September 24, 2021

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in the Sequoia Regional Cancer Center Maynard Faught Conference Room on Monday September 27, 2021 beginning at 4:00PM in open session followed by a closed session beginning at 4:01PM pursuant to Government Code 54956.9(d)(2) and Health and Safety Code 1461 and 32155 followed by an open session at 4:30PM.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings (special meetings are posted 24 hours prior to meetings) in the Kaweah Health Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

The disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Health Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via phone 559-624-2330 or email: cmoccio@kdhcd.org, or on the Kaweah Delta Health Care District web page http://www.kaweahhealth.org.

KAWEAH DELTA HEALTH CARE DISTRICT
Garth Gipson, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk / Executive Assistant to CEO

DISTRIBUTION:
Governing Board
Legal Counsel
Executive Team
Chief of Staff
www.kaweahhealth.org

KAWEAH DELTA HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING

Sequoia Regional Cancer Center - Maynard Faught Conference Room
4945 W. Cypress Avenue

Monday September 27, 2021

OPEN MEETING AGENDA {4:00PM}

1. **CALL TO ORDER**
2. **APPROVAL OF AGENDA**
3. **PUBLIC PARTICIPATION –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdictions of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.
4. **APPROVAL OF THE CLOSED AGENDA – 4:01PM**
   - 4.1. **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 2 Cases **–** *Evelyn McEntire, Director of Risk Management and Rachele Berglund, Legal Counsel*
   - 4.2. **Credentialing** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 – *Monica Manga, MD Chief of Staff*
   - 4.3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Monica Manga, MD Chief of Staff & Gary Herbst, CEO*
   - 4.4. **Approval of the closed meeting minutes** – August 23, 2021 and September 17, 2021.

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

Action Requested – Approval of the September 27, 2021 closed meeting agenda.

5. **ADJOURN**

CLOSED MEETING AGENDA {4:01PM}

1. **CALL TO ORDER**
2. **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case.

   Evelyn McEntire, Director of Risk Management and Rachele Berglund, Legal Counsel
3. **CREDENTIALING** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 & 32155.

   Monica Manga, MD Chief of Staff
4. **QUALITY ASSURANCE** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee.

   Monica Manga, MD Chief of Staff
5. **APPROVAL OF THE CLOSED MEETING MINUTES** – August 23, 2021 and September 17, 2021.

   Action Requested – Approval of the closed meeting minutes – August 23, 2021 and September 17, 2021.
6. **ADJOURN**

OPEN MEETING AGENDA {4:30PM}

1. **CALL TO ORDER**
2. **APPROVAL OF AGENDA**
3. **PUBLIC PARTICIPATION –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdictions of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board

Clerk (Cindy Moccio 559-624-2330) or cmoccio@kaweahhealth.org to make arrangements to address the Board.

4. **CLOSED SESSION ACTION TAKEN** – Report on action(s) taken in closed session.

5. **OPEN MINUTES** – Request approval of the August 23, 2021 and September 17, 2021 open minutes.

   Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

   Action Requested – Approval of the open meeting minutes – August 23, 2021 and September 17, 2021 *open board of directors meeting minutes.*

6. **INTRODUCTIONS**

   6.1. William J. Kennedy, Director of Patient Navigation

7. **RECOGNITIONS** – *Mike Olmos*

   7.1. Presentation of Resolution 2141 to Alice Vega in recognition as the World Class Employee of the Month recipient – September 2021

8. **CREDENTIALS** - Medical Executive Committee requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the Medical Executive Committee be reviewed for approval.
   Monica Manga, MD Chief of Staff

   Public Participation – Members of the public may comment on agenda items before action is taken and after the Board has discussed the item.

   Recommended Action: Whereas a thorough review of all required information and supporting documentation necessary for the consideration of initial applications, reappointments, request for additional privileges, advance from provision al status and release from proctoring and resignations (pursuant to the Medical Staff bylaws) has been completed by the Directors of the clinical services, the Credentials Committee, and the MEC, for all of the medical staff scheduled for reappointment, Whereas the basis for the recommendations now before the Board of Trustees regarding initial applications, reappointments, request for additional privileges, advance from provision al status and release from proctoring and resignations has been predicated upon the required reviews, including all supporting documentation, Be it therefore resolved that the following medical staff be approved or reappointed (as applicable), as attached, to the organized medical staff of Kaweah Delta Health Care District for a two year period unless otherwise specified, with physician-specific privileges granted as recommended by the Chief of Service, the Credentials Committee, and the Executive Committee of the Medical Staff and as will be documented on each medical staff member's letter of initial application approval and reappointment from the Board of Trustees and within their individual credentials files.

9. **CHIEF OF STAFF REPORT** – Report relative to current Medical Staff events and issues.
   Monica Manga , MD Chief of Staff

10. CONSENT CALENDAR - All matters under the Consent Calendar will be approved by one motion, unless a Board member requests separate action on a specific item.

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

Action Requested – Approval of the September 27, 2021 Consent Calendar.

10.1. REPORTS

A. Physician Recruitment
B. Environment of Care
C. Orthopedic Service Line
D. Quail Park (Cypress), Laural Court (Memory Care) & Quail Park at Shannon Ranch
E. Rehabilitaton Services

10.2. Approval of the Exclusive Professional Services Agreement effective October 1, 2021 by and between Kaweah Delta Health Care District and Kaweah Cardiac Anesthesia Professionals, Inc.

10.3. Approval of the Exclusive Professional Services Agreement effective October 1, 2021 by and between Kaweah Delta Health Care District and Kaweah Nurse Anesthesia Services.

10.4. Approval of the Exclusive Professional Services Agreement effective October 1, 2021 by and between Kaweah Delta Health Care District and Kaweah Anesthesiologist Services, Inc.

10.5. Approval of Deferred Compensation amount for Plan Year July 1, 2021 through June 30, 2022. In accordance with the provisions of Section 4.1 of the Kaweah Health Care District Nonqualified Deferred Compensatino Plan for Gary Herbst (the"Plan"), the Board set the amount of the CEO's compensation to be credited to the Account of the Participant for Plan Year July 1, 2021 through June 30, 2022 at One Hundred and Thirty-Five Thousand dollars ($135,000.00).

10.6. Approval to reject the claim of Dennis Hundsforfer. Beverly Hundsdorfer. Erin Moody. Estate of Dennis Hundsdorfer vs Kaweah Health.

10.7. Approval to reject the claim of Victoria Vital v. Kaweah Delta Health Care District.

10.8. Recommendations from the Medical Executive Committee (September 2021) - Family Medicine Privileges Form.

10.9. Approval of Resolution 2142 in recognition of his service as Chief of Staff from 2019-2019 – Byron Mendenhall, MD.

11. QUALITY – CARDIOLOGY SERVICES – A review of key quality indicators and action through the American College of Cardiology (ACC) Data Registry.

Ashok Verma, MD, Medical Director Cardiac Cath Lab

12. **QUALITY – DIVERSION PREVENTION COMMITTEE** – Review of current initiatives and measures related to the prevention of medication diversion.

Keri Noeske, DNP, Vice President & Chief Nursing Officer

13. **FINANCIALS** – Review of the most current fiscal year financial results and budget.

Malinda Tupper –Vice President & Chief Financial Officer

14. REPORTS

14.1. Chief Executive Officer Report - Report relative to current events and issues.
Gary Herbst, Chief Executive Officer

14.2. Board President **-** Report relative to current events and issues.

A. Kaweah Delta Health Care District is aware that they will need to evaluate its current district zones after reviewing the 2020 census information which will be released at the end of September 2021. The next District election is scheduled in November 2022, the deadline for the final map to be submitted is mid April-2022.

David Francis, Board President

15. ADJOURN

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors meeting.

KAWEAH DELTA HEALTH CARE DISTRICT

BOARD OF DIRECTORS MEETING

MONDAY SEPTEMBER 27, 2021

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MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY AUGUST 23, 2021, AT 4:00PM, IN THE SEQUOIA REGIONAL CANCER CENTER MAYNARD FAUGHT CONFERENCE ROOM

PRESENT: Directors Francis, Gipson, Havard Mirviss, Olmos & Rodriguez; G. Herbst, CEO; M. Manga, MD, Chief of Staff, K. Noeske, VP& CNO; M. Tupper, VP & CFO; D. Cox, VP Chief HR Officer; M. Mertz, VP & Chief Strategy Officer; D. Leeper, VP & CIO; R. Gates, VP Population Health; D. Allain, VP Cardiac & Surgical Services; J. Batth, VP of Rehabilitation & Post-Acute Care; B. Cripps, Chief Compliance Officer, R. Berglund, Legal Counsel; and C. Moccio, recording

The meeting was called to order at 4:00PM by Director Francis.

Director Francis entertained a motion to approve the agenda.

MMSC (Havard Mirviss/Gipson) to approve the open agenda. . This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Gipson, and Francis – Absent: Rodriguez

PUBLIC PARTICIPATION – none

APPROVAL OF THE CLOSED AGENDA – 4:01PM

- **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case **-** *Ben Cripps, Vice President, Chief Compliance and Risk Officer and Rachele Berglund, Legal Counsel*
- **Conference with Legal Counsel – Anticipated Litigation –** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) – 1 Case **-** *Ben Cripps, Vice President, Chief Compliance and Risk Officer and Rachele Berglund, Legal Counsel*
- **Credentialing** - Medical Executive Committee (MEC) requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the MEC be reviewed for approval pursuant to Health and Safety Code 1461 and 32155 – *Monica Manga, MD Chief of Staff*
- **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Monica Manga, MD Chief of Staff & Gary Herbst, CEO*
- **Approval of the closed meeting minutes** – July 26, 2021.

MMSC (Olmos/Havard Mirviss) to approve the closed agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

ADJOURN - Meeting was adjourned at 4:04PM

David Francis, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:
Garth Gipson, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD MONDAY AUGUST 23, 2021, AT 4:30PM, IN THE SEQUOIA REGIONAL CANCER CENTER MAYNARD FAUGHT CONFERENCE ROOM

PRESENT: Directors Francis, Gipson, Havard Mirviss, Olmos & Rodriguez; G. Herbst, CEO; M. Manga, MD, Chief of Staff, K. Noeske, VP& CNO; M. Tupper, VP & CFO; D. Cox, VP Chief HR Officer; M. Mertz, VP & Chief Strategy Officer; D. Leeper, VP & CIO; R. Gates, VP Population Health; D. Allain, VP Cardiac & Surgical Services; J. Batth, VP of Rehabilitation & Post-Acute Care; B. Cripps, Chief Compliance Officer, R. Berglund, Legal Counsel; and C. Moccio, recording

The meeting was called to order at 4:30pm by Director Francis.

Director Francis asked for approval of the agenda.

MMSC (Olmos/Havard Mirviss) to approve the open agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

PUBLIC PARTICIPATION – none

CLOSED SESSION ACTION TAKEN: Approval of closed minutes from July 26, 2021.

OPEN MINUTES – Request approval of the meeting minutes July 26, 2021 and August 17, 2021 open minutes.

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

MMSC (Havard Mirviss/Rodriguez) Approval of the open meeting minutes July 26, 2021 and August 17, 2021 open minutes. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

RECOGNITIONS – Presentation of Resolution 2140 to Renee Crain, RN in recognition as the World Class Employee of the Month recipient – August 2021.

CREDENTIALING – Medical Executive Committee requests that the appointment, reappointment and other credentialing activity regarding clinical privileges and staff membership recommended by the respective department chiefs, the credentials committee and the Medical Executive Committee be reviewed for approval.

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

Director Francis requested a motion for the approval of the credentials report excluding Stephan Zerlang, DO {copy attached to the original of these minutes and considered a part thereof}.

MMSC (Gipson/Rodriguez) Whereas a thorough review of all required information and supporting documentation necessary for the consideration of initial applications, reappointments, request for additional privileges, advance from provisional status and release from proctoring and resignations (pursuant to the Medical Staff bylaws) has been completed by the Directors of the clinical services, the Credentials Committee, and the Executive Committee of the Medical Staff, for all of the medical staff scheduled for reappointment, Whereas the basis for the recommendations now before the Board of Trustees regarding initial applications, reappointments, request for additional privileges, advance from provisional status and release from proctoring and resignations has been predicated

upon the required reviews, including all supporting documentation, Be it therefore resolved that the following medical staff, excluding Emergency Medicine Providers as highlighted on Exhibit A (copy attached to the original of these minutes and considered a part thereof), be approved or reappointed (as applicable), to the organized medical staff of Kaweah Delta Health Care District for a two year period unless otherwise specified, with physician-specific privileges granted as recommended by the Chief of Service, the Credentials Committee, and the Executive Committee of the Medical Staff and as will be documented on each medical staff member's letter of initial application approval and reappointment from the Board of Trustees and within their individual credentials files . This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

Director Francis requested a motion for the approval of the credentials for Stephan Zerlang, DO {copy attached to the original of these minutes and considered a part thereof}.

MMSC (Olmos/Havard Mirviss) Whereas a thorough review of all required information and supporting documentation necessary for the consideration of initial applications, reappointments, request for additional privileges, advance from provisional status and release from proctoring and resignations (pursuant to the Medical Staff bylaws) has been completed by the Directors of the clinical services, the Credentials Committee, and the Executive Committee of the Medical Staff, for all of the medical staff scheduled for reappointment, Whereas the basis for the recommendations now before the Board of Trustees regarding initial applications, reappointments, request for additional privileges, advance from provisional status and release from proctoring and resignations has been predicated upon the required reviews, including all supporting documentation, Be it therefore resolved that the following medical staff, excluding Emergency Medicine Providers as highlighted on Exhibit A (copy attached to the original of these minutes and considered a part thereof), be approved or reappointed (as applicable), to the organized medical staff of Kaweah Delta Health Care District for a two year period unless otherwise specified, with physician-specific privileges granted as recommended by the Chief of Service, the Credentials Committee, and the Executive Committee of the Medical Staff and as will be documented on each medical staff member's letter of initial application approval and reappointment from the Board of Trustees and within their individual credentials files . This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, and Francis Abstained - Gipson

CHIEF OF STAFF REPORT – Report from Monica Manga, MD – Vice Chief of Staff (copy attached to the original of these minutes and considered a part thereof).

- We have started a virtual medical staff huddle to promote better communication between the medical staff, nurses, and staff which will be held weekly.
- There is a new medical director for best practice teams.

CONSENT CALENDAR – Director Francis entertained a motion to approve the consent calendar (copy attached to the original of these minutes and considered a part thereof).

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

MMSC (Havard Mirviss/Gipson) to approve the consent calendar as submitted. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

QUALITY – STROKE PROGRAM - A review of key quality indicators for the stroke population and review of accreditation survey results and actions (copy attached to the original of these minutes

and considered a part thereof) - *Cheryl Smit, RN, Stroke Program Manager & Sean Oldroyd, OD., Stroke Program Medical Director*

STRAGEGIC PLAN – Review of the Kaweah Health Strategic Plan Initiative – Organizational Effectiveness and Efficiency including a review of the metrics and strategies/tactics (copy attached to the original of these minutes and considered a part thereof) - *Jag Batth, Vice President Ancillary & Post Acute Services and Kassie Waters, Director of Cardiac Critical Care Services*

VISALIA INDUSTRIAL PARK – Review and discussion relative to a potential project in the industrial park as reviewed and supported by the Finance, Property, Services and Acquisition Committee on August 18, 2021 (copy attached to the original of these minutes and considered a part thereof) - *Marc Mertz, VP & Chief Strategy Officer, Malinda Tupper, Vice President & Chief Financial Officer and Coby LaBlue, Director of Finance for Population Health*

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

MMSC (Olmos/Havard Mirviss) To authorized management to enter into the necessary agreements and take all necessary steps for the development of an occupational health and primary care clinic in the industrial park, Visalia, CA at or below the estimated capital cost of $197,000 and the estimated building lease at or below the estimated annual cost of $215,040. . This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

OPEN ARMS HOSPICE – Discussion regarding the future operations of the Open Arms Hospice facility as reviewed and supported by the Finance, Property, Services and Acquisition Committee on August 18, 2021 (copy attached to the original of these minutes and considered a part thereof) - *Jag Batth, Vice President Ancillary & Post-Acute Services and Coby LaBlue, Director of Finance for Population Health*

Public Participation – Members of the public may comment on agenda items before action is taken and after the item has been discussed by the Board.

MMSC (Havard Mirviss/Gipson) To authorized management to enter into the necessary agreements and take all necessary steps to operate the Ruth Wood Open Arms Hospice Home with minimal financial exposure to Kaweah Health. Management is requested to give the Board an updated after 9 months of operation. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

FINANCIALS – Review of the most current fiscal year financial results and budget (copy attached to the original of these minutes and considered a part thereof) - *Malinda Tupper –Vice President & Chief Financial Officer*

CHIEF EXECUTIVE OFFICER REPORT – Report relative to current events and issues - Gary Herbst, Chief Executive Officer

- We are experiencing another surge in COVID cases being admitted to the Medical Center which affects our capacity to be able to do surgical cases that require inpatient care following their surgery.

BOARD PRESIDENT REPORT – Report from David Francis, Board President

- Director Francis requested that in the future new Directors should be invited to the Board meeting to be introduced to the Board.

APPROVAL OF CLOSED AGENDA AS FOLLOWS: Closed Meeting Agenda – Immediately following the 4:00pm open session

- **CEO Evaluation** – Discussion of with the Board and the Chief Executive Officer relative to the evaluation of the Chief Executive Officer pursuant to Government Code 54957(b)(1) – *Rachele Berglund, Legal Counsel & Board of Directors*

Public Participation – Members of the public may comment on agenda items before action is taken and after the Board has discussed the item.

MMSC (Havard Mirviss/Gipson) to approve the closed agenda immediately following the 4:00pm open session. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Rodriguez, Gipson, and Francis

ADJOURN - Meeting was adjourned at 7:21PM

David Francis, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

Garth Gipson, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD FRIDAY SEPTEMBER 17, 2021, AT 7:00AM, IN THE EXECUTIVE OFFICE CONFERENCE ROOM, KAWEAH HEALTH MEDICAL CENTER

PRESENT: Directors Francis, Gipson, Havard Mirviss & Olmos; G. Herbst, CEO; R. Berglund, Legal Counsel; and R. Gonzales, recording

The meeting was called to order at 7:07AM by Director Francis.

Director Francis entertained a motion to approve the agenda.

MMSC (Olmos/Gipson) to approve the open agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Gipson, and Francis – Absent: Rodriguez

PUBLIC PARTICIPATION – none

APPROVAL OF THE CLOSED AGENDA – 7:01AM

- **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461, report of quality assurance committee –– *Gary Herbst, CEO*

MMSC (Havard Mirviss/Gipson) to approve the closed agenda. This was supported unanimously by those present. Vote: Yes – Havard Mirviss, Olmos, Gipson, and Francis – Absent: Rodriguez

ADJOURN - Meeting was adjourned at 7:07AM

David Francis, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

Garth Gipson, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

MINUTES OF THE OPEN MEETING OF THE KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS HELD FRIDAY SEPTEMBER 17, 2021, AT 7:42AM, IN THE EXECUTIVE OFFICE CONFERENCE ROOM, KAWEAH HEALTH MEDICAL CENTER

PRESENT: Directors Francis, Gipson, Havard Mirviss & Olmos; G. Herbst, CEO; R. Berglund, Legal Counsel; and R. Gonzales, recording

The meeting was called to order at 7:42AM by Director Francis.

PUBLIC PARTICIPATION – none

CLOSED SESSION ACTION TAKEN: *Authorized management to provide Golden State Cardiac and Thoracic Surgery Inc. with a 120 day "no cause" notice of termination of their contract with Kaweah Delta Health Care District. This was supported unanimously by those present. Vote: Yes – Gipson, Olmos, Havard Mirviss, and Francis Absent - Rodriguez*

ADJOURN - Meeting was adjourned at 7:43AM

David Francis, President
Kaweah Delta Health Care District and the Board of Directors

ATTEST:

Garth Gipson, Secretary/Treasurer
Kaweah Delta Health Care District Board of Directors

Employee of the Month – Alice Vega—Patient Accounting

Manager – Chris Rodriguez / Nominated by: Cathy Teague

This past year has been quite challenging for our department. Some of us have been able to work from home while others stayed in the office. Alice Vega stayed at the office and took on a lot of responsibilities including mailing all of our insurance claims and having us call her frequently to reset our computer. She was alone without her team. When we would take turns coming in to assist her with sending out claims, Alice always had a smile on her face and never complained about it. She always does her work to the best of her abilities and she helps you out whenever you need it. Alice has passion and compassion for her job and her coworkers. I feel she needs to be recognized for everything she has done. She is a person that does not like to be in the spotlight but our commercial team loves Alice and all she does for us.

Alice goes out of her way to speak with our patients to get the information she needs in order for insurance companies to accurately and timely process patient claims. Her friendliness towards our patients and her passion to get that claim paid are exemplary. She advocates for our patients when working with insurance companies and does great job supporting them.

When our Commercial Team has need for anything with our family, she is willing to help out and never questions. Alice doesn't have a single selfish bone in her entire body. She is a role model to the young that work in our area. They see her perseverance and how she handles herself. She is quiet and keeps to herself but she does an amazing job.

She is professional with how she presents herself. She is a woman of integrity. She manages her family and her job as a loving mom.

Alice makes time with her family by going on trips and has love for her immediate family and her friends. She will help you with anything if you ask her and go out of her way. I am honored to work with Alice. I see how her children respect her and she has taught them the meaning of working and saving their money. I see her as a mother who has nurtured her children and her job. She has taught me some things in life that she is not aware of.

Alice, it is an honor to work with you and to nominate you as our World Class Employee of the Month.

Kaweah Delta Health Care District
Annual Report to the Board of Directors

Respiratory Services

Wendy Jones, BS, RRT, RPFT, Director, (559) 624-2329
Johnny Mata, BS, RRT-NPS, Manager, (559) 624-2192
July 2021

Summary Issue/Service Considered

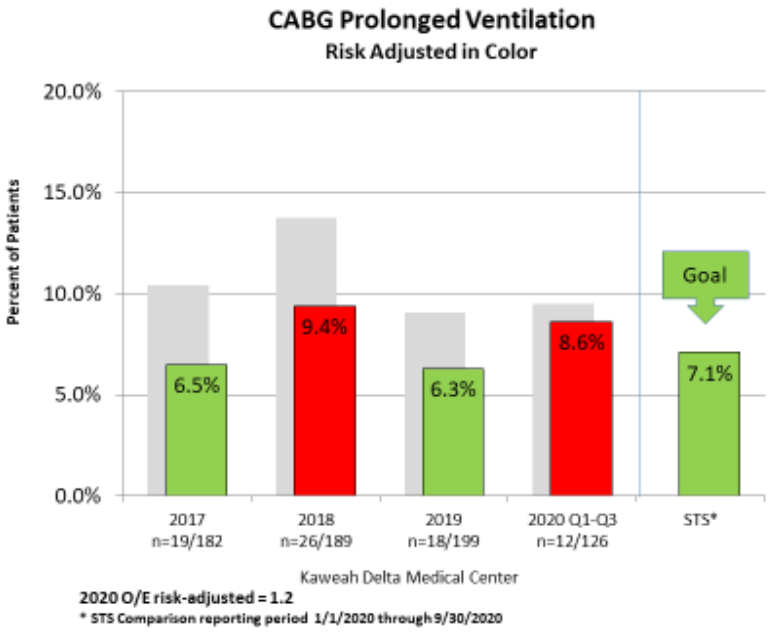
1. Respiratory Services will continue to provide/support primary and advanced respiratory care services emphasizing stabilization, maintenance, and restorative goal driven patient care.
2. As active and vital members of acute, emergent, critical, sub-acute and rehabilitative care teams, we continue to work jointly with physicians, nurses, Allied Health Leaders, and the Executive Team to assure the provision of:
   - High Quality Care
   - Optimal Patient safety
   - Service excellence
   - Optimal health outcomes
   - Financial Stability
   - Cultural change resulting in establishing and maintaining ideal work environments for our staffs and physicians.
3. Specific Clinical Focus:
   - In collaboration with our Critical Care Intensivists and RNs, we will continue to dedicate our full attention on utilization of our Ventilator Associated Events (VAE) bundle as a means to continue to reduce ventilator days associated with hospital acquired infections.
   - Continue to work collaboratively with Rapid Response Team (RRT) to:
     * Decrease RRT response time
     * Decrease code blue events
     * Decrease transfers to higher levels of care
     * Provide optimal care and patient safety by improving our knowledge and assessment skills through routine and frequent utilization of our 10 signs of vitality initiative.
     * Support Clinical Lab Technicians with performing Arterial blood gas draws as needed during when certified Lab Technicians are not available during RRTs.
   - Continue to actively support our Intensivist group while enculturating necessary change to assure a continuum of care and service excellence is sustained.
   - Continue to work collaboratively with our Neonatologists and nursing staffs in the provision of clinical excellence resulting in optimal patient outcomes in our Neonatal population.
   - Provide necessary resources to develop a Chronic Obstructive Pulmonary Disease (COPD) management program within our acute care setting which will then transition to our Chronic Disease Management Clinic with the goal of lowering 30 day readmissions and geographic length of stays.

- Continue to support integration of Respiratory Care Practitioners (RCP's) into the expanding Emergency Department staffing mix to provide advanced clinical expertise to the ED team.
- Focus on "preventative care measures" as a platform driving respiratory health for our community through education and outreach opportunities.
- Continue to support respiratory care education for our Residents.

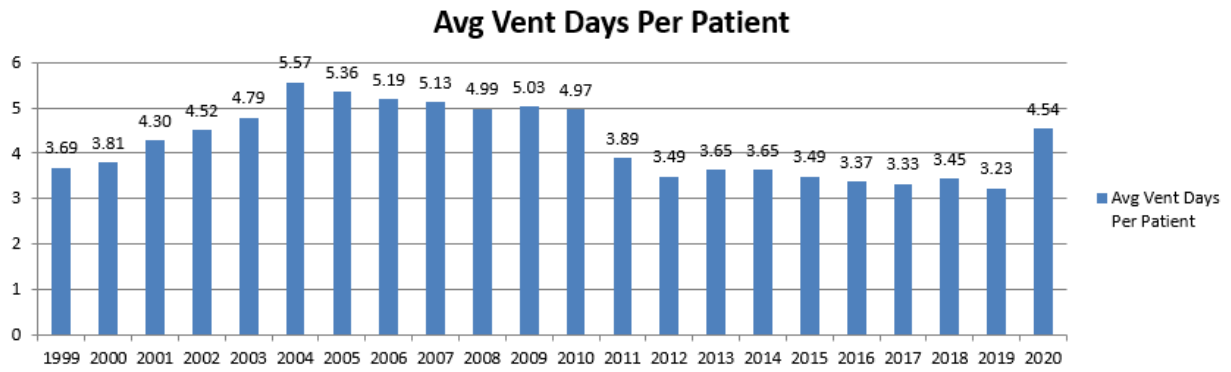
Quality/Performance Improvement Data

The following Quality measures are in place:

- Respiratory Care practitioners continue to work closely with Anesthesia, Cardiac Surgeons, Intensivists, and nursing staff on rapidly weaning patients post-coronary artery bypass graft (CABG) surgery in 24 hours or less. While we continue to improve we remain relentless in our pursuit and commitment to achieving The Society of Thoracic Surgeons (STS) national benchmark of 7.2%. As a direct result of our collaboration and commitment we have improved in 2019 to 8.3% which is within 1.1% of achieving the STS benchmark.



- **Average Ventilator Days Per Patient**
  As a continuing reflection of the success of our collaboration with our multidisciplinary critical care team we continue to support and champion our Ventilator Acquired Pneumonia (VAP) bundle as key to continuing success with:
  - Decreasing Ventilator Days
  - Increase throughput
  - Improving patient safety by rapid weaning and extubation
  - Reduction in hospital acquired infections
  - Reducing overall Hospital Length of Stay
  - Reducing Direct Expense when possible



Policy, Strategic or Tactical Issues

Ideal Work Environment:

1. Provide staff with continuing education through the American Association for Respiratory Care (AARC) to help fulfill license requirements while advancing clinical knowledge in pursuit of best practices.
2. Encourage staff to advance their education by offering loan repayment for baccalaureate level achievement.
3. Provide staff with educational resources culminating in RRT-ACCS (Registered Respiratory Therapist-Adult Critical Care Specialist) or RRT-NPS (registered Respiratory Therapist-Neonatal Pediatric Specialist) credentials.
4. Reward and recognize staff for living our Mission and Vision Statements.
5. Work collaboratively with our Medical Director on developing Respiratory Care policies, procedures and processes designed to standardize/optimize best evidence based respiratory care throughout the District.
6. Maintain an internal per diem pool of RCP's to support fluctuations in staffing in an effort to maintain uncompromising high quality care while optimizing our financial performance..
7. Develop a clinical ladder for professional advancement based on established standards.

Service Excellence:

1. Daily rounding with staff to identify top patient care priorities with a goal of care planning to assure patient expectation are achieved and optimal outcomes met.
2. Celebrate staff achievements/contributions/recognition for supporting our Mission, Values, Goals and Behavioral Standards of Performance.
3. Weekly "newsletter' from Manager informing staff of current events/education opportunities and staff recognition.

Quality Outcomes:

1. Continue to support VAE improvement process.
2. Work collaboratively with District Leaders on hardwiring Kaweah Care initiatives
3. Continue to support/manage our quality initiatives resulting in our exceeding HCAPS benchmarks.

Financial Strength:

1. Manage personnel resources and supply utilization to achieve productivity/financial goals set forth during the annual budget development process.
2. Continue to monitor and assess technological/professional advancements that add value, operational efficiency and have potential to increase profitability.
3. Validate value in all aspects of care and service.

Recommendations/Next Steps

1. Continue to recognize and reward staffs for walking the talk.
2. Development of education program for managing COPD in our acute care population that will transition to our Chronic Disease Management Clinic.
3. Challenge every RCP with developing two cost saving initiatives per year.
4. Develop a plan to move all Certified Respiratory Therapists to Registered Respiratory Therapist credential.

Conclusions

Although faced with wide variations in patient care demands our respiratory care service continues to provide exceptional acute, critical, emergent, rehabilitative, and Sub-Acute Care for the communities we serve.

Top priorities for 2021:

- Staff recognition, reward, satisfaction, education and professional development.
- Continue to work with the physician group from Valley Children's Hospital to advance our expertise with caring for our pediatric population.
- Continue to support our Intensivist group through sustaining strong working relationships, shared vision, and standardized ventilator management.
- Sustain optimal clinical care and expertise designed to enhance Physician satisfaction and collaboration.
- Closely monitor vital clinical indicators/core measures to assure optimal patient safety, outcomes, experiences, operational efficiency and profitability.
- Continue to emphasize our professional paradigm shift to preventative health care management of Cardio-Pulmonary Disease for the communities we serve.

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2021 Annualized

Respiratory Services - Summary

*** FY 2021 ANNUALIZED ON THE ELEVEN MONTHS ENDED MAY 31, 2021**

KEY METRICS - FY 2021 ANNUALIZED

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
6,272	$49,895,756	$36,951,183	$12,944,572	$776,477
▲ 16%	▲ 126%	▲ 117%	▲ 157%	▲ 160%

*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS BY SERVICE LINE - FY 2021 ANNUALIZED

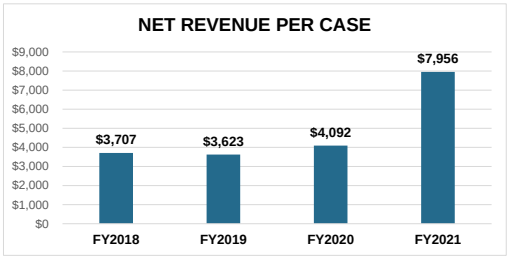
SERVICE LINE	PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
PULMONARY INPATIENT	2,491	$48,112,052	$35,619,169	$12,492,883	$896,637
SLEEP DISORDERS CENTER OUTPATIEN	2,301	$1,427,852	$1,144,178	$283,673	($184,281)
PULMONARY FUNCTION OUTPATIENT	1,117	$291,523	$119,330	$172,192	$91,721
OUTPATIENT EEG	363	$64,330	$68,506	($4,176)	($27,600)
RESPIRATORY SERVICES TOTAL	6,272	$49,895,756	$36,951,183	$12,944,572	$776,477

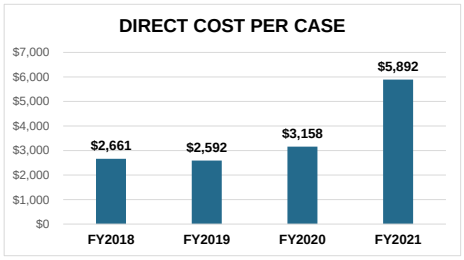
METRICS SUMMARY - 4 YEAR TREND

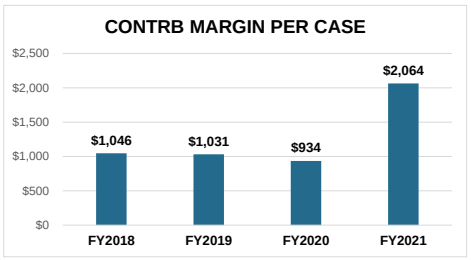
*Annualized

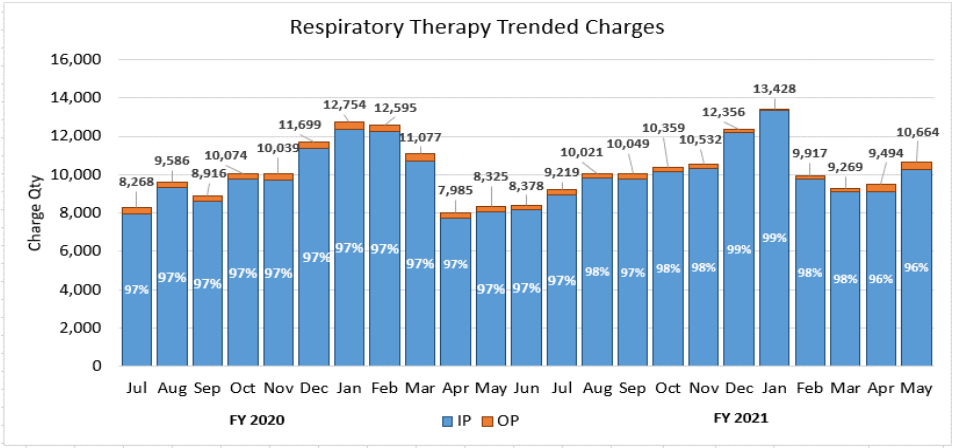
METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
PATIENT CASES	6,139	5,968	5,385	6,272	▲ 16%	
NET REVENUE	$22,756,879	$21,621,184	$22,037,047	$49,895,756	▲ 126%	
DIRECT COST	$16,334,835	$15,467,753	$17,005,475	$36,951,183	▲ 117%	
CONTRIBUTION MARGIN	$6,422,044	$6,153,431	$5,031,572	$12,944,572	▲ 157%	
INDIRECT COST	$6,066,213	$5,704,538	$6,318,714	$12,168,095	▲ 93%	
NET INCOME	$355,831	$448,893	($1,287,142)	$776,477	▲ 160%	
NET REVENUE PER CASE	$3,707	$3,623	$4,092	$7,956	▲ 94%	
DIRECT COST PER CASE	$2,661	$2,592	$3,158	$5,892	▲ 87%	
CONTRB MARGIN PER CASE	$1,046	$1,031	$934	$2,064	▲ 121%	

GRAPHS









Report Notes:

The inpatient Pulmonary service line has a significantly higher contribution margin this year due to the high number of COVID patients in FY 2021. However, this represents only a subsection of our total COVID inpatients and offsets the overall negative financial experience during the pandemic.

Selection Criteria: Kaweah Delta Medical Center Inpatient Pulmonary Service Line and Outpatient Service Line 1 Respiratory Services.

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2021 Annualized

Respiratory Services - Pulmonary

*** FY 2021 ANNUALIZED ON THE ELEVEN MONTHS ENDED MAY 31, 2021**

KEY METRICS - FY 2021 ANNUALIZED

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
2,491	$48,112,052	$35,619,169	$12,492,883	$896,637
▲ 49%	▲ 137%	▲ 128%	▲ 168%	▲ 190%

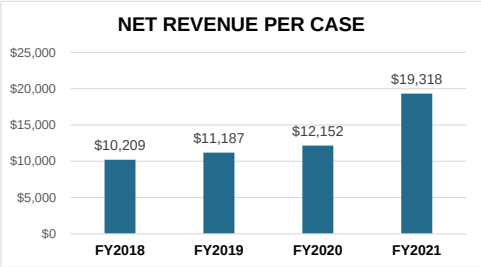
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

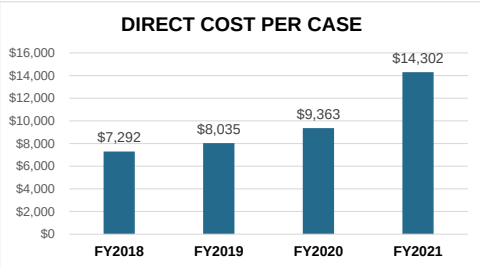
METRICS SUMMARY - 4 YEAR TREND

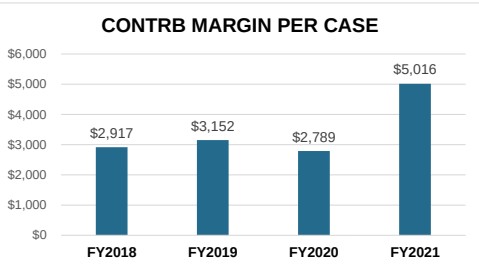
*Annualized

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
PATIENT CASES	2,036	1,732	1,672	2,491	▲ 49%	
PATIENT DAYS	9,535	7,919	7,680	17,824	▲ 132%	
ALOS	4.68	4.57	4.59	7.16	▲ 56%	
GM LOS	3.89	3.85	4.02	5.09	▲ 27%	
OPPORTUNITY LOS	0.79	0.72	0.57	2.07	▲ 261%	
NET REVENUE	$20,784,720	$19,376,064	$20,318,069	$48,112,052	▲ 137%	
DIRECT COST	$14,846,664	$13,917,394	$15,654,215	$35,619,169	▲ 128%	
CONTRIBUTION MARGIN	$5,938,056	$5,458,670	$4,663,854	$12,492,883	▲ 168%	
INDIRECT COST	$5,519,898	$5,134,656	$5,661,728	$11,596,246	▲ 105%	
NET INCOME	$418,158	$324,014	($997,874)	$896,637	▲ 190%	
NET REVENUE PER CASE	$10,209	$11,187	$12,152	$19,318	▲ 59%	
DIRECT COST PER CASE	$7,292	$8,035	$9,363	$14,302	▲ 53%	
CONTRB MARGIN PER CASI	$2,917	$3,152	$2,789	$5,016	▲ 80%	

PER CASE TRENDED GRAPHS



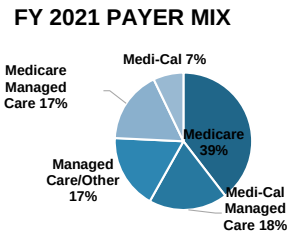




PAYER MIX - 4 YEAR TREND (GROSS REVENUE)

*Annualized

PAYER	FY2018	FY2019	FY2020	FY2021
Medicare	56%	54%	49%	39%
Medi-Cal Managed Care	18%	19%	20%	18%
Managed Care/Other	9%	9%	13%	17%
Medicare Managed Care	12%	11%	12%	17%
Medi-Cal	4%	5%	5%	7%



Report Notes:

The inpatient Pulmonary service line has a significantly higher contribution margin this year due to the high number of COVID patients in FY 2021. However, this represents only a subsection of our total COVID inpatients and offsets the overall negative financial experience during the pandemic.

