaluation and Monitoring of Quality Assurance/Organizational Performance Improvement Program. The Medical Staff and staffs of the Hospital departments and services are required to implement and report on the activities and mechanisms for monitoring and evaluation of quality of patient care, for identifying and resolving problems, and for identifying opportunities to improve patient care and leadership. These areas shall, at a minimum, include: patient rights and organizational ethics, patient assessment, patient care, education (patient, family, community and staff), continuance of care, improving organizational performance, providing a framework for planning, directing, coordinating, providing and improving health care services that are responsive to community and patient needs and that improve patient health outcomes, the environment of care, human resources and information, and infection control.

10.3 Risk Management. In addition to quality assurance and organizational performance improvement functions, the Board will provide resources and support systems for risk management functions related to patient care and the safety of patients, staff, practitioners and the community.

10.4 Administrator's Involvement. At all times, the Administrator shall carry out the policies of the Board of Directors supporting these activities and mechanisms.

ARTICLE 11

AUXILIARY ORGANIZATIONS

11.1 Formation. The Board may authorize the formation of auxiliary organizations to assist in the fulfillment of the purposes of the District. Each such organization shall establish its bylaws, rules and regulations, which shall be subject to Board approval, and which shall not be inconsistent with these bylaws or the policies of the Board.

11.2 Healthcare District Auxiliary. The Pioneers Memorial Healthcare District Auxiliary, a non-profit California corporation, shall be and is hereby recognized as an organization, the

activities of which shall include promotion and advancement of the welfare District and its patients.

11.3 Pioneers Memorial Hospital Foundation. The Pioneers Memorial Hospital Foundation, a non-profit California corporation, shall be and is hereby recognized as an organization, which supports the District through the solicitation, receipt and prudent administration of gifts from individuals, corporations, private foundations and grant-making entities.

ARTICLE 12 CLAIMS AND JUDICIAL REMEDIES

12.1 Judicial Review. Section 1094.6 of the California Code of Civil Procedure shall govern the rights of any person aggrieved by any decision of the Board or the District.

12.2 Claims Procedure. Notwithstanding any exceptions contained in Section 905 of the Government Code, no action based on a claim shall be brought against the District unless presented to the District within the time limitations and in the manner prescribed by Section 910 through 915.4 of the Government Code. Such claims shall further be subject to Section 945.4 of the Government Code.

ARTICLE 13 AMENDMENT

13.1 These bylaws may be amended or repealed by vote of at least three members of the Board at any Board meeting. Such amendments or repeal shall be effective immediately, except as otherwise indicated by the Board.

ARTICLE 14 REVISIONS TO BYLAWS

Approved: 4-22-82
Reviewed: 5-30-83
Revised: 3-26-84
Revised: 9-30-85
Revised: 3-26-90 *Complete Review and Update
Revised: 3-29-93
Revised: 4-26-93
Revised: 7-26-93

Revised: 1-24-94
Revised: 3-28-94
Revised: 4-25-94
Revised: 7-24-95
Revised: 11-27-95*Complete Review and Update
Revised: 12-11-95
Revised: approved 03/05
Revised: 3/22/2010 Complete Review and Update
Revised: 12/18/2014 Complete Review and Update
Revised: 1/4/2018 Complete Review and Update
Revised: 3/16/23 Complete Review and Update
Revised: 4/9/24 Review and Update
Revised: 8/9/24 Revised day of meetings

ADOPTION OF AMENDED AND RESTATED BYLAWS

Approved and adopted at a meeting of the Board of Directors of Pioneers Memorial Healthcare District, duly held on August 27, 2024.

CERTIFICATE OF SECRETARY

I, the undersigned, certify that I am the currently elected and acting Secretary of Pioneers Memorial Healthcare District, a public hospital district, and the above Amended and Restated Bylaws, consisting of 22 pages, are the Bylaws of the Pioneers Memorial Healthcare District as adopted pursuant to the required affirmative vote of the Board of Directors of Pioneers Memorial Healthcare District as amended and restated on August 27, 2024.

IN WITNESS WHEREOF, the undersigned has executed this Certificate of Secretary on August 27, 2024.



Nickolas Aguirre, PMHD Board of Directors