Source: KHMC, Inpatient Service Line Report

Selection Criteria: Service Line 1 = Pulmonary

KAWEAH HEALTH ANNUAL BOARD REPORT

Respiratory Services - Pulmonary Function

FY2021 Annualized

*** FY 2021 ANNUALIZED ON THE ELEVEN MONTHS ENDED MAY 31, 2021**

KEY METRICS - FY 2021 ANNUALIZED

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,117	$291,523	$119,330	$172,192	$91,721
▲ 10%	▲ 12%	▲ 2%	▲ 20%	▲ 50%

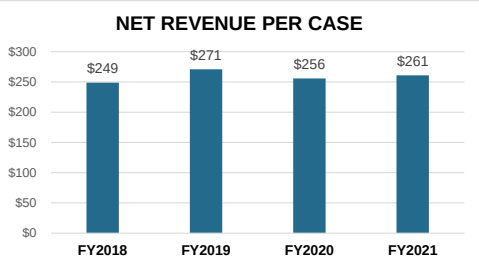
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

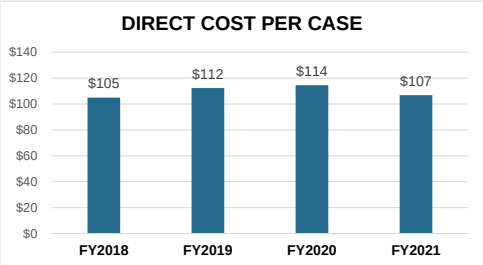
METRICS SUMMARY - 4 YEAR TREND

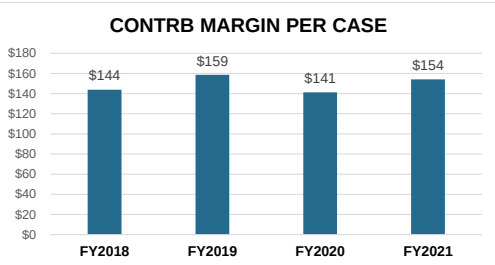
*Annualized

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
PATIENT CASES	1,127	1,142	1,018	1,117	▲ 10%	
NET REVENUE	$280,351	$309,443	$260,315	$291,523	▲ 12%	
DIRECT COST	$118,246	$128,241	$116,525	$119,330	▲ 2%	
CONTRIBUTION MARGIN	$162,105	$181,202	$143,790	$172,192	▲ 20%	
INDIRECT COST	$77,851	$75,842	$82,740	$80,471	▼ -3%	
NET INCOME	$84,254	$105,360	$61,050	$91,721	▲ 50%	
NET REVENUE PER CASE	$249	$271	$256	$261	▲ 2%	
DIRECT COST PER CASE	$105	$112	$114	$107	▼ -7%	
CONTRB MARGIN PER CASI	$144	$159	$141	$154	▲ 9%	

PER CASE TRENDED GRAPHS



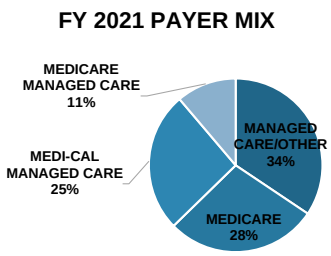




PAYER MIX - 4 YEAR TREND

*Annualized

PAYER	FY2018	FY2019	FY2020	FY2021
MANAGED CARE/OTHER	29%	33%	32%	34%
MEDICARE	45%	39%	34%	28%
MEDI-CAL MANAGED CARE	15%	15%	19%	25%
MEDICARE MANAGED CARE	10%	11%	13%	11%



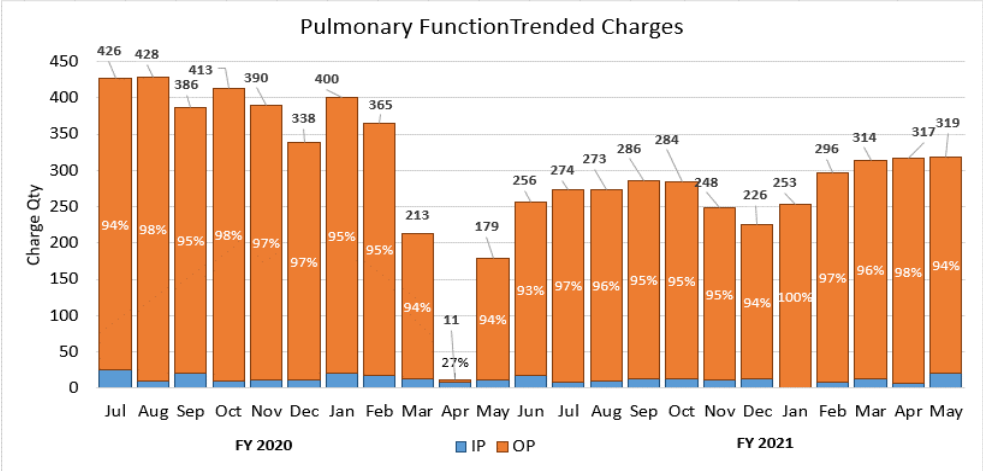
KAWEAH HEALTH ANNUAL BOARD REPORT

Respiratory Services - Pulmonary Function

FY2021 Annualized

*** FY 2021 ANNUALIZED ON THE ELEVEN MONTHS ENDED MAY 31, 2021**

KEY METRICS - FY 2021 ANNUALIZED



Note: ▫

Source: Outpatient Service Line Report

Selection Criteria: Service Line 1 = Respiratory Services and Service Line 2 = Pulmonary Function

Second Chart is based off of Pulmonary Charges

Physician Recruitment and Relations

Medical Staff Recruitment Report - September 2021

Prepared by: Brittany Taylor, Director of Physician Recruitment and Relations - btaylor@kdhcd.org - (559)624-2899

Date prepared: 9/22/2021

Central Valley Critical Care Medicine	
Intensivist (1- Part-Time; 1 - Full-Time)	2

Delta Doctors Inc.	
OB/Gyn	1

Kaweah Delta Faculty Medical Group	
Family Medicine Associate Program Director	1

Kaweah Health Medical Group	
Audiology	1
Dermatology	2
Family Medicine	3
Internal Medicine	1
Gastroenterology	2
Gastroenterology- Advanced Practice Provider	1
Orthopedic Surgery (Hand)	1
Otolaryngology	2
Pulmonology	1
Radiology - Diagnostic	1
Rheumatology	1
Urology	3
Pediatrics	1

Key Medical Associates	
Internal Medicine/Family Medicine	2

Oak Creek Anesthesia	
Anesthesia - General	1.5
Anesthesia - Intensivist	1
Anesthesia - Obstetrics	1
Anesthesia - Program Director	1

Other Recruitment	
Hematology/Oncology	1
Neurology	1
Orthopedic Surgery (Trauma)	1

Valley Children's Health Care	
Maternal Fetal Medicine	2
Neonatology	1

Valley Hospitalist Medical Group	
GI Hospitalist	1

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Anesthesia	Oak Creek Anesthesia	Ajede, M.D.	Kehinde	09/22	Direct email	Currently under review
Anesthesia	Oak Creek Anesthesia	Hart, M.D.	Travis	TBD	CompHealth - 8/5/21	Currently under review
Anesthesia	Oak Creek Anesthesia	He, M.D.	Chaoying	ASAP	Direct	Site Visit: 9/21/21; Offer accepted; Tentative Start Date: January 2022
Anesthesia	Oak Creek Anesthesia	Lin, M.D.	Steven	ASAP	Direct	Site Visit: 9/21/21; Offer accepted; Tentative Start Date: January 2022
Anesthesia	Oak Creek Anesthesia	Janiczek, M.D.	David	06/22	Direct	Offer accepted; pending execution of contract; Coming back to interview for Program Director position 9/10/21
Certified Registered Nurse Anesthetist	Oak Creek Anesthesia	Caceres	Cesar	ASAP	Direct - 5/21/21	Offer accepted; Credentialing in process
Certified Registered Nurse Anesthetist	Oak Creek Anesthesia	Sobotka	Tyler	01/22	Direct - 6/1/21	Offer accepted; Tentative start date: January 2022
Certified Registered Nurse Anesthetist	Oak Creek Anesthesia	Spolsdoff	Allison	12/21	Direct	Offer accepted; Tentative start date: December 1, 2021
Dermatology	Kaweah Health Medical Group	Chang, M.D.	Judy	09/22	Curative - 6/11/2021 (Spouse is Dr. Ming Lee, Dermatology-Mohs)	Site visit pending - November 2021
Dermatology - Mohs Surgery	Kaweah Health Medical Group	Lee, M.D.	Ming	09/22	Curative - 6/11/2021 (Spouse is Dr. Judy Chang, Dermatology)	Site visit pending - November 2021
Family Medicine	Kaweah Health Medical Group/Key Medical Associates	Shin, M.D.	Chang-Sung	09/22	Kaweah Health Resident	Currently under review
Family Medicine	Kaweah Health Medical Group	Hsueh, D.O.	Marion	09/21	Direct referral	Site Visit: 3/23/21; Start Date: 9/20/2021

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Rangel-Orozco, M.D.	Daniela	08/22	Kaweah Health Resident	Site visit pending dates - October 2021
Family Medicine Core Faculty	Kaweah Delta Faculty Medical Group	Bassali, M.D.	Mariam	08/21	Referred by Dr. Martinez - 10/14/20	Site Visit: 3/10/21; Start Date: 9/13/2021
Gastroenterology	Kaweah Health Medical Group	Ali, M.D.	Asad	08/22	Direct - PracticeLink	Site visit pending dates in November
Gastroenterology	Key Medical Associates	Eskandari, MD	Armen	ASAP	Direct	Offer accepted; contract in process
Hospitalist	Central Valley Critical Care Medicine	Malik, M.D.	Sara	08/21	Direct - Dr. Umer Hayyat's spouse	Site Visit: 10/7/20; Tentative Start Date: October 2021
Hospitalist	Central Valley Critical Care Medicine	Reed, M.D.	Jennifer	08/21	Vista Staffing - 1/18/21	Start Date: 9/8/2021
Intensivist	Central Valley Critical Care Medicine	Dierksheide, M.D.	Julie	09/21	Vista Staffing - 4/15/21	Start Date: 9/9/21
Intensivist	Central Valley Critical Care Medicine	Hansen, M.D.	Diana	09/21	Vista Staffing - 2/25/21	Start Date: 8/26/21
Intensivist	Central Valley Critical Care Medicine	Islam, M.D.	Tasbirul	TBD	PracticeLink - 5/5/21	Site Visit: 7/21/21
Intensivist	Central Valley Critical Care Medicine	Montano, M.D.	Nicholas	07/22	PracticeMatch - 6/28/21	Currently under review
Intensivist	Central Valley Critical Care Medicine	Li, M.D.	William	07/22	Vista Staffing - 7/12/21	Site visit pending dates (October 2021)
Interventional Cardiology	Independent	Singla, M.D.	Atul	01/22	Direct referral	Site Visit: 6/14/21; Offer accepted
Neonatology	Valley Children's	Agu, D.O.	Cindy	TBD	Valley Children's - 9/1/21	Site Visit: 9/20/21
Neonatology	Valley Children's	Singh, M.D.	Himanshu	08/22	Valley Children's - 3/31/21	Site Visit: 4/19/2021; Offer accepted. Start date 8/29/2022
Nurse Practitioner - Gastroenterology	Kaweah Health Medical Group	Garcia	Yesenia	TBD	Direct	Site Visit: 9/23/21
OB/GYN	Delta Doctors	Pelletier	Carole-Anne	TBD	CareerMD Fresno Career Fair	Currently under review

Candidate Activity						
Specialty/Position	**Group**	**Last Name**	**First Name**	**Availability**	**Referral Source**	**Current Status**
Otolaryngology	Kaweah Health Medical Group	Nguyen, D.O.	Cang	07/22	Curative - 3/15/21	Offer accepted; contract in process
Palliative Medicine	Independent	Grandhe, M.D.	Sundeep	08/21	Direct -12/7/20	Virtual Interview: 12/28/20; Offer accepted; Start Date: 9/1/21
Pediatrics	Kaweah Health Medical Group	Galindo, M.D.	Ramon	09/22	Direct referral - 6/28/21	Site visit: 9/14/21; Offer pending
Physical Therapy	Kaweah Health Medical Group	Zigo	Dominique	TBD	CliniPost - 8/25/21	Offer accepted
Urology	Kaweah Health Medical Group	Patel, M.D.	Neil	10/21	Los Angeles Career MD Fair 9/14/19	Site Visit: 9/25/20; Part-Time; Tentative Start date: October 2021

Kaweah Health
MORE THAN MEDICINE. LIFE.

Environment of Care
2nd Quarter Report
April 1, 2021 through July 31, 2021
Presented by

Maribel Aguilar, Safety Officer
559-624-2381

SAFETY (Employee Health)

Second Quarter 2021

Performance Standard: Reduce Occupational Safety & Health Administration (OSHA) recordable work related injury cases by 10% from 2020.
Goal: No more than 421 recordable workplace injuries in 2021 (105 per qtr.)
Status: Goal met for 2nd Quarter 2021: 54 OSHA Reportable Injuries.
Sponsor: Sarah Amend
Plan for Improvement: (Summary)

1. Implement same day on-site investigation with employee (performed by Employee Health)
2. Work with Infection Prevention (IP) to reduce COVID exposure/claims
3. Employee Health Services (EHS) to meet with department managers with greater than 3 OSHA recordable in the last 24 months
4. Increase sharps education in employee orientation
5. Implement workplace ergonomic evaluations (performed by Employee Health: Physical Therapy Assistant)

Evaluation:

- 54 OSHA recordable injuries in Qtr. 2-2021 , plus 3 Covid 19 claims
- Covid 19 vaccination began 12/18/20
- Provided 2 ergonomic evaluations 2nd Qtr.- 9 YTD.
- 2021 Sharps Exposure- Quarter 2—17 total (5-GME)

Type of injury	Q1	Q2	Q3	Q4	Totals 2021	Totals 2020	Per 1000 employees	Annualized # of injuries
Total Incidents	178	73			251	759	14.17	502
Covid 19+	50	3			53	271	0.58	106
OSHA recordable	60	54			114	467	13.59	228
Lost time cases	90	42			132	378	0.58	264
Strain/sprain	30	32			62	101	5.83	124
Sharps Exp	23	17			40	76	2.91	80
# EE end of QTR	5150	5139						

- **Detailed Plan for Improvement:**
- Continue to work with Infection Prevention to decrease Covid 19+ exposures/ claims by Health Care Workers in 3rd qtr. of 2021.
- Identify employees with ≥ 3 OSHA recordable injuries in last 2 year --EHS speaks with managers directly noting any trends per employee and/or injuries.
- Same day on-site incident investigation with employee. Follow-up with manager for prevention opportunities and/or process changes and policy review. Investigation/ follow-up may include photos, video and interview of witnesses/ manager.
- Increase Sharps education in General Orientation by Infection Prevention and Manager orientation by Employee Health Services. Demonstrate correct sharps activation in new hire physicals with all employees handling sharps.
- Utilize Physical Therapy Assistants in Employee Health for Ergonomic evaluations, evaluate for proper body mechanics to prevent injury, stretching exercises and equipment recommendations to ensure safety with our jobs.

SAFETY (Risk Management)

Second Quarter 2021

Performance Standard: No patient death or serious disability associated with a fall while cared for in a Kaweah Health Facility.
Goal: 100% Compliance (0 events)
Status: Goal met for 2nd Quarter 2021
Sponsor: Evelyn McEntire

Evaluation:

There were no incidents of patient death or serious disability associated with a fall while being cared for in a Kaweah Health (KH) facility.

The Minimum Performance Level was met for this standard.

*Serious disability means physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function if the impairment lasts more than seven (7) days, or is still present at the time of discharge, or loss of a body part.

Detailed Plan for Improvement:

Hazardous Surveillance inspections of all Kaweah Health facilities conducted on a scheduled basis. Safety issues identified are resolved by department manager.

Continue to monitor.

SAFETY (Infection Prevention)

Second Quarter 2021

Performance Standard: Departments demonstrate compliance with Infection Prevention performance measures/criteria during bi-annual audits
Goal: Minimum of 90% compliance per department
Status: Goal not met for 2nd Quarter 2021: 18/27 areas surveyed exceeded 90% compliance; 66% department compliance, improvement of 2% from previous quarter.
Sponsor: Shawn Elkin
Plan for Improvement: (Summary)
1. IP to require non-compliant departments to submit Corrective Action Plan.

Evaluation:

Inpatient and Outpatient Areas Average Compliance for Q2: 93.1%

Opportunities to Improve: Replacement of expired hand sanitizer table top pumps. Avoidance of storing shipping containers on unit. Proper maintenance of germicidal wipes. Covering and securing of biohazard containers.

Surgical Services Compliance for Q2: 78.1%

Opportunities to Improve: Proper use of PPE. Proper transport of lab specimens. Clean/dirty designation/signage. Locking of medical waste storage. Cleaning of equipment between patients. Storage room and cart cleanliness. Supplies on floors. Furniture without rips/tears. Staff knowledge regarding bodily fluid exposures. Avoidance of shipping containers in area. Plastic barriers on bottom of carts. Limiting opening of doors. Staff use of appropriate PPE. Verification of CHG bathing. Labeling of IV tubing.

Sterile Processing Compliance for Q2: 93.6%

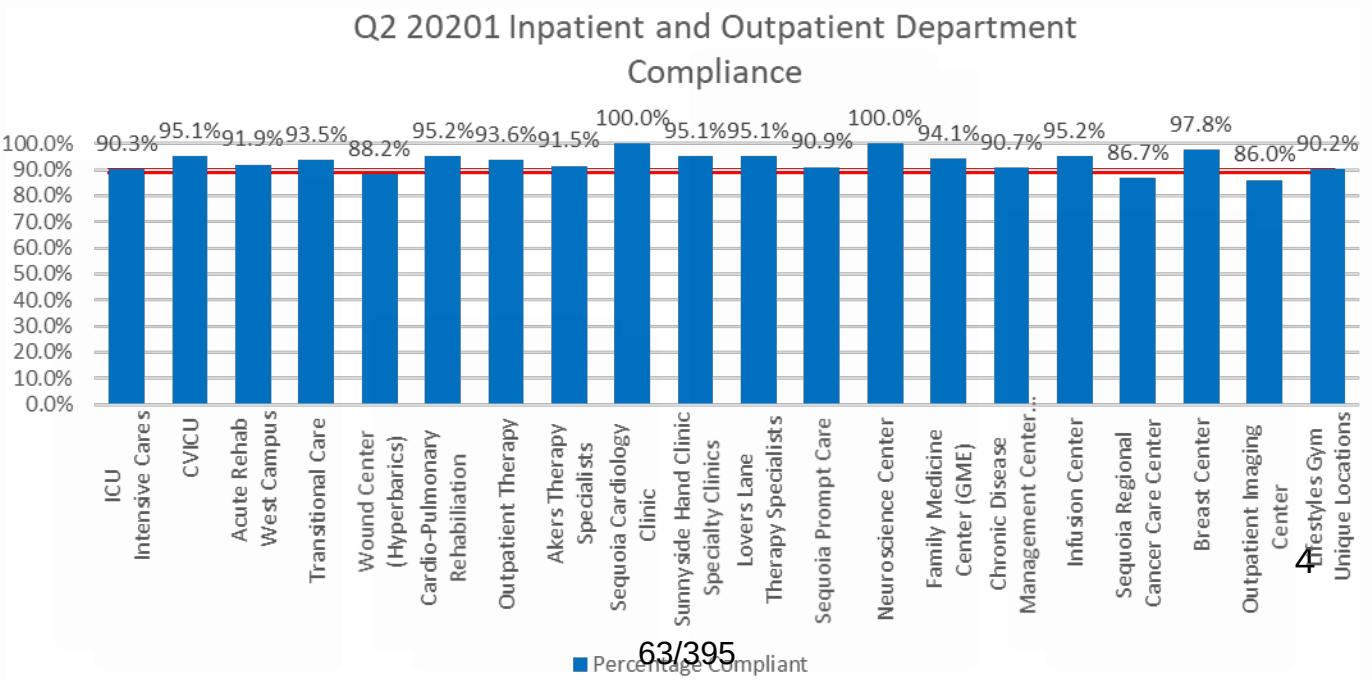
Opportunities to Improve: Ceiling tiles and flooring intactness/stains. Cleanliness of supply areas and vents. Supplies on floors.

Dialysis Compliance for Q2: 81%

Opportunities to Improve: Hand hygiene supplies and implementation. Clean/dirty signage/designation. Covering, labeling, and dating containers. Supply cart cleanliness/organization. Ceiling clearance. Removal of expired supplies.

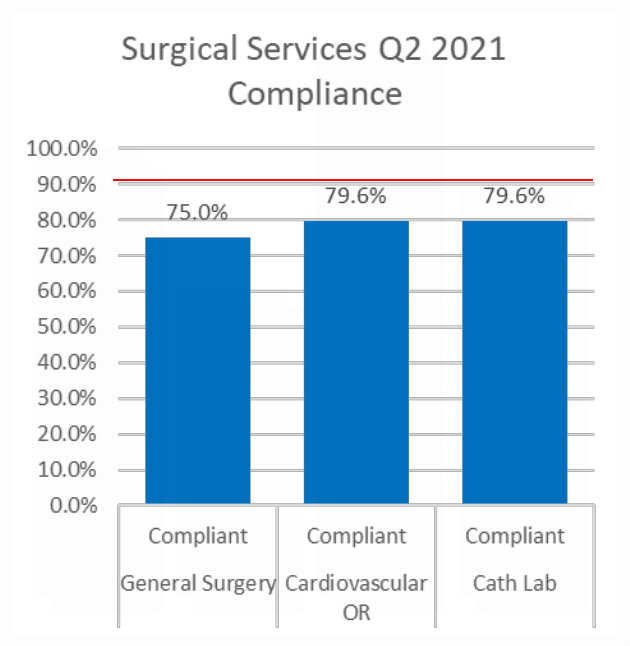
Pharmacy Compliance for Q2: 86.8%

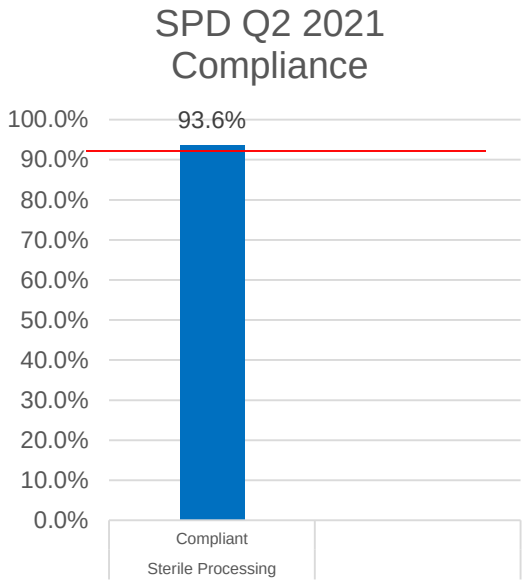
Opportunities to Improve: Hand hygiene products (approved and not expired). Organization of supplies. Avoidance of staff beverages near medications. Floor/walls/ceiling cleanliness. Removal of expired supplies. Furniture defects.

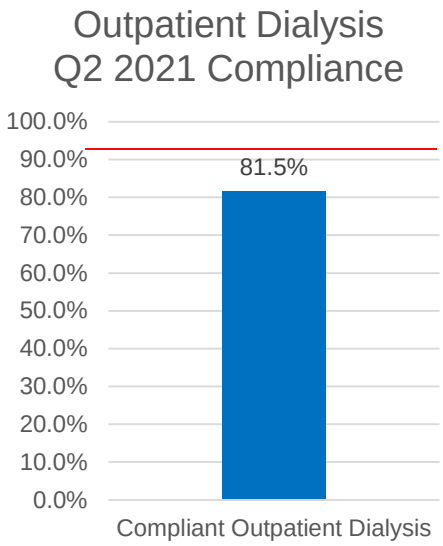


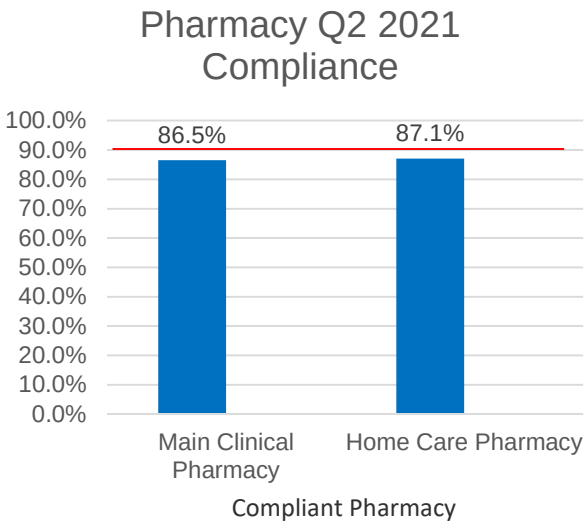
SAFETY (Infection Prevention)

Second Quarter 2021 (cont.)









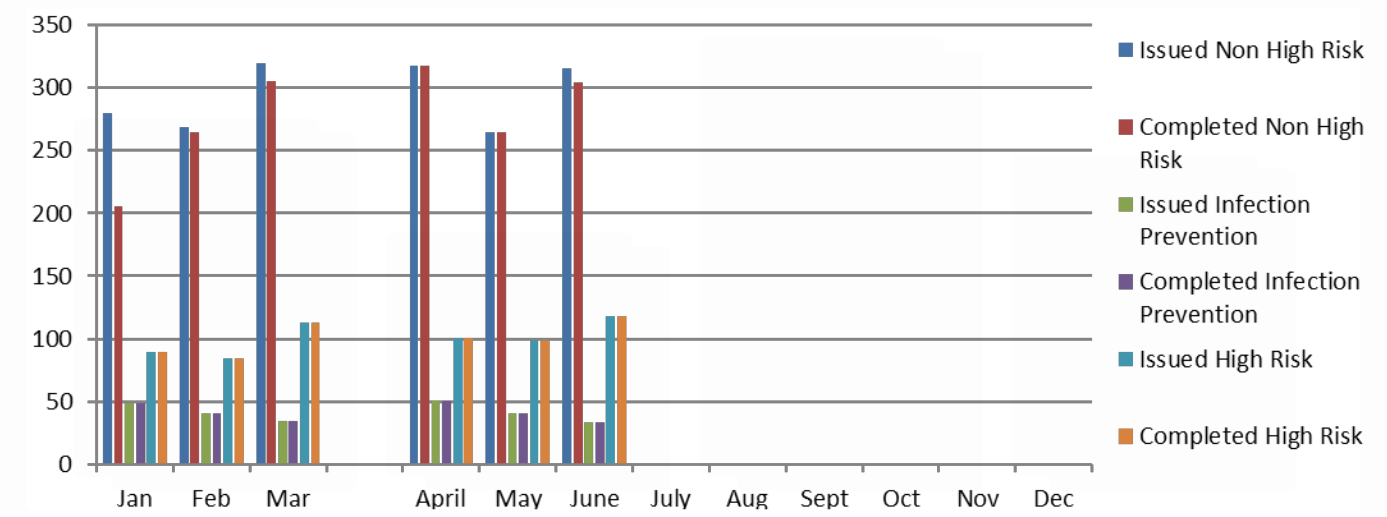
Detailed Plan for Improvement:

Action plans from each area requested for items out of compliance. Leaders of the area are required to submit in writing their actions to correct the items out of compliance. Infection Prevention will follow up with manager or director as appropriate.

UTILITIES MANAGEMENT

Second Quarter 2021

Performance Standard: High Risk, Low Risk, Infection Control Preventive Maintenance to be completed on time
Goal: 100% Compliance (no missed PM's)
Status: Goal not met for 2nd Quarter 2021 (2116/2127 completed on time: 99%) Improvement of 3% from 1st Qtr.
Sponsor: Steve Gloeckler
Plan for Improvement: (Summary)
1. Continue to work with Nursing to improve access to Mineral King (MK) North & South patient rooms.



Evaluation:
There were 2116/2127 preventative maintenance work orders completed.

Non-High Risk	1449/1460 =	99%
Infection Prevention	154/154 =	100%
High Risk	513/513 =	100%

Plan for Improvement: Most work orders not complete due to high census. Improvement plan implemented with Nursing has been effective in improving completion percentage: Improved from 96% on time completion to 99% on time completion.

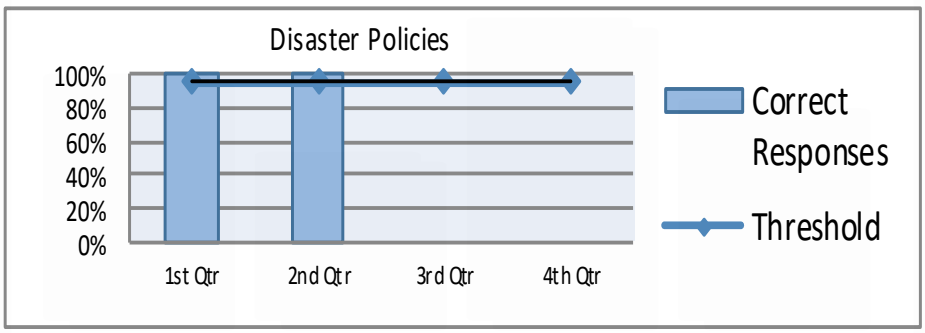
EMERGENCY PREPAREDNESS

Second Quarter 2021

Performance Standard: Employees able to provide correct responses related to Emergency Preparedness questions.
Goal: 100% Compliance (all employees surveyed answered correctly)
Status: Goal met for 2nd Quarter 2021 (New goal for 2021).
Sponsor: Maribel Aguilar

Evaluation:
Fifty departments were surveyed in the 2nd quarter. In all departments surveyed staff where able to verbalize location of disaster policies, which resulted in a 100% compliance rate.

Minimum performance level was met for this quarter.



Detailed Plan for Improvement:
In each department visited there was knowledge of Disaster Policies.

We will continue to monitor through hazard surveillance rounding and during the quarterly mini drills.

LIFE SAFETY

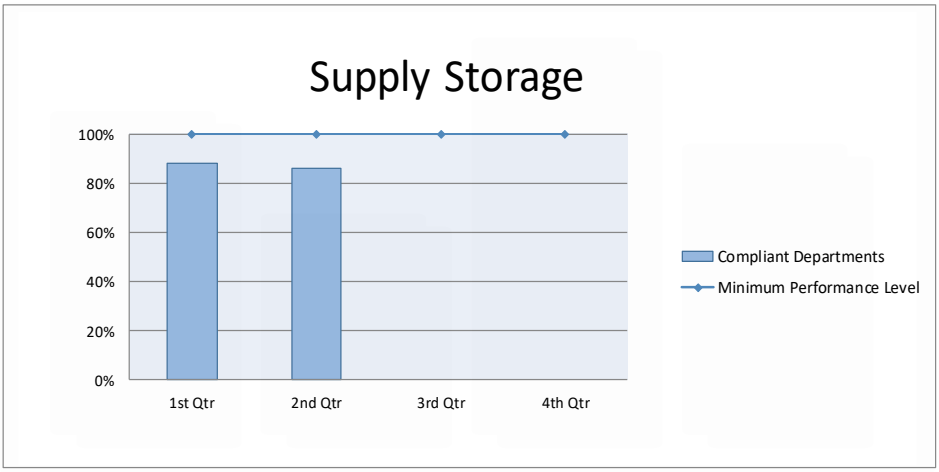
Second Quarter 2021

Performance Standard: Equipment & Supplies stored in accordance with Safety requirements.
Goal: 100% Compliance (no storage compliance issues)
Status: Goal not met for 2nd Quarter 2021; 43/50 areas surveyed were compliant 86% change of minus 2% from previous quarter.
Sponsor: Maribel Aguilar
Plan for Improvement: (Summary)

1. For areas with repeat violations, will eliminate non-compliant storage areas.
2. Continue to monitor and educate.

Evaluation:
Fifty departments were surveyed in the 2nd quarter. Of the 50 departments, 7 were found to be non-compliant with storage. This resulted in 86% compliance rate.

Minimum Performance Level was not met during this quarter.



Detailed Plan for Improvement:

Identified repeat no-compliance areas and are in the process of implementing physical changes to ensure fire safety systems can operate effectively.

We will continue to monitor through hazard surveillance and report to appropriate director and VP. Departments with repeat violations are being further evaluated for possible change in area design.

SECURITY

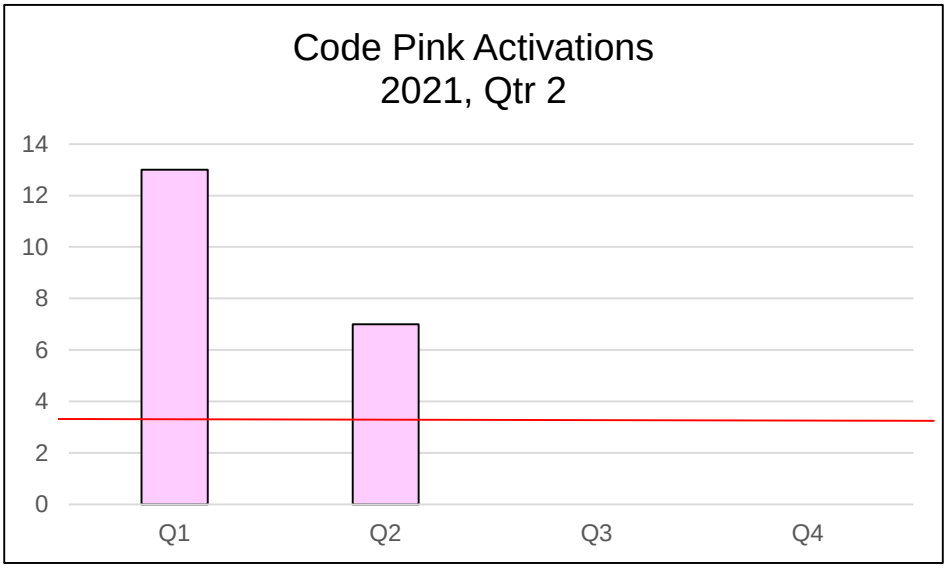
Second Quarter 2021

Performance Standard: Reduce false "Code Pink" Activations by 75% from 2020
Goal: No more than 12 false "Code Pink" activations in 2021 (3 per qtr.) (New goal for 2021)
Status: Goal not met for 2nd Quarter 2021: 7 false "Code Pink" activations
Sponsor: Miguel Morales
Plan for Improvement: (Summary)

1. Adjust alarm sensor range to prevent false alarms (completed: April 7, 2021)
2. Install "Alert" Sensors to "beep" as someone begins to leave the "secure" area
3. Install visual indicators (floor tape) to show where the alarms will sound
4. Security to meet with Maternal Child Health leaders to discuss staff errors.

Evaluation:
Goal was **NOT** met.

In year 2020 the medical center experienced 48 ***false*** Code Pink activations. In the 2nd quarter of 2021, the Maternal-child Health Program experienced 7 ***false*** Code Pink activations. Of the 7 events, two events resulted from parents walking too close to the HUGS receiver with the banded child. Five events were due to staff error, forgetting to deactivate the HUGS tag or putting the tag in transport mode when moving the child from one unit to another.
80% reduction of false Code Pink activations was achieved in 2nd quarter.



Detailed Plan for Improvement:
The majority of ***false*** Code Pink activations are due to staff forgetting to deactivate or to set the HUGS transmitter in transport when moving the child/newborn from the home unit to the transport unit.

Opportunities:

- Security Department provided the Maternal-child Health leaders with a flyer to help educate unit staff.
- Floor tape (CAUTION ALARM WILL SOUND) will be used as a visual indicator/ limit line to mitigate avoidable false alarms due to stepping to close to the proximity field. Floor vinyl tape has been purchased. Coordinating with Anthony Bishop and EVS to place adhesive take at predetermined areas.
- Anthony Bishop (ISS) will work with TRL to install ALERT receivers as an early warning device. Anthony Bishop had the HUGS service company (TRL) perform a function test of 2E10 and PEDS RM1, the two areas that were identified as problematic by the respective unit managers. The Pediatrics RM 1 issue was resolved by tuning the coverage area closer to ceiling level to prevent false alarms from inside the room. The Labor and Delivery RM 10 issue was not duplicated; however, the field outside the room does trigger the HUGS system to activate. Placing the vinyl tape as a visual indicator will help as a boundary visual indicator.

SECURITY

Second Quarter 2021

Performance Standard: Reduce Workplace Violence Events
Goal: TBD (new)
Status: Workplace Violence events decreased organization wide by 17% from previous quarter (1st Qtr. 2021)
Sponsor: Chris Luttrell
Plan for Improvement: **(Summary)**

1. Re-convene Workplace Violence Prevention Team (first meeting held June 7, 2021)
2. Expand use of "Aggressive Patient" Alert System (first meeting August 2nd, 2021)
3. Safety Team to utilize 6 Sigma (DMAIC principles) to perform case review of Midas Workplace Violence Events. Findings to be shared with Leadership & Staff.

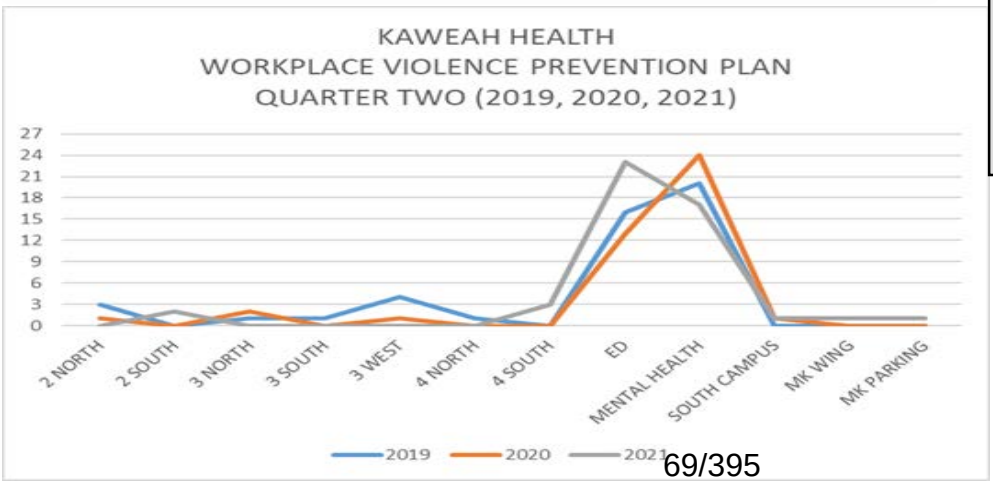
Evaluation:
Workplace violence events decreased organization wide from the previous quarter (2021, 1st quarter) by **9 events**. WPV events in the Emergency Department has decreased by **2** events. WPV events at Mental Health have increased by **9 events**.

Detailed Plan for Improvement:

1. The Safety Department will continue the Midas Workplace Violence case review where event factors are identified and discussed in order to mitigate future events and to offer staff options to better manage assaultive events and to minimize employee injuries. Factors will be communicated to leadership.

2. Problematic patients are added to the electronic Aggressive Patient Alert system, which flags patients when they register at any Kaweah Health clinic or hospital. The Security Department provides proactive patrols and supports staff with early intervention Plan of Care and Code Gray: Combative Person response.

3. Reconvene Workplace Violence Prevention Team, meeting.



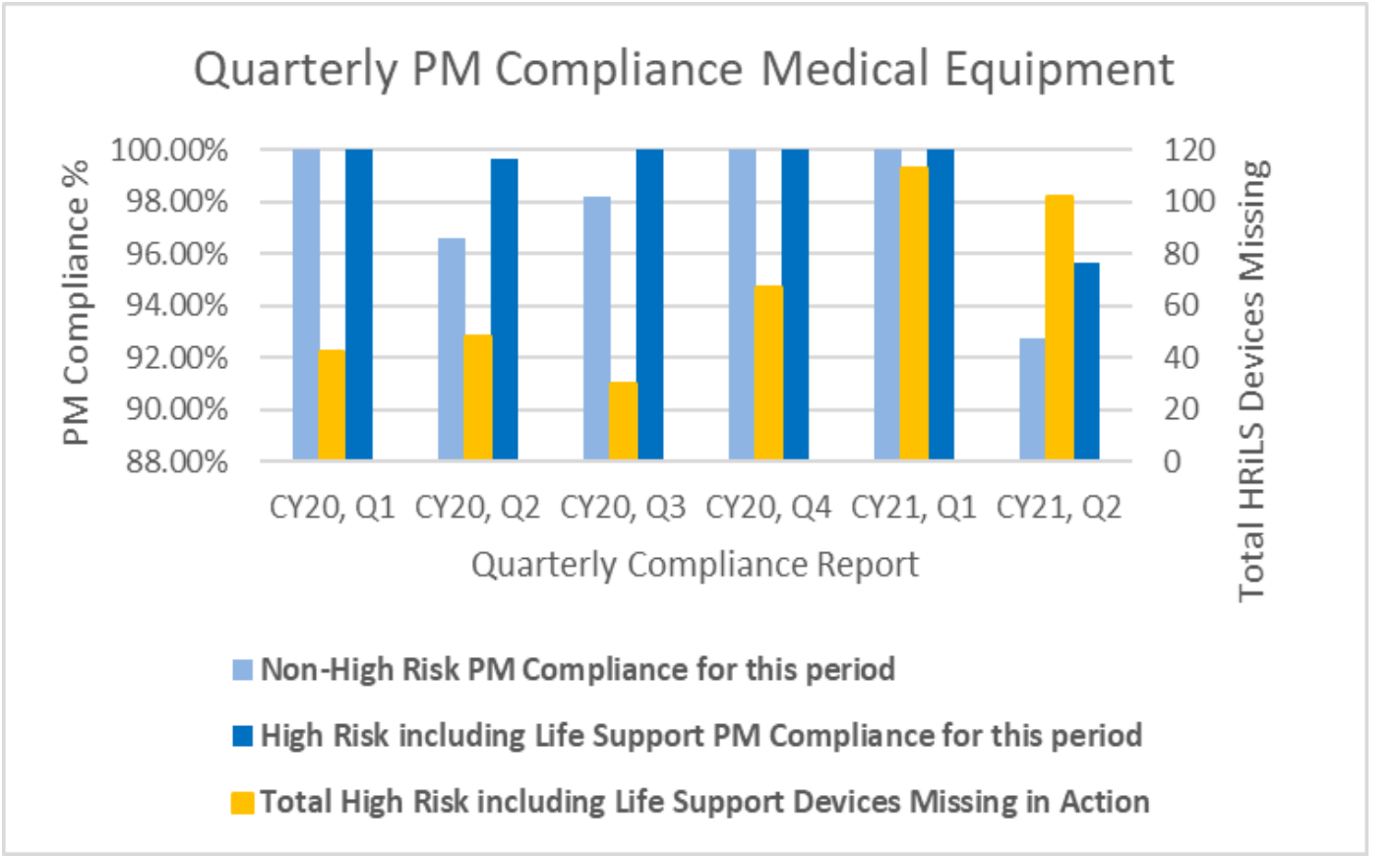
MEDICAL EQUIPMENT

Second Quarter 2021

Performance Standard: Medical Equipment Preventive Maintenance to be completed on time
Goal: 100% Compliance (0 missed PM's)
Status: Goal not met for 2nd Quarter 2021: 2911/3105 completed on time: 94%, decrease in compliance from previous quarter.
Sponsor: Paul Gatley

Evaluation:
For the reporting quarter, CY 2021, Q2 (Apr-Jun), There are 3105 Devices that were available to receive Preventive Maintenance and 2911 of those devices received Preventive Maintenance as scheduled.

PM Compliance for Non-High Risk Devices is 92.72% and **does not meet the 100% Goal**.
PM Compliance for High Risk Including Life Support Devices is 95.63% and **does not meet the Goal of 100% compliance**.



Detailed Plan for Improvement:
The Department posted two job openings during CY21 Q2 to fill vacancies. One was filled on August 8th and the other will be filled October 3rd. A third position is being requested for a late September post date. Filling these three positions will return staffing to Q2 of CY20 levels. Requesting Department Managers to review the devices in their areas for devices with PM stickers that are over due and report them to Clinical Engineering so they may be serviced and placed into the PM completed category.

Kaweah Health
Annual Report to the Board of Directors

Orthopedic Service Line

Daniel L. Allain, NP-C, Vice President Cardiac and Surgical Services
Tracy Salsa, RN, Director Specialty Clinics
Kari Knudsen, RN, Director of Post-Surgical Care
Contact number: 559-624-2536
September 7,, 2021

Summary Issue/Service Considered

1. Providing exceptional comprehensive orthopedic care through quality outcomes, efficiency, and cost effective care.
2. Ensuring that Orthopedics Services continues to provide the full continuum of services to the community.
3. Partner with Orthopedic Associates in the recruitment of needed orthopedic specialists.
4. Reduction of direct costs through effective and successful negotiation of contracts with our orthopedic vendors.
5. Current Length of Stay (LOS) exceeds the Geometric Mean Length of Stay (GMLOS). Develop strategies and process improvement to meet GMLOS.
6. Market the ROSA Robotics system to our primary and secondary markets

Analysis of financial/statistical data:

The orthopedic service line continues to maintain a strong contribution margin of $5.6 million, which is consistent with fiscal year (FY) 2020 performance of $5.7 million. However, the current performance is down from the performance in FY 2019 of $9.5 million. This change in the contribution margin is secondary to the COVID pandemic impact on elective surgery shut down along with the increased expenses in FY 2020 and FY 2021.

Overall, the orthopedic case volumes have declined by 23% from last FY, which is again due to the COVID impact on elective surgeries. The overall contribution margin is down by 2% from FY 2020. Orthopedic surgeries, which typically make up 34% of our inpatient surgery contribution margin, are down by 18% from FY 2020. Outpatient orthopedic financial performance has historically resulted in a substantial contribution margin loss. In FY 2021, the contribution margin was $583,000, an improvement of 145% from FY 2020. The driving factors influencing this outpatient change in contribution margin are the movement of total knee and total hip arthroplasties coupled with a reduction in the number of hand surgeries performed in the outpatient surgery environment.

The inpatient medical orthopedic volume also experienced a decrease in volume associated with COVID by 9% from FY 2020. The contribution margin per case decreased by 23% compared to last FY with the direct cost per case increasing 16% per case despite an increase in revenue per case by 5%. The inpatient medical orthopedic service line contribution margin for FY 2021 was $676,131 compared to the previous year of $969,353.

Overall, the impact of the restrictions implemented with the pandemic to reduce the exposure to the virus had a significant impact on the case volume, coupled with the increase in direct expenses impacted the contribution margin.

Quality/Performance Improvement Data

Actively working with the marketing department to provide educational events in our community led by the orthopedic surgeons. We continue to offer educational events via social media web cast events. During the month of May, Kaweah Health sponsored an in-person event with two of our orthopedic surgeons with a focus on spine surgery and New Trends in Knee Surgery to our local primary care physicians. The purpose is to build long-term referral relationships.

Orthopedic Surgical Quality Improvement is tracked in-house through the STATIT. The running 12-month complication rate for orthopedic hip/knee surgery at 0.95% is outperforming the target rate of 1.4% for the comparative all payer group. The running 12-month complication rate for hip/knee surgery at 0% is outperforming the target rate of 2.3% for the Medicare group.

Orthopedics continues to work closely with the trauma department to track the orthopedic trauma transfers. In calendar year 2020, 340 trauma orthopedic consultations occurred with 31 orthopedic related cases transferred out. These cases are reviewed on a quarterly basis to evaluate for appropriateness. We are working closely with the orthopedic traumatologist to provide call coverage and are actively recruiting a second orthopedic traumatologist.

Patient satisfaction overall rating in FY 2021 with the orthopedic physicians reflected a significant decline to the 77th percentile compared to the 90th percentile in FY 2020.

The average LOS over 7 quarters 2020-2021 for elective knee joint replacement patients is 1.66 days compared to an expected 2.25 days. The average length of stay for elective hip arthroplasty is 4.12 compared to an expected 3.35 days.

Performance and trends are carefully monitored for implant cost per case, infection rates, re-admission rates, complication rates, and functional assessments. Case reviews are completed with surgeons regarding infection, re-admission, and complications.

Orthopedics continues to be designated as a Blue Distinction Center for the spine, knee, and hip replacement. To earn this distinction, the program must demonstrate high quality, cost effective care supported by a full range of patient support services with multidisciplinary teams to coordinate and streamline care, including shared decision-making and preoperative patient education.

Policy, Strategic or Tactical Issues

1. The orthopedic co-management arrangement has been renewed for additional two years. This arrangement promotes the growth of the orthopedic service line, improves safety and quality in direct patient care as well as overall efficiency.

2. Sub-committees continue to focus efforts around outreach/marketing and operational performance and efficiency.

3. Working closely with media relations, marketing, and internal key leaders created a comprehensive and robust orthopedic program known in the community as the Kaweah

Delta Joint Replacement Institute. In light of the COVID pandemic, the Joint Replacement Institute was converted to a virtual presentation with the booklets being distributed during the preoperative KATS appointment.

4. Closely monitoring referral leakage and outmigration numbers. Focusing on both community members and primary care physicians to increase the market share. Emphasizing the importance of using local surgeons.

5. Evaluating enhancements in knee joint replacement through the addition of the ROSA Robotic system.

6. Working closely with our physician recruiter seeking additional orthopedic surgeons as the orthopedic demands continue to grow in the region with the retirement and relocation of two orthopedic surgeons along with our orthopedic trauma needs.

7. Nurse Practitioner is working with the orthopedic service with a focus on improved throughput and better coordination of care and efficiency with the entire continuum of care for orthopedics.

8. Developing the marketing strategy in collaboration with our orthopedic physicians trained in the use of the system and the Zimmer Biomet company featuring the ROSA knee system.

Recommendations/Next Steps

1. The co-management agreement will continue to promote alignment of both parties' interests in improving quality, outcomes, and efficiency. In addition, it prepares both groups for the changing healthcare delivery models.

2. Carefully watching the orthopedic surgical market shifting into the outpatient surgical arena for total hips and knees. These orthopedic surgeries were traditionally performed as an inpatient and now are authorized for outpatient surgeries. Working with the outpatient surgery staff and contracting department to provide orthopedic procedures safely and efficiently in the outpatient surgery areas. Piloting same-day outpatient joint replacement surgeries.

3. Continuing to work on patient flow, improving efficiency in the surgery department, and clinical quality with the entire orthopedic service line with the primary focus on hip fractures and joint replacement patients.

4. Continue efforts in reducing the overall length of stay with orthopedic surgical cases to the geometric length of stay (GMLOS).

5. Continue with the physician partnership development, as well as referral relations, and marketing/community health outreach in orthopedics.

6. Support recruitment efforts for Board Certified Orthopedic Surgeons that specialize in the latest treatment in the area hands and trauma.

7. Continue to respond to Medicare initiatives related to Orthopedics at the State and National level.

Approvals/Conclusions

In the coming year, orthopedic services will:

1. Work with the entire continuum of care from pre-surgery to post-surgery to provide quality and comprehensive orthopedic services.

2. Continue to review profitability, contribution margin to identify opportunities for volume, growth, cost containment, customer satisfaction, and clinical excellence.

3. Analyze the factors currently affecting the actual LOS and make appropriate changes to achieve the GMLOS.

KDHCD ANNUAL BOARD REPORT

Orthopedic Services - Summary

FY2021

***KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021**

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
2,975	$39,083,012	$33,441,461	$5,641,551	($3,268,097)
▼ -23%	▼ -5%	▼ -5%	▼ -2%	▲ 18%

*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS BY SERVICE LINE - FY 2021

SERVICE LINE	PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
Inpatient Orthopedic -Surgical Service	1,121	$24,799,974	$20,417,455	$4,382,519	($838,988)
Inpatient Orthopedic - Medical Service	300	$3,227,459	$2,551,328	$676,131	($193,088)
OP Orthopedic Surgeries	1,554	$11,055,579	$10,472,678	$582,901	($2,236,021)
Services Line Totals	2,975	$39,083,012	$33,441,461	$5,641,551	($3,268,097)

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	3,830	4,164	3,840	2,975	▼ -23%	
Net Revenue	$38,337,385	$42,082,852	$40,986,607	$39,083,012	▼ -5%	
Direct Cost	$31,160,101	$32,537,680	$35,248,708	$33,441,461	▼ -5%	
Contribution Margin	$7,177,284	$9,545,172	$5,737,899	$5,641,551	▼ -2%	
Indirect Cost	$8,367,281	$8,870,223	$9,736,846	$8,909,648	▼ -8%	
Net Income	($1,189,997)	$674,949	($3,998,947)	($3,268,097)	▲ 18%	
Net Revenue Per Case	$10,010	$10,106	$10,674	$13,137	▲ 23%	
Direct Cost Per Case	$8,136	$7,814	$9,179	$11,241	▲ 22%	
Contrb Margin Per Case	$1,874	$2,292	$1,494	$1,896	▲ 27%	

GRAPHS

Notes:
Source: Inpatient and Outpatient Service Line Reports
Selection Criteria Inpatient Data: Entity ID= KDHS, Service Line 1= Orthopedics, Surg vs Medical (S/M)
Selection Criteria for OP Orthopedic Surgeries: Service Line 1= O/P Surgery and Surgeon Specialty = Neurological Surgery, Podiatrist, Sugery - Surgery of the Hand & Orthopaedic Surgery

KDHCD ANNUAL BOARD REPORT

Orthopedic Services - Inpatient Surgery

FY2021

***KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021**

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,121	$24,799,974	$20,417,455	$4,382,519	($838,988)
▼ -18%	▼ -10%	▼ -5%	▼ -28%	▼ -371%

*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	1,366	1,545	1,374	1,121 ▼	-18%	
Patient Days	5,067	5,254	4,525	4,474 ▼	-1%	
ALOS	3.71	3.40	3.29	3.99 ▲	21%	
GM LOS	3.23	3.07	3.16	3.25 ▲	3%	
Opportunity LOS	0.48	0.33	0.14	0.74 ▲	435%	
Net Revenue	$26,944,836	$29,794,700	$27,659,604	$24,799,974 ▼	-10%	
Direct Cost	$20,025,058	$21,161,234	$21,595,551	$20,417,455 ▼	-5%	
Contribution Margin	$6,919,778	$8,633,466	$6,064,053	$4,382,519 ▼	-28%	
Indirect Cost	$4,946,587	$5,542,705	$5,754,533	$5,221,507 ▼	-9%	
Net Income	$1,973,191	$3,090,761	$309,520	($838,988) ▼	-371%	
Net Revenue Per Case	$19,725	$19,285	$20,131	$22,123 ▲	10%	
Direct Cost Per Case	$14,660	$13,697	$15,717	$18,214 ▲	16%	
Contrb Margin Per Case	$5,066	$5,588	$4,413	$3,909 ▼	-11%	

PER CASE TRENDED GRAPHS

PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2018	FY2019	FY2020	FY2021
Medicare	51%	43%	42%	37%
Medicare Managed Care	12%	16%	18%	22%
Managed Care/Other	22%	21%	22%	21%
Medi-Cal Managed Care	9%	13%	10%	13%
Work Comp	3%	3%	3%	4%
Medi-Cal	3%	3%	3%	3%

Notes:
Source: Inpatient Service Line Report
Selection Criteria: Inpatient Service Line is Orthopedics, Surgery Flag= 1 and DaVinci Flag =0

KDHCD ANNUAL BOARD REPORT

Orthopedic Services - Inpatient Medical Service Line

FY2021

***KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021**

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
300	$3,227,459	$2,551,328	$676,131	($193,088)
▼ -9%	▼ -5%	▲ 5%	▼ -30%	▼ -298%

*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

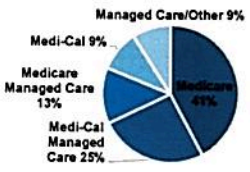
METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	410	461	331	300	▼ -9%	
Patient Days	1,825	1,845	1,384	1,581	▲ 14%	
ALOS	4.45	4.00	4.18	5.27	▲ 26%	
GM LOS	3.47	3.44	3.36	3.42	▲ 2%	
Opportunity LOS	0.98	0.56	0.82	1.85	▲ 125%	
Net Revenue	$3,815,253	$3,945,516	$3,392,190	$3,227,459	▼ -5%	
Direct Cost	$2,628,394	$2,793,652	$2,422,837	$2,551,328	▲ 5%	
Contribution Margin	$1,186,859	$1,151,864	$969,353	$676,131	▼ -30%	
Indirect Cost	$1,009,568	$1,058,368	$872,009	$869,219	▶ 0%	
Net Income	$177,291	$93,496	$97,344	($193,088)	▼ -298%	
Net Revenue Per Case	$9,305	$8,559	$10,248	$10,758	▲ 5%	
Direct Cost Per Case	$6,411	$6,060	$7,320	$8,504	▲ 16%	
Contrb Margin Per Case	$2,895	$2,499	$2,929	$2,254	▼ -23%	

PER CASE TRENDED GRAPHS

PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2018	FY2019	FY2020	FY2021
Medicare	47%	43%	41%	41%
Medi-Cal Managed Care	22%	26%	20%	25%
Medicare Managed Care	6%	9%	13%	13%
Medi-Cal	9%	9%	11%	9%
Managed Care/Other	12%	9%	14%	9%

FY 2021 Payer Mix



Notes:
Source: Inpatient Service Line Report
Selection Criteria: Entity ID: KDHS, Service Line 1= Orthopedics, Surg vs Medical = M

KDHCD ANNUAL BOARD REPORT

FY2021

Orthopedic Services - Outpatient Surgery Service Line

*Includes: Neurological Surgery, Podiatrist, Sugery - Surgery of the Hand & Orthopaedic Surgery

***KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021**

PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
1,554	$11,055,579	$10,472,678	$582,901	($2,236,021)
▼ -27%	▲ 11%	▼ -7%	▲ 145%	▲ 49%

*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

METRICS SUMMARY - 4 YEAR TREND

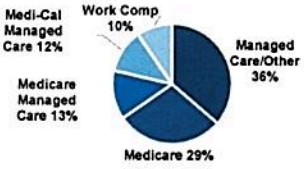
METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	2,054	2,158	2,135	1,554	▼ -27%	
Net Revenue	$7,577,296	$8,342,636	$9,934,813	$11,055,579	▲ 11%	
Direct Cost	$8,506,649	$8,582,794	$11,230,320	$10,472,678	▼ -7%	
Contribution Margin	($929,353)	($240,158)	($1,295,507)	$582,901	▲ 145%	
Indirect Cost	$2,411,126	$2,269,150	$3,110,304	$2,818,922	▼ -9%	
Net Income	($3,340,479)	($2,509,308)	($4,405,811)	($2,236,021)	▲ 49%	
Net Revenue Per Case	$3,689	$3,866	$4,653	$7,114	▲ 53%	
Direct Cost Per Case	$4,142	$3,977	$5,260	$6,739	▲ 28%	
Contrb Margin Per Case	($452)	($111)	($607)	$375	▲ 162%	

PER CASE TRENDED GRAPHS

PAYER MIX - 4 YEAR TREND (GROSS CHARGES)

PAYER	FY2018	FY2019	FY2020	FY2021
Managed Care/Other	32%	32%	36%	36%
Medicare	30%	26%	26%	29%
Medicare Managed Care	8%	8%	8%	13%
Medi-Cal Managed Care	19%	23%	19%	12%
Work Comp	9%	10%	10%	10%

FY 2021 PAYOR MIX



Notes:

Source: Outpatient Service Line Reports

Selection Criteria for OP Orthopedic Surgeries: Service Line 1= O/P Surgery and Surgeon Specialty = Neurological Surgery, Podiatrist, Sugery - Surgery of the Hand & Orthopaedic Surgery

REPORT TO THE BOARD OF DIRECTORS

Quail Park (Cypress) and Laurel Court (Memory Care)

Marc Mertz, VP/Chief Strategy Officer, 624-2511
September 13, 2021

Summary Issue/Service Considered

Quail Park (Cypress campus) consists of a senior independent living facility and a secure memory care facility. These are organized as separate legal entities.

The independent living facility is a 127-unit senior retirement village owned 44 percent by Kaweah Health and 56 percent by Living Care Senior Housing. Denis Bryant from Living Care is the Managing Member.

The 40-unit Memory Care Center (Laurel Court) is an Alzheimer's/Dementia facility located east of the Rehabilitation Hospital on Kaweah Health's west campus. It has the same ownership percentage split as Quail Park.

Denis Bryant is the manager of both entities. Lynn Havard Mirviss and Marc Mertz represent Kaweah Health on the Quail Park and Memory Care Center Boards of Members. Cathy Boshaw and Elling Halverson (recently deceased) represent Living Care Senior Housing on the two boards. Kaweah Health and Living Care have equal voting rights on the boards.

Quality/Performance Improvement Data

Quail Park has historically operated nearly at capacity, significantly above industry benchmarks. As recently as June 2019, Quail Park had a 28-unit waiting list. Like all senior living facilities, Quail Park has been impacted by COVID-19. Many individuals have chosen to delay moving into the facility. As of August 2020, occupancy in Quail Park was 87.4%, down more than 10% from prior year. By June 30, 2021 occupancy had decreased to 81.1%%. According to The National Investment Center for Seniors Housing & Care (NIC), occupancy rates for US assisted living facilities reached a record low of 77.7% at the end of 2020. Similarly, occupancy in independent living facilities also reached a record low of 83.5% at the end of 2020.

During fiscal year 2021, Quail Park at Cypress was a defendant in a class action lawsuit related to employment practices. The case alleged that Quail Park failed to properly compensate employees for meal periods, rest breaks, and waiting time. Other accusations include inappropriate rounding of hours and errors on wage statements/paychecks. A settlement was reached during mediation, and Quail Park has agreed to pay $721,287. The issue is pending court approval and the amount will likely be paid in fiscal year 2022. In anticipation of this payment, profit distributions to owners were decreased during the second half of FY2021 in order to preserve cash for the payment of this settlement. Owners will not be required to contribute to the settlement amount.

During fiscal year 2021 (July 2020 and June 2021), Quail Park paid Kaweah Health $297,000 in quarterly profit distributions based on Kaweah Health's 44 percent ownership. The first profit distributions were made in 2003. Since then, Quail Park has paid Kaweah Health profit

distributions totaling $5,569,500 through June 30, 2021. In addition, through a series of loan refinancing activities, Kaweah Health has received an addition $5,934,841 in distributions. Total distributions to Kaweah Health for this property are $10,815,571 based on an original investment of $1,588,770. $900,000 of the initial investment was made via donation of land, with the remaining $688,770 being invested in cash.

The 40-unit Memory Care Center, which opened in July 2012, was operating at 77.5% occupancy on June 30, 2021, down from 82.5% in August 2020 and well below its historic near-capacity rate of nearly 100%.

The Memory Care Center paid Kaweah Health a $77,000 profit distribution between July 2020 and June 2021. The Memory Care Center has paid Kaweah Health a total of $1,485,000 in profit distributions through June 2021. Kaweah Health has received an additional $1,505,040 in refinance distributions from this property. Total distributions are $2,719,104 based on an original Kaweah Health investment of $990,936. Of the $990,936 investment, $720,000 was invested via land donation and $270,936 was invested in cash. The first profit distributions were made in 2012.

Policy, Strategic or Tactical Issues

COVID-19 has had a significant negative impact on the occupancy rates of senior living facilities nationwide. The Quail Park independent living and memory care centers were not spared. Current occupancy rates are fairly consistent with industry averages.

Management was taken significant precautions to keep residents and employees safe during COVID-19, including restricting visitation, mandatory quarantine at move-in, frequent testing, and enhanced cleaning and sanitizing practices.

Recommendations/Next Steps

Continue to operate Quail Park and the Memory Care facility as high-level senior retirement centers with services ranging from independent living to assisted living to expanded dementia care.

Approvals/Conclusions

Despite challenging years in 2020 and 2021 due to COVID-19, Quail Park is filling a significant health care need in our community, providing exceptional services to its residents, and at the same time generating an income stream for Kaweah Health.

REPORT TO THE BOARD OF DIRECTORS

Quail Park at Shannon Ranch

Marc Mertz, VP/Chief Strategy Officer, 624-2511
September 13, 2021

Summary Issue/Service Considered

In 2016 Kaweah Health approved construction of a new 120-unit independent, assisted, and memory care senior living project called Quail Park at Shannon Ranch near the intersection of Demaree and Flagstaff in northwest Visalia. The 139,000 square foot project is located on a 3.65 acre site next to the 6,100 square foot Urgent Care Center which Kaweah Health opened on a 1.01 acre parcel on the east side of Demaree. The main independent living facility has 100 units ranging from studios to 2-bedroom units, and the secure memory care facility has 20 rooms.

Kaweah Health owns 33 and one third percent of the project, which is held by Northwest Visalia Senior Housing. Other partners are Shannon Senior Care, LLC, BTV Senior Housing, LLC, BEE, Inc., and Millennium Advisors. Shannon Senior Care is owned by members of the Shannon family; BTV is owned by Bernard te Velde, Jr.; BEE is owned by Cathy Boshaw and Doug Eklund of the Seattle area; Millennium Advisors is owned primarily by Denis Bryant, the current managing partner of Quail Park and the Memory Care Center.

The approximately $40 million project broke ground in March 2018 and was completed in early 2020. All Kaweah Health equity contributions to the project have originated from the Bettie Quilla Fund at Kaweah Health Hospital Foundation. The Quilla Fund is restricted by the donor for support of senior living projects in collaboration with Kaweah Health. Kaweah Health has made a total equity contribution in Quail Park Shannon Ranch of $3,997,000.

Quality/Performance Improvement Data

Before COVID-19, management expected that occupancy of the main building would reach 50% within 90 days of opening and that the memory care center would be completely filled within that time frame. Early deposits and waiting lists supported this. However, by July 2020 occupancy of the independent living building reached just 7% and the memory care was at 35%. During fiscal year 2021, management has worked hard to provide a safe environment for residents and visitors and they have dramatically increased marketing efforts, including offering limited-time discounts to encourage people to move in. As a result, the independent living building reached 28% occupancy by June 20, 2021 and the memory care reached 50%. In the last two months, the number of move-ins has continued to increase and current occupancy is 39% for independent living and 60% for the memory care building. These trends are expected to continue, pending any significant changes in COVID.

Due to the lower-than-expected occupancy, Quail Park at Shannon Ranch (including memory care) generated an operating loss of $1,308,436 from July 1, 2020 to June 30, 2021. Combined with non-operating expenses, which include pre-opening expenses, loan fees, interest, depreciation, and management, the total net income/(loss) was $4,332,416 during fiscal year 2021. Owners of Northwest Visalia Senior Housing have made a series of cash calls to fund operations. These contributions are being treated as loans payable with a 5% interest rate. During

fiscal years 2020 and 2021, Kaweah Health has made loan payments totaling $1,257,029, which was paid entirely from the Quilla Fund.

Policy, Strategic or Tactical Issues

The COVID-19 pandemic and its impact on senior living could not have been predicted. Management of Quail Park at Shannon Ranch have continued to actively promote the facility, providing both in-person and virtual tours. The sales staff routinely delivers meals to individuals that have expressed interest in Quail Park as a way to stay in touch with potential residents. The facility is also very active on social media. Management offered various discounts to entice people to move in during FY2021, although that practice has been discontinued as the occupancy rates have increased in recent months.

Recommendations/Next Steps

Continue to support the startup of Quail Park at Shannon Ranch during these challenging times.

Approvals/Conclusions

Quail Park at Shannon Ranch opened at perhaps the worst possible time in recent memory. However, the facility is the premier senior living in Visalia and perhaps the Central Valley. The amenities and services offered are unrivaled in the market. As the pandemic abates, this facility will be a significant asset to the community. The recent increase in resident move-ins has been encouraging and is expected to continue.

KAWEAH HEALTH ANNUAL BOARD REPORT

Senior Housing Joint Ventures

FY2020 - FY2021

	Quail Park	Laurel Court	Shannon Ranch	Total
FY2021				
Loans			($883,279)	($883,279)
Profit distributions	$297,000	$77,000		$374,000
Total cash inflow (outflow) from investment	**$297,000**	**$77,000**	**($883,279)**	**($509,279)**
Total income (loss) from Investment	**$297,000**	**$77,000**	**($1,434,149)**	**($1,060,149)**
FY2020				
Loans			($373,750)	($373,750)
Profit distributions	$363,000	$319,000		$682,000
Total cash inflow (outflow) from investment	**$363,000**	**$319,000**	**($373,750)**	**$308,250**
Total income (loss) from Investment	**$363,000**	**$319,000**	**($948,982)**	**($266,982)**
From Inception				
Initial investment - land	($900,000)	($720,000)		($1,620,000)
Initial Investment - cash	($688,770)	($270,936)	($3,997,054)	($4,956,760)
Loans			($1,257,029)	($1,257,029)
Profit distributions	$5,569,500	$1,485,000		$7,054,500
Refinance distributions	$5,934,841	$1,505,040		$7,439,881
Total cash inflow (outflow) from investment	**$10,815,571**	**$2,719,104**	**($5,254,083)**	**$8,280,592**
Total income (loss) from Investment	**$9,915,570**	**$2,043,104**	**($2,383,131)**	**$9,575,543**

REPORT TO THE BOARD OF DIRECTORS

Rehab Services

Molly Niederreiter, Director of Rehabilitation Services, 624-2541
September 27, 2021

Summary Issue/Service Considered

1. Achieving optimum balance of program priorities to address quality of care, compliance, profitability, and quality of work environment.
2. Ensuring that Rehabilitation Services continues to provide the full continuum of services to the community as a District Center of Excellence

Analysis of financial/statistic data:

The inpatient Rehabilitation program ended FY 2021 with a contribution margin of $2.4 million, a decrease from previous year. Contributing factors included decreased admissions over the course of the first half of the fiscal year due to the COVID pandemic and an increase in direct cost per case. Net revenue per case increased however not by enough of a margin to offset the increased cost per case.

Acute Rehabilitation: The number of admission decreased by 9% from prior year and 23% from FY 2019, although we are trending upward from February to June ending above budget for average patients per day. The patient days decreased 9% from prior year and 19% from FY 2019. The majority of the lost volume is from the decline of surgical aftercare patients, which have dropped from approximately 100 discharges per year in FY 2019, down to 21 in FY 2021. The Average Length Of Stay trended higher in FY2021 as a result of the declined volume of the surgical aftercare patients as they have a lower ALOS (right around 10 days in FY 2019 and now a little over 11 days). This also explains why ALOS has increased in the last 2 years.

Factors affecting the increase cost per case included: opening of COVID Care unit affecting staffing ratios as it requires a dedicated nurse for a small number of patients (1-3 patients on average), opening of a Med/Surg overflow unit to accommodate high census at the medical center, spreading of overhead costs across fewer patients, longer length of stay due to increased complexity of patients accepted. The expense trend of 3.7% increase is a result of RN and LVN salaries and extra shift incentives.

There were also significant shifts in payer mix, with Medicare days down the most of all payers by 4% from FY 2020 and Medicare/Medicare Managed Care business lost a total of 7% since FY 2018. Reimbursement per case for Medicare improved from $23,700 to $27,200. In comparison, Medi-Cal managed care pays an average of $19,200 per case and the Medi-Cal/Medi-Cal Managed Care have gained 8% to 30% of the business. Commercial managed care business is stable, down slightly in FY 2021.

Outpatient Therapy Clinics: The Outpatient Rehabilitation Services ended the FY 2021 with a contribution margin of $3 million, overall stable although down from FY 2019. COVID had a negative impact on volumes in FY 2020 and FY 2021, which was the primary reason for the lower contribution margin since FY 2019. Therapies at KDRH, Hand Therapy, Therapies at Lovers Lane and Therapies at Dinuba all saw an increase in volume, which is great for the COVID year. Contribution margin per Unit of Service is consistent over the last 4 years. Direct cost per Unit of Service is also very stable, ending slightly down in FY 2021. Contribution Margin per UOS runs $10-$12, down slightly in FY 2021. This is due to a slight shift toward Medi-Cal Managed Care, which typically runs at a Contribution Margin loss on the outpatient side.

Cardiac Rehabilitation: The cardiac rehab program re-opened in June with smaller class sizes meeting less frequently in order to maintain the required social distancing and cleaning requirements in the treatment gym. This continued through the entire fiscal year. As a result, patient volume decreased an additional 2% in FY 2021 compared to prior year. Net Revenue per Unit of Service is up 5% and contribution margin per UOS improved from $28 to $32. Direct cost per unit of service increased slightly, largely due to this decrease in patient volume and the inherent inefficiencies of running smaller classes. The program maintained a positive contribution margin of $137,315 for FY 2021, up from $123,417 in FY 2020. The pulmonary rehab program has been closed the entire fiscal year due to COVID, the current surge has put re-opening plans on hold. Goal to re-open is October, we are contacting patients to determine the caseload and number of classes we can fill.

Wound Clinic: The wound center's units of service decreased by 23% this year. COVID was the main factor affecting this service; however, there is a notable downward trend in volume over the last four years. Due to a Medicare audit, screening of hyperbaric patients has been stricter to ensure that all patients had adequate required documentation at admission, resulting in decreased volume. Direct cost per unit of service increased by 15%, primarily due to spreading of expenses over fewer units, as the performance report expenses have been trending downward. Net revenue per unit of service decreased by 2%. Payer mix has shifted, with a 4% increase in Medi-Cal managed care and a decrease in Medicare/Medicare Managed Care from 62% in FY 2020 to 54% in FY 2021. The decrease in volume in the hyperbaric program has also contributed to the decrease in net revenue per unit of service. The contribution margin has now turned into a loss at 4% per Unit of Service.

Quality/Performance Improvement Data

Acute Rehabilitation: The program continues to exceed the national benchmark for community discharges, with 82% of patients discharged home compared to 79% nationally. Average length of stay for the year was 13.5 days, lower than the national average of 14.5 days. Patient satisfaction has averaged 92% overall this fiscal year, placing the program in the 62nd percentile. Referrals are tracked for all of the post-acute areas (acute rehabilitation and skilled nursing/LTC). In the first six months of 2020, the average was 527 per month. For the FY 2021 the average increased to 563 per month with a slight dip in the 4th quarter. The majority of referrals continue to be from Kaweah Health, with small numbers of consistent referrals from Adventist, CRMC, UC Davis and St Agnes. Trends regarding patient falls, urinary tract infection, and

hospital acquired skin breakdown demonstrate facility performance exceeding national benchmarks on all indicators.

Outpatient Therapy Clinics: An internal survey measures patient satisfaction and results benchmarked against prior performance. Patient satisfaction averages at or above 96% in each clinic, with ongoing focus on improving patient satisfaction as it pertains to their involvement in setting therapy goals and the outcomes in comparison to those goals. Therapy outcomes are measured on a quarterly basis, using a pre and post treatment plan outcome tools to measure significant functional improvement and therapy effectiveness. Each therapy clinic uses outcomes measures that are specific to the patient's diagnosis and useful to the clinician. The results are shared with the clinicians in an effort to bring focus to specific areas that could benefit from additional review and update of evidence based treatment approaches.

Acute Therapy Services: Therapy evaluation response time is monitored; measuring from the time of the MD order and the patient is admitted to a nursing unit to the time the therapy evaluation is completed/attempted. The goal is to complete therapy evaluations within 24 hours of the MD order. Physical therapy was at an average of 86% and speech therapy was at an average of 85% compliance for the first 3 quarters of FY 2021.with this measure in the most recent quarter. Occupational therapy is now included in the report and came in at an average of 78% for Q2 and Q3 of FY 2021; the goal will be established in the coming months. The drops in these results are due to consistently higher than normal census as well as the resulting decrease in efficiency associated with PPE guidelines with COVID patients.

Wound Center: The wound center evaluates the average days to heal for wounds, with results above the national benchmarks most of this fiscal year. Some patients being treated for pressure ulcers wounds that took more than 200 days to heal which skews the data as patients with diabetic ulcers and surgical wounds are below the national average. The team continues regular case reviews of stalled wounds in order to facilitate timely adjustments in the treatment plan for complex wounds that are not initially responsive to treatment. The improve efficiency with the process, information regarding clinical recommendations is collected and provided to the practitioner instead of requiring their attendance at the chart review.

Policy, Strategic or Tactical Issues

1. The acute rehab program underwent a successful CARF survey this past year, with full 3-year accreditation achieved. There were no significant clinical findings and many areas singled out for commendation. The recommendations for improvement included detailed expectations about how certain data related to quality is assessed and reported, enhanced stakeholder input on data collection and strategic planning, and the development of a more comprehensive technology plan.
2. The COVID pandemic continues to challenge the rehabilitation programs. The census has recently stabilized after dropping during the pandemic, and the outpatient clinics have been building back volume. The recent surge may lead to setbacks in this, and will likely mean that the maintaining volume and ensuring staff and patient safety while maintaining all of the required protocols will continue to be a challenge as this pandemic continues. The rehabilitation hospital established a

COVID isolation wing for acute rehab and skilled nursing patients last year and has recently re-opened this wing in response to the current surge. We will continue to work with post-acute liaisons to stabilize census.

3. The hyperbaric medicine program at the Wound Center has been undergoing a Recovery Audit Contractor (RAC) audit this year. Appeals have been completed with successful results overall for the majority of the appealed denied claims, and stricter processes were implemented for patient screening and documentation. These stricter processes in combination with patient reluctance to come to the clinic environment during the pandemic have created challenges in maintaining patient volume. A key focus in the coming year will be building that patient volume back up.
4. An interface with the outpatient clinical documentation system and the Cerner financial systems was developed and implemented this month. This will eliminate the time consuming and error prone process of manual charge posting.
5. The rehabilitation hospital is configured for 45 acute rehab beds and 16 skilled nursing beds. In order to make better use of the beds in the future, given the regulatory and payer constraints that indicate that acute rehab is not likely to need that number of beds in the future, we will look to adjust the licensing so that the facility has 31 skilled nursing beds and 30 acute rehab beds. This balance will more than accommodate the demand for acute rehab while allowing the expansion of the skilled nursing program. During the coming year an initial review of the OSHPD implications of this initiative will be conducted.

Recommendations/Next Steps

1. Fully implement and monitor effectiveness of goals established via leadership performance system addressing the four cornerstones identified by Kaweah Health (outstanding health outcomes, financial strength, ideal work environment and excellent service)
2. Maintain positive productivity in support of improved or sustained positive financial performance for all programs. Ensure ongoing marketing of all inpatient and outpatient programs. Monitor all publicly reported quality measures with goal of achieving or sustaining performance that exceeds national benchmarks.
3. Provide high quality, affordable care for patients in our existing market as well as expand our service to more patients. Continue to work closely with patient billing department to ensure we address all revenue issues promptly.
4. Work closely with post-acute liaisons to stabilize census in the Acute Rehab Program including analysis of current referral processes and workflows.
5. Participate in outreach programs and opportunities such as runs/walks, community forums, and health fairs to market to consumers, physicians, and the overall community. Focus on strategies using social media and consumer reviews.
6. Establish a strategic plan to expand the pelvic health specialty program currently housed at the Akers Therapy Specialists.
7. Determine if centralizing the referral process for the outpatient clinics, as we did with the authorization process, will result in a more efficient and appropriate distribution of patients.
8. Working with HR with retaining and recruiting clinical staff by re-evaluating loan repayment, clinical ladder, sign-on bonuses, and pay ranges.
9. Continue to respond to Medicare initiatives related to acute rehabilitation services at the state and national level. Actively monitor processes that support appropriate admissions and documentation that supports medical necessity.

10. Monitor and respond to legislative developments such as the IMPACT Act that impose new requirements for post- acute care related to data collection and quality measures, and that signal forthcoming changes in reimbursement structures that would favor a bundled approach or site neutral payment policies.
11. Review results of employee satisfaction survey with each department, develop, and implement action plans.
12. Implement Post-Acute division strategic plan. Collaborate with key Kaweah health leaders for improved management of patients with complex needs and chronic conditions.

Approvals/Conclusions

Rehabilitation services will focus in the coming year on:

1. Census development/patient volumes, management of productivity, maintaining compliance with all regulatory and payer expectations, customer satisfaction, clinical excellence and financial performance.
2. Implementation of goals related to Kaweah Health cornerstones for all of rehabilitation services to enhance program development, satisfaction of all stakeholders, program marketing, and ideal work environment for staff, and clinical quality of services.
3. Continued support of shared governance via rehabilitation councils (both nursing unit based council and therapy/business services council).

KAWEAH HEALTH ANNUAL BOARD REPORT

Inpatient Services - Acute Rehabilitation

FY2021

KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021

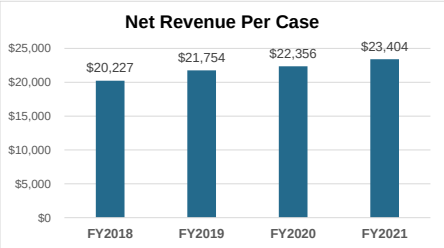
PATIENT CASES	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
406	$9,501,965	$7,127,594	$2,374,371	($1,715,075)
▼ -9%	▼ -4%	▼ -1%	▼ -13%	▼ -20%

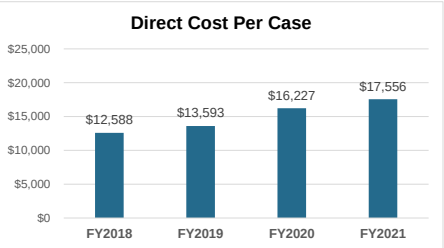
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

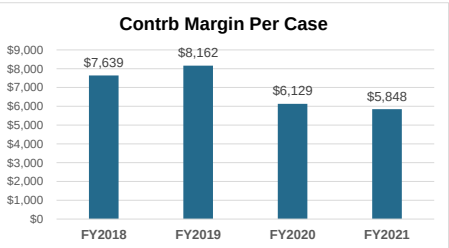
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Patient Cases	554	528	445	406 ▼	-9%	
Patient Days	6,788	6,697	5,956	5,422 ▼	-9%	
ALOS	12.25	12.68	13.38	13.35 ▶	0%	
Net Revenue	$11,205,794	$11,486,351	$9,948,398	$9,501,965 ▼	-4%	
Direct Cost	$6,973,555	$7,176,951	$7,221,143	$7,127,594 ▼	-1%	
Contribution Margin	$4,232,239	$4,309,400	$2,727,255	$2,374,371 ▼	-13%	
Indirect Cost	$3,989,886	$3,966,299	$4,157,589	$4,089,446 ▼	-2%	
Net Income	$242,353	$343,101	($1,430,334)	($1,715,075) ▼	-20%	
Net Revenue Per Case	$20,227	$21,754	$22,356	$23,404 ▲	5%	
Direct Cost Per Case	$12,588	$13,593	$16,227	$17,556 ▲	8%	
Contrb Margin Per Case	$7,639	$8,162	$6,129	$5,848 ▼	-5%	

PER CASE TRENDED GRAPHS



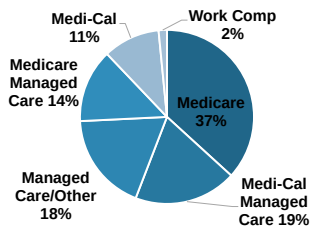




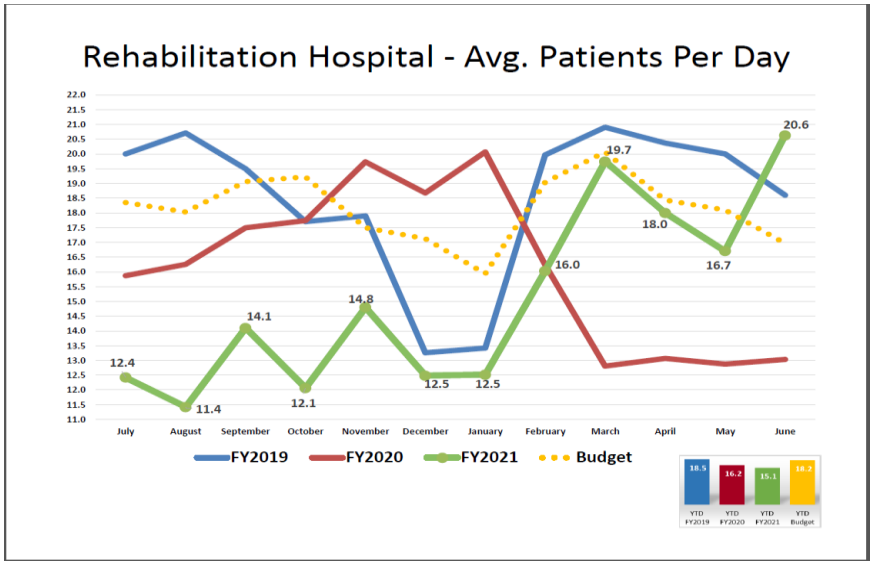
PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

PAYER	FY2018	FY2019	FY2020	FY2021
Medicare	49%	45%	41%	37%
Medi-Cal Managed Care	13%	20%	21%	19%
Managed Care/Other	19%	19%	20%	18%
Medicare Managed Care	9%	7%	10%	14%
Medi-Cal	9%	6%	7%	11%
Work Comp	1%	3%	1%	2%

FY 2021 PAYER MIX



KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021



Notes:
Source: Inpatient Service Line Report
Selection Criteria: Servcie Name is Kaweah Health Rehabilitation Hospital

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2021

Rehabilitation Services - Outpatient Summary

KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021

UNITS OF SERVICE	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
285,442	$10,908,377	$7,732,596	$3,175,781	$218,902
▲ 1%	▶ 0%	▶ 0%	▲ 1%	▲ 142%

*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

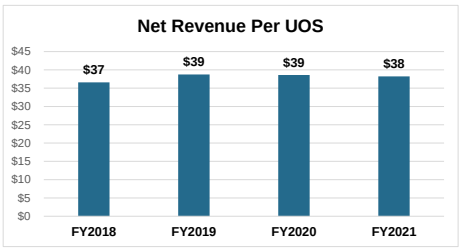
METRICS BY SERVICE LINE - FY 2020

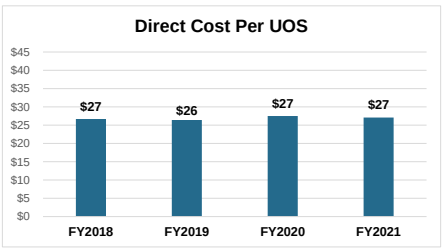
SERVICE LINE	UNITS OF SERVICE	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
Therapies - Akers	102,279	$3,988,992	$2,655,262	$1,333,730	$451,216
Therapies - KDRH	54,436	$2,069,496	$1,432,232	$637,264	($27,901)
Hand Therapy	33,678	$1,372,241	$925,073	$447,168	$162,619
Therapy Lover's Lane	22,391	$870,953	$507,903	$363,050	$196,639
Therapies - Dinuba	24,519	$620,484	$455,648	$164,836	$31,461
Therapies - Exeter	25,396	$721,368	$563,012	$158,356	($13,600)
Cardiac Rehabilitation	4,263	$452,745	$313,464	$139,281	($58,218)
Wound Care Center	18,480	$812,098	$880,002	($67,904)	($523,314)
OP Rehabilitation Services Totals	285,442	$10,908,377	$7,732,596	$3,175,781	$218,902

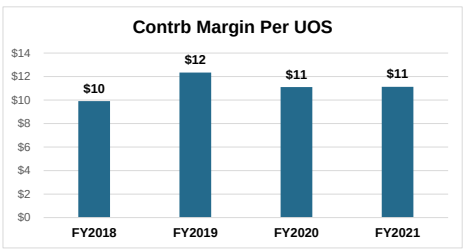
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	295,418	307,549	281,869	285,442 ▲	1%	
Net Revenue	$10,809,102	$11,916,547	$10,881,731	$10,908,377 ▶	0%	
Direct Cost	$7,882,030	$8,120,434	$7,751,074	$7,732,596 ▶	0%	
Contribution Margin	$2,927,072	$3,796,113	$3,130,657	$3,175,781 ▲	1%	
Indirect Cost	$2,914,374	$2,945,951	$3,651,652	$2,956,879 ▼	-19%	
Net Income	$12,698	$850,162	($520,995)	$218,902 ▲	142%	
Net Revenue Per UOS	$37	$39	$39	$38 ▼	-1%	
Direct Cost Per UOS	$27	$26	$27	$27 ▼	-1%	
Contrb Margin Per UOS	$10	$12	$11	$11 ▶	0%	

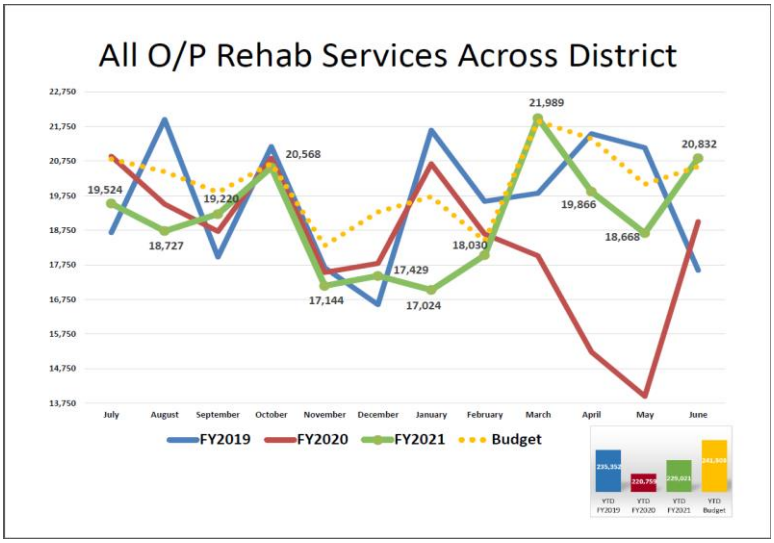
GRAPHS







KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Lines and Secondary Service Line selections
Criteria: specific selection for each Service Line (noted on the individual Service Line Tabs)

KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Services - Therapies - Akers

FY2021

KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021

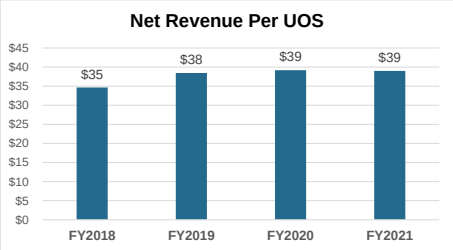
UNITS OF SERVICE	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
102,279	$3,988,992	$2,655,262	$1,333,730	$451,216
▼ -4%	▼ -4%	▼ -1%	▼ -11%	▲ 34%

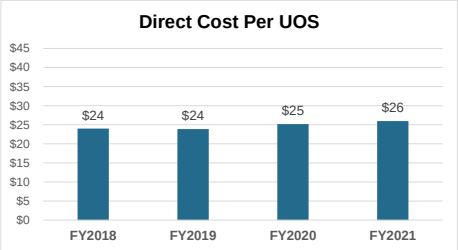
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

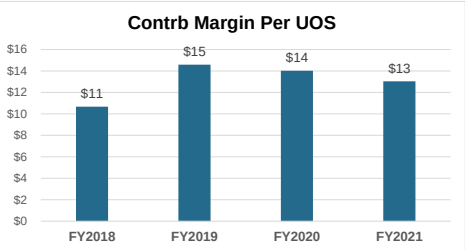
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	107,657	110,119	106,432	102,279	-4%	
Net Revenue	$3,731,626	$4,234,815	$4,170,952	$3,988,992	-4%	
Direct Cost	$2,582,362	$2,628,361	$2,678,431	$2,655,262	-1%	
Contribution Margin	$1,149,264	$1,606,454	$1,492,521	$1,333,730	-11%	
Indirect Cost	$888,852	$874,234	$1,156,267	$882,514	-24%	
Net Income	$260,412	$732,220	$336,254	$451,216	34%	
Net Revenue Per UOS	$35	$38	$39	$39	0%	
Direct Cost Per UOS	$24	$24	$25	$26	3%	
Contrb Margin Per UOS	$11	$15	$14	$13	-7%	

PER CASE TRENDED GRAPHS

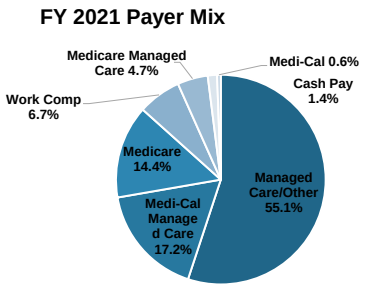






PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

PAYER	FY2018	FY2019	FY2020	FY2021
Managed Care/Other	54.8%	53.8%	55.1%	55.1%
Medi-Cal Managed Care	16.3%	17.1%	16.8%	17.2%
Medicare	17.7%	16.8%	15.8%	14.4%
Work Comp	6.7%	6.4%	6.6%	6.7%
Medicare Managed Care	2.9%	4.4%	4.0%	4.7%
Cash Pay	0.6%	0.8%	0.9%	1.4%
Medi-Cal	1.0%	0.7%	0.6%	0.6%

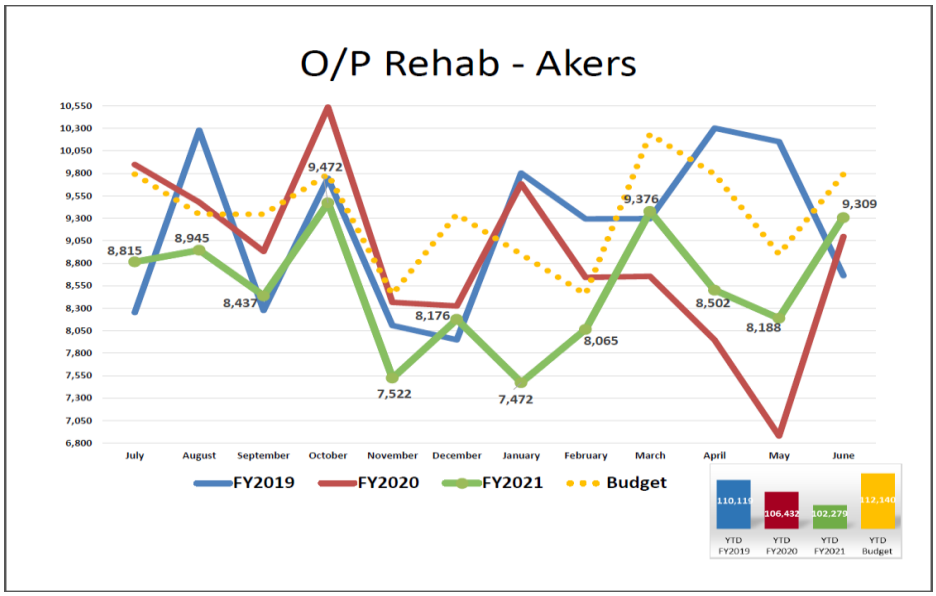


KAWEAH HEALTH ANNUAL BOARD REPORT

FY2021

Outpatient Services - Therapies - Akers

KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line is O/P Therapies and Secondary Service Line is CCPTS

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2021

Outpatient Services - Therapies - KHRH

KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021

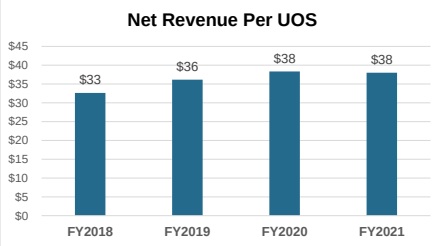
UNITS OF SERVICE	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
54,436	$2,069,496	$1,432,232	$637,264	($27,901)
▲ 16%	▲ 15%	▲ 10%	▲ 30%	▲ 90%

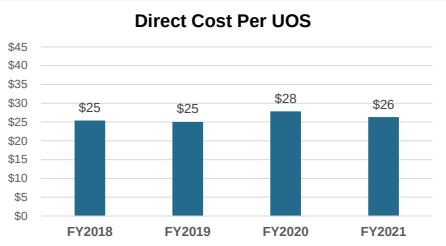
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

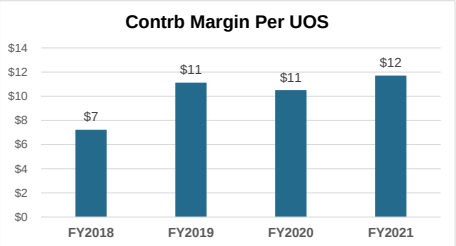
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	51,177	56,224	46,800	54,436	▲ 16%	
Net Revenue	$1,669,420	$2,032,459	$1,794,419	$2,069,496	▲ 15%	
Direct Cost	$1,299,786	$1,407,119	$1,302,846	$1,432,232	▲ 10%	
Contribution Margin	$369,634	$625,340	$491,573	$637,264	▲ 30%	
Indirect Cost	$586,272	$622,650	$781,047	$665,165	▼ -15%	
Net Income	($216,638)	$2,690	($289,474)	($27,901)	▲ 90%	
Net Revenue Per UOS	$33	$36	$38	$38	▼ -1%	
Direct Cost Per UOS	$25	$25	$28	$26	▼ -5%	
Contrb Margin Per UOS	$7	$11	$11	$12	▲ 11%	

PER CASE TRENDED GRAPHS

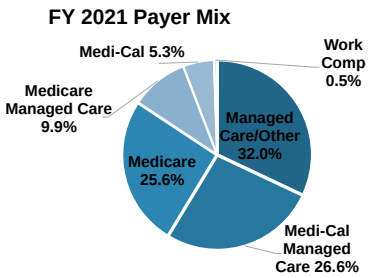






PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

PAYER	FY2018	FY2019	FY2020	FY2021
Managed Care/Other	33.5%	31.1%	31.9%	32.0%
Medi-Cal Managed Care	18.0%	18.1%	21.4%	26.6%
Medicare	37.0%	38.0%	35.0%	25.6%
Medicare Managed Care	7.1%	8.0%	7.2%	9.9%
Medi-Cal	2.5%	3.3%	3.3%	5.3%
Work Comp	1.8%	1.3%	0.9%	0.5%



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line is O/P Therapies and Secondary Service Line is Neuro Clinic

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2021

Outpatient Services - Hand Therapy

KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021

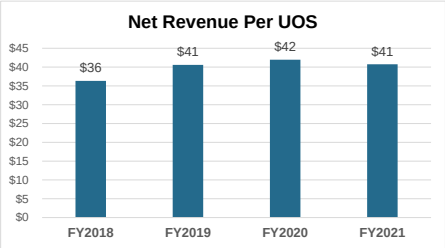
UNITS OF SERVICE	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
33,678	$1,372,241	$925,073	$447,168	$162,619
▲ 3%	▶ 0%	▼ -4%	▲ 8%	▲ 1229%

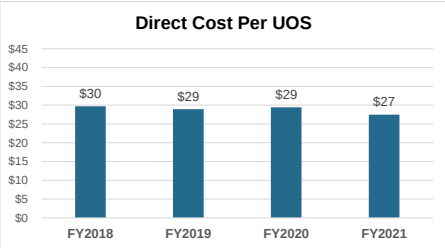
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

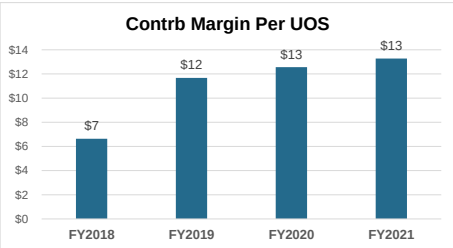
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	33,136	39,560	32,830	33,678	▲ 3%	
Net Revenue	$1,203,968	$1,605,473	$1,377,849	$1,372,241	▶ 0%	
Direct Cost	$984,005	$1,143,785	$965,569	$925,073	▼ -4%	
Contribution Margin	$219,963	$461,688	$412,280	$447,168	▲ 8%	
Indirect Cost	$320,147	$293,512	$400,048	$284,549	▼ -29%	
Net Income	($100,184)	$168,176	$12,232	$162,619	▲ 1229%	
Net Revenue Per UOS	$36	$41	$42	$41	▼ -3%	
Direct Cost Per UOS	$30	$29	$29	$27	▼ -7%	
Contrb Margin Per UOS	$7	$12	$13	$13	▲ 6%	

PER CASE TRENDED GRAPHS

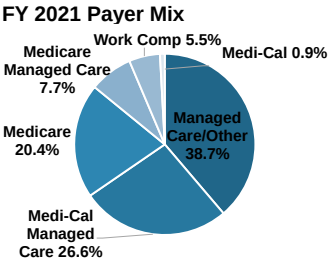




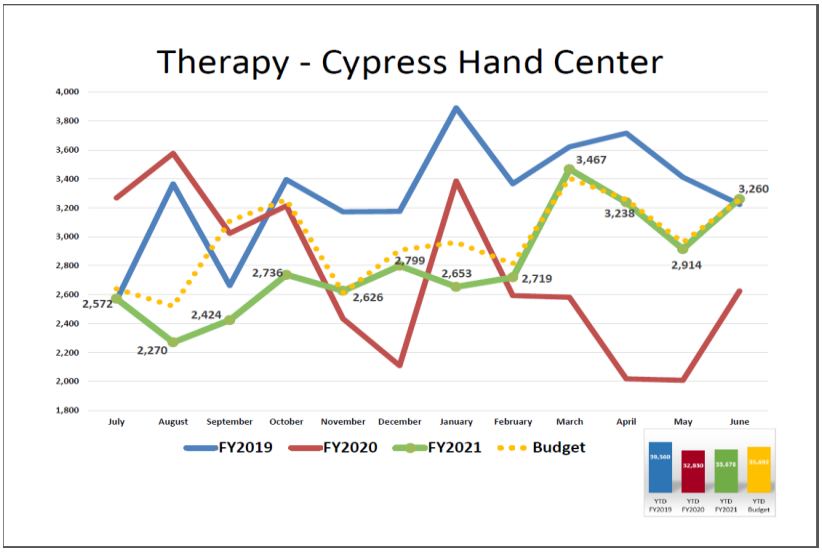


PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

PAYER	FY2018	FY2019	FY2020	FY2021
Managed Care/Other	33.0%	42.3%	41.8%	38.7%
Medi-Cal Managed Care	18.9%	16.3%	24.6%	26.6%
Medicare	27.5%	24.5%	18.6%	20.4%
Medicare Managed Care	6.0%	7.0%	8.0%	7.7%
Work Comp	12.4%	8.6%	5.6%	5.5%
Medi-Cal	0.8%	1.0%	1.1%	0.9%



KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line is O/P Therapies and Secondary Service Line is Hand Center
*Visit = monthly billing

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2021

Outpatient Services - Therapy Lover's Lane

KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021

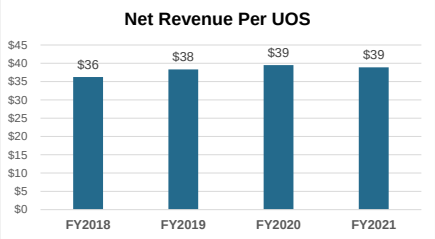
UNITS OF SERVICE	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
22,391	$870,953	$507,903	$363,050	$196,639
▲ 25%	▲ 23%	▲ 10%	▲ 47%	▲ 455%

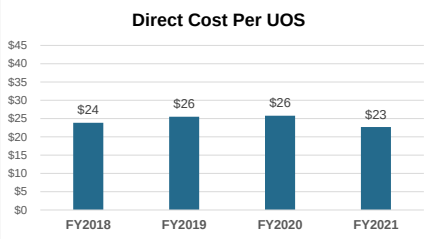
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

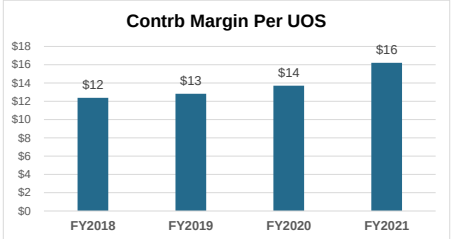
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	21,595	19,535	17,975	22,391	▲ 25%	
Net Revenue	$782,491	$748,650	$709,843	$870,953	▲ 23%	
Direct Cost	$515,097	$498,179	$463,505	$507,903	▲ 10%	
Contribution Margin	$267,394	$250,471	$246,338	$363,050	▲ 47%	
Indirect Cost	$207,024	$160,759	$210,903	$166,411	▼ -21%	
Net Income	$60,370	$89,712	$35,435	$196,639	▲ 455%	
Net Revenue Per UOS	$36	$38	$39	$39	▼ -2%	
Direct Cost Per UOS	$24	$26	$26	$23	▼ -12%	
Contrb Margin Per UOS	$12	$13	$14	$16	▲ 18%	

PER CASE TRENDED GRAPHS

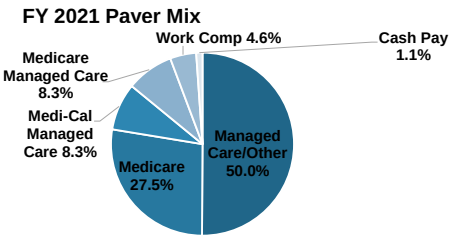




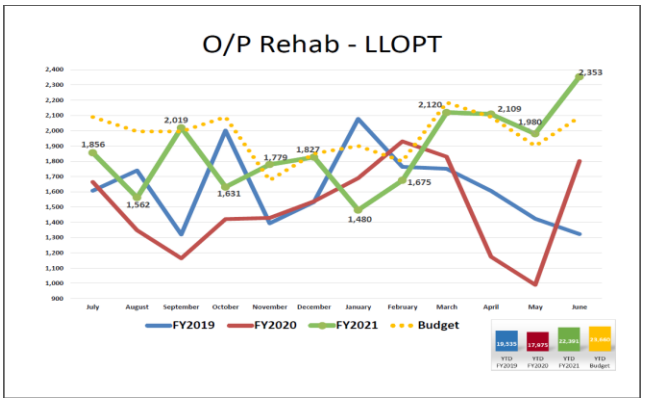


PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

PAYER	FY2018	FY2019	FY2020	FY2021
Managed Care/Other	48.6%	51.3%	50.6%	50.0%
Medicare	27.7%	28.7%	26.8%	27.5%
Medi-Cal Managed Care	13.3%	8.1%	7.3%	8.3%
Medicare Managed Care	7.0%	5.5%	10.3%	8.3%
Work Comp	3.1%	6.0%	3.5%	4.6%
Cash Pay	0.2%	0.4%	0.8%	1.1%



KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line is O/P Therapies and Secondary Service Line is Lover's Lane Therapy

KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Services - Therapies - Dinuba

FY2021

KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021

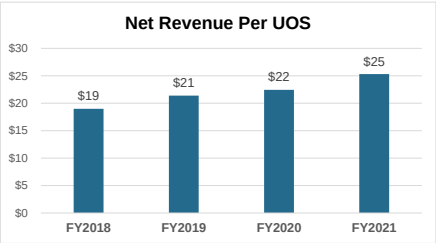
UNITS OF SERVICE	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
24,519	$620,484	$455,648	$164,836	$31,461
▲ 6%	▲ 19%	▲ 2%	▲ 130%	▲ 131%

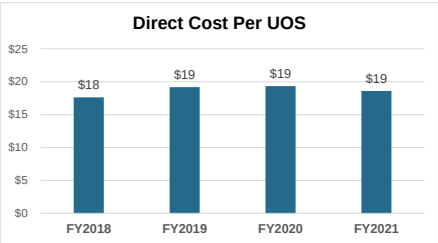
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

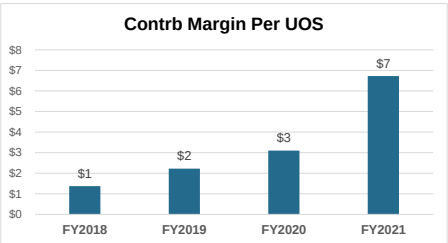
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	20,128	23,955	23,163	24,519	▲ 6%	
Net Revenue	$382,179	$512,434	$519,646	$620,484	▲ 19%	
Direct Cost	$354,613	$459,155	$447,849	$455,648	▲ 2%	
Contribution Margin	$27,566	$53,279	$71,797	$164,836	▲ 130%	
Indirect Cost	$121,935	$122,434	$174,086	$133,375	▼ -23%	
Net Income	($94,369)	($69,155)	($102,289)	$31,461	▲ 131%	
Net Revenue Per UOS	$19	$21	$22	$25	▲ 13%	
Direct Cost Per UOS	$18	$19	$19	$19	▼ -4%	
Contrb Margin Per UOS	$1	$2	$3	$7	▲ 117%	

PER CASE TRENDED GRAPHS

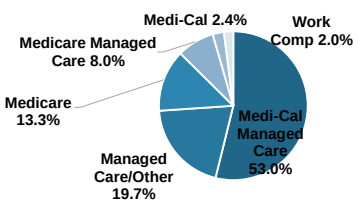




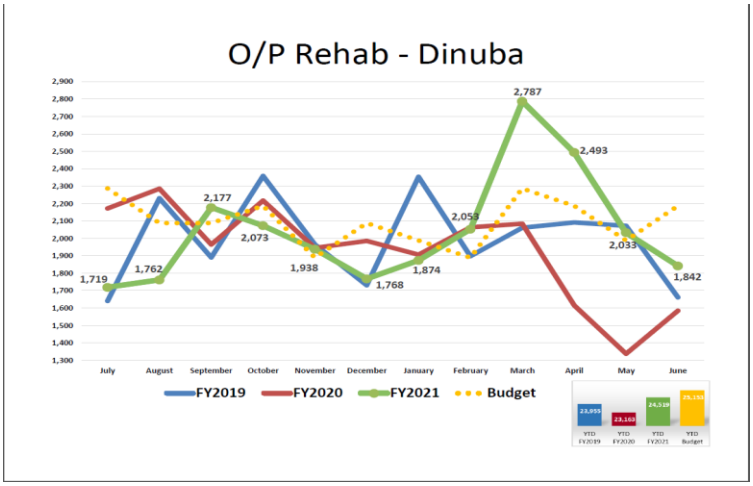


PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

PAYER	FY2018	FY2019	FY2020	FY2021
Medi-Cal Managed Care	68.2%	68.2%	67.9%	53.0%
Managed Care/Other	7.4%	11.7%	18.4%	19.7%
Medicare	15.4%	10.7%	7.4%	13.3%
Medicare Managed Care	4.1%	5.7%	4.2%	8.0%
Medi-Cal	1.9%	1.8%	1.1%	2.4%
Work Comp	2.3%	1.3%	0.5%	2.0%



KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line is O/P Therapies and Secondary Service Line is Dinuba Clinic

KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Services - Therapies - Exeter

FY2021

KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021

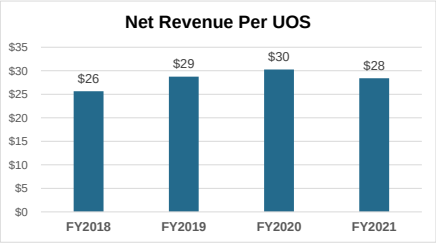
UNITS OF SERVICE	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
25,396	$721,368	$563,012	$158,356	($13,600)
▼ -4%	▼ -10%	▼ -3%	▼ -27%	▼ -304%

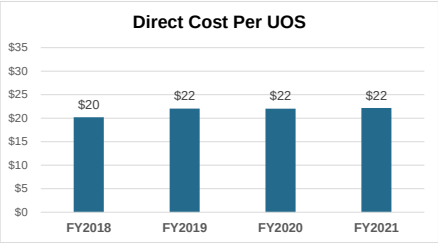
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

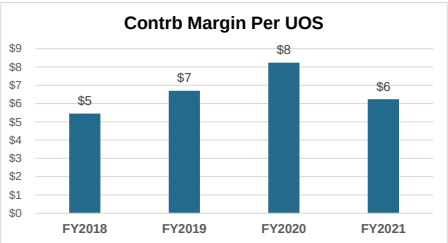
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	26,712	25,519	26,389	25,396	▼ -4%	
Net Revenue	$684,873	$733,413	$798,474	$721,368	▼ -10%	
Direct Cost	$539,328	$562,500	$581,126	$563,012	▼ -3%	
Contribution Margin	$145,545	$170,913	$217,348	$158,356	▼ -27%	
Indirect Cost	$162,720	$177,316	$210,688	$171,956	▼ -18%	
Net Income	($17,175)	($6,403)	$6,660	($13,600)	▼ -304%	
Net Revenue Per UOS	$26	$29	$30	$28	▼ -6%	
Direct Cost Per UOS	$20	$22	$22	$22	▲ 1%	
Contrb Margin Per UOS	$5	$7	$8	$6	▼ -24%	

PER CASE TRENDED GRAPHS

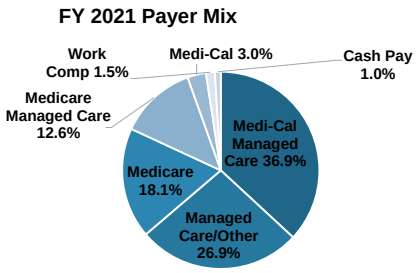




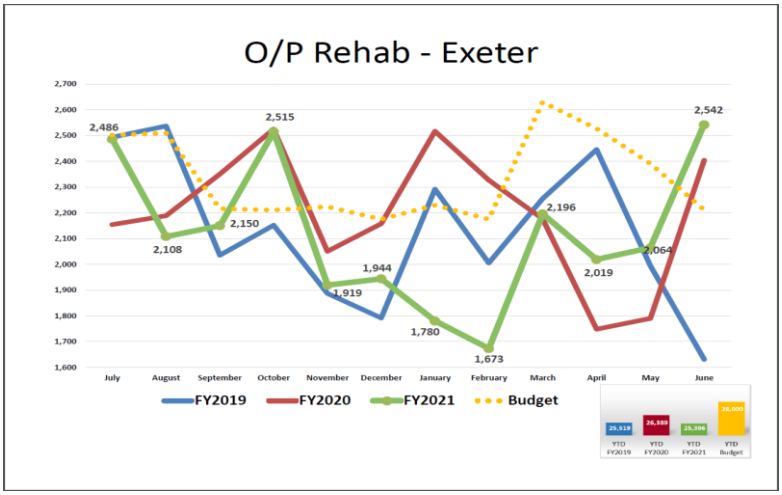


PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

PAYER	FY2018	FY2019	FY2020	FY2021
Medi-Cal Managed Care	35.5%	34.8%	29.8%	36.9%
Managed Care/Other	31.0%	30.0%	34.3%	26.9%
Medicare	20.3%	23.1%	24.3%	18.1%
Medicare Managed Care	6.5%	7.8%	8.5%	12.6%
Medi-Cal	1.8%	0.9%	1.6%	3.0%
Work Comp	4.5%	2.9%	0.6%	1.5%
Cash Pay	0.3%	0.5%	0.8%	1.0%



KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line is O/P Therapies and Secondary Service Line is Exeter Clinic

KAWEAH HEALTH ANNUAL BOARD REPORT

FY2021

Outpatient Services - Cardiac Rehabilitation

KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021

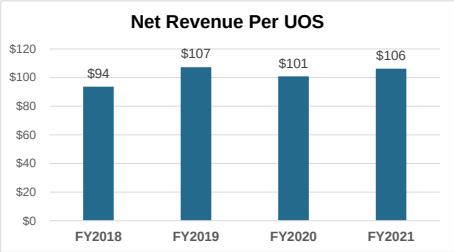
UNITS OF SERVICE	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
4,263	$452,745	$313,464	$139,281	($58,218)
▼ -2%	▲ 3%	▼ -2%	▲ 16%	▶ 0%

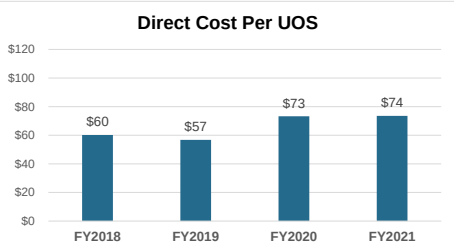
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

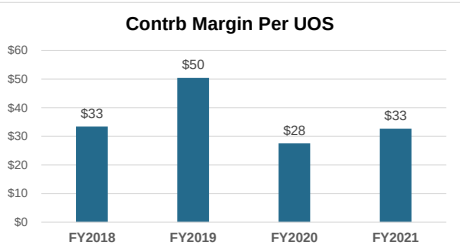
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	6,628	6,486	4,366	4,263 ▼	-2%	
Net Revenue	$620,625	$695,347	$440,253	$452,745 ▲	3%	
Direct Cost	$399,014	$368,270	$319,929	$313,464 ▼	-2%	
Contribution Margin	$221,611	$327,077	$120,324	$139,281 ▲	16%	
Indirect Cost	$175,143	$191,898	$178,781	$197,499 ▲	10%	
Net Income	$46,468	$135,179	($58,457)	($58,218) ▶	0%	
Net Revenue Per UOS	$94	$107	$101	$106 ▲	5%	
Direct Cost Per UOS	$60	$57	$73	$74 ▶	0%	
Contrb Margin Per UOS	$33	$50	$28	$33 ▲	19%	

PER CASE TRENDED GRAPHS



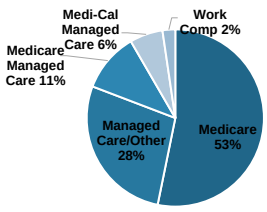




PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

PAYER	FY2018	FY2019	FY2020	FY2021
Medicare	49%	57%	52%	53%
Managed Care/Other	39%	33%	37%	28%
Medicare Managed Care	9%	9%	9%	11%
Medi-Cal Managed Care	0%	1%	2%	6%
Work Comp	1%	0%	0%	2%

FY 2021 PAYER MIX



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line is O/P Therapies and Secondary Service Line is Cardiac Rehab

KAWEAH HEALTH ANNUAL BOARD REPORT

Outpatient Services - Wound Care Center

FY2021

KEY METRICS - FY 2021 TWELVE MONTHS ENDED JUNE 30, 2021

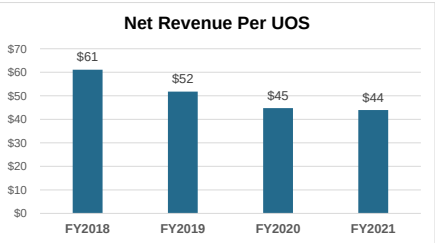
UNITS OF SERVICE	NET REVENUE	DIRECT COST	CONTRIBUTION MARGIN	NET INCOME
18,480	$812,098	$880,002	($67,904)	($523,314)
▼ -23%	▼ -24%	▼ -11%	▼ -187%	▼ -13%

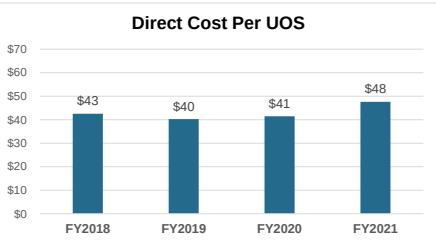
*Note: Arrows represent the change from prior year and the lines represent the 4-year trend

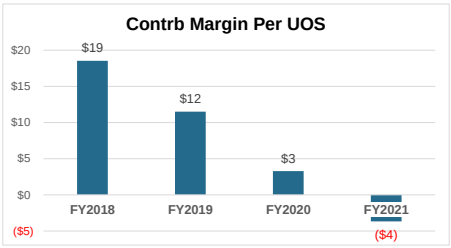
METRICS SUMMARY - 4 YEAR TREND

METRIC	FY2018	FY2019	FY2020	FY2021	%CHANGE FROM PRIOR YR	4 YR TREND
Units of Service	28,385	26,151	23,914	18,480	▼ -23%	
Net Revenue	$1,733,920	$1,353,956	$1,070,295	$812,098	▼ -24%	
Direct Cost	$1,207,825	$1,053,065	$991,819	$880,002	▼ -11%	
Contribution Margin	$526,095	$300,891	$78,476	($67,904)	▼ -187%	
Indirect Cost	$452,281	$503,148	$539,832	$455,410	▼ -16%	
Net Income	$73,814	($202,257)	($461,356)	($523,314)	▼ -13%	
Net Revenue Per UOS	$61	$52	$45	$44	▼ -2%	
Direct Cost Per UOS	$43	$40	$41	$48	▲ 15%	
Contrb Margin Per UOS	$19	$12	$3	($4)	▼ -212%	

PER CASE TRENDED GRAPHS

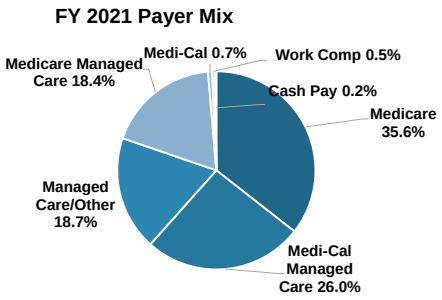






PAYER MIX - 4 YEAR TREND (TOTAL CHARGES)

PAYER	FY2018	FY2019	FY2020	FY2021	
Medicare	54.6%	54.7%	52.4%	35.6%	54%
Medi-Cal Managed Care	17.0%	16.8%	22.1%	26.0%	27%
Managed Care/Other	14.9%	16.0%	14.1%	18.7%	
Medicare Managed Care	11.5%	10.4%	9.6%	18.4%	
Medi-Cal	1.2%	1.6%	0.5%	0.7%	
Work Comp	0.6%	0.6%	0.4%	0.5%	
Cash Pay	0.1%	0.0%	0.9%	0.2%	



Notes:
Source: Outpatient Service Line Reports
Criteria: Outpatient Service Line is Wound Care

KAWEAH DELTA HEALTH CARE DISTRICT
EXCLUSIVE PROFESSIONAL SERVICES AGREEMENT

Regarding the Service of ANESTHESIOLOGY
[Cardiac Anesthesiology]

This Exclusive Professional Services Agreement ("**Agreement**") is entered into effective October 1, 2021 ("**Effective Date**"), by and between **KAWEAH DELTA HEALTH CARE DISTRICT** ("**District**"), a local health care district organized and existing under the laws of the State of California, Health and Safety Code §§ 32000 *et seq*. and **KAWEAH CARDIAC ANESTHESIA PROFESSIONALS, INC** a California professional medical corporation ("**Contractor**"):

BACKGROUND

A. District is the operator of a general acute care Hospital known as Kaweah Delta Medical Center (the "Hospital") in Visalia, California, in which there is located and operated an Anesthesia Department (the "Department").

B. Contractor is a medical corporation whose shareholders and professional personnel are physicians licensed to practice medicine in the State of California and who are (or will be by the Effective Date) members in good standing of the Medical Staff of the Hospital (the "Medical Staff"), and who have been (or will by the Effective Date have been) approved by the administration and the appropriate Medical Staff committee to practice within the Hospital. The physicians providing services under this Agreement are referred to as "Providers." The services to be provided by the Providers under this Agreement are referred to as the "Services."

C. This is one of three contracts being entered into by the District for anesthesia services at the Hospital. The other contracts are with Kaweah Nurse Anesthesia Services (the "CRNA Contractor" for the services of certified nurse anesthetist services, and Kaweah Anesthesiologist Services Inc. (the "General Anesthesia Contractor" for general anesthesia services. Contractor, the CRNA Contractor and the General Anesthesia Contractor are referred to collectively in this Agreement as the "Co-contractors."

D. District, in accordance with its Bylaws administered through its Board of Directors, has determined that the best interests of patients, insofar as the quality of medical care is concerned, and insofar as the future quality of medical care and the availability of anesthesia at Hospital are concerned, shall be served by having the Co-Contractors exclusively provide professional services within the Department as provided in Section 2.1 and in accordance with the Bylaws and Rules and Regulations of the Medical Staff ("Medical Staff Bylaws").

E. It is anticipated that the District's contracting exclusively with the Co-contractors will facilitate the administration of the Department and the training of personnel therein, enhance interdepartmental communications within District, simplify and permit more flexibility in scheduling, promote better availability of anesthesia services, enhance convenience to and safety of patients, encourage more efficient use of equipment and personnel, and ultimately lower the cost of anesthesia services for the patients of District.

F. In view of the foregoing, District desires that the Contractor, with the Co-contractors, shall have the full and exclusive right and obligation to provide professional services within the Department as provided in Section 5.1, and Contractor desires to accept such sole and exclusive rights and responsibilities, in cooperation with the other Co-contractors; it being agreed, however, that he District's contract with each Co-contractor is a separate contract; that the obligations of the Co-contractors under their respective contracts are individual and several, not joint; and that Contractor shall not be liable for any obligations or entitled to any of the rights of the other Co-contractors under their respective contracts.

G. District and Contractor desire to enter into this Agreement in order to provide a full statement of their respective rights and responsibilities in connection with the operation of the Department and the provision of professional cardiac anesthesia services at District during the term of this Agreement.

THEREFORE, in consideration of the foregoing recitals, the mutual covenants, conditions and promises hereinafter set forth, and other good and valuable consideration, the sufficiency of which is hereby acknowledged, and intending to be legally bound, District and Contractor agree as follows:

Section 1. Term and Termination.

1.1. **Term**. This Agreement shall be effective on the Effective Date and shall continue in full force and effect until **September 30, 2024**. The execution and delivery of this Agreement is subject to approval by the District's Board of Directors. For purposes of this Agreement, a "**Contract Year**" is a twelve-month period beginning on the Effective Date or any anniversary of the Effective Date.

1.2. **Termination without Cause**. Either party may terminate this Agreement at any time, without cause, by providing not less than one hundred twenty (120) days' prior written notice stating the intended date of termination.

1.3. **Material Breach**. Either party may terminate this Agreement at any time in the event the other party engages in an act or omission constituting a material breach of any term or condition of this Agreement. The party electing to terminate this Agreement pursuant to this Section shall provide the breaching party with not less than ten (10) days prior written notice specifying the nature and extent of the material breach. The breaching party shall have ten (10) days from the date of the notice to remedy the breach and conform its conduct to this Agreement. If corrective action is not taken within the time specified to the satisfaction of the party giving the notice, this terminating party may terminate this Agreement upon written notice to the breaching party. For purposes of this Section, "**material breach**" shall mean any breach of the terms or conditions of this Agreement which is substantial and material to the stated purpose of this Agreement as set forth in the Recitals hereto.

1.4. **Termination by District.** District may terminate this Agreement on notice to Contractor upon the occurrence of any of the following:

1.4.1. The death, disability, termination or withdrawal of any Provider which materially impairs Contractor's ability to provide services under this Agreement, unless such Provider is replaced as soon as practicable, and in any event within thirty (30) days.

1.4.2. Any of the following events affecting a Provider, unless Contractor immediately causes the Provider to cease providing services under this Agreement, and continues to provide the services required by this Agreement:

1.4.2.1. The revocation or suspension of the license of a Provider to practice medicine as issued by the California Medical Board.

1.4.2.2. The revocation or suspension of the Drug Enforcement Administration (DEA) licensure of a Provider issued by the United States Department of Justice Drug Enforcement Administration for just cause.

1.4.2.3. The loss of or suspension from membership on the Medical Staff of Hospital of a Provider for just cause after appropriate hearing procedures in accordance with the Medical Staff Bylaws and other applicable rules and regulations and other applicable law.

1.4.2.4. Failure of any Provider to comply with any of the qualifications set forth or referred to in Section 4.2, unless the Provider is promptly removed from service under this Agreement without impairing Contractor's ability to fulfill its obligations hereunder.

1.4.3. Failure to comply with any of the representations set forth in Section 4.1 of this Agreement, which failure continues uncured for more than thirty (30) days following receipt of written notice from District of such failure, unless the failure relates to a particular Provider, and the Provider is promptly removed from service under this Agreement without impairing Contractor's ability to fulfill its obligations hereunder. Notice of failure shall specify with reasonable certainty the nature and extent of the failure.

1.4.4. Failure to provide any of the services and anesthesia coverage set forth in this Agreement, including the attached Exhibits, in accordance with the requirements of this Agreement, which failure continues uncured for more than thirty (30) days following receipt of written notice from District of such failure. Notice of failure shall specify with reasonable certainty the nature and extent of the failure.

1.4.5. Failure to use commercially reasonable efforts to manage its revenue cycle, except for causes beyond the reasonable control of Contractor or its agents or contractors, which failure is not cured within sixty (60) days following receipt of written notice from District of such failure.

1.4.6. Failure of Contractor to promptly address and resolve issues of non-performance or inappropriate conduct on the part of any of its Providers (which failure continues uncured for more than thirty (30) days following receipt of written notice from District of such failure. Notice of failure shall specify with reasonable certainty the nature and extent of the failure to comply) provided, however, that nothing contained in this Agreement is intended to supersede or supplant the role of the Chief of Staff, the MEC or the Medical Staff's Wellness Committee in addressing issues raised by the personal conduct of any of Contractor's Providers.

Termination for any of the reasons set forth above shall be considered as termination with cause.

1.5. **Termination of a Provider**. Upon request by District or Medical Staff's Medical Executive Committee ("**MEC**"), subject to any applicable cure period set forth in this section, Contractor shall remove from service under this Agreement any Provider: (i) who is convicted of a crime other than a minor traffic violation; (ii) who has a guardian or trustee of its person or estate appointed by a court of competent jurisdiction; (iii) who becomes permanently disabled so as to be unable to perform the duties required by this Agreement; (iv) who fails to maintain professional liability insurance required by this Agreement; (v) who has his/her license(s) and/or privileges required to provide services for the Department either suspended, revoked or otherwise limited; (vi) who discontinues services on a permanent basis; (vii) who is excluded, debarred or otherwise ineligible to participate in any federal health care program or in federal procurement or non-procurement programs or is convicted of or pleads no contest to a crime; (viii) who fails to comply with any of the terms and conditions of this Agreement after being given notice of that failure and a reasonable opportunity to comply; (ix) who fails to comply with the Standards and/or Codes described in Section 5.25; or (x) whose removal is requested pursuant to Section 4.7.1. For purposes of this Section 1.2, the term "permanently disabled" means the inability of a Provider, as a result of sickness or injury, to perform his or her duties under this Agreement for a period of more than one hundred eighty (180) days in the aggregate during any twenty-four (24) month period, despite reasonable accommodation.

1.6. **Immediate Termination**. District may terminate this Agreement immediately upon the occurrence of any of the following events:

1.6.1. Upon District's loss of certification as a Medicare provider;

1.6.2. Upon the closure of the Hospital or the Program; or

1.6.3. If Contractor is excluded, debarred or otherwise ineligible to participate in federal health care programs or in federal procurement or non-procurement programs or if Contractor is convicted of a crime. For purposes of this Paragraph, "**crime**" shall mean a felony as defined by the laws of the State of California or the United States of America punishable by imprisonment for a term of at least one (1) year.

1.7. **Tax-Exempt Financing**. If District is advised by its bond counsel that any amendment is required to this Agreement in order to establish or maintain the exemption from federal income tax of any obligations issued by or on behalf of the District, the parties shall, at the request of the District, cooperate to effect such amendment. If the parties fail to agree to such an amendment within thirty (30) days of the District's request, the District may terminate this Agreement on thirty (30) days' notice to Contractor. The Contractor agrees that it is not entitled to and will not take any tax position that is inconsistent with being a service provider to the District with respect to the Department. For example, the Contractor shall not to claim any depreciation or amortization deduction, investment tax credit, or deduction for any payment as rent with respect to the Department.

1.8. **Survival**. Upon any termination of this Agreement, neither party shall have further rights against, or obligations to, the other party except with respect to any rights or obligations accruing prior to the date and time of termination and any obligations, promises or arrangements which expressly extend beyond the termination, including, but not limited to, the following: Section 1 (Term and Termination); Section 5.24 (Books and Records); Section 5.27 (Confidentiality); Section 8 (Insurance and Indemnification); Section 9.6 (Dispute Resolution); Section 9.11 (HIPAA); and Paragraphs 3 (Billing and Collection), 5 (Reports), 6(f) (Audit) and 6(h) (Post-Termination Collections) of Exhibit 4.

1.9. **Effect of Termination on Medical Staff Membership and Clinical Privileges**. Contractor and each Provider agrees and acknowledges that: (a) upon termination of this Agreement without cause or for any cause or reason, the clinical privileges and Medical Staff membership of each Provider who provides Services that are exclusively granted under this Agreement shall be immediately terminated, without further action by or on behalf of the District or the Medical Staff, and without right of review, fair hearing or appeal; and (b) the clinical privileges and Medical Staff membership of any Provider to provide services in the Department shall similarly terminate if he/she ceases, without cause or for any cause or reason, to be contracted by Contractor to provide services under this Agreement. Upon termination of this Agreement, Contractor and its Providers shall immediately vacate the Department. Contractor shall obtain a written acknowledgement in the form attached hereto as Exhibit 5 from each Provider providing Services under this Agreement, and shall provide the acknowledgement to District before the Provider is assigned to provide services under this Agreement.

Section 2. Independent Contractor Relationship.

2.1. The parties acknowledge that, in performing the Service, (i) Contractor shall be an independent contractor with respect to District; (ii) this Agreement is not a contract of employment within the meaning of California Labor Code §2750, and no provider shall be an employee of District for any purpose; and (iii) nothing contained in this Agreement shall be construed to create a partnership, agency or joint venture between District and Contractor, or to authorize either District or Contractor to act as a general or special agent of the other in any respect, except as may be specifically set forth in this Agreement.

2.2. Contractor shall be solely responsible for all compensation, benefits and required employment-related taxes, contributions and insurance for all of the Providers. District shall have no obligation under this Agreement to compensate or pay taxes for, or provide employee benefits of any kind (including contributions to government

mandated, employment-related insurance and similar programs) to, or on behalf of, the Providers or any other person employed or retained by Contractor.

Section 3. Contractor's Representations. Contractor represents and warrants that:

3.1. Contractor is duly organized and operated in good standing as a professional medical corporation in the State of California;

3.2. Contractor is free to enter into this Agreement and is not violating any terms of any other agreement between Contractor and any third party by entering into this Agreement;

3.3. Contractor is a participating provider in the Medicare and Medi-Cal programs, and in other governmental health plans in which District participates, and conversely, is not an excluded, debarred or suspended provider for any federal health care program, federal procurement program or of the U.S. Food and Drug Administration;

3.4. Contractor is covered by one or more policies of professional liability insurance maintained by Contractor pursuant to Section 8.

3.5. No action, proceeding, inquiry, enforcement action, investigation, suit, claim or demand or legal, administrative, arbitration, or other method of settling disputes, whether legal or administrative or in mediation or arbitration (any of the foregoing, a "**Dispute**"), is pending or, to Contractor's knowledge, threatened against Contractor, or any of its officers, directors, employees, agents or contractors (collectively, **"Contractor's Personnel**") as a result of their activities hereunder as such, including (without limitation) (1) any Dispute concerning Contractor's or its Personnel's billing practices or alleging healthcare fraud or abuse on the part of Contractor or its Personnel, (2) any Dispute that relates in any way to Contractor's or its Personnel's services to or activities at the District or its facilities, (3) any dispute between Contractor and any of Contractor's Personnel relating to services provided under this Agreement, including any Dispute concerning Contractor's employment or contracting practices, or (4) any Dispute that could otherwise have a material adverse effect on Contractor's continued ability to perform any or all of its duties and obligations under this Agreement; nor is Contractor aware of any basis for any such Dispute. Contractor agrees to promptly notify the District's Compliance Officer in writing of the assertion or occurrence of any Dispute, and of any material change in status of any Dispute throughout the term of this Agreement.

Section 4. Providers.

4.1. Contractor represents and warrants to District, and agrees with District, as follows:

4.1.1. All Providers shall be employees or contractors of Contractor. The Providers providing services under this Agreement as of the Effective Date are mutually agreed upon by the parties. No person shall become a Provider thereafter without the approval of District, and without appropriate Medical Staff privileges.

4.1.2. All Providers meet, and shall continue to meet, the applicable requirements of Section 4.2.

4.1.3. Neither Contractor nor any Provider is bound by any agreement or arrangement which would preclude Contractor or any Provider from entering into, or from fully performing the services required under, this Agreement.

4.1.4. No Provider's license to practice medicine in the State or in any other jurisdiction or Drug Enforcement Agency number has ever been denied, suspended, revoked, terminated, relinquished under threat of disciplinary action, or restricted in any way.

4.1.5. No Provider's medical staff privileges at any health care facility have ever been denied, suspended, revoked, terminated, relinquished under threat of disciplinary action, or made subject to terms of probation or any other restriction.

4.1.6. Contractor and each Provider shall perform the services required by this Agreement in accordance with: (1) all applicable federal, state, and local laws, rules and regulations; (2) all applicable standards of the accreditation organizations and any other relevant accrediting organizations, and (3) all applicable bylaws, rules, regulations, procedures, and policies of Hospital and the Medical Staff.

4.1.7. Contractor and each Provider is or shall be a participant in Medicare and the State's Medicaid program.

4.1.8. Neither Contractor nor any Provider has in the past conducted, and is not presently conducting, its or his/her medical practice in such a manner as to cause Contractor or the Provider to be suspended, excluded, debarred or sanctioned under the Medicare or Medicaid Programs or by any government licensing agency, and has never been charged with or convicted of an offense related to health care, or listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation.

4.1.9. The compensation paid or to be paid by Contractor to any Provider is and shall, at all times during the term of the Agreement, be fair market value for services actually provided by such Provider, not taking into account the value or volume of referrals or other business generated by such Provider for District. Contractor represents to District that Contractor has and shall at all times maintain a written agreement with each Provider receiving compensation from Contractor, which written agreement is or shall be signed by the parties, and does or shall specify the services covered by the arrangement. Further, Contractor shall comply with all relevant claim submission and billing laws and regulations. Each of the representations and warranties set forth herein shall be continuing and in the event any such representation or warranty fails to remain true and accurate during the Term, Contractor shall immediately notify District.

4.1.10. Prior to the Effective Date, Contractor has submitted to District copies of all its contracts with Providers. Thereafter, if Contractor proposes to enter into a contract with a Provider in a form substantially different from the forms previously approved by the District, Contractor shall submit the form of agreement to District for approval at least thirty (30) days prior to execution the contract. Contractor shall not enter into any agreement with a Provider in a form substantially different from the approved form unless the form of agreement has been approved by District, which may grant or withhold its approval in its discretion, provided that District shall not unreasonably withhold its approval. Contractor shall provide District with copies of all its contracts with Providers from time to time upon request.

4.1.11. Contractor shall compensate Providers on a payer-neutral basis.

4.1.12. Contractor shall provide statistical analyses to its Providers on a periodic basis related to their productivity and performance under this Agreement.

4.1.13. Contractor and its Providers acknowledge and agree that the primary professional responsibility of Contractor and its full-time Providers is to provide services under this Agreement. Contractor shall not, and shall not permit its full-time Providers to, become involved in any other contracts or professional obligations that materially interfere with the ability of Contractor to honor all of the terms and conditions of this Agreement, including, but not limited to, the responsibilities detailed on the Exhibits attached to this Agreement.

4.1.14. Contractor shall ensure that each Provider complies with all terms and conditions contained herein. Providers shall also: (a) cooperate with District's employee health program and the designated employee health nurse in providing, reviewing and developing health services for employees who work at District; (b) attend any and all meetings within District that Providers are asked to attend by District's Vice President of Cardiac and Surgical Services (the "VP"); and (c) perform such other duties as may from time to time be reasonably requested by District's Governing Board, or Medical Staff, Chief Executive Officer (the "CEO") and/or VP.

4.1.15. The foregoing representations and covenants (except for those relating expressly to the Effective Date) shall be deemed to continue throughout the term of this Agreement.

4.2. **Qualifications of Providers**. Each Provider who provides Services under this Agreement shall:

4.2.1. Maintain an unrestricted license to practice medicine in the State of California;

4.2.2. Be Board Certified by the American Board of Anesthesiology ("ABA"), or Board Eligible (defined as having an application filed for Board Certification with the ABA, and having been accepted into the process). If Board Eligible, the Physician shall obtain certification within five (5) years of acceptance into the process. If Board Certified, the Physician shall maintain Board Certification at all times during the performance of Services hereunder. Contractor shall provide proof of such certification or eligibility to District upon District's request;

4.2.3. Maintain membership on the Medical Staff with appropriate clinical privileges;

4.2.4. Be a participating provider in the Medicare and Medi-Cal programs, and in other government health plans in which District participates;

4.2.5. Participate in continuing education as necessary to maintain licensure, professional competence and skills commensurate with the standards of the medical community, as applicable, and as otherwise required by Contractor's continuing medical. education policy;

4.2.6. Be covered by the policy or policies of professional liability insurance maintained by Contractor or the Provider pursuant to Section 8.

4.3. **Acknowledgment**. Each Provider who provides Services under this Agreement shall have executed an acknowledgement in the form set forth in Exhibit 5 prior to the commencement of such Services.

4.4. **Use of Temporary Providers**. Contractor shall make commercially reasonable efforts to staff the Department with Providers who are dedicated to the Hospital, and will not rely on locum tenens and temporary anesthesia providers retained through third party staffing companies ("**Temporary Providers**") except with the prior approval of the District, and only as necessary to cover temporary absences of regularly scheduled Providers, or while Contractor is making commercially reasonable efforts to hire dedicated personnel. Such Temporary Providers must meet the qualifications set forth above, must be approved by the District prior to their assignment, and may not be retained beyond the period approved by the District. If Contractor's use of a Temporary Provider is expected to extend beyond the period approved by the District, Contractor shall notify the District promptly (and in any event no later than three (3) working days before the expiration of the period); provided that the District shall not be required to agree to any extension of the approved period.

4.5. **Composition of Providers**. Contractor, in cooperation with the other Co-contractors, shall be primarily responsible for determining the number of Providers necessary to meet anesthesia requirements of District's patient load. Contractor may, with the agreement of the other Co-contractors, change the composition of Providers to meet temporary needs so long as changes in the composition of Providers do not reduce coverage or cause disruption within the Department or increase the District's aggregate costs for anesthesia services; provided that (i) the compensation payable to Contractor under Exhibit 4 shall be adjusted to reflect any change in the number of FTEs provided by Contractor, and (ii) any sustained change shall require the approval of the District and the OR Policy Committee.

4.6. **Addition of Providers.** If Contractor proposes to add a new Provider, Contractor shall notify District not less than seven (7) days prior to contracting with the new Provider and provide to District, on request, the proposed contract with the Provider prior to its execution in order to verify that it is consistent with this Agreement and requires compliance by the Provider with terms and conditions of this Agreement. The addition of any new Provider shall require the prior approval of the District.

4.7. **Termination of Providers**.

4.7.1. At all times while this Agreement is in effect, the CEO or VP of the District shall have the right to request removal in writing, with specification of cause, of any Provider from providing the Services hereunder for reasons related to clinical performance or failure to comply with this Agreement or with the policies, bylaws, rules, regulations or codes of conduct of the District or the Medical Staff. Contractor shall comply with such a request.

4.7.2. Contractor shall notify District not less than five (5) working days prior to Contractor's proposed termination of a Provider, whether with or without cause, which shall be subject to prior consultation with District. The notification shall include if the termination is for reasons related to clinical performance or compliance with clinical or conduct standards adopted by the Medical Staff. The notification need not be in writing, and the District shall keep the notification of the proposed termination confidential.

4.7.3. Contractor shall promptly notify District of the termination by a Provider of his or her contract with Contractor, or its expiration without extension or renewal.

4.7.4. Upon the termination of the contract between Contractor and a Provider, whether by the Provider or the Contractor, or automatically under the terms of the contract, the Provider shall be immediately removed by Contractor from the schedule for Services.

4.8. **Compensation of Providers**. All Guarantee Payments and other payments, other than the amounts for Practice Expense (as defined in Exhibit 4), shall be passed through to Contractor's providers as salary or benefits on an equitable basis, and shall not be retained or used by Contractor for administrative costs or profit. The District shall have the right from time to time upon request to review Contractor's agreements with its Personnel to determine their compensation and benefits.

4.9. **Exclusion Lists Screening**. Contractor shall screen all of its current and prospective owners, legal entities, officers, directors, employees, contractors, and agents ("**Screened Persons**") to ensure that none of the Screened Persons are currently excluded, debarred, suspended, or otherwise ineligible to participate in Federal healthcare programs or in Federal procurement programs, or have been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a), but have not yet been excluded, debarred, suspended, or otherwise declared ineligible (each, an "**Ineligible Person**"). If, at any time during the term of this Agreement any Screened Person becomes an Ineligible Person, Contractor shall immediately notify Hospital of the same. Screened Persons shall not include any employee, Contractor or agent who is not providing Services under this Agreement.

Section 5. Anesthesia Services.

5.1. **Coverage Schedule**. The District will establish an anesthesia committee (the "Anesthesia Committee") with responsibility for meeting regularly (as determined by the District) to assist the District and the O.R. Policy Committee to develop a schedule for anesthesia services (the "O.R. Schedule"), to modify and update the O.R. Schedule from time to time to address staffing needs and availability as the District expands its surgery services, and to review anesthesia services generally. Contractor shall participate actively on the Anesthesia Committee. The District shall be responsible for establishing the O.R. Schedule as provided in Section 5.2.6, and shall make the O.R. Schedule available to Contractor in writing (which may be on-line) in advance of its implementation.

5.2. **Contractor's Services**.

5.2.1. Contractor shall cooperate with the other Co-contractors to provide all anesthesia services necessary for the proper operation of the Department, except for services provided by others pursuant to Section 5.2.2 of this Agreement. If any Provider is unable to staff the O.R. Schedule, Contractor shall communicate promptly with the District, including the Surgical Charge Nurse and O.R. Management,

and shall use its best efforts to replace the Provider with a substitute Provider. References in this Agreement to the O.R. Schedule refer to the O.R. Schedule as modified from time to time in accordance with this section and Section 5.2.6.

5.2.2. Contractor shall have the exclusive right and the responsibility to provide all cardiac anesthesiology services required for daily scheduled surgery at Hospital, except for: (1) consulting services requested by the admitting physician; and (2) local anesthetics administered by a treating physician (including for pain management), where such treating physician elects to do his or her own local anesthetic, if and when permissible pursuant to applicable Medical Staff Bylaws (the "Services"). Without limiting the foregoing, the Services include sedation integral to the performance of operative procedures in the surgery suites at the Hospital, and to obstetrical services performed in the Hospital's labor and delivery department and other departments of the Hospital as needed, including but not limited to endoscopy, Cath Lab, Cardioversions, MRI sedations, emergency department, critical care and (subject to the exception set forth above) pain management for acute pain.

5.2.3. Notwithstanding anything to the contrary set forth in this Agreement, the parties acknowledge and agree that there may be certain members of the Medical Staff who are not affiliated with Contractor and currently or shall hold clinical privileges in pain management, acute and/or chronic, and that such clinical privileges shall not constitute a breach of Section 5.2.

5.2.4. Contractor shall have the ability to provide services to patients twelve (12) months of age and older through appropriately trained and supervised Providers.

5.2.5. All Services shall be provided in accordance with all applicable laws, regulations, accreditation requirements, and Medical Staff Bylaws and standards. District and Contractor recognize that the treating physician or surgeon is the primary customer of the anesthesiologist along with the needs of the patient, and that anesthesia services are subject to the availability of sufficient anesthesia providers. Contractor shall devote its best efforts and sufficient time to provide for the proper management and operation of the Department.

5.2.6. Contractor shall cooperate with the other Co-contractors to provide, on premises, a sufficient number of anesthesiologists and CRNAs to cover the Services, on a twenty-four (24) hours per day basis, every day of the calendar year, with a sufficient number of Physicians and CRNAs physically present to provide full coverage the Services at all times as described in detail in the OR Schedule established pursuant to Section 5.1, as the Schedule may be modified from time to time, subject to reasonable and workable hours being established for elective surgery, and subject to the needs of the treating physician surgeon and the needs of the patients. The District, in consultation with the Medical Staff's O.R. Policy Committee ("O.R. Policy Committee"), shall determine, and Contractor shall abide by, scheduling and coverage needs, including modification of the days and/or hours on the O.R. Schedule, provided that (i) in the event that the District increases the coverage obligations, Contractor shall be given a reasonable time (not exceeding five months) to secure any additional staff necessary to meet the increased coverage obligations and District shall provide additional income support at the rate set forth in Exhibit 4; and (ii) to the extent practicable under the circumstances, the District shall give Contractor reasonable notice of any material reduction in required coverage.

5.2.7. It shall be the Contractor's responsibility to cooperate with the other Co-contractors to provide adequate numbers of Providers to fulfill the coverage requirements from time to time set forth in the O.R. Coverage Schedule, in compliance with all applicable laws, regulations, accreditation requirements, and Medical Staff Bylaws and standards.

5.2.8. Contractor shall cooperate with the other Co-contractors to ensure that the ratio of CRNAs to Physicians providing services under this Agreement shall not exceed 3:1 based on total hours worked, except for occasional variations from schedule to accommodate vacancies, volumes unexpected events or preferences of the medical staff.

5.3. **Emergency OR Call Coverage**.

5.3.1. Contractor shall cooperate with the other Co-contractors to provide first call emergency anesthesiology coverage twenty-four (24) hours per day, seven (7) days per week, including holidays. This call emergency coverage shall not be "in house" coverage, but rather shall be on-call coverage and Contractor shall exercise all reasonable efforts to have an appropriate anesthesiologist at Hospital within thirty (30) minutes from the time a Contractor is paged for the on-call physician. At the request of the District, Contractor will make all reasonable attempts to provide an additional anesthesiologist to provide call coverage on Saturdays and Sundays given sufficient notice.

5.3.2. When a third (3rd) call room is made available to the Co-contractors, the Contractor will cooperate with the other Co-contractors to provide in-house first call emergency anesthesiology coverage twenty-four (24) hours per day, seven (7) days per week, including holidays. The Contractor shall exercise all reasonable efforts to have an appropriate anesthesiologist report to the Operating Room immediately from the time a Contractor is paged for the on-call physician. The District will make reasonable efforts to provide this call room as soon as possible, and the Co-contractors shall be the first recipient of an available Call Room prior to all other entities providing services for the District.

5.3.3. If an emergency C-Section occurs at the Hospital, Contractor will cooperate with the other Co-contractors to ensure that an anesthesiologist or CRNA will come to the Hospital to continue epidurals and be available for another simultaneous emergency C Section. If a trauma or emergency surgery occurs simultaneously during these obstetrical emergencies, Contractor will cooperate with the other Co-contractors to ensure that an anesthesiologist or CRNA will come to the Hospital, and another an anesthesiologist or CRNA will come in if there is a further emergency, which constitutes the fourth anesthetizing location.

5.4. **On-Call Requirement – No Discrimination**. In accordance with California Health and Safety Code §1317.3(b), Contractor shall provide on-call emergency services without discrimination to patients based on: race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, HIV status, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

5.5. **Obstetrical Coverage**.

5.5.1. Contractor shall cooperate with the other Co-contractors to provide all necessary obstetrical anesthesiology coverage for obstetrical (OB) cases at Hospital, including, but not limited to, epidural administration, twenty-four (24) hours per day, seven (7) days per week, including holidays. Exhibit 1 sets forth additional detail with respect to Contractor's obligations in this regard. Contractor cooperate with the other Co-contractors to have an anesthesiologist or CRNA physically present in Hospital within thirty (30) minutes after a call is placed to Contractor for emergency OB anesthesia services. The opinion of the responsible obstetrician that an emergency exists shall be conclusive.

5.5.2. Contractor shall cooperate with the other Co-contractors to include the obstetrical call schedule with their regular operating room call schedule. This schedule shall be posted with Operating Room Management and locations requested by District, and Co-contractors shall notify District of any changes as soon as possible.

5.6. **Unscheduled Surgeries**.

5.6.1. Contractor agrees to respond to unscheduled surgeries in an expeditious manner. The O.R. Policy Committee has established standardized policies regarding unscheduled surgeries, which shall be adhered to by the Contractor, as modified by the O.R. Policy Committee from time to time. Contractor shall provide the surgeon who shall be performing the unscheduled procedure, with an approximate time for the procedure and that time shall be adhered to insofar as possible. During normal surgery hours as set forth on the O.R. Schedule, add-on cases shall be scheduled pursuant to existing policies. Unscheduled cases shall be divided into three categories: emergent surgery, urgent surgery, and routine add-on surgery.

5.6.2. An emergent surgery (e.g., ruptured AAA, post-operative bleeding, C-Section for fetal distress) shall be done in the first available room by the first available Provider even if this requires interrupting a scheduled room and another surgeon.

5.6.3. An urgent surgery (e.g., appendectomy, open fracture, etc.) shall be done in an appropriate room within one (1) to three (3) hours of the patient being available for surgery. Contractor shall make a good-faith effort not to interrupt a scheduled room, but the parties acknowledge that on occasion this may be necessary. When it is necessary to interrupt a scheduled room, the interrupted surgeon shall be notified by the interrupting surgeon, in accordance with the policy of the O.R. Policy Committee.

5.6.4. A routine add-on surgery shall be done in the first available room with the first available anesthesiologist or CRNA as soon as he/she is done with his/her elective schedule. A routine add-on shall not interrupt a scheduled room and shall not inconvenience scheduled cases. Upon receiving an add-on request, Contractor and the charge nurse shall promptly provide the surgeon requesting the add-on with an approximate time for the surgery. Routine add-ons shall be accommodated in the same order in which the requests are received by Contractor. If a request is made after normal surgery hours as reflected on the O.R. Schedule, it shall be accommodated at the discretion of Contractor. Rooms shall be made available for add-ons consistent with current requirements set by the O.R. Policy Committee working in consultation with Contractor and consistent with the days and hours set forth on the O.R. Schedule.

5.6.5. Contractor shall respond in a courteous, timely, professional manner to requests to do these non-scheduled cases.

5.7. **Phone Number for Requesting Anesthesia Services**. As part of the increased efficiency to be realized through this exclusive provider arrangement, Contractor shall be available for contact by District's House Supervisor through the PBX Operator twenty-four (24) hours per day, seven (7) days per week, including holidays. District's House Supervisor through the PBX Operator shall contact Contractor by making a direct telephone call to the anesthesiologist on-call, as is the current practice. District's PBX number shall be the only number which a physician or District representative (other than the PBX Operator) shall be required to call to make a request of Contractor for anesthesia coverage. The Nursing Supervisor through District's PBX Operator shall promptly relay the request for anesthesia services to Contractor by means of the telephone number, which Contractor has provided, to District's PBX Operator for the date and time of the call. In contacting Contractor, the House Supervisor through District's PBX Operator shall be required only to communicate to the authorized representative of Contractor who answers the call, the identity of the physician who requested anesthesia coverage and whether the physician identified the need for anesthesia services as an emergency. Once this number has been called and the request relayed by the House Supervisor through District's PBX Operator, Contractor shall be deemed paged for the purposes of this Agreement.

5.8. **Responses to Requests for Anesthesia Services**. Contractor agrees to respond to calls for anesthesia services by having a Provider in Hospital ready to perform the procedure within the following times:

5.8.1. Hospital Emergency: As soon as possible but no later than thirty (30) minutes;

5.8.2. Emergency Obstetrical Call: As soon as possible but no later than thirty (30) minutes;

5.8.3. Urgent Case Call: One (1) to three (3) hours.

5.8.4. The medical judgment of the responsible surgeon at the time of surgery shall be conclusive as to the classification of the case as emergency, urgent, or non-urgent. Retrospectively, any disagreements with the classification used by the surgeon should be brought to the attention of the O.R. Policy Committee. Contractor agrees to have a Provider physically present at Hospital within these designated response times.

5.9. **Assignments for Scheduled Surgery**.

5.9.1. Contractor acknowledges that it is the desire of District that surgeons at Hospital retain the ability to request which of the Providers employed or engaged by Contractor shall provide anesthesiology services during a scheduled surgical procedure. Therefore, every reasonable effort shall be made to honor a surgeon's request for a specific Provider, as well as any of the following:

1.1.1.1. A bona fide request by a surgeon for the expertise of a particular Provider;

1.1.1.2. A specific patient request; or

1.1.1.3. A request for legitimate patient care needs based on the careful following of protocols and/or clinical pathways that have been pre-established to eliminate variabilities.

5.9.2. It is further acknowledged by Contractor that patient care is enhanced by a surgeon knowing, in advance, which of the Providers shall provide anesthesia services during a scheduled surgical procedure. Therefore, Contractor agrees to post the surgical assignments for the Providers in the Operating Room Scheduling Office before the start of that day's scheduled surgery and thereafter to endeavor to accommodate reasonable requests by surgeons to adjust those assignments.

5.10. **Membership of the Department**. All Providers who provide anesthesia services at Hospital shall be members of the Department of Anesthesia, and all anesthesia services contemplated by this Agreement shall be provided by Providers in their capacity as members of the Department of Anesthesia. With the approval of District administration, Providers with locum tenens privileges (granted by Contractor and the Medical Staff) may also provide services under this Agreement.

5.11. **Department Premises**. During the term of this Agreement, District shall continue to provide to or on behalf of Contractor, at District's sole cost and expense, the use of the Department's premises located in, on, or about the Hospital as currently used in connection with the Department and as expanded or relocated as may in the determination of the District be reasonably necessary in the future for the safe and efficient operation of the Department and the provision of anesthesia to patients at the Hospital. Contractor shall inform District as to future increased needs for Department premises. The District shall, at no cost to Contractor, provide two (2) offices suitable for an on-site administrator and the Medical Director of Anesthesia Services, and three (3) on-call rooms (one for OB, one for Surgery, and one for OR Call when available).

5.12. **Use of Premises**. Contractor shall use the Department's premises solely for the practice of anesthesia, pain management and related procedures provided by the Department under this Agreement, and the administrative and clerical activities attendant to that practice. Use of the premises by Contractor shall be limited to Contractor's Providers and administrative staff. No part of the premises shall be used at any time by Contractor, nor shall Contractor permit anyone else to use the premises, as an office for the private practice of medicine unless a separate agreement in writing is reached by the parties to that effect.

5.13. **Professional Standards**. Contractor and its Providers shall perform their duties under this Agreement in accordance with the rules of ethics of the medical profession. Contractor and its Providers also shall perform their duties under this Agreement in accordance with the appropriate standard of care for their respective professions and specialties including the guidelines of the American Society of Anesthesiologists and the Medical Staff Bylaws.

5.14. **Medical Direction and Administration**.

5.14.1. Spokesperson.

5.14.1.1. Contractor shall designate a spokesperson (the "**Spokesperson**") for Contractor, and may change its designation from time to time on prior notice to the District. The Spokesperson shall communicate in all matters involving the terms and conditions of this Agreement. Contractor shall arrange for the Spokesperson to be available to consult with District or its designees at reasonable times on a regular basis to discuss any matters concerning this Agreement or the administration or operation of the Department.

5.14.1.2. In addition, the Spokesperson shall act as the facilitator to ensure that the duties of Contractor described in this Agreement are met in a timely manner. Communications by District or its designee made to the Spokesperson shall be considered as made to Contractor and the Spokesperson shall be responsible for the forwarding of all such communications by District to the appropriate boards, committees, or Providers of Contractor. Statements made by the Spokesperson regarding this Agreement or the administration or operation of the Department shall be deemed by District as the statements of Contractor.

5.14.2. Director for Cardiac Anesthesia Contractor shall provide a Director for Cardiac Anesthesia (the "**Cardiac Anesthesia Director**"), who is approved by the District and the MEC. The Cardiac Anesthesia Director shall be credentialed in cardiac anesthesia. The Cardiac Anesthesia Director shall be responsible under the Medical Director for Anesthesia Services for the provision of Anesthesia Services for cardiac surgery, and shall perform the duties set forth in Exhibit 2.

5.14.3. Practice Leadership. The Contractor shall provide the services of one or more licensed anesthesia providers to provide practice leadership services, consisting of meeting attendance, policy review, personnel matters, scheduling, recruitment, and other administrative duties as appropriate.

5.15. **Additional Services**. In addition to the above coverage, Contractor agrees, in the operation of the Department, to provide to District the additional services listed on the attached Exhibit 3, it being understood by both parties that these additional services are a material part of the consideration for this Agreement.

5.16. **Service Obligations**. Contractor shall provide the Services in accordance with the Service obligations set forth in **Exhibit B** to this Agreement.

5.17. **Services to Medicare and Other Patients**. Contractor shall provide Services in a manner consistent with District's charitable purpose of providing medical service to a broad class of patients in the Service Area, maintaining Medicare and Medi-Cal provider status and treating Medicare and Medi-Cal inpatients in a nondiscriminatory manner throughout the term of this Agreement. Contractor shall provide uncompensated care to patients as reasonably requested by District throughout the term of this Agreement. District and Contractor shall cooperate in designating the patient recipients of uncompensated care.

5.18. **Reports**. Contractor shall prepare such administrative and business records and reports related to the Service in such format and upon such intervals as District may reasonably require.

5.19. **Conflicts of Interest**. Contractor shall inform District of any other arrangements which may present a conflict of interest or materially interfere in the performance of its duties under this Agreement. In the event Contractor or any Provider pursues conduct which constitutes a conflict of interest or which materially interferes with (or is reasonably anticipated to interfere with) Contractor's performance under this Agreement, District may exercise its rights and privileges under Section 1.

5.20. **Use of Hospital**. Contractor shall use the Department's premises solely for the practice of anesthesia, pain management and related procedures provided by the Department under this Agreement, and the administrative and clerical activities attendant to that practice. Use of the premises by Contractor shall be limited to Contractor's Providers and administrative staff. Contractor shall not use, or permit any Provider to use, any part of the Hospital or other District facility for any purpose other than the performance of Services under this Agreement. Without limiting the generality of the foregoing, Contractor agrees that no part of the premises of Hospital shall be used at any time as an office for private practice and delivery of care for non-Hospital patients. This provision shall not apply to any office for private practice at any professional building owned by District or any of its affiliates, pursuant to a separate lease agreement, or other private patients and practices of Contractor independent of this Agreement.

5.21. **Authority**. Neither Contractor nor any Provider may enter into any contract in the name of District or otherwise bind District in any way without the express consent of District.

5.22. **Compliance with Laws**. Contractor shall perform all services under this Agreement in accordance with any and all requirements and accreditation standards applicable to District and the Service, including, without limitation, those requirements imposed by the California Departments of Health Care Services and Public Health, The Joint Commission and the Medicare/Medicaid conditions of participation.

5.23. **Compliance with District Policies and Bylaws**. Contractor and Physicians shall at all times comply with the bylaws, rules and regulations, policies and directives of District and the Medical Staff.

5.24. **Books and Records**.

5.24.1. Record-Keeping and Auditing. Contractor shall maintain current and detailed records of all its Services, its billing and collection activities and results, its personnel services and costs of compensation and benefits, and all other expenses that are included in the expenses guaranteed in Exhibit 4, in accordance with accepted accounting and record-keeping practices, and sufficient to document and support such expenses and the Monthly Reports to be provided pursuant to Exhibit 4. District may at its sole discretion audit, either internally or through an independent consultant, Contractor's coding, billing and collection activities, and its compensation records relating to Services provided under this Agreement by Contractor's employees and independent contractors. Without limiting the foregoing, District shall have access to Contractor's records relating to billing, collection, accounting, timekeeping, payroll and independent contractor services and compensation. At District's request, Contractor shall provide copies of any records described in this paragraph.

5.24.2. Access. Upon written request of the Secretary of Health and Human Services, the Comptroller General or any of their duly authorized representatives, Contractor shall make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such services. If Contractor carries out any of the duties of this Agreement through a subcontract with a value of ten thousand dollars ($10,000.00) or more over a twelve (12) month period

with a related individual or organization, Contractor agrees to include this requirement in any such subcontract. This Section is included pursuant to and is governed by the requirements of 42 C.F.R. §§ 300-304. No attorney-client, accountant-client or other legal privilege shall be deemed to be waived by District or Contractor by virtue of this Agreement. This Section shall survive the termination or expiration of this Agreement.

5.25. **Compliance Program**. Contractor and each Provider shall (i) comply with all District policies, procedures and codes of conduct ("**Standards**"); (ii) sign and adhere to any disclosures or attestations related to District's compliance program (the "**Compliance Program**"); and (iii) participate in and support the Compliance Program. With respect to Contractor's and each Provider's business dealings with District and their performance of the Services, neither Contractor nor any Provider shall act in any manner that conflicts with or violates the Standards, nor cause another person to act in any manner which conflicts with or violates the Standards. Contractor and each Physician shall comply with the Standards (as they may be revised in the future), as they relate to Contractor's business relationship with District and its affiliates, employees, agents, contractors, and suppliers. Contractor further acknowledges and agrees that, pursuant to the Compliance Program, Contractor shall be subject to routine monitoring and review, and, potentially, external audit (limited to Contractor's office(s) used in the performance of this Agreement). Contractor agrees to cooperate fully in any such review conducted in connection with the administration of the Compliance Program

5.26. **Notification of Certain Events**. Contractor shall notify District, in writing, promptly (and where feasible, within twenty-four (24) hours) of the occurrence of any of the following: (i) Contractor or any Provider becomes the subject of, or otherwise materially involved in, any government investigation regarding business practices, the provision of Services pursuant to this Agreement or the provision of professional services, including, without limitation, being served with a search warrant in connection with such activities; (ii) the Medical Staff membership or clinical privileges of a Provider at any hospital are denied, suspended, restricted, revoked or voluntarily relinquished, regardless of the availability of civil or administrative hearing rights or judicial review with respect thereto; (iii) Contractor or any Provider becomes the subject of any suit, action or other legal proceeding arising out of Contractor's professional services and/or the Service provided pursuant to this Agreement; (iv) Contractor or any Provider is required to pay damages or any other amount in any professional liability (malpractice) action by way of judgment or settlement; (v) any Provider become the subject of any disciplinary proceeding or action before any state's medical board or similar agency responsible for professional standards or behavior; (vi) any Provider becomes incapacitated or disabled from providing the Services, or voluntarily or involuntarily retire from the practice of medicine; (vii) any Provider's license to practice medicine in the State of California is restricted, suspended or terminated, regardless of the availability of civil or administrative hearing rights or judicial review with respect thereto; (viii) Contractor or any Provider becomes the subject of any disciplinary proceeding or action before any state's medical board or similar agency responsible for professional standards or behavior; (ix) any Provider changes his/her medical specialty; (x) any Provider is charged with or convicted of a criminal offense other than an infraction; (xi) the federal Drug Enforcement Agency Number of any Provider is revoked; (xii) any event or occurrence which has a material adverse effect on a Provider's ability to perform any or all of the Service under this Agreement; (xiii) Contractor or any of Provider is debarred, suspended or otherwise ineligible to participate in any federal or state health care program, (xiv) Contractor or any Provider is charged with or convicted of a felony, or any criminal offense related to the provision of health care, (xv) any act of nature or any other event occurs which has a material adverse effect on Contractor's or any Provider's ability to perform the Services, (xvi) any Provider ceases to meet the requirements set forth in Section 4, or (xvii) Contractor gives notice of termination to any Provider for reasons relating to clinical performance or compliance with clinical standards or standards of conduct adopted by the Medical Staff.

5.27. **Confidentiality**. Contractor understands and acknowledges that Contractor shall have access to confidential information ("**Confidential Information**") concerning District's business and that Contractor has a duty at all times not to use such information in competition with District or to disclose such information or permit such information to be disclosed to any other person, firm, corporation, entity or third party, during the term of this Agreement or at any time thereafter. For purposes of this Agreement, Confidential Information shall include, without limitation, any and all secrets or confidential technology, proprietary information, customer or patient lists, trade secrets, records, notes, memoranda, data, ideas, processes, methods, techniques, systems, formulas, patents, models, devices, programs, computer software, writings, research, personnel information, customer or patient information, plans or any other information of whatever nature in the possession or control of District that is not generally known or available to members of the general public or the medical profession, including any copies, worksheets or extracts from any of the above. Contractor further agrees that if this Agreement is terminated for any reason, it will neither take nor retain, without prior written authorization from District, originals or copies of any records, papers, programs, computer software, documents, x-rays or other imaging materials, slides, medical data, medical records, patient lists, fee books, files or any other matter of whatever nature which is or contains Confidential Information. This Section shall survive the termination or expiration of this Agreement.

5.28. **Quality**. Contractor shall provide Services in accordance with high professional standards of care in the area and consistent with the quality standards of District, as determined by the applicable oversight committee, the standards of The Joint Commission and District's quality assurance/ performance improvement programs and in compliance with all laws and regulations. Contractor shall, upon reasonable notice by District, make available to District the examination of its records and data with respect to the Services, including all quality data. Contractor shall, upon reasonable notice by District, permit District to audit and inspect all such records and data necessary to ensure compliance with the terms of this Agreement.

5.29. **Medical Residency Programs**. Contractor acknowledges that District is a teaching facility accredited by the Accreditation Council for Graduate Medical Education (ACGME) for teaching and training of medical residents, including residency programs in anesthesiology, family medicine, emergency medicine, behavioral medicine, general surgery and transitional year. Contractor further acknowledges that the resident physicians are trainees practicing on a progressive continuum of independence and authority, and accordingly the residents must have collegial access to attending staff and medical directors for consultation and teaching, and that all patient care services provided by the residents are supervised by attending physicians. Contractor (i) acknowledges the present and future participation (after consultation with Contractor) of its employees and contractors as Core Faculty Members, Faculty Members and Program Director for the Program; (ii) will support and accommodate the Core Faculty Members, Faculty Members and Program Director in providing Faculty Services and otherwise meeting their Program duties, including supervision of the residents in the operating rooms and other locations; (iii) will provide prior notice and an opportunity to meet and confer with the District before terminating or restricting surgery room or other assignments of a participating anesthesiologist who is the Program Director or a Core Faculty Member or Faculty Member of the Program; and (iv) will otherwise support and facilitate the Program and the performance of services by the anesthesiology residents in the operating rooms and other hospital departments that are covered by this Agreement, provided that this provision shall not require Contractor to accommodate any faculty activities that would impair its ability to provide services under this Agreement, and provided, further, Contractor will not be required to incur any material cost in connection with such support.

5.29.1. Kaweah Health has an established Anesthesiology Residency training program. The group shall ensure that resident physicians are provided with the educational experiences, both clinical and non-

clinical time, required by the ACGME. The group must ensure residents clinical duties and expectations do not exceed the allowable duty hours and do not exceed the abilities of each individual resident. Supervision ratios and levels of supervision, as defined by the ACGME and Kaweah Health's GME Committee (GMEC), must be followed at all times. At the discretion of the program director, anesthesiology residents may be requested to perform clinical services during protected educational time if the educational value of the service is determined to be significant. This discretion can be exercised for only a single patient case. The residency program must track and report these instances and justifications to the office of GME regularly.

Section 6. District's Obligations. District shall perform the following undertakings:

6.1. **Compensation**. The compensation terms are set forth in Exhibit 4 to this Agreement.

6.2. **Facilities and Service Provided by District**.

6.2.1. District shall provide on District premises the space designated by District for the Department, plus expendable supplies, equipment and services necessary for the proper operation of the Department.

6.2.2. District shall employ all technical and clerical personnel it deems necessary for the proper operation of the Department. District, with input from Contractor and Providers, shall direct and supervise the technical work and services of such Department personnel, with District retaining full administrative control and responsibility for all non-physician Service personnel. All personnel furnished by District shall be subject to the direction of Contractor while performing any clinical work or duties in the Department; however, all such personnel are not and shall not be made or considered to be agents of Contractor, but rather shall remain employees of District and under its general supervision and report to the management of the Surgery Department.

6.2.3. District agrees to provide, at its expense, a Practice Manager to oversee the day-to-day operations of Contractor within the Department, and at least one full-time on-site Administrative Analyst for the Service.

6.3. **District's Professional and Administrative Responsibilities**. To the extent required by Title 22, California Code of Regulations §70713, District shall retain the professional and administrative responsibility for the Service. District's retention of these responsibilities shall not alter or modify, in any way, the hold harmless, indemnification, insurance or independent contractor provisions set forth in this Agreement. Contractor shall apprise District of recommendations, plans for implementation and continuing assessment through dated and signed reports, which shall be retained by District for follow-up action and evaluation of performance.

Section 7. Change of Circumstances. In the event (i) Medicare, Medicaid, any third party payor or any federal, state or local legislative or regulatory authority adopts any law, rule, regulation, policy, procedure, or interpretation thereof which establishes a material change in the method or amount of reimbursement or payment for services under this Agreement, or if (ii) any or all such payors/authorities impose requirements which require a material change in the manner of either party's operations under this Agreement and/or costs related thereto, then, upon the request of either party materially affected by any such change in circumstances, the parties shall enter into good faith negotiations for the purpose of establishing such amendments or modifications as may be appropriate in order to accommodate the new requirements and change of circumstances while preserving the original intent of this Agreement to the greatest extent possible. If, after thirty (30) days of such negotiations, the parties are unable to reach an agreement as to how or whether this Agreement shall continue, either party may terminate this Agreement upon thirty (30) days' prior written notice.

Section 8. Insurance and Indemnification.

8.1. **Contractor's Coverage**. Contractor shall ensure that Contractor and each Provider maintains professional liability insurance coverage with such insurance companies, issued upon such forms and containing such terms and limitations as required by the Medical Staff and as reasonably acceptable to District. The insurance coverage shall provide District defense for claims arising solely on the basis of vicarious liability or ostensible or apparent agency, for the act or inaction of Contractor or its Providers. As a minimum, the insurance shall provide coverage in the amount of one million dollars ($1,000,000.00) per occurrence, three million dollars ($3,000,000.00) in the aggregate. If the insurance is maintained on a claims-made basis, the insurance shall continue throughout the term of this Agreement; and upon the termination of this Agreement, or the expiration or cancellation of the insurance, Contractor shall ensure that it and/or each Provider purchases, or arranges for the purchase of, either (i) an extended reporting endorsement ("**Tail Coverage**") for the maximum period that may be purchased from its insurer (ii) "Prior Acts" coverage from the new insurer with a retroactive date on or prior to the date Contractor (or a Provider, as the case may be) began performing services at Hospital under this Agreement or (iii) maintain continuous coverage with the same carrier for the period of the statute of limitations for personal injury. In the event Contractor is unable to obtain the required insurance for or on behalf of Providers, Contractor shall require Providers to keep and maintain such insurance coverage individually. All such insurance shall be kept and maintained without cost or expense to District. In the event neither Contractor nor Providers purchase required coverage, District, in addition to other rights it may have under the terms of this Agreement or under law, shall be entitled, but not obligated to purchase such coverage. District shall be entitled to immediate reimbursement from Contractor for the cost thereof. District may enforce its right of reimbursement through set-off against any sums otherwise payable to Contractor or any Provider who failed to maintain the required coverage. Contractor shall provide District with one or more certificates of insurance certifying the existence of all coverages required hereunder. Contractor and Providers shall require their insurance carrier to provide District with not less than thirty (30) days' prior written notice in the event of a change in the professional liability policies of Contractor or Providers.

8.2. **District's Coverage**. District shall maintain, at its sole cost and expense, professional and general liability coverage for the acts and omissions of District, its officers, directors, employees and agents (excluding Contractor and Providers should it or they be deemed to be agents notwithstanding the contrary intent of the parties). The District's coverage may be provided through one or more programs of self-insurance.

8.3. **Indemnification**.

8.3.1. District shall defend, indemnify, and hold Contractor, its shareholders and Providers harmless from and against any and all liability, loss, expense, attorneys' fees, or claims for injury or damages arising out of the performance of this Agreement but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of District, its officers, directors, employees, or agents.

8.3.2. Contractor shall defend, indemnify, and hold District, its officers, directors, and employees harmless from and against any and all liability, loss, expense, attorneys' fees, or claims (i) for injury or damages arising out of the performance of this Agreement but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of Contractor, its shareholders, officers, Providers, contractors, employees, or agents, (ii) any claim, loss or liability arising out of or with respect to its obligations to its employees or contractors for compensation or benefits, or arising from Contractor's failure to withhold or pay required employment-related taxes or compensation, and (iii) any claim,

action and cause of action arising out of, or in any way connected to, a claim by a Provider, or other contractor or employee of Contractor, that he or she has in any way been treated wrongfully by Contractor or any of its present or future officers, directors, shareholders, contractors or employees.

8.3.3. Contractor shall be solely responsible for compliance will all employment-related laws and regulations with respect to Providers, including California Assembly Bill 5 of 2019, and shall indemnify, defend and hold the District harmless against any claim, cost or liability arising from any claim that any Provider is or was an employee of the District. Without limiting the foregoing, if District is required to compensate or pay taxes for, or provide employee compensation or benefits of any kind (including contributions to government mandated, employment-related insurance and similar programs) to, or on behalf of, any Provider or any other person employed or retained by Contractor, or to pay any costs or penalties resulting from its failure to pay any such compensation, benefits or other amount, the amount of all such costs, claims and liabilities shall be an obligation of Contractor to District, for which Contractor shall reimburse District within thirty (30) calendar days after being notified thereof; provided that District may, at its option, set off the amount of the obligation against any sums otherwise due to Contractor under this Agreement.

8.3.4. The provisions of this Section 8.3 shall survive termination of this Agreement.

Section 9. Miscellaneous Provisions.

9.1. **Notice**. Any notice required or desired to be given in respect to this Agreement shall be deemed to be given upon the earlier of (i) actual delivery to the intended recipient or its agent, or (ii) upon the third business day following deposit in the United States mail, postage prepaid, certified or registered mail, return receipt requested. Notice to either party may be given by the other party, in writing, personally delivered, or deposited in the United States mail, postage prepaid and addressed to the appropriate party, as follows:

If to District:
Kaweah Delta Health Care District
Attn: Gary Herbst, CEO
400 West Mineral King Avenue
Visalia, California 93291-6263

If to Contractor:
Kaweah Cardiac Anesthesia Professionals, Inc.
Attn: _____
400 West Mineral King Avenue
Visalia, California 93291

With copies to each of the following:
Herr Pedersen Berglund
Attn: Rachele Berglund
100 Willow Plaza, Suite 300
Visalia, California 93291

Attn: Peter Zeitler
5260 North Palm, Suite 421
Fresno, California 93704

With a copy to:
Benjamin Cripps, Chief Compliance Officer
Kaweah Delta Health Care District
400 West Mineral King Avenue
Visalia, California 93291-6263

9.2. **Entire Agreement**. This Agreement contains the entire agreement of the parties hereto and supersedes all prior agreements, contracts and understandings, whether written or otherwise, between the parties relating to the subject matter hereof.

9.3. **Partial Invalidity**. In the event any provision of this Agreement is found to be legally invalid or unenforceable for any reason, the remaining provisions of the Agreement shall remain in full force and effect provided the fundamental rights and obligations remain reasonably unaffected.

9.4. **Assignment**. Because this is a personal service contract, Contractor may not assign or subcontract any of its rights or obligations hereunder without the prior written consent of District. District may assign this Agreement to any successor to all, or substantially all, of District's operating assets or to any affiliate of District. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors and permitted assigns.

9.5. **Regulatory Requirements**. The parties expressly agree that nothing contained in this Agreement shall require Contractor or any Provider to refer or admit any patients to, or order any goods or services from, District. Notwithstanding any unanticipated effect of any provision of this Agreement, neither party shall knowingly or intentionally act in such a manner as to violate the prohibition against fraud and abuse in connection with the Medicare and Medicaid programs (42 U.S.C. §1320a-7b).

9.6. **Dispute Resolution**. The parties firmly desire to resolve all disputes arising hereunder without resort to litigation in order to protect their respective business reputations and the confidential nature of certain aspects of their relationship. Accordingly, any controversy or claim arising out of or relating to this Agreement, or breach thereof, shall first be addressed by and between Contractor and the District's Vice President responsible for the administrative oversight of the Service. If still unresolved to the mutual satisfaction of the parties, the dispute shall be referred to the Board of Directors for final resolution, subject to receiving the recommendation of the MEC to the extent required under the Medical Staff Bylaws. The Board of Directors shall, within a reasonable time, notify Contractor of its decision in accordance with the requirements of this Section. The parties expressly agree litigation may not be commenced regarding the terms and conditions of this Agreement or any controversy or dispute hereunder unless and until the contractual procedures and remedies described in this Section are exhausted. Nothing in this Section 9.6, however, shall require either party to complete the pre-litigation dispute resolution process in this Section 9.6 prior to exercising its respective rights under Section 1 to terminate this Agreement.

9.7. **Third Party Beneficiaries**. This Agreement is entered into for the sole benefit of District and Contractor. Nothing contained herein or in the parties' course of dealing shall be construed as conferring any third party **beneficiary** status on any person or entity not a party to this Agreement, including any Provider.

9.8. **Governing Law**. This Agreement shall be governed by the laws of the State of California.

9.9. **Approvals**. Neither this Agreement nor any amendment of or modification hereto shall be effective or legally binding upon either party unless it is set forth in a written document executed by the parties hereto.

9.10. **Attorneys' Fees**. If any legal action at law or in equity or any arbitration proceeding, is brought for the interpretation or enforcement of this Agreement or any part hereof, or because of an alleged dispute, breach, default or misrepresentation in connection with any of the provisions of this Agreement, the prevailing party shall be entitled to recover its reasonable attorneys' fees and other costs incurred in that action or arbitration proceeding, in addition to any other relief to which it may be entitled.

9.11. **HIPAA**. The parties acknowledge that they are part of an "organized health care arrangement" for purposes of the privacy provisions of the Health Information Portability and Accountability Act of 1996 ("**HIPAA**"). Contractor and each Provider shall perform the Services in accordance with (i) applicable state and federal

laws and regulations relating to health information privacy and security, including the California Confidentiality of Medical Information Act (Civil Code § 56 and following), and regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA); (ii) the District's policies and procedures relating to health information privacy and security; and (iii) the District's notice of privacy practices.

9.12. **Cross Referenced Agreements**. According to regulations implementing 42 U.S.C. §1395nn *et seq.*, respecting the prohibition of physician referrals to entities with which those physicians or their family members have financial **arrangements**, all arrangements shall be cross referenced for audit purposes. In accordance with 42 CFR §411.357(d)(ii), any arrangements between Contractor and District, or between any Group Physician of Contractor and District, are listed in a master list of contracts that is maintained by District and updated centrally, preserves the historical record of contracts and is available for review by the Secretary of Health and Human Services upon request.

9.13. **Modification**. This Agreement may be modified only by a signed, written instrument.

9.14. **Compliance with Laws.** District and Contractor agree to comply with all applicable statutes and regulations, both state and federal, governing the operation and administration of District, as well as standards set forth by the Joint **Commission**.

1.1.2. In addition to the obligations of the parties to comply with applicable federal, state and local laws respecting the conduct of their respective businesses and professions, District and Contractor each acknowledge that they are subject to certain federal and state laws governing the referral of patients which are in effect or will become effective during the term of this Agreement. These laws include:

1.1.2.1. Prohibition on payments for referral or to induce the referral of patients (California Business and Professions Code §650; California Labor Code §3215; and the Medicare/Medicaid Fraud and Abuse Law, §1128B of the Social Security Act); and

1.1.2.2. Prohibition on the referral of patients by a physician for certain designated health care services to an entity with which the physician (or his/her immediate family) has a financial relationship including (California Business and Professions Code §§650.01 and 650.02, and §1877 of the Social Security Act).

1.1.3. Nothing in this Agreement is intended or shall be construed to require either party to violate the California or federal laws described in Section 1.1.2, and this Agreement shall not be interpreted to:

1.1.3.1. Require any Provider to make referrals to District, be in a position to make or influence referrals to District, or otherwise generate business for the District.

1.1.3.2. Restrict any Provider from establishing staff privileges at, referring any patient to, or from otherwise generating any business for any other entity of the Provider's choosing.

1.1.3.3. Provide for payments in excess of the fair market value or comparable compensation paid to physicians for similar services in comparable locations and circumstances.

1.1.4. In the event of any changes in law or regulations implementing or interpreting the Internal Revenue Act or the Medicare and Medicaid Patient Protection Act of 1987, including the adoption or amendment of Medicare Fraud and Abuse Safe Harbor Regulations, or to any other Federal or State law relating to the subject matter of such Acts, to fraud and abuse, or to payment-for-patient referral, including the laws referenced in Section 7.14.1, the Parties shall use all reasonable efforts to revise this Agreement to conform and comply with such changes.

9.15. **Force Majeure**. Neither party shall be liable nor deemed to be in default for any delay or failure in performance under the Agreement or other interruption of service or employment deemed resulting, directly or indirectly, from: Acts of God; acts of civil or military authority; acts of terrorism, bioterrorism, or public enemy; bomb threats; computer virus; epidemic/pandemic, power outage; acts of war; accidents; fires; explosions; earthquakes; floods; failure of transportation, machinery, or supplies; vandalism; strikes or other work interruptions by District's employees; or any similar or dissimilar cause beyond the reasonable control of either party. Both parties shall, however, make good faith efforts to perform under this Agreement in the event of any such circumstance. This force majeure provision shall not relieve aa party of the obligation to make any monetary payments provided for hereunder.

9.16. **Counterparts**. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same agreement.

9.17. **Legal Counsel**. Each party understands the advisability of seeking legal counsel and financial/tax advice and has exercised its own judgment in this regard.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement effective on the date first set forth above. This Agreement shall be binding when all signatories listed below have executed this Agreement.

DISTRICT: **KAWEAH DELTA HEALTH CARE DISTRICT**

By: _____
Gary K. Herbst, Chief Executive Officer

CONTRACTOR: _____
a California professional medical corporation

By: _____
_____, President

EXHIBIT 1
[RESERVED]

EXHIBIT 2
MEDICAL DIRECTOR FOR CARDIAC ANESTHESIA SERVICES

1. The Medical Director for Cardiac Anesthesia Services shall perform the following duties, as they pertain to cardiac surgery:

(a) Participating in the educational programs conducted by District and the Medical Staff in order to assure Hospital's overall compliance with accreditation and licensing requirements, and performing such other reasonable teaching functions as District may request;

(b) Directing non-physician personnel in the performance of professional services for patients;

(c) Advising District with respect to the selection, retention and termination of all personnel who may be required for the proper performance of anesthesia services; provided, however, that District shall retain the ultimate decision-making authority regarding the selection, retention and termination of all such personnel;

(d) Establishing schedules for all services provided by Providers in accordance with the terms of this Agreement;

(e) Supervising the development and implementation of Hospital quality assurance and quality improvement programs and procedures relative to the Services;

(f) Assisting District in the preparation and conduct of surveys by The Joint Commission and/or any other national, state or local agency relating to the Anesthesia Service and the Services provided under this Agreement; and

(g) Performing any other duties related to the Anesthesia Services contemplated herein that District's Governing Board, Medical Staff and/or the VP may reasonably request.

EXHIBIT 3
ADDITIONAL SERVICE AND STAFFING REQUIREMENTS

Contractor, in cooperation with the other Co-contractors, shall meet the following service and staffing requirements, all of which shall be considered material requirements of this Agreement, as provided in Section 5.15 of the Agreement:

1. **General Requirements**:

(a) An adequate number of anesthesia providers shall be qualified to perform epidural, spinal, regional, MAC, total intravenous anesthesia (TIVA), central line placement, double lumen endotracheal tube intubation, fiber-optic bronchoscopy, use of glide scope, and general anesthesia to support institutional demand.

(b) Two dedicated CV Anesthesiologists shall be assigned to CV Surgery. Call is dedicated primarily to this area, but the anesthesiologists may respond to emergent needs in other areas.

(c) The OB Anesthesia Director shall be dedicated primarily to Obstetrics & Gynecology on 2 East, but the anesthesiologists may respond to emergent needs in the main OR and other areas.

(d) Contractor shall be responsible for the monitoring of medication administration and correction of medication charge errors to ensure billing compliance for District.

(e) All Providers shall be ACLS certified as of the Effective Date, except for new Providers and Providers who have served less than one year under this Agreement, who shall be certified within one (1) year of commencing Services under this Agreement.

(f) Contractor shall actively participate with all hospital quality or improvement initiatives related to Surgical Services and Anesthesia Services

(g) Contractor shall exert commercially reasonable efforts to improve Physician Satisfaction results year-over-year as related to Surgical Services and Anesthesia.

(h) Contractor shall strive to improve Patient Satisfaction (HCAHPS) scores year-over-year as related to Anesthesia. Contractor shall cooperate with Hospital's Perioperative Medical Director on initiatives to improve quality and service in the main operating room and Surgical Center.

(i) Contractor shall participate in and cooperate with Hospital's OR Policy Committee, and shall collaborate with Hospital's surgical medical director.

(j) Contractor shall actively support Hospital's Quality initiatives, including the reduction of anesthesia-related OR case delays by assuring that patients have been interviewed and are ready on time for their scheduled surgical start times and that all anesthesiologists are consistently on time.

(k) Contractor shall conduct a minimum of one post-anesthesia evaluation on all inpatients and outpatients.

(l) Contractor, through a designated member, shall reasonably participate in the medical and paramedical educational programs conducted by District.

(m) Contractor shall comply with regulations and standards as outlined by The Joint Commission and California Code of Regulations ("CCR") Title 22, the State Board of Pharmacy, CMS Conditions of Participation and other agencies having authority over the Hospital and the Department, to include medication safety and control,

appropriate documentation in the medical record, pre-induction assessments, and full compliance with all hazardous waste streams and HIPAA regulations, or as otherwise set forth in the Agreement.

(n) Contractor shall be responsible for and have authority to ensure District's compliance with anesthesia requirements of accrediting bodies such as the American Medical Association, The Joint Commission and California Department of Public Health, to include active participation in the Department and District-wide quality monitoring activities.

(o) Contractor shall on an ongoing basis participate through the Cardiac Anesthesia Medical Director or his/her designee, at meetings of all required Performance Improvement committees and assigned activities.

(p) Contractor shall make available to the Performance Improvement Department on a consistent and systematic basis all relevant information in the computerized or paper patient record for collection, display, and analysis.

(q) Contractor shall comply on an ongoing basis with all of The Joint Commission requirements, including dating and timing of pre-induction physicals.

(r) Contractor shall have bi-monthly Department meetings, and shall maintain, on an ongoing basis, Departmental minutes which accurately reflect appropriate and consistent involvement in the Performance Improvement process.

(s) Contractor shall on an ongoing basis demonstrate a multi-Departmental team approach to solving quality problems that involve multi-Departmental processes.

(t) Contractor shall on an ongoing basis demonstrate responsibility and accountability in the protection of the patient and with respect to unsolved problems that involve interdepartmental responsibility.

(u) Contractor shall maintain, on an ongoing basis, bi-monthly Departmental minutes which accurately reflect review of data, problems, mortality, and outcomes, with analysis and action appropriate to the solution of problems in a timely and effective manner.

(v) Contractor shall collaborate to support educational programs as requested by the District.

(w) Contractor shall direct and arrange for anesthesiologists proctoring per applicable Medical Staff Bylaws.

(x) Contractor and its Providers shall participate actively in the affairs of the Medical Staff, including, without limitation, serving on committees and discharging such other obligations as may be requested by the Medical Staff, or any duly appointed officer or committee thereof.

(y) Contractor and its Providers shall conform to any and all lawful administrative directive issued from time to time by the CEO, Vice President of Cardiac and Surgical Services and/or CMO, provided that such directives are consistent with the scope and principles of this Agreement.

2. **Monthly Meeting**. The Medical Director shall meet with District's Medical Director for Surgical Services and Director for Surgical Services at the monthly meeting to review performance of services identified in this Exhibit 3 and any other operational issues of concern.

3. **Quality Assurance**. Specific anesthesia criteria shall be developed by the Department of Anesthesia ("Department") that shall identify variances in Hospital practice/medical care (e.g. difficult intubations, OPs admitted to Hospital due to N & V, etc.) A medical record review shall be conducted by the Department when a patient's

criteria are not satisfied. This information accompanied with any corrective action implemented shall be reported monthly to the O.R. Policy Committee and Medical Care Review Committee.

4. **Documentation Requirements**. Contractor shall promptly complete all records, forms and reports reasonably required by District and the Medical Staff. District has developed an integrated computerized information system so as to more efficiently interface and collate medical data for patient care and billing. Contractor shall actively utilize District's electronic medical records technology and tools. It is expected that anesthesia records, both computerized and written, prepared by Providers shall be accurate, complete and timely in accordance with Title 22.

5. **Qualifications**. In order to assure and enhance present and on-going clinical qualifications of Contractor and its Providers:

(a) Contractor shall ensure that any Provider providing pediatric anesthesiology shall have training in pediatric anesthesiology and PALs certification. Pediatric definition by age to be determined by Surgery, Anesthesia, and Pediatrics Departments.

(b) All Providers, to the extent eligible, shall be trained, privileged and expected to place arterial/central lines and fiber optic difficult intubations.

(c) Whenever possible, all staffing assignments by Contractor shall be based on Provider competency in the required skills.

(d) Contractor or Contractor's representatives shall acknowledge receipt all complaints within two (2) business days or sooner after receipt of notification.

6. **Dress Code**. All Providers shall adhere to the OR attire/dress code and the prohibitions on food and drink in the operating room, as required by the Surgical Services Policy.

7. **Professional Behavior**.

(a) Contractor shall ensure that its Providers comply with the Code of Professional Conduct for Medical Staff/Allied Staff and the Conduct Guidelines of Medical/Allied Staff Granted Privileges at Kaweah Delta Medical Center, each as adopted by the Medical Staff of Hospital.

(b) Contractor's Providers shall maintain professional behavior toward District's patients, patient's family members, Medical Staff members, visitors, and District staff as required by the Department of Anesthesia Policy and Procedure Manual, all related District Policies and the Medical Staff Bylaws.

(c) Providers shall arrive for scheduled cases at a reasonable time in order to allow for appropriate assessment, possible intervention, orders, etc., to avoid delays in surgery.

8. **Medication Management**. All Providers shall document and practice the following:

(a) Appropriate syringe labeling practices;

(b) Documentation of drugs received from Pyxis to ensure accountability of drug and restocking;

(c) Documentation of drug charges in collaboration with the Hospital pharmacy in appropriate systems;

(d) In collaboration with the District, Contractor shall achieve one hundred percent (100%) accountability for all drugs used and their disposition;

(e) Contractor shall achieve greater than an 85% initial charting accuracy compliance rate.

(f) Comply with District policies to ensure proper disposal of sharps and/or pharmaceutical waste in collaboration with the Hospital pharmacy;

(g) Comply with District Policy to ensure compliance, as applicable, with any compounding standards in collaboration with the Hospital pharmacy, such as aseptic techniques.

(h) Assure that Providers standardize their use of drug utilization with best practices, where feasible.

(i) When the mass transfusion protocol is in effect, Providers shall abide by the protocol until it is terminated.

9. **Anesthesia Business Indicators –** Unless specified differently, the following anesthesia business indicators will be monitored and reported quarterly and annually to the O.R. Policy Committee, O.R. Management, and Administration:

(a) **Anesthesia -** Staffing in comparison to anesthesia O.R. coverage schedule – will be reviewed quarterly with O.R. Management

(b) **Anesthetic Volume**

- By anesthetic location
- By anesthesia type
- By ASA class

(c) **Number of Clinicians**

- By type (Physician, Resident, CRNA, etc.)

(d) **Total Minutes (and Units) Billed**

- By anesthetic coverage location

(e) **Anesthesia Clinical Indicators.** The following anesthesia clinical indicators will be monitored and reported quarterly and annually to the Chief Medical Officer and Administration:

- Number of cases completed eventfully
- Occurrence of critical events (by location/service; definitions):
    - Death
    - Cardiac Arrest
    - Perioperative MI
    - Anaphylaxis
    - Malignant Hyperthermia
    - Transfusion Reaction
    - New Stroke
    - Visual Loss

- Incorrect Surgical Site
- Incorrect Patient
- Medication Error
- Unplanned Admission
- Unplanned ICU Admission
- Intraoperative Awareness
- Unplanned Difficult Airway
- Unplanned Reintubation
- Dental Trauma
- Perioperative Aspiration
- Vascular Access Complication
- Pneumothorax
- Infection After Regional Anesthesia
- Epidural Hematoma
- High Spinal
- Postdural Puncture Headache
- Local Anesthetic Toxicity
- Peripheral Neurologic Deficit

10. **Performance Expectations**. In addition to the general service requirements of this Agreement, the Contractor shall use commercially reasonable efforts to ensure that its Providers meet specific performance expectations from time to time set by agreement by the parties. The performance expectations in effect on the Effective Date are as follows:

Indicators	
OB Patient Satisfaction (overall)[1]	>90%
Post Op PACU Pain Satisfaction	>90%
Anesthesia Related OR Case OR Delays[2]	<4%
On-time starts for Scheduled Surgery	>90%
On-time start for Scheduled Endoscopy, Electrophysiology Studies, AICD's, and Cardioversions	>90%

[1] As measured by MTC Health.

[2] Contractor and District to work together to establish a mutually agreeable definition.

EXHIBIT 4
COMPENSATION

1. Entire Compensation. Except as provided in this Agreement, neither District nor Contractor shall charge the other for Services provided pursuant to this Agreement.

2. Meet and Confer. The parties shall meet and confer at least quarterly to discuss the performance of the Contractor, including Provider recruitment and retention, billing and collection for Services, and Practice Expenses.

3. Billing and Collection of Fees for Services.

(a) Fee Schedule. Contractor shall prepare a schedule of fees representing its full professional charges for Services rendered to District patients under this Agreement. The fee schedule, and any change thereto, shall be approved in advance by District in order for District to ensure that fees are reasonable, fair and consistent with the basic commitment of District to provide adequate health care to all residents within the Service Area. The fee schedule shall, at all times, comply with all applicable laws, rules, regulations and payer agreements. The fees shall at all times be reasonable and competitive. Nothing herein shall be construed to cause Contractor to violate any federal or state laws concerning the establishment of fees. Contractor shall provide prompt notice to District of any and all proposed changes in Contractor's fee structures

(b) Documentation of Services. Contractor shall ensure that its Providers document all Services fully, completely, accurately and promptly in the District's electronic medical records, including entering appropriate billing codes, and provide such additional documentation as the District or the contracted billing company requires to ensure prompt billing of and payment for Contractor' Services.

(c) Billing Services. Contractor shall use the services of a qualified contractor approved by District for the billing and collection of claims for all Services provided during the term of this Agreement. The approved billing service provider is R1 RCM. Contractor shall obtain such assignments as are necessary to enable the services of its Providers to be billed in the name and for the account of Contractor. Contractor shall be responsible for ensuring that the billing service bills and collects claims for Contactor's services competently and diligently, and in accordance with commercial standards of practice.

(d) Provider Enrollment and Participation Agreements. Contractor shall diligently pursue and maintain, participation in good standing for Medicare, Medi-Cal and all managed care contracts for health care services in which District participates, e.g., health maintenance organizations (HMOs) and preferred provider organizations (PPOs), and shall ensure that its Subcontractors do the same. Contractor shall follow the same procedures for credentialing new Providers in order to obtain payment for Services in a timely manner.

(e) Global Contracts. To the extent that District enters into a contract with a health plan or other payor that does not permit Contractor and District to separately bill for their respective professional and technical services ("**Global Contract**"), Contractor shall look solely to District for payment and District shall compensate Contractor for such services by a mutually agreeable amount (to be set in advance in writing), but in no event shall the amount be less that the amount that Contractor would have received for such services, but for the Global Contract. Any such reimbursement shall be Program Collections for purposes of this Agreement.

(f) Collections.

(i) Program Collections. For purposes of this this Exhibit, "**Program Collections**" means revenues or receipts received by or on behalf of Contractor or any of its Providers during the applicable month from any and every source in any way related to Services performed at the District's facilities, including (without limitation) (i) payments under policies of business interruption insurance, and grants from government agencies relating to Services provided, lost revenues, or reimbursement of costs (except insofar as such grants are intended and used to cover unanticipated costs that are not reimbursable under this Agreement), and (ii)

Abandoned Collections, as defined below; but excluding Guarantee payments made by the District under this Agreement, and less refunds, recoupments, offsets, takebacks or withholds.

(ii) Audit; Abandoned Collections. District may at its sole discretion, audit, either internally or through an independent consultant, Contractor's documentation and coding practices. If, as a result of an audit or otherwise, District identifies claims that have not been billed (i) because of the failure of Contractor or a Provider to document or code its services promptly and appropriately in accordance with industry standards, or (ii) because of the failure of Contractor to reasonably cooperate with the District's efforts to establish its eligibility, or the eligibility of any Provider, for payment from any third-party payor, or to bill for and collect claims for services, and the billing contractor is not able to resubmit such claims to the payor by statute or payor requirements for timely claim submission ("Abandoned Collections"), the amount of Abandoned Collections, adjusted to reflect the Contractor's historical collections rate for the payor, shall be added to Contractor's Program Collections during the Term of this Agreement; provided that the Abandoned Collections shall not include the professional portion of any global rates that were billed and collected by District. For purposes of this Agreement, Abandoned Collections shall not include any charity care discount or other appropriate decision to reduce the charges to or payable by a Program patient; however, Abandoned Collections shall include any courtesy discount (including professional courtesy to a health provider or any family members of a health care provider) unrelated to individual need or appropriate exigent circumstances. The amount of Abandoned Collections identified subsequent to the expiration or termination of this Agreement that relate to Services performed by Contractor during the Term of this Agreement shall be promptly repaid by Contractor to District in an amount equal to, taking into consideration the historical collections rate for the payor, what would have been paid by the payor to Contractor had the collections not been abandoned.

(g) District Billing. District shall be responsible to bill and collect for all technical Hospital services provided to District patients during their Hospital stay.

(h) Billing Errors. The parties shall have reasonable access to records necessary to verify each party's compliance with this Agreement. Each party shall promptly correct or assist the other party in correcting any billing errors.

4. Submission of Pro Forma Estimates. On an annual basis, commencing three (3) months before each anniversary of this Agreement, Contractor shall provide to District (i) a pro forma estimate of the Program Collections, all Variable Provider Expenses (as defined below), by category, and all Practice Expenses (as defined by below (by Category) for the then current year, and (ii) a pro forma estimate of Program Collections, all Variable Provider Expenses (by category) and all Practice Expenses (by category) for the following year. At its option, District may request Contractor to provide information as necessary for District to evaluate the adequacy of the Practice Expenses.

5. Reports; Other Information.

(a) Documentation of Time. Medical Directors shall report their time through the District's Physician Time Study Database. With the exception of CV Anesthesiologists, all Clinical Providers shall be required to clock in and out via ADP Geo-fencing technology or other mutually agreed upon program. Medical Director, Practice Leadership and GME/Faculty hours (payable under a separate Agreement) may not be recorded for time spent while the Provider is providing clinical shifts, except as approved in advance by District, or on occasional instances where avoidance would be impractical.

(b) Monthly Reports. Within fifteen (15) days after the end of each month of this Agreement, Contractor shall submit to District an itemized report ("**Monthly Report**") setting forth the following in form and content reasonably satisfactory to the District, for the month just ended and for the Contract Year to date:

(i) The number of shifts and hours of Services performed each day of the month, with a description of the Services provided each day, and an indication of any variations from the staffing schedule set forth in the O.R. Schedule;

(ii) The number, identities and schedules of the individuals who provided Services during the month;

(iii) Contractor's billings for Services;

(iv) Program Collections;

(v) Abandoned Collections;

(vi) Refunds, recoupments and offsets of or to Program Collections, and any claims for any of these;

(vii) Accounts receivable, and an accounts receivable aging report;

(viii) A report on Contractor's performance during the month with respect to the goals set forth in Exhibit 4-2 (the "**Billing and Collection Targets**").

(ix) The Contractor's cost of Provider compensation and benefits ("**Variable Provider Expenses**")

(x) Other financial information maintained by Contractor or its billing agent as may be reasonably requested by District in order to determine its obligations under this Agreement or monitor compliance with this Agreement.

(c) The Contractor shall continue to submit the Monthly Report for each of the twelve (12) months following the termination or expiration of this Agreement for any cause or reason (the "**Tail Period**") in accordance with subsection (b), except that the reports for the Tail Period need contain only the information described in clauses (b)(iii) through (b)(vii) and (b)(x).

(d) Quarterly Report. As soon as practicable after the end of each quarter of each Contract Year, Contractor shall submit to District an itemized report ("**Quarterly Report**") for the prior quarter, setting forth the information required to be included in the Monthly Report, but aggregated for the quarter, in form and content reasonably satisfactory to the District.

(e) Annual Report. As soon as practicable after the end of each Contract Year, Contractor shall submit to District an itemized report ("**Annual Report**") for the prior Contract Year, setting forth the information required to be included in the Monthly Report, but aggregated for the Contract Year, in form and content reasonably satisfactory to the District.

(f) Other Information. In addition to the Monthly, Quarterly and Annual Reports, Contractor shall provide District with such additional reports and information as the District may reasonably request, including but not limited to collections activity, etc., with such frequency as the District may reasonably request.

(g) Production of Reports. If the District requests any report or information under this Section 5 that is not available as a standard report from the reporting systems of the Contractor or its contractors, the Contractor shall within fifteen (15) days of the District's request notify the District when the report may be available, or if the report is not available in the form or format requested by the District, how the Contractor proposes to make the information available to the District. The District shall not unreasonably withhold its approval of the Contractor's proposal, as long as the proposal would provide the information requested by the District in a timely manner. Once the parties have agreed upon the form and format of the report, the Contractor shall provide it in accordance with the District's request.

6. Compensation.

(a) Retention of Program Collections. Contractor shall retain all Program Collections, except as provided in Paragraph (f) (as to adjustments of estimated and actual Program Collections) and Paragraph (h) (as to Post-Termination Collections).

(b) Guaranty. Provided that Contractor submits Monthly, Quarterly and Annual Reports as required by Section 5, and subject to the provisions of this Exhibit, the District shall pay Contractor the amount, if any, by which Contractor's Total Allowed Expenses exceeds its Program Collections during the term of this Agreement on an aggregate term-to-date basis (the "**Guaranty**"). Payments in relation to the Guaranty shall be made as provided in subsection (e) below. For purposes of this Exhibit, "**Total Allowed Expenses**" means the aggregate of Contractor's actual and reasonable expenses incurred in in connection with the provision of Services, as set forth in (and not exceeding the amounts set forth in) Schedule 4 hereto. The expense limitations in Schedule 4 shall be applied on a line-item basis, not an aggregate basis.

(c) Contract Year. The amounts set forth in Schedule 4 are for a Contract Year, which means each year of the term of this Agreement commencing October 1 and ending September 30 of the following year (or sooner if this Agreement is terminated before the end of the current Contract Year); and the terms "per year" or "annually" mean for each Contract Year.

(d) Total Allowed Expenses. In determining Total Allowed Expenses:

(i) Except with the approval of the District, which it may give or withhold in its discretion:

(A) The number of FTE Providers whose compensation and benefit expense is included in Total Allowed Expenses shall not exceed the number in Schedule 4, or such lesser number as may be reasonably necessary to meet the coverage schedule from time to time set forth in the O.R. Schedule, as modified pursuant to Section 5.2.1 of the Agreement. The FTE status of Providers shall be determined in accordance with the criteria set forth in Schedule 4. The Parties acknowledge and agree that Contractor may, with the approval of District, deviate temporarily from the actual number of Providers set forth in Schedule 4, so long as the coverage set forth in the O.R. Schedule is provided and the deviation does not increase the District's expenses under this Agreement without its prior approval.

(B) For any period during which the Cardiac Anesthesia Director does not provide the services required by this Agreement (except for regular time away from practice for vacation, continuing medical education and the like), upon prior notice the relevant expense for MD Leadership Stipends shall be reduced proportionately.

(ii) The District shall reimburse Contractor's cost of billing and collection directly to the Contractor's contracted billing service, and the costs of billing and collection shall not be Allowed Expenses.

(iii) The Total Allowed Expenses shall not include any expense, cost, charge, reduction, recoupment or offset incurred prior to the Effective Date, or arising from circumstances or events existing or occurring prior to the Effective Date, and the Contractor shall provide the District with such information as the District may reasonably request to satisfy itself that all charges and expenses included in the Monthly Reports arose or were incurred on or after the Effective .

(iv) The Total Allowed Expenses shall also include the cost to Contractor of sign-on bonuses not exceeding $30,000 for a new Provider, subject to the prior approval of the District in each case, and contingent upon a two-year service commitment by the Provider in form approved by the District.

(e) Payment Obligations and Reconciliation.

(i) Monthly Guarantee Payments. The District shall make the following payments to Contractor, each an "**Estimated Monthly Guarantee Payment**," and all of which shall be deemed to be "**Guarantee Payments**" for purposes of this Agreement, and which shall be reduced in the aggregate by the amount of Program Collections for the most recent month for which the Monthly Report is available, and shall be subject to periodic reconciliation as provided in Paragraph (ii) below:

(a) Clinical Services. By the fifth (5th) day of each month District will pay Contractor an amount equal to District's estimate of Contractor's expenses for the month for the salaries and benefits for the clinical services of Providers, based on budgeted Provider hours, adjusted to add or deduct any amount necessary to reflect any difference in actual hours, as reflected in the reports referred to in Section 5(a), as against estimated hours for the most recent month for which such reports are available, and based on the relevant hourly rate set forth in Schedule 4.

(b) Medical Director and Physician Leadership Costs. By the twentieth (20th) day of each month District will pay Contractor the amount due for Medical Director Services and Physician Leadership costs for the prior month. Payment for Medical Director and Physician Leadership shall be in accordance with the hours documented via the Physician Time Study Database, at the hourly rates and subject to the monthly caps set forth in Schedule 4.

(c) Practice Expenses.

(i) As provided in Section 4 of this Exhibit 4, at least three (3) months before each anniversary of the Effective Date of this Agreement, Contractor shall provide District with a proposed budget for its expenses related solely to the performance of Services under this Agreement in the categories listed below, or such other categories as the parties may agree upon from time to time in connection with the process described in this paragraph ("**Practice Expenses**"). With the proposed budget, Contractor shall also provide such information concerning its historical expenses in each category of Practice Expense as the District may request in order to assess the proposed budget. In collaboration with Contractor, the District shall establish a final budget for Contractor's Practice Expenses for the ensuing year (the "**Practice Expense Budget**"), and shall provide Contractor a copy of the Practice Expense Budget before the start of the year. The District shall pay Contractor the amount of the Practice Expense Budget in twelve (12) equal monthly installments over the year. The Practice Expense Budget shall be updated annually and shall operate prospectively; provided that if the District fails to provide a budget for the current year for any reason other than delay by Contractor in the submission of its proposed budget, the Practice Expense Budget for the prior year shall continue in effect, pro rata, until the new one is provided by the District. The following categories of expense incurred by Contractor in connection with the performance of Services shall be included in the initial Practice Expense Budget; provided that the categories may be changed prospectively in connection with each annual budget:

- Bank Service Charges
- Computer Software & Internet
- Continuing Education
- Health Insurance
- Malpractice and Employment Insurance
- Worker's Compensation
- Meals and Entertainment
- Office Expense
- Office Supplies

- Payroll Expenses
- Payroll Fees
- Payroll Taxes
- Payroll Taxes (Federal)
- Payroll Taxes (State)
- Postage/Printing
- Professional Fees
- Accounting Fees
- Credentialing Fees
- Consulting/Management Fees
- Consulting/Management Travel
- Legal Fees
- State Tax
- Communications Expense
- Utilities
- Financial Planning and Retirement Fees
- Recruitment
- Additional Administrative Support deemed necessary by the contractor

(ii) The Contractor shall provide the District with any information that the District may reasonably request to document any Practice Expense.

(iii) In no event shall the Practice Expenses reimbursable under this Agreement exceed the aggregate amount set forth in the relevant Practice Expense Budget.

(ii) Periodic Reconciliation. Following delivery of the Quarterly Report and the Annual Report to the District, the District shall reconcile the Estimated Monthly Guarantee Payments over the term of this Agreement to date to the Contractor's actual Total Allowed Expenses and Program Collections over the term of this Agreement (each such reconciliation, a "**Reconciliation**"). If the amount determined by subtracting aggregate actual Program Collections for the quarter or the year from aggregate actual Total Allowed Expenses for the period (the "**Deficit**") exceeds the aggregate Guarantee Payments for the period, the District shall forthwith pay the excess to the Contractor by ACH transfer. If the aggregate Guarantee Payments for the period exceed the Deficit, the Contractor shall forthwith pay the excess to the District; provided that the District may in its discretion recover the excess by setting it off against future Estimated Monthly Guarantee Payments.

(iii) Cost of Locum Tenens Providers. Provided the conditions set forth in Section 4.4 of the Agreement are met, District shall pay the cost of locum tenens and Temporary Providers either to the Contractor or directly to the Providers, at the District's election. Contractor shall promptly forward invoices for the services to the District.

(f) Additional Information; Adjustments. The District may from time to time reasonably request supporting documentation for the Monthly Report or the Quarterly Report, and may from time to time, on not less than ten (10) days' prior written notice to Contractor, audit (through its employees or independent accountants) Contractor's books and records relating to the Services, the Program Collections, and the expenses for which Contractor has claimed reimbursement under this Agreement. If District determines that any Guarantee Payment has exceeded the amount to which Contractor is entitled, it shall give the Contractor written notice of its determination (an "**Overpayment Notice**"), and (subject to Contractor's right to dispute the determination) the excess shall be an obligation of Contractor to District, which District may recoup by deduction from future Guarantee Payments, or

otherwise. If Contractor disputes District's determination, it shall give the District written notice of the dispute within thirty (30) days of delivery of the Overpayment Notice, and if the parties are unable to settle the dispute informally it shall be resolved in accordance with Section 9.6 of the Agreement.

(g) Excess Collections. If in any month Contractor's Program Collections exceed its Total Allowed Expenses for the month, the excess shall be offset against the next Guarantee Payment; provided that the aggregate amount to be paid to the District under this paragraph over the term of this Agreement shall not exceed the aggregate amount of expenses reimbursed by the District over the term of this Agreement, plus the District's costs of billing for the Contractor's Services. If District determines that any Guarantee Payment was less than the amount to which Contractor is entitled, it shall give the Contractor written notice of its determination, and shall pay the deficit to the Contractor (less any amount owed to the District by the Contractor under this Agreement).

(h) Post-Termination Collections. Upon expiration or termination of this Agreement which is not superseded by an extended or new agreement between parties for Services, District shall determine the aggregate Guarantee Payments made to Contractor, plus the District's aggregate costs of billing services, that were not offset by Program Collections during the term **("Net Payments**"). The following shall apply so long as the District has Net Payments that have not been repaid by Contractor.

(i) Any Program Collections in excess of the Monthly Guarantee Payments as of the expiration or termination of the Agreement shall be remitted to the District within ten (10) days after the termination of the Agreement, but in no event shall Contractor remit to District any Program Collections that are greater than the amount of Net Payments then outstanding.

(ii) If there are still Net Payments then outstanding, District shall be entitled to Program Collections for Program Services rendered by Contractor prior to the expiration or termination date but not collected prior to the expiration or termination date ("**Post-Termination Collections**"). Throughout the Tail Period, Contractor shall (i) continue to bill and collect for the Post-Termination Collections with the same diligence as during the term of this Agreement; (ii) continue to submit to District the Monthly Report; and (iii) pay District the amount of the Post-Termination Collections, but in no event shall Contractor remit any Post-Termination Collections that are greater than the amount of Net Payments then outstanding. Contractor may deduct its actual costs related to managing billing and collection activities of the Post-Termination Collections.

Allowable Expenses – Cardiac Anesthesia Services
(Subject to the terms of the foregoing Agreement)

Clinical Compensation Terms:

1. FTE's Required: As agreed upon from time to time and documented in writing; at the commencement of this Agreement, the number is 2.
2. Shift Compensation: $2,500 per weekday shift (2 physicians per day, Monday - Friday)
3. Call Compensation: $350,000 (all evenings and weekends)
    a. $850 per weekday call shift (Monday - Friday)
    b. $1,250 per weekend call shift (Saturday and Sunday)
4. Payment Terms
    a. Annual Increase – 2% increase in base compensation (only)
5. Locum Tenens – District reimbursement for the use of Locums or Temporary Providers is contemplated in Section 4.4 of the Agreement and Section 6(e)(iii) of Exhibit 4. The use of Locums or Temporary Providers for Call Coverage will result in a proportional decrease to the stated Call Compensation Amount.
    a. Providers are required to provide Uninterrupted Coverage. Providers must use their best efforts to arrange coverage to ensure their contractual obligations are met (2 physicians Monday – Friday). Providers shall give the District as much advance notice as practicable of any anticipated interruption in coverage, and not less than seven (7) days' notice of any interruption resulting from a planned absence.

Practice Expenses

1. To be determined as provided in Section 6(e) of Exhibit 4.

Sign-on Bonus

1. $30,000 for new Full-Time Physicians – 2 year commitment

Exhibit 5

PROVIDER ACKNOWLEDGEMENT

The undersigned, a Physician providing anesthesia services within the Anesthesia Department at Kaweah Delta Medical Center (the "Hospital") pursuant to an Exclusive Provider Agreement for Anesthesia Services (the "Provider Agreement") between Kaweah Delta Health Care District (the "District"), and Kaweah Cardiac Anesthesia Professionals, Inc., a California professional medical corporation (the "Contractor") agrees and acknowledges as follows:

(a) The Provider Agreement does not confer any contractual rights on the undersigned or any other individuals who currently are under contract with Contractor in any capacity.

(b) The clinical privileges of the undersigned to provide services in the Department that are exclusively assigned under the Provider Agreement (and if these are the only clinical privileges of the undersigned, his or her Medical Staff membership also) shall forthwith terminate, without further action by or on behalf of the District or the Medical Staff, and without right of review, fair hearing or appeal (which the undersigned expressly waives), if (i) the Provider Agreement expires or is terminated for any cause or reason, or without cause, or (ii) if the undersigned is providing services under a subcontract with Contractor, the subcontract expires or is terminated for any cause or reason, or without cause, or (iii) the undersigned ceases, without cause or for any cause or reason, to be employed or contracted by Contractor to provide services under the Provider Agreement.

(c) Upon termination of the Provider Agreement or of his or her employment or service agreement with the Contractor, the undersigned shall immediately vacate the Department.

ACKNOWLEDGED:

_____
Sign

_____
Print Name

Date: _____

KAWEAH DELTA HEALTH CARE DISTRICT
EXCLUSIVE PROFESSIONAL SERVICES AGREEMENT

Regarding the Service of ANESTHESIOLOGY
[CRNA Services]

This Exclusive Professional Services Agreement ("**Agreement**") is entered into effective October 1, 2021 ("**Effective Date**"), by and between **KAWEAH DELTA HEALTH CARE DISTRICT** ("**District**"), a local health care district organized and existing under the laws of the State of California, Health and Safety Code §§ 32000 *et seq.* and **KAWEAH NURSE ANESTHESIA SERVICES**, a California professional nursing partnership ("**Contractor**"):

BACKGROUND

A. District is the operator of a general acute care Hospital known as Kaweah Delta Medical Center (the "Hospital") in Visalia, California, in which there is located and operated an Anesthesia Department (the "Department").

B. Contractor is a ***nursing*** partnership whose shareholders and professional personnel are registered nurses licensed to practice nursing and certified to practice nurse anesthesia by the California Board of Registered Nursing ("CRNAs"), and who have been (or will by the Effective Date have been) approved by the administration and the appropriate Medical Staff committee to practice within the Hospital. The CRNAs providing services under this Agreement are referred to as "Providers." The services to be provided by the Providers under this Agreement are referred to as the "Services."

C. This is one of three contracts being entered into by the District for anesthesia services at the Hospital. The other contracts are with Kaweah Anesthesiologist Services, Inc. the "General Anesthesia Contractor" for general anesthesia services, and Kaweah Cardiac Anesthesia Professionals, Inc. (the "Cardiac Anesthesia Contractor" for cardiac anesthesia services. Contractor, the General Anesthesia Contractor and the Cardiac Anesthesia Contractor are referred to collectively in this Agreement as the "Co-contractors."

D. District, in accordance with its Bylaws administered through its Board of Directors, has determined that the best interests of patients, insofar as the quality of medical care is concerned, and insofar as the future quality of medical care and the availability of anesthesia at Hospital are concerned, shall be served by having the Co-Contractors exclusively provide professional services within the Department as provided in Section 2.1 and in accordance with the Bylaws and Rules and Regulations of the Medical Staff ("Medical Staff Bylaws").

E. It is anticipated that the District's contracting exclusively with the Co-contractors will facilitate the administration of the Department and the training of personnel therein, enhance interdepartmental communications within District, simplify and permit more flexibility in scheduling, promote better availability of anesthesia services, enhance convenience to and safety of patients, encourage more efficient use of equipment and personnel, and ultimately lower the cost of anesthesia services for the patients of District.

F. In view of the foregoing, District desires that the Contractor, with the Co-contractors, shall have the full and exclusive right and obligation to provide professional services within the Department as provided in Section 5.1, and Contractor desires to accept such sole and exclusive rights and responsibilities, in cooperation with the other Co-contractors; it being agreed, however, that he District's contract with each Co-contractor is a separate contract; that the obligations of the Co-contractors under their respective contracts are individual and several, not joint; and that Contractor shall not be liable for any obligations or entitled to any of the rights of the other Co-contractors under their respective contracts.

G. District and Contractor desire to enter into this Agreement in order to provide a full statement of their respective rights and responsibilities in connection with the operation of the Department and the provision of professional CRNA services at District during the term of this Agreement.

THEREFORE, in consideration of the foregoing recitals, the mutual covenants, conditions and promises hereinafter set forth, and other good and valuable consideration, the sufficiency of which is hereby acknowledged, and intending to be legally bound, District and Contractor agree as follows:

Section 1. Term and Termination.

1.1. **Term**. This Agreement shall be effective on the Effective Date and shall continue in full force and effect until **September 30, 2024**. The execution and delivery of this Agreement is subject to approval by the District's Board of Directors. For purposes of this Agreement, a "**Contract Year**" is a twelve-month period beginning on the Effective Date or any anniversary of the Effective Date.

1.2. **Termination without Cause**. Either party may terminate this Agreement at any time, without cause, by providing not less than one hundred twenty (120) days' prior written notice stating the intended date of termination.

1.3. **Material Breach**. Either party may terminate this Agreement at any time in the event the other party engages in an act or omission constituting a material breach of any term or condition of this Agreement. The party electing to terminate this Agreement pursuant to this Section shall provide the breaching party with not less than ten (10) days prior written notice specifying the nature and extent of the material breach. The breaching party shall have ten (10) days from the date of the notice to remedy the breach and conform its conduct to this Agreement. If corrective action is not taken within the time specified to the satisfaction of the party giving the notice, this terminating party may terminate this Agreement upon written notice to the breaching party. For purposes of this Section, "**material breach**" shall mean any breach of the terms or conditions of this Agreement which is substantial and material to the stated purpose of this Agreement as set forth in the Recitals hereto.

1.4. **Termination by District.** District may terminate this Agreement on notice to Contractor upon the occurrence of any of the following:

1.4.1. The death, disability, termination or withdrawal of any Provider which materially impairs Contractor's ability to provide services under this Agreement, unless such Provider is replaced as soon as practicable, and in any event within thirty (30) days.

1.4.2. Any of the following events affecting a Provider, unless Contractor immediately causes the Provider to cease providing services under this Agreement, and continues to provide the services required by this Agreement:

1.4.2.1. The revocation or suspension of the certification of a Provider to practice as a nurse anesthetist as issued by the California Board of Registered Nursing.

1.4.2.2. The loss of or suspension of the approval by the appropriate Medical Staff committee of the practice of a CRNA within the Hospital.

1.4.2.3. Failure of any Provider to comply with any of the qualifications set forth or referred to in Section 4.2, unless the Provider is promptly removed from service under this Agreement without impairing Contractor's ability to fulfill its obligations hereunder.

1.4.3. Failure to comply with any of the representations set forth in Section 4.1 of this Agreement, which failure continues uncured for more than thirty (30) days following receipt of written notice from District of such failure, unless the failure relates to a particular Provider, and the Provider is promptly removed from

service under this Agreement without impairing Contractor's ability to fulfill its obligations hereunder. Notice of failure shall specify with reasonable certainty the nature and extent of the failure.

1.4.4. Failure to provide any of the services and anesthesia coverage set forth in this Agreement, including the attached Exhibits, in accordance with the requirements of this Agreement, which failure continues uncured for more than thirty (30) days following receipt of written notice from District of such failure. Notice of failure shall specify with reasonable certainty the nature and extent of the failure.

1.4.5. Failure to use commercially reasonable efforts to manage its revenue cycle, except for causes beyond the reasonable control of Contractor or its agents or contractors, which failure is not cured within sixty (60) days following receipt of written notice from District of such failure.

1.4.6. Failure of Contractor to promptly address and resolve issues of non-performance or inappropriate conduct on the part of any of its Providers (which failure continues uncured for more than thirty (30) days following receipt of written notice from District of such failure. Notice of failure shall specify with reasonable certainty the nature and extent of the failure to comply) provided, however, that nothing contained in this Agreement is intended to supersede or supplant the role of the Chief of Staff, the MEC or the Medical Staff's Wellness Committee in addressing issues raised by the personal conduct of any of Contractor's Providers.

Termination for any of the reasons set forth above shall be considered as termination with cause.

1.5. **Termination of a Provider**. Upon request by District or Medical Staff's Medical Executive Committee ("**MEC**"), subject to any applicable cure period set forth in this section, Contractor shall remove from service under this Agreement any Provider: (i) who is convicted of a crime other than a minor traffic violation; (ii) who has a guardian or trustee of its person or estate appointed by a court of competent jurisdiction; (iii) who becomes permanently disabled so as to be unable to perform the duties required by this Agreement; (iv) who fails to maintain professional liability insurance required by this Agreement; (v) who has his/her license(s) and/or privileges required to provide services for the Department either suspended, revoked or otherwise limited; (vi) who discontinues services on a permanent basis; (vii) who is excluded, debarred or otherwise ineligible to participate in any federal health care program or in federal procurement or non-procurement programs or is convicted of or pleads no contest to a crime; (viii) who fails to comply with any of the terms and conditions of this Agreement after being given notice of that failure and a reasonable opportunity to comply; (ix) who fails to comply with the Standards and/or Codes described in Section 5.25; or (x) whose removal is requested pursuant to Section 4.7.1. For purposes of this Section 1.2, the term "permanently disabled" means the inability of a Provider, as a result of sickness or injury, to perform his or her duties under this Agreement for a period of more than one hundred eighty (180) days in the aggregate during any twenty-four (24) month period, despite reasonable accommodation.

1.6. **Immediate Termination**. District may terminate this Agreement immediately upon the occurrence of any of the following events:

1.6.1. Upon District's loss of certification as a Medicare provider;

1.6.2. Upon the closure of the Hospital or the Program; or

1.6.3. If Contractor is excluded, debarred or otherwise ineligible to participate in federal health care programs or in federal procurement or non-procurement programs or if Contractor is convicted of a crime. For purposes of this Paragraph, "**crime**" shall mean a felony as defined by the laws of the State of California or the United States of America punishable by imprisonment for a term of at least one (1) year.

1.7. **Tax-Exempt Financing**. If District is advised by its bond counsel that any amendment is required to this Agreement in order to establish or maintain the exemption from federal income tax of any obligations issued by or on behalf of the District, the parties shall, at the request of the District, cooperate to effect such amendment. If the parties fail to agree to such an amendment within thirty (30) days of the District's request,

the District may terminate this Agreement on thirty (30) days' notice to Contractor. The Contractor agrees that it is not entitled to and will not take any tax position that is inconsistent with being a service provider to the District with respect to the Department. For example, the Contractor shall not to claim any depreciation or amortization deduction, investment tax credit, or deduction for any payment as rent with respect to the Department.

1.8. **Survival**. Upon any termination of this Agreement, neither party shall have further rights against, or obligations to, the other party except with respect to any rights or obligations accruing prior to the date and time of termination and any obligations, promises or arrangements which expressly extend beyond the termination, including, but not limited to, the following: 0 (Term and Termination); Section 5.24 (Books and Records); Section 5.27 (Confidentiality); Section 8 (Insurance and Indemnification); Section 9.6 (Dispute Resolution); Section 9.11 (HIPAA); and Paragraphs 3 (Billing and Collection), 5 (Reports), 6(f) (Audit) and 6(h) (Post-Termination Collections) of Exhibit 4.

1.9. **Effect of Termination on Approval to Practice**. Contractor and each Provider agrees and acknowledges that: (a) upon termination of this Agreement without cause or for any cause or reason, the approval of the Medical Staff to practice as a CRNA within the Hospital]of each Provider who provides Services that are exclusively granted under this Agreement shall be immediately terminated, without further action by or on behalf of the District or the Medical Staff, and without right of review, fair hearing or appeal; and (b) the approval of the Medical Staff to practice as a CRNA within the Hospital of any Provider to provide services in the Department shall similarly terminate if he/she ceases, without cause or for any cause or reason, to be contracted by Contractor to provide services under this Agreement. Upon termination of this Agreement, Contractor and its Providers shall immediately vacate the Department. Contractor shall obtain a written acknowledgement in the form attached hereto as Exhibit 5 from each Provider providing Services under this Agreement, and shall provide the acknowledgement to District before the Provider is assigned to provide services under this Agreement.

Section 2. Independent Contractor Relationship.

2.1. The parties acknowledge that, in performing the Service, (i) Contractor shall be an independent contractor with respect to District; (ii) this Agreement is not a contract of employment within the meaning of California Labor Code §2750, and no provider shall be an employee of District for any purpose; and (iii) nothing contained in this Agreement shall be construed to create a partnership, agency or joint venture between District and Contractor, or to authorize either District or Contractor to act as a general or special agent of the other in any respect, except as may be specifically set forth in this Agreement.

2.2. Contractor shall be solely responsible for all compensation, benefits and required employment-related taxes, contributions and insurance for all of the Providers. District shall have no obligation under this Agreement to compensate or pay taxes for, or provide employee benefits of any kind (including contributions to government mandated, employment-related insurance and similar programs) to, or on behalf of, the Providers or any other person employed or retained by Contractor.

Section 3. Contractor's Representations. Contractor represents and warrants that:

3.1. Contractor is duly organized and operated in good standing as a professional medical corporation in the State of California;

3.2. Contractor is free to enter into this Agreement and is not violating any terms of any other agreement between Contractor and any third party by entering into this Agreement;

3.3. Contractor is a participating provider in the Medicare and Medi-Cal programs, and in other governmental health plans in which District participates, and conversely, is not an excluded, debarred or suspended provider for any federal health care program, federal procurement program or of the U.S. Food and Drug Administration;

3.4. Contractor is covered by one or more policies of professional liability insurance maintained by Contractor pursuant to Section 8.

3.5. No action, proceeding, inquiry, enforcement action, investigation, suit, claim or demand or legal, administrative, arbitration, or other method of settling disputes, whether legal or administrative or in mediation or arbitration (any of the foregoing, a "**Dispute**"), is pending or, to Contractor's knowledge, threatened against Contractor, or any of its officers, directors, employees, agents or contractors (collectively, **"Contractor's Personnel**") as a result of their activities hereunder as such, including (without limitation) (1) any Dispute concerning Contractor's or its Personnel's billing practices or alleging healthcare fraud or abuse on the part of Contractor or its Personnel, (2) any Dispute that relates in any way to Contractor's or its Personnel's services to or activities at the District or its facilities, (3) any dispute between Contractor and any of Contractor's Personnel relating to services provided under this Agreement, including any Dispute concerning Contractor's employment or contracting practices, or (4) any Dispute that could otherwise have a material adverse effect on Contractor's continued ability to perform any or all of its duties and obligations under this Agreement; nor is Contractor aware of any basis for any such Dispute. Contractor agrees to promptly notify the District's Compliance Officer in writing of the assertion or occurrence of any Dispute, and of any material change in status of any Dispute throughout the term of this Agreement.

Section 4. Providers.

4.1. Contractor represents and warrants to District, and agrees with District, as follows:

4.1.1. All Providers shall be employees or contractors of Contractor. The Providers providing services under this Agreement as of the Effective Date are mutually agreed upon by the parties. No person shall become a Provider thereafter without the approval of District, and without appropriate Medical Staff privileges.

4.1.2. All Providers meet, and shall continue to meet, the applicable requirements of 4.2.

4.1.3. Neither Contractor nor any Provider is bound by any agreement or arrangement which would preclude Contractor or any Provider from entering into, or from fully performing the services required under, this Agreement.

4.1.4. No CRNA's license to practice nurse anesthesia in the State of California or in any other jurisdiction has been denied, suspended, revoked, terminated, relinquished under treat of disciplinary action or restricted in any way.

4.1.5. No CRNA's allied health practitioner prerogatives or privileges at any health care facility have ever been denied, suspended, revoked, terminated, relinquished under threat of disciplinary action or made subject to terms of probation or any other restriction.

4.1.6. Contractor and each Provider shall perform the services required by this Agreement in accordance with: (1) all applicable federal, state, and local laws, rules and regulations; (2) all applicable standards of the accreditation organizations and any other relevant accrediting organizations, and (3) all applicable bylaws, rules, regulations, procedures, and policies of Hospital and the Medical Staff.

4.1.7. Contractor and each Provider is or shall be a participant in Medicare and the State's Medicaid program.

4.1.8. Neither Contractor nor any Provider has in the past conducted, and is not presently conducting, its or his/her medical practice in such a manner as to cause Contractor or the Provider to be suspended, excluded, debarred or sanctioned under the Medicare or Medicaid Programs or by any government licensing agency, and has never been charged with or convicted of an offense related to health care, or listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation.

4.1.9. The compensation paid or to be paid by Contractor to any Provider is and shall, at all times during the term of the Agreement, be fair market value for services actually provided by such Provider, not taking into account the value or volume of referrals or other business generated by such Provider for District. Contractor represents to District that Contractor has and shall at all times maintain a written agreement with each Provider receiving compensation from Contractor, which written agreement is or shall be signed by the parties, and does or shall specify the services covered by the arrangement. Further, Contractor shall comply with all relevant claim submission and billing laws and regulations. Each of the representations and warranties set forth herein shall be continuing and in the event any such representation or warranty fails to remain true and accurate during the Term, Contractor shall immediately notify District.

4.1.10. Prior to the Effective Date, Contractor has submitted to District copies of all its contracts with Providers. Thereafter, if Contractor proposes to enter into a contract with a Provider in a form substantially different from the forms previously approved by the District, Contractor shall submit the form of agreement to District for approval at least thirty (30) days prior to execution the contract. Contractor shall not enter into any agreement with a Provider in a form substantially different from the approved form unless the form of agreement has been approved by District, which may grant or withhold its approval in its discretion, provided that District shall not unreasonably withhold its approval. Contractor shall provide District with copies of all its contracts with Providers from time to time upon request.

4.1.11. Contractor shall compensate Providers on a payer-neutral basis.

4.1.12. Contractor shall provide statistical analyses to its Providers on a periodic basis related to their productivity and performance under this Agreement.

4.1.13. Contractor and its Providers acknowledge and agree that the primary professional responsibility of Contractor and its full-time Providers is to provide services under this Agreement. Contractor shall not, and shall not permit its full-time Providers to, become involved in any other contracts or professional obligations that materially interfere with the ability of Contractor to honor all of the terms and conditions of this Agreement, including, but not limited to, the responsibilities detailed on the Exhibits attached to this Agreement.

4.1.14. Contractor shall ensure that each Provider complies with all terms and conditions contained herein. Providers shall also: (a) cooperate with District's employee health program and the designated employee health nurse in providing, reviewing and developing health services for employees who work at District; (b) attend any and all meetings within District that Providers are asked to attend by District's Vice President of Cardiac and Surgical Services (the "VP"); and (c) perform such other duties as may from time to time be reasonably requested by District's Governing Board, or Medical Staff, Chief Executive Officer (the "CEO") and/or VP

4.1.15. The foregoing representations and covenants (except for those relating expressly to the Effective Date) shall be deemed to continue throughout the term of this Agreement.

4.2. **Qualifications of Providers**. Each Provider who provides Services under this Agreement shall:

4.2.1. Be an advanced practice registered nurse ("APRN") who has acquired graduate level education in anesthesia overseen by the American Association of Nurse Anesthetists ("ARNA") Council on Accreditation of Nurse Anesthesia Educational Programs;

4.2.2. Be duly licensed and qualified as a certified registered nurse anesthetist in the State of California;

4.2.3. Be approved for practice prerogatives or privileges as an Advanced Practice Provider on the Medical Staff in accordance with the Medical Staff Bylaws, and

4.2.4. Be covered by the policy or policies of professional liability insurance maintained by Contractor or the Provider pursuant to Section 8.

4.3. **Acknowledgment**. Each Provider who provides Services under this Agreement shall have executed an acknowledgement in the form set forth in Exhibit 5 prior to the commencement of such Services.

4.4. **Use of Temporary Providers**. Contractor shall make commercially reasonable efforts to staff the Department with Providers who are dedicated to the Hospital, and will not rely on locum tenens and temporary anesthesia providers retained through third party staffing companies ("**Temporary Providers**") except with the prior approval of the District, and only as necessary to cover temporary absences of regularly scheduled Providers, or while Contractor is making commercially reasonable efforts to hire dedicated personnel. Such Temporary Providers must meet the qualifications set forth above, must be approved by the District prior to their assignment, and may not be retained beyond the period approved by the District. If Contractor's use of a Temporary Provider is expected to extend beyond the period approved by the District, Contractor shall notify the District promptly (and in any event no later than three (3) working days before the expiration of the period); provided that the District shall not be required to agree to any extension of the approved period.

4.5. **Composition of Providers**. Contractor, in cooperation with the other Co-contractors, shall be primarily responsible for determining the number of Providers necessary to meet anesthesia requirements of District's patient load. Contractor may, with the agreement of the other Co-contractors, change the composition of Providers to meet temporary needs so long as changes in the composition of Providers do not reduce coverage or cause disruption within the Department or increase the District's aggregate costs for anesthesia services; provided that (i) the compensation payable to Contractor under Exhibit 4 shall be adjusted to reflect any change in the number of FTEs provided by Contractor, and (ii) any sustained change shall require the approval of the District and the OR Policy Committee.

4.6. **Addition of Providers.** If Contractor proposes to add a new Provider, Contractor shall notify District not less than seven (7) days prior to contracting with the new Provider and provide to District, on request, the proposed contract with the Provider prior to its execution in order to verify that it is consistent with this Agreement and requires compliance by the Provider with terms and conditions of this Agreement. The addition of any new Provider shall require the prior approval of the District.

4.7. **Termination of Providers**.

4.7.1. At all times while this Agreement is in effect, the CEO or VP of the District shall have the right to request removal in writing, with specification of cause, of any Provider from providing the Services hereunder for reasons related to clinical performance or failure to comply with this Agreement or with the policies, bylaws, rules, regulations or codes of conduct of the District or the Medical Staff. Contractor shall comply with such a request.

4.7.2. Contractor shall notify District not less than five (5) working days prior to Contractor's proposed termination of a Provider, whether with or without cause, which shall be subject to prior consultation with District. The notification shall include if the termination is for reasons related to clinical performance or compliance with clinical or conduct standards adopted by the Medical Staff. The notification need not be in writing, and the District shall keep the notification of the proposed termination confidential.

4.7.3. Contractor shall promptly notify District of the termination by a Provider of his or her contract with Contractor, or its expiration without extension or renewal.

4.7.4. Upon the termination of the contract between Contractor and a Provider, whether by the Provider or the Contractor, or automatically under the terms of the contract, the Provider shall be immediately removed by Contractor from the schedule for Services.

4.8. **Compensation of Providers**. All Guarantee Payments and other payments, other than the amounts for Practice Expense (as defined in Exhibit 4), shall be passed through to Contractor's providers as salary or benefits on an equitable basis, and shall not be retained or used by Contractor for administrative costs or profit. The District shall have the right from time to time upon request to review Contractor's agreements with its Personnel to determine their compensation and benefits.

4.9. **Exclusion Lists Screening**. Contractor shall screen all of its current and prospective owners, legal entities, officers, directors, employees, contractors, and agents ("**Screened Persons**") to ensure that none of the Screened Persons are currently excluded, debarred, suspended, or otherwise ineligible to participate in Federal healthcare programs or in Federal procurement programs, or have been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a), but have not yet been excluded, debarred, suspended, or otherwise declared ineligible (each, an "**Ineligible Person**"). If, at any time during the term of this Agreement any Screened Person becomes an Ineligible Person, Contractor shall immediately notify Hospital of the same. Screened Persons shall not include any employee, Contractor or agent who is not providing Services under this Agreement.

Section 5. Anesthesia Services.

5.1. **Coverage Schedule**.

5.1.1. Schedule. The District will establish an anesthesia committee (the "Anesthesia Committee") with responsibility for meeting regularly (as determined by the District) to assist the District and the O.R. Policy Committee to develop a schedule for anesthesia services (the "O.R. Schedule"), to modify and update the O.R. Schedule from time to time to address staffing needs and availability as the District expands its surgery services, and to review anesthesia services generally. Contractor shall participate actively on the Anesthesia Committee. The District shall be responsible for establishing the O.R. Schedule as provided in Section 5.2.6, and shall make the O.R. Schedule available to Contractor in writing (which may be on-line) in advance of its implementation. References in this Agreement to the O.R. Schedule refer to the O.R. Schedule as modified from time to time in accordance with this section and Section 5.2.6.

5.1.2. Endoscopy Coverage. In addition to the coverage set forth in the O.R. Schedule, Contractor shall, in cooperation with the other Co-contractors, provide up to the mutually agreed anesthesia coverage per month for Outpatient endoscopy, at variable hours confirmed by the Endoscopy Department and Contractor.

5.2. **Contractor's Services**.

5.2.1. Contractor shall cooperate with the other Co-contractors to provide all anesthesia services necessary for the proper operation of the Department, except for services provided by others pursuant to Section 5.2.2 of this Agreement. If any Provider is unable to staff the O.R. Schedule, Contractor shall communicate promptly with the District, including the Surgical Charge Nurse and O.R. Management, and shall use its best efforts to replace the Provider with a substitute Provider.

5.2.2. Contractor shall have the exclusive right and responsibility to provide all professional CRNA services required for daily scheduled surgery at Hospital, except for: (1) consulting services requested by the admitting physician; and (2) local anesthetics administered by a treating physician (including for pain management), where such treating physician elects to do his or her own local anesthetic, if and when permissible pursuant to applicable Medical Staff Bylaws (the "Services"). Without limiting the foregoing, the Services include sedation integral to the performance of operative procedures in the surgery suites at the Hospital, and to obstetrical services performed in the Hospital's labor and delivery department and other departments of the Hospital as needed, including endoscopy, emergency department, critical care and (subject to the exception set forth above) pain management for acute pain.

5.2.3. Notwithstanding anything to the contrary set forth in this Agreement, the parties acknowledge and agree that there may be certain members of the Medical Staff who are not affiliated with Contractor and currently or shall hold clinical privileges in pain management, acute and/or chronic, and that such clinical privileges shall not constitute a breach of Section 5.2.1.

5.2.4. Contractor shall have the ability to provide services to patients twelve (12) months of age and older through appropriately trained and supervised Providers.

5.2.5. All Services shall be provided in accordance with all applicable laws, regulations, accreditation requirements, and Medical Staff Bylaws and standards. District and Contractor recognize that the treating physician or surgeon is the primary customer of the CRNA along with the needs of the patient, and that anesthesia services are subject to the availability of sufficient anesthesia providers. Contractor shall devote its best efforts and sufficient time to provide for the proper management and operation of the Department.

5.2.6. Contractor shall cooperate with the other Co-contractors to provide, on premises, a sufficient number of anesthesiologists and CRNAs to cover the Services, on a twenty-four (24) hours per day basis, every day of the calendar year, with a sufficient number of Physicians and CRNAs physically present to provide full coverage the Services at all times as described in detail in the OR Schedule established pursuant to Section 5.1.1, as the Schedule may be modified from time to time, subject to reasonable and workable hours being established for elective surgery, and subject to the needs of the treating physician surgeon and the needs of the patients. The District, in consultation with the Medical Staff's O.R. Policy Committee ("O.R. Policy Committee"), shall determine, and Contractor shall abide by, scheduling and coverage needs, including modification of the days and/or hours on the O.R. Schedule, provided that (i) in the event that the District increases the coverage obligations, Contractor shall be given a reasonable time (not exceeding five months) to secure any additional staff necessary to meet the increased coverage obligations and District shall provide additional income support at the rate set forth in Exhibit 4; and (ii) to the extent practicable under the circumstances, the District shall give Contractor reasonable notice of any material reduction in required coverage.

5.2.7. It shall be the Contractor's responsibility to cooperate with the other Co-contractors to provide adequate numbers of Providers to fulfill the coverage requirements from time to time set forth in the O.R. Coverage Schedule, in compliance with all applicable laws, regulations, accreditation requirements, and Medical Staff Bylaws and standards.

5.2.8. Contractor shall cooperate with the other Co-contractors to ensure that the ratio of CRNAs to Physicians providing services under this Agreement shall not exceed 3:1 based on total hours worked, except for occasional variations from schedule to accommodate vacancies, volumes unexpected events or preferences of the medical staff.

5.3. **Emergency OR Call Coverage**.

5.3.1. Contractor shall cooperate with the other Co-contractors to provide first call emergency anesthesiology coverage twenty-four (24) hours per day, seven (7) days per week, including holidays. This call emergency coverage shall not be "in house" coverage, but rather shall be on-call coverage and Contractor shall exercise all reasonable efforts to have an appropriate CRNA at Hospital within thirty (30) minutes from the time a Contractor is paged for the on-call physician. At the request of the District, Contractor will make all reasonable attempts to provide an additional CRNA to provide call coverage on Saturdays and Sundays given sufficient notice.

5.3.2. When a third (3rd) call room is made available to the Co-contractors, the Contractor will cooperate with the other Co-contractors to provide in-house first call emergency anesthesiology coverage twenty-four (24) hours per day, seven (7) days per week, including holidays. The Contractor shall exercise all reasonable efforts to have an appropriate CRNA report to the Operating Room immediately from the time a Contractor is paged for the on-call physician. The District will make reasonable efforts to provide this call room as soon as possible, and the Co-contractors shall be the first recipient of an available Call Room prior to all other entities providing services for the District.

5.3.3. If an emergency C-Section occurs at the Hospital, Contractor will cooperate with the other Co-contractors to ensure that an anesthesiologist or CRNA will come to the Hospital to continue epidurals and be available for another simultaneous emergency C Section. If a trauma or emergency surgery occurs simultaneously during these obstetrical emergencies, Contractor will cooperate with the other Co-contractors to ensure that an anesthesiologist or CRNA will come to the Hospital, and another an anesthesiologist or CRNA will come in if there is a further emergency, which constitutes the fourth anesthetizing location.

5.4. **On-Call Requirement – No Discrimination**. In accordance with California Health and Safety Code §1317.3(b), Contractor shall provide on-call emergency services without discrimination to patients based on: race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, HIV status, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

5.5. **Obstetrical Coverage**.

5.5.1. Contractor shall cooperate with the other Co-contractors to provide all necessary obstetrical anesthesiology coverage for obstetrical (OB) cases at Hospital, including, but not limited to, epidural administration, twenty-four (24) hours per day, seven (7) days per week, including holidays. Exhibit 1 sets forth additional detail with respect to Contractor's obligations in this regard. Contractor cooperate with the other Co-contractors to have an anesthesiologist or CRNA physically present in Hospital within thirty (30) minutes after a call is placed to Contractor for emergency OB anesthesia services. The opinion of the responsible obstetrician that an emergency exists shall be conclusive.

5.5.2. Contractor shall cooperate with the other Co-contractors to include the obstetrical call schedule with their regular operating room call schedule. This schedule shall be posted with Operating Room Management and locations requested by District, and Co-contractors shall notify District of any changes as soon as possible.

5.6. **Unscheduled Surgeries**.

5.6.1. Contractor agrees to respond to unscheduled surgeries in an expeditious manner. The O.R. Policy Committee has established standardized policies regarding unscheduled surgeries, which shall be adhered to by the Contractor, as modified by the O.R. Policy Committee from time to time. Contractor shall provide the surgeon who shall be performing the unscheduled procedure, with an approximate

time for the procedure and that time shall be adhered to insofar as possible. During normal surgery hours as set forth on the O.R. Schedule, add-on cases shall be scheduled pursuant to existing policies. Unscheduled cases shall be divided into three categories: emergent surgery, urgent surgery, and routine add-on surgery.

5.6.2. An emergent surgery (e.g., ruptured AAA, post-operative bleeding, C-Section for fetal distress) shall be done in the first available room by the first available Provider even if this requires interrupting a scheduled room and another surgeon.

5.6.3. An urgent surgery (e.g., appendectomy, open fracture, etc.) shall be done in an appropriate room within one (1) to three (3) hours of the patient being available for surgery. Contractor shall make a good-faith effort not to interrupt a scheduled room, but the parties acknowledge that on occasion this may be necessary. When it is necessary to interrupt a scheduled room, the interrupted surgeon shall be notified by the interrupting surgeon, in accordance with the policy of the O.R. Policy Committee.

5.6.4. A routine add-on surgery shall be done in the first available room with the first available anesthesiologist or CRNA as soon as he/she is done with his/her elective schedule. A routine add-on shall not interrupt a scheduled room and shall not inconvenience scheduled cases. Upon receiving an add-on request, Contractor and the charge nurse shall promptly provide the surgeon requesting the add-on with an approximate time for the surgery. Routine add-ons shall be accommodated in the same order in which the requests are received by Contractor. If a request is made after normal surgery hours as reflected on the O.R. Schedule, it shall be accommodated at the discretion of Contractor. Rooms shall be made available for add-ons consistent with current requirements set by the O.R. Policy Committee working in consultation with Contractor and consistent with the days and hours set forth on the O.R. Schedule.

5.6.5. Contractor shall respond in a courteous, timely, professional manner to requests to do these non-scheduled cases.

5.7. **Phone Number for Requesting Anesthesia Services**. As part of the increased efficiency to be realized through this exclusive provider arrangement, Contractor shall be available for contact by District's House Supervisor through the PBX Operator twenty-four (24) hours per day, seven (7) days per week, including holidays. District's House Supervisor through the PBX Operator shall contact Contractor by making a direct telephone call to the anesthesiologist on-call, as is the current practice. District's PBX number shall be the only number which a physician or District representative (other than the PBX Operator) shall be required to call to make a request of Contractor for anesthesia coverage. The Nursing Supervisor through District's PBX Operator shall promptly relay the request for anesthesia services to Contractor by means of the telephone number, which Contractor has provided, to District's PBX Operator for the date and time of the call. In contacting Contractor, the House Supervisor through District's PBX Operator shall be required only to communicate to the authorized representative of Contractor who answers the call, the identity of the physician who requested anesthesia coverage and whether the physician identified the need for anesthesia services as an emergency. Once this number has been called and the request relayed by the House Supervisor through District's PBX Operator, Contractor shall be deemed paged for the purposes of this Agreement.

5.8. **Responses to Requests for Anesthesia Services**. Contractor agrees to respond to calls for anesthesia services by having a Provider in Hospital ready to perform the procedure within the following times:

5.8.1. Hospital Emergency: As soon as possible but no later than thirty (30) minutes;

5.8.2. Emergency Obstetrical Call: As soon as possible but no later than thirty (30) minutes;

5.8.3. Urgent Case Call: One (1) to three (3) hours.

5.8.4. The medical judgment of the responsible surgeon at the time of surgery shall be conclusive as to the classification of the case as emergency, urgent, or non-urgent. Retrospectively, any disagreements with

the classification used by the surgeon should be brought to the attention of the O.R. Policy Committee. Contractor agrees to have a Provider physically present at Hospital within these designated response times.

5.9. **Assignments for Scheduled Surgery**.

5.9.1. Contractor acknowledges that it is the desire of District that surgeons at Hospital retain the ability to request which of the Providers employed or engaged by Contractor shall provide anesthesiology services during a scheduled surgical procedure. Therefore, every reasonable effort shall be made to honor a surgeon's request for a specific Provider, as well as any of the following:

5.9.1.1. A bona fide request by a surgeon for the expertise of a particular Provider;

5.9.1.2. A specific patient request; or

5.9.1.3. A request for legitimate patient care needs based on the careful following of protocols and/or clinical pathways that have been pre-established to eliminate variabilities.

5.9.2. It is further acknowledged by Contractor that patient care is enhanced by a surgeon knowing, in advance, which of the Providers shall provide anesthesia services during a scheduled surgical procedure. Therefore, Contractor agrees to post the surgical assignments for the Providers in the Operating Room Scheduling Office before the start of that day's scheduled surgery and thereafter to endeavor to accommodate reasonable requests by surgeons to adjust those assignments.

5.10. **Membership of the Department**. All Providers who provide anesthesia services at Hospital shall be members of the Department of Anesthesia, and all anesthesia services contemplated by this Agreement shall be provided by CRNAs approved by the appropriate committee of the Medical Staff. With the approval of District administration, Providers with locum tenens privileges (granted by Contractor and the Medical Staff) may also provide services under this Agreement.

5.11. **Department Premises**. During the term of this Agreement, District shall continue to provide to or on behalf of Contractor, at District's sole cost and expense, the use of the Department's premises located in, on, or about the Hospital as currently used in connection with the Department and as expanded or relocated as may in the determination of the District be reasonably necessary in the future for the safe and efficient operation of the Department and the provision of anesthesia to patients at the Hospital. Contractor shall inform District as to future increased needs for Department premises. The District shall, at no cost to Contractor, provide three (3) on-call rooms (one for OB, one for Surgery, and one for OR Call when available).

5.12. **Use of Premises**. Contractor shall use the Department's premises solely for the practice of anesthesia, pain management and related procedures provided by the Department under this Agreement, and the administrative and clerical activities attendant to that practice. Use of the premises by Contractor shall be limited to Contractor's Providers and administrative staff. No part of the premises shall be used at any time by Contractor, nor shall Contractor permit anyone else to use the premises, as an office for the private practice of medicine unless a separate agreement in writing is reached by the parties to that effect.

5.13. **Professional Standards**. Contractor and its Providers shall perform their duties under this Agreement in accordance with the rules of ethics of the nursing profession. Contractor and its Providers also shall perform their duties under this Agreement in accordance with the appropriate standard of care for their respective professions and specialties including the guidelines of the American Society of Anesthesiologists and the Medical Staff Bylaws.

5.14. **Medical Direction and Administration**.

5.14.1. Spokesperson.

5.14.1.1. Contractor shall designate a spokesperson (the "**Spokesperson**") for Contractor, and may change its designation from time to time on prior notice to the District. The Spokesperson shall communicate in all matters involving the terms and conditions of this Agreement. Contractor shall arrange for the Spokesperson to be available to consult with District or its designees at reasonable times on a regular basis to discuss any matters concerning this Agreement or the administration or operation of the Department.

5.14.1.2. In addition, the Spokesperson shall act as the facilitator to ensure that the duties of Contractor described in this Agreement are met in a timely manner. Communications by District or its designee made to the Spokesperson shall be considered as made to Contractor and the Spokesperson shall be responsible for the forwarding of all such communications by District to the appropriate boards, committees, or Providers of Contractor. Statements made by the Spokesperson regarding this Agreement or the administration or operation of the Department shall be deemed by District as the statements of Contractor.

5.14.2. Director for CRNA Services. Contractor shall provide a Director for CRNA Services (the "**CRNA Director**"), who is approved by the District and the MEC. The CRNA Director shall be responsible under the Medical Director for Anesthesia Services for the direction of CRNA services, and shall perform the duties set forth in Exhibit 2.

5.14.3. Practice Leadership. The Contractor shall provide the services of one or more qualified CRNAs to provide practice leadership services, consisting of meeting attendance, policy review, personnel matters, scheduling, recruitment, and other administrative duties as appropriate.

5.15. **Additional Services**. In addition to the above coverage, Contractor agrees, in the operation of the Department, to provide to District the additional services listed on the attached Exhibit 3, it being understood by both parties that these additional services are a material part of the consideration for this Agreement.

5.16. **Service Obligations**. Contractor shall provide the Services in accordance with the Service obligations set forth in **Exhibit B** to this Agreement.

5.17. **Services to Medicare and Other Patients**. Contractor shall provide Services in a manner consistent with District's charitable purpose of providing medical service to a broad class of patients in the Service Area, maintaining Medicare and Medi-Cal provider status and treating Medicare and Medi-Cal inpatients in a nondiscriminatory manner throughout the term of this Agreement. Contractor shall provide uncompensated care to patients as reasonably requested by District throughout the term of this Agreement. District and Contractor shall cooperate in designating the patient recipients of uncompensated care.

5.18. **Reports**. Contractor shall prepare such administrative and business records and reports related to the Service in such format and upon such intervals as District may reasonably require.

5.19. **Conflicts of Interest**. Contractor shall inform District of any other arrangements which may present a conflict of interest or materially interfere in the performance of its duties under this Agreement. In the event Contractor or any Provider pursues conduct which constitutes a conflict of interest or which materially interferes with (or is reasonably anticipated to interfere with) Contractor's performance under this Agreement, District may exercise its rights and privileges under 0.

5.20. **Use of Hospital**. Contractor shall use the Department's premises solely for the practice of anesthesia, pain management and related procedures provided by the Department under this Agreement, and the administrative and clerical activities attendant to that practice. Use of the premises by Contractor shall be limited to Contractor's Providers and administrative staff. Contractor shall not use, or permit any Provider to use, any

part of the Hospital or other District facility for any purpose other than the performance of Services under this Agreement. Without limiting the generality of the foregoing, Contractor agrees that no part of the premises of Hospital shall be used at any time as an office for private practice and delivery of care for non-Hospital patients. This provision shall not apply to any office for private practice at any professional building owned by District or any of its affiliates, pursuant to a separate lease agreement, or other private patients and practices of Contractor independent of this Agreement.

5.21. **Authority**. Neither Contractor nor any Provider may enter into any contract in the name of District or otherwise bind District in any way without the express consent of District.

5.22. **Compliance with Laws**. Contractor shall perform all services under this Agreement in accordance with any and all requirements and accreditation standards applicable to District and the Service, including, without limitation, those requirements imposed by the California Departments of Health Care Services and Public Health, The Joint Commission and the Medicare/Medicaid conditions of participation.

5.23. **Compliance with District Policies and Bylaws**. Contractor and Physicians shall at all times comply with the bylaws, rules and regulations, policies and directives of District and the Medical Staff.

5.24. **Books and Records**.

5.24.1. Record-Keeping and Auditing. Contractor shall maintain current and detailed records of all its Services, its billing and collection activities and results, its personnel services and costs of compensation and benefits, and all other expenses that are included in the expenses guaranteed in Exhibit 4, in accordance with accepted accounting and record-keeping practices, and sufficient to document and support such expenses and the Monthly Reports to be provided pursuant to Exhibit 4. District may at its sole discretion audit, either internally or through an independent consultant, Contractor's coding, billing and collection activities, and its compensation records relating to Services provided under this Agreement by Contractor's employees and independent contractors. Without limiting the foregoing, District shall have access to Contractor's records relating to billing, collection, accounting, timekeeping, payroll and independent contractor services and compensation. At District's request, Contractor shall provide copies of any records described in this paragraph.

5.24.2. Access. Upon written request of the Secretary of Health and Human Services, the Comptroller General or any of their duly authorized representatives, Contractor shall make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such services. If Contractor carries out any of the duties of this Agreement through a subcontract with a value of ten thousand dollars ($10,000.00) or more over a twelve (12) month period with a related individual or organization, Contractor agrees to include this requirement in any such subcontract. This Section is included pursuant to and is governed by the requirements of 42 C.F.R. §§ 300-304. No attorney-client, accountant-client or other legal privilege shall be deemed to be waived by District or Contractor by virtue of this Agreement. This Section shall survive the termination or expiration of this Agreement.

5.25. **Compliance Program**. Contractor and each Provider shall (i) comply with all District policies, procedures and codes of conduct ("**Standards**"); (ii) sign and adhere to any disclosures or attestations related to District's compliance program (the "**Compliance Program**"); and (iii) participate in and support the Compliance Program. With respect to Contractor's and each Provider's business dealings with District and their performance of the Services, neither Contractor nor any Provider shall act in any manner that conflicts with or violates the Standards, nor cause another person to act in any manner which conflicts with or violates the Standards. Contractor and each Physician shall comply with the Standards (as they may be revised in the future), as they relate to Contractor's business relationship with District and its affiliates, employees, agents, contractors, and suppliers. Contractor further acknowledges and agrees that, pursuant to the Compliance Program, Contractor shall be subject to routine monitoring and review, and, potentially, external audit (limited to

Contractor's office(s) used in the performance of this Agreement). Contractor agrees to cooperate fully in any such review conducted in connection with the administration of the Compliance Program

5.26. **Notification of Certain Events**. Contractor shall notify District, in writing, promptly (and where feasible, within twenty-four (24) hours) of the occurrence of any of the following: (i) Contractor or any Provider becomes the subject of, or otherwise materially involved in, any government investigation regarding business practices, the provision of Services pursuant to this Agreement or the provision of professional services, including, without limitation, being served with a search warrant in connection with such activities; (ii) the approval of a Provider to practice at any hospital are denied, suspended, restricted, revoked or voluntarily relinquished, regardless of the availability of civil or administrative hearing rights or judicial review with respect thereto; (iii) Contractor or any Provider becomes the subject of any suit, action or other legal proceeding arising out of Contractor's professional services and/or the Service provided pursuant to this Agreement; (iv) Contractor or any Provider is required to pay damages or any other amount in any professional liability (malpractice) action by way of judgment or settlement; (v) any Provider become the subject of any disciplinary proceeding or action before any state's medical board or similar agency responsible for professional standards or behavior; (vi) any Provider becomes incapacitated or disabled from providing the Services, or voluntarily or involuntarily retire from the practice of medicine; (vii) any Provider's license to practice nursing in the State of California is restricted, suspended or terminated, regardless of the availability of civil or administrative hearing rights or judicial review with respect thereto; (viii) Contractor or any Provider becomes the subject of any disciplinary proceeding or action before any state's nursing board or similar agency responsible for professional standards or behavior; (ix) any Provider changes his/her medical specialty; (x) any Provider is charged with or convicted of a criminal offense other than an infraction; (xi) any event or occurrence which has a material adverse effect on a Provider's ability to perform any or all of the Service under this Agreement; (xii) Contractor or any of Provider is debarred, suspended or otherwise ineligible to participate in any federal or state health care program, (xiii) Contractor or any Provider is charged with or convicted of a felony, or any criminal offense related to the provision of health care, (xiv) any act of nature or any other event occurs which has a material adverse effect on Contractor's or any Provider's ability to perform the Services, (xv) any Provider ceases to meet the requirements set forth in Section 4, or (xvi) Contractor gives notice of termination to any Provider for reasons relating to clinical performance or compliance with clinical standards or standards of conduct adopted by the Medical Staff.

5.27. **Confidentiality**. Contractor understands and acknowledges that Contractor shall have access to confidential information ("**Confidential Information**") concerning District's business and that Contractor has a duty at all times not to use such information in competition with District or to disclose such information or permit such information to be disclosed to any other person, firm, corporation, entity or third party, during the term of this Agreement or at any time thereafter. For purposes of this Agreement, Confidential Information shall include, without limitation, any and all secrets or confidential technology, proprietary information, customer or patient lists, trade secrets, records, notes, memoranda, data, ideas, processes, methods, techniques, systems, formulas, patents, models, devices, programs, computer software, writings, research, personnel information, customer or patient information, plans or any other information of whatever nature in the possession or control of District that is not generally known or available to members of the general public or the medical profession, including any copies, worksheets or extracts from any of the above. Contractor further agrees that if this Agreement is terminated for any reason, it will neither take nor retain, without prior written authorization from District, originals or copies of any records, papers, programs, computer software, documents, x-rays or other imaging materials, slides, medical data, medical records, patient lists, fee books, files or any other matter of whatever nature which is or contains Confidential Information. This Section shall survive the termination or expiration of this Agreement.

5.28. **Quality**. Contractor shall provide Services in accordance with high professional standards of care in the area and consistent with the quality standards of District, as determined by the applicable oversight committee, the standards of The Joint Commission and District's quality assurance/ performance improvement programs and in compliance with all laws and regulations. Contractor shall, upon reasonable notice by District, make available to District the examination of its records and data with respect to the Services, including all quality data.

Contractor shall, upon reasonable notice by District, permit District to audit and inspect all such records and data necessary to ensure compliance with the terms of this Agreement.

5.29. **Medical Residency Programs**. Contractor acknowledges that District is a teaching facility accredited by the Accreditation Council for Graduate Medical Education (ACGME) for teaching and training of medical residents, including residency programs in anesthesiology, family medicine, emergency medicine, behavioral medicine, general surgery and transitional year. Contractor further acknowledges that the resident physicians are trainees practicing on a progressive continuum of independence and authority, and accordingly the residents must have collegial access to attending staff and medical directors for consultation and teaching, and that all patient care services provided by the residents are supervised by attending physicians. Contractor (i) acknowledges the present and future participation (after consultation with Contractor) of its employees and contractors as Core Faculty Members, Faculty Members and Program Director for the Program; (ii) will support and accommodate the Core Faculty Members, Faculty Members and Program Director in providing Faculty Services and otherwise meeting their Program duties, including supervision of the residents in the operating rooms and other locations; (iii) will provide prior notice and an opportunity to meet and confer with the District before terminating or restricting surgery room or other assignments of a participating anesthesiologist who is the Program Director or a Core Faculty Member or Faculty Member of the Program; and (iv) will otherwise support and facilitate the Program and the performance of services by the anesthesiology residents in the operating rooms and other hospital departments that are covered by this Agreement, provided that this provision shall not require Contractor to accommodate any faculty activities that would impair its ability to provide services under this Agreement, and provided, further, Contractor will not be required to incur any material cost in connection with such support.

Section 6. District's Obligations. District shall perform the following undertakings:

6.1. **Compensation**. The compensation terms are set forth in Exhibit 4 to this Agreement.

6.2. **Facilities and Service Provided by District**.

6.2.1. District shall provide on District premises the space designated by District for the Department, plus expendable supplies, equipment and services necessary for the proper operation of the Department.

6.2.2. District shall employ all technical and clerical personnel it deems necessary for the proper operation of the Department. District, with input from Contractor and Providers, shall direct and supervise the technical work and services of such Department personnel, with District retaining full administrative control and responsibility for all non-physician Service personnel. All personnel furnished by District shall be subject to the direction of Contractor while performing any clinical work or duties in the Department; however, all such personnel are not and shall not be made or considered to be agents of Contractor, but rather shall remain employees of District and under its general supervision and report to the management of the Surgery Department.

6.2.3. District agrees to provide, at its expense, a Practice Manager to oversee the day-to-day operations of Contractor within the Department, and at least one full-time on-site Administrative Analyst for the Service.

6.3. **District's Professional and Administrative Responsibilities**. To the extent required by Title 22, California Code of Regulations §70713, District shall retain the professional and administrative responsibility for the Service. District's retention of these responsibilities shall not alter or modify, in any way, the hold harmless, indemnification, insurance or independent contractor provisions set forth in this Agreement. Contractor shall apprise District of recommendations, plans for implementation and continuing assessment through dated and signed reports, which shall be retained by District for follow-up action and evaluation of performance.

Section 7. Change of Circumstances. In the event (i) Medicare, Medicaid, any third party payor or any federal, state or local legislative or regulatory authority adopts any law, rule, regulation, policy, procedure, or interpretation thereof

which establishes a material change in the method or amount of reimbursement or payment for services under this Agreement, or if (ii) any or all such payors/authorities impose requirements which require a material change in the manner of either party's operations under this Agreement and/or costs related thereto, then, upon the request of either party materially affected by any such change in circumstances, the parties shall enter into good faith negotiations for the purpose of establishing such amendments or modifications as may be appropriate in order to accommodate the new requirements and change of circumstances while preserving the original intent of this Agreement to the greatest extent possible. If, after thirty (30) days of such negotiations, the parties are unable to reach an agreement as to how or whether this Agreement shall continue, either party may terminate this Agreement upon thirty (30) days' prior written notice.

Section 8. Insurance and Indemnification.

8.1. **Contractor's Coverage**. Contractor shall ensure that Contractor and each Provider maintains professional liability insurance coverage with such insurance companies, issued upon such forms and containing such terms and limitations as required by the Medical Staff and as reasonably acceptable to District. The insurance coverage shall provide District defense for claims arising solely on the basis of vicarious liability or ostensible or apparent agency, for the act or inaction of Contractor or its Providers. As a minimum, the insurance shall provide coverage in the amount of one million dollars ($1,000,000.00) per occurrence, three million dollars ($3,000,000.00) in the aggregate. If the insurance is maintained on a claims-made basis, the insurance shall continue throughout the term of this Agreement; and upon the termination of this Agreement, or the expiration or cancellation of the insurance, Contractor shall ensure that it and/or each Provider purchases, or arranges for the purchase of, either (i) an extended reporting endorsement ("**Tail Coverage**") for the maximum period that may be purchased from its insurer (ii) "Prior Acts" coverage from the new insurer with a retroactive date on or prior to the date Contractor (or a Provider, as the case may be) began performing services at Hospital under this Agreement or (iii) maintain continuous coverage with the same carrier for the period of the statute of limitations for personal injury. In the event Contractor is unable to obtain the required insurance for or on behalf of Providers, Contractor shall require Providers to keep and maintain such insurance coverage individually. All such insurance shall be kept and maintained without cost or expense to District. In the event neither Contractor nor Providers purchase required coverage, District, in addition to other rights it may have under the terms of this Agreement or under law, shall be entitled, but not obligated to purchase such coverage. District shall be entitled to immediate reimbursement from Contractor for the cost thereof. District may enforce its right of reimbursement through set-off against any sums otherwise payable to Contractor or any Provider who failed to maintain the required coverage. Contractor shall provide District with one or more certificates of insurance certifying the existence of all coverages required hereunder. Contractor and Providers shall require their insurance carrier to provide District with not less than thirty (30) days' prior written notice in the event of a change in the professional liability policies of Contractor or Providers.

8.2. **District's Coverage**. District shall maintain, at its sole cost and expense, professional and general liability coverage for the acts and omissions of District, its officers, directors, employees and agents (excluding Contractor and Providers should it or they be deemed to be agents notwithstanding the contrary intent of the parties). The District's coverage may be provided through one or more programs of self-insurance.

8.3. **Indemnification**.

8.3.1. District shall defend, indemnify, and hold Contractor, its shareholders and Providers harmless from and against any and all liability, loss, expense, attorneys' fees, or claims for injury or damages arising out of the performance of this Agreement but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of District, its officers, directors, employees, or agents.

8.3.2. Contractor shall defend, indemnify, and hold District, its officers, directors, and employees harmless from and against any and all liability, loss, expense, attorneys' fees, or claims (i) for injury or damages arising out of the performance of this Agreement but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of Contractor, its shareholders, officers, Providers,

contractors, employees, or agents, (ii) any claim, loss or liability arising out of or with respect to its obligations to its employees or contractors for compensation or benefits, or arising from Contractor's failure to withhold or pay required employment-related taxes or compensation, and (iii) any claim, action and cause of action arising out of, or in any way connected to, a claim by a Provider, or other contractor or employee of Contractor, that he or she has in any way been treated wrongfully by Contractor or any of its present or future officers, directors, shareholders, contractors or employees.

8.3.3. Contractor shall be solely responsible for compliance will all employment-related laws and regulations with respect to Providers, including California Assembly Bill 5 of 2019, and shall indemnify, defend and hold the District harmless against any claim, cost or liability arising from any claim that any Provider is or was an employee of the District. Without limiting the foregoing, if District is required to compensate or pay taxes for, or provide employee compensation or benefits of any kind (including contributions to government mandated, employment-related insurance and similar programs) to, or on behalf of, any Provider or any other person employed or retained by Contractor, or to pay any costs or penalties resulting from its failure to pay any such compensation, benefits or other amount, the amount of all such costs, claims and liabilities shall be an obligation of Contractor to District, for which Contractor shall reimburse District within thirty (30) calendar days after being notified thereof; provided that District may, at its option, set off the amount of the obligation against any sums otherwise due to Contractor under this Agreement.

8.3.4. The provisions of this Section 8.3 shall survive termination of this Agreement.

Section 9. Miscellaneous Provisions.

9.1. **Notice**. Any notice required or desired to be given in respect to this Agreement shall be deemed to be given upon the earlier of (i) actual delivery to the intended recipient or its agent, or (ii) upon the third business day following deposit in the United States mail, postage prepaid, certified or registered mail, return receipt requested. Notice to either party may be given by the other party, in writing, personally delivered, or deposited in the United States mail, postage prepaid and addressed to the appropriate party, as follows:

If to District:
Kaweah Delta Health Care District
Attn: Gary Herbst, CEO
400 West Mineral King Avenue
Visalia, California 93291-6263

If to Contractor:
Kaweah Nurse Anesthesia Services
Attn: _____
400 West Mineral King Avenue
Visalia, California 93291

With copies to each of the following:
Herr Pedersen Berglund
Attn: Rachele Berglund
100 Willow Plaza, Suite 300
Visalia, California 93291

Attn: Peter Zeitler
5260 North Palm, Suite 421
Fresno, California 93704

With a copy to:
Benjamin Cripps, Chief Compliance Officer
Kaweah Delta Health Care District
400 West Mineral King Avenue
Visalia, California 93291-6263

9.2. **Entire Agreement**. This Agreement contains the entire agreement of the parties hereto and supersedes all prior agreements, contracts and understandings, whether written or otherwise, between the parties relating to the subject matter hereof.

9.3. **Partial Invalidity**. In the **event** any provision of this Agreement is found to be legally invalid or unenforceable for any reason, the remaining provisions of the Agreement shall remain in full force and effect provided the fundamental rights and obligations remain reasonably unaffected.

9.4. **Assignment**. Because this is a personal service contract, Contractor may not assign or subcontract any of its rights or obligations hereunder without the prior written consent of District. District may assign this Agreement to any successor to all, or **substantially** all, of District's operating assets or to any affiliate of District. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors and permitted assigns.

9.5. **Regulatory Requirements**. The parties expressly agree that nothing contained in this Agreement shall require Contractor or any Provider to **refer** or admit any patients to, or order any goods or services from, District. Notwithstanding any unanticipated effect of any provision of this Agreement, neither party shall knowingly or intentionally act in such a manner as to violate the prohibition against fraud and abuse in connection with the Medicare and Medicaid programs (42 U.S.C. §1320a-7b).

9.6. **Dispute Resolution**. The parties firmly desire to resolve all disputes arising hereunder without resort to litigation in order to protect their respective **business** reputations and the confidential nature of certain aspects of their relationship. Accordingly, any controversy or claim arising out of or relating to this Agreement, or breach thereof, shall first be addressed by and between Contractor and the District's Vice President responsible for the administrative oversight of the Service. If still unresolved to the mutual satisfaction of the parties, the dispute shall be referred to the Board of Directors for final resolution, subject to receiving the recommendation of the MEC to the extent required under the Medical Staff Bylaws. The Board of Directors shall, within a reasonable time, notify Contractor of its decision in accordance with the requirements of this Section. The parties expressly agree litigation may not be commenced regarding the terms and conditions of this Agreement or any controversy or dispute hereunder unless and until the contractual procedures and remedies described in this Section are exhausted. Nothing in this Section 9.6, however, shall require either party to complete the pre-litigation dispute resolution process in this Section 9.6 prior to exercising its respective rights under 0 to terminate this Agreement.

9.7. **Third Party Beneficiaries**. This Agreement is entered into for the sole benefit of District and Contractor. Nothing contained herein or in the **parties'** course of dealing shall be construed as conferring any third party beneficiary status on any person or entity not a party to this Agreement, including any Provider.

9.8. **Governing Law**. This Agreement shall **be** governed by the laws of the State of California.

9.9. **Approvals**. Neither this Agreement nor **any** amendment of or modification hereto shall be effective or legally binding upon either party unless it is set forth in a written document executed by the parties hereto.

9.10. **Attorneys' Fees**. If any legal action at law or in equity or any arbitration proceeding, is brought for the interpretation or **enforcement** of this Agreement or any part hereof, or because of an alleged dispute, breach, default or misrepresentation in connection with any of the provisions of this Agreement, the prevailing party shall be entitled to recover its reasonable attorneys' fees and other costs incurred in that action or arbitration proceeding, in addition to any other relief to which it may be entitled.

9.11. **HIPAA**. The parties **acknowledge** that they are part of an "organized health care arrangement" for purposes of the privacy provisions of the Health Information Portability and Accountability Act of 1996 ("**HIPAA**"). Contractor and each Provider shall perform the Services in accordance with (i) applicable state and federal laws and regulations relating to health information privacy and security, including the California Confidentiality of Medical Information Act (Civil Code § 56 and following), and regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA); (ii) the District's policies and procedures relating to health information privacy and security; and (iii) the District's notice of privacy practices.

9.12. **Modification**. This Agreement may be modified only by a signed, written instrument.

9.13. **Compliance with Laws.** District and Contractor agree to comply with all applicable statutes and regulations, both state and federal, governing the operation and administration of District, as well as standards set forth by the Joint Commission.

9.13.1. In addition to the obligations of the parties to comply with applicable federal, state and local laws respecting the conduct of their respective businesses and professions, District and Contractor each acknowledge that they are subject to certain federal and state laws governing the referral of patients which are in effect or will become effective during the term of this Agreement. These laws include the prohibition on payments for referral or to induce the referral of patients (California Business and Professions Code §650; California Labor Code §3215; and the Medicare/Medicaid Fraud and Abuse Law, §1128B of the Social Security Act); and

9.13.2. Nothing in this Agreement is intended or shall be construed to require either party to violate the California or federal laws described in Section 9.13.1, and this Agreement shall not be interpreted to:

9.13.2.1. Require any Provider to make referrals to District, be in a position to make or influence referrals to District, or otherwise generate business for the District.

9.13.2.2. Restrict any Provider from establishing staff privileges at, referring any patient to, or from otherwise generating any business for any other entity of the Provider's choosing.

9.13.2.3. Provide for payments in excess of the fair market value or comparable compensation paid to physicians for similar services in comparable locations and circumstances.

9.13.3. In the event of any changes in law or regulations implementing or interpreting the Internal Revenue Act or the Medicare and Medicaid Patient Protection Act of 1987, including the adoption or amendment of Medicare Fraud and Abuse Safe Harbor Regulations, or to any other Federal or State law relating to the subject matter of such Acts, to fraud and abuse, or to payment-for-patient referral, including the laws referenced in Section 7.14.1, the Parties shall use all reasonable efforts to revise this Agreement to conform and comply with such changes.

9.14. **Force Majeure**. Neither party shall be liable nor deemed to be in default for any delay or failure in performance under the Agreement or other interruption of service or employment deemed resulting, directly or indirectly, from: Acts of God; acts of civil or military authority; acts of terrorism, bioterrorism, or public enemy; bomb threats; computer virus; epidemic/pandemic, power outage; acts of war; accidents; fires; explosions; earthquakes; floods; failure of transportation, machinery, or supplies; vandalism; strikes or other work interruptions by District's employees; or any similar or dissimilar cause beyond the reasonable control of either party. Both parties shall, however, make good faith efforts to perform under this Agreement in the event of any such circumstance. This force majeure provision shall not relieve aa party of the obligation to make any monetary payments provided for hereunder.

9.15. **Counterparts**. **This** Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same agreement.

9.16. **Legal Counsel**. Each party understands the advisability of seeking legal counsel and financial/tax advice and has exercised its own judgment in this regard.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement effective on the date first set forth above. This Agreement shall be binding when all signatories listed below have executed this Agreement.

DISTRICT: **KAWEAH DELTA HEALTH CARE DISTRICT**

By: _____
Gary K. Herbst, Chief Executive Officer

CONTRACTOR: _____
a California professional nursing partnership

By: _____
_____, President

EXHIBIT 1
[RESERVED]

EXHIBIT 2
MEDICAL DIRECTOR FOR CRNA SERVICES

1. The Medical Director for CRNA Services shall perform the following duties, as they pertain to CRNA services:

(a) Participating in the educational programs conducted by District and the Medical Staff in order to assure Hospital's overall compliance with accreditation and licensing requirements, and performing such other reasonable teaching functions as District may request;

(b) Directing non-physician personnel in the performance of professional services for patients;

(c) Advising District with respect to the selection, retention and termination of all personnel who may be required for the proper performance of anesthesia services; provided, however, that District shall retain the ultimate decision-making authority regarding the selection, retention and termination of all such personnel;

(d) Establishing schedules for all services provided by Providers in accordance with the terms of this Agreement;

(e) Supervising the development and implementation of Hospital quality assurance and quality improvement programs and procedures relative to the Services;

(f) Assisting District in the preparation and conduct of surveys by The Joint Commission and/or any other national, state or local agency relating to the Anesthesia Service and the Services provided under this Agreement; and

(g) Performing any other duties related to the Anesthesia Services contemplated herein that District's Governing Board, Medical Staff and/or the VP may reasonably request.

EXHIBIT 3
ADDITIONAL SERVICE AND STAFFING REQUIREMENTS

Contractor, in cooperation with the other Co-contractors, shall meet the following service and staffing requirements, all of which shall be considered material requirements of this Agreement, as provided in Section 5.15 of the Agreement:

1. **General Requirements**:

(a) An adequate number of anesthesia providers shall be qualified to perform epidural, spinal, regional, MAC, total intravenous anesthesia (TIVA), central line placement, double lumen endotracheal tube intubation, fiber-optic bronchoscopy, use of glide scope, and general anesthesia to support institutional demand.

(b) Contractor shall be responsible for the monitoring of medication administration and correction of medication charge errors to ensure billing compliance for District.

(c) All Providers shall be ACLS certified as of the Effective Date, except for new Providers and Providers who have served less than one year under this Agreement, who shall be certified within one (1) year of commencing Services under this Agreement.

(d) Contractor shall actively participate with all hospital quality or improvement initiatives related to Surgical Services and Anesthesia Services

(e) Contractor shall exert commercially reasonable efforts to improve Physician Satisfaction results year-over-year as related to Surgical Services and Anesthesia.

(f) Contractor shall strive to improve Patient Satisfaction (HCAHPS) scores year-over-year as related to Anesthesia. Contractor shall cooperate with Hospital's Perioperative Medical Director on initiatives to improve quality and service in the main operating room and Surgical Center.

(g) Contractor shall participate in and cooperate with Hospital's OR Policy Committee, and shall collaborate with Hospital's surgical medical director.

(h) Contractor shall actively support Hospital's Quality initiatives, including the reduction of anesthesia-related OR case delays by assuring that patients have been interviewed and are ready on time for their scheduled surgical start times and that all anesthesiologists are consistently on time.

(i) Contractor shall conduct a minimum of one post-anesthesia evaluation on all inpatients and outpatients.

(j) Contractor, through a designated member, shall reasonably participate in the medical and paramedical educational programs conducted by District.

(k) Contractor shall comply with regulations and standards as outlined by The Joint Commission and California Code of Regulations ("CCR") Title 22, the State Board of Pharmacy, CMS Conditions of Participation and other agencies having authority over the Hospital and the Department, to include medication safety and control, appropriate documentation in the medical record, pre-induction assessments, and full compliance with all hazardous waste streams and HIPAA regulations, or as otherwise set forth in the Agreement.

(l) Contractor shall be responsible for and have authority to ensure District's compliance with anesthesia requirements of accrediting bodies such as the American Medical Association, The Joint Commission and California Department of Public Health, to include active participation in the Department and District-wide quality monitoring activities.

(m) Contractor shall on an ongoing basis participate through the Cardiac Anesthesia Medical Director or his/her designee, at meetings of all required Performance Improvement committees and assigned activities.

(n) Contractor shall make available to the Performance Improvement Department on a consistent and systematic basis all relevant information in the computerized or paper patient record for collection, display, and analysis.

(o) Contractor shall comply on an ongoing basis with all of The Joint Commission requirements, including dating and timing of pre-induction physicals.

(p) Contractor shall have bi-monthly Department meetings, and shall maintain, on an ongoing basis, Departmental minutes which accurately reflect appropriate and consistent involvement in the Performance Improvement process.

(q) Contractor shall on an ongoing basis demonstrate a multi-Departmental team approach to solving quality problems that involve multi-Departmental processes.

(r) Contractor shall on an ongoing basis demonstrate responsibility and accountability in the protection of the patient and with respect to unsolved problems that involve interdepartmental responsibility.

(s) Contractor shall maintain, on an ongoing basis, bi-monthly Departmental minutes which accurately reflect review of data, problems, mortality, and outcomes, with analysis and action appropriate to the solution of problems in a timely and effective manner.

(t) Contractor shall collaborate to support educational programs as requested by the District.

(u) Contractor shall direct and arrange for anesthesiologists proctoring per applicable Medical Staff Bylaws.

(v) Contractor and its Providers shall participate actively in the affairs of the Medical Staff, including, without limitation, serving on committees and discharging such other obligations as may be requested by the Medical Staff, or any duly appointed officer or committee thereof.

(w) Contractor and its Providers shall conform to any and all lawful administrative directive issued from time to time by the CEO, Vice President of Cardiac and Surgical Services and/or CMO, provided that such directives are consistent with the scope and principles of this Agreement.

2. **Monthly Meeting**. The Medical Director shall meet with District's Medical Director for Surgical Services and Director for Surgical Services at the monthly meeting to review performance of services identified in this Exhibit 3 and any other operational issues of concern.

3. **Quality Assurance**. Specific anesthesia criteria shall be developed by the Department of Anesthesia ("Department") that shall identify variances in Hospital practice/medical care (e.g. difficult intubations, OPs admitted to Hospital due to N & V, etc.) A medical record review shall be conducted by the Department when a patient's criteria are not satisfied. This information accompanied with any corrective action implemented shall be reported monthly to the O.R. Policy Committee and Medical Care Review Committee.

4. **Documentation Requirements**. Contractor shall promptly complete all records, forms and reports reasonably required by District and the Medical Staff. District has developed an integrated computerized information system so as to more efficiently interface and collate medical data for patient care and billing. Contractor shall actively utilize District's electronic medical records technology and tools. It is expected that anesthesia records, both computerized and written, prepared by Providers shall be accurate, complete and timely in accordance with Title 22.

5. **Qualifications**. In order to assure and enhance present and on-going clinical qualifications of Contractor and its Providers:

(a) Contractor shall ensure that any Provider providing pediatric anesthesiology shall have training in pediatric anesthesiology and PALs certification. Pediatric definition by age to be determined by Surgery, Anesthesia, and Pediatrics Departments.

(b) All Providers, to the extent eligible, shall be trained, privileged and expected to place arterial/central lines and fiber optic difficult intubations.

(c) Whenever possible, all staffing assignments by Contractor shall be based on Provider competency in the required skills.

(d) Contractor or Contractor's representatives shall acknowledge receipt all complaints within two (2) business days or sooner after receipt of notification.

6. **Dress Code**. All Providers shall adhere to the OR attire/dress code and the prohibitions on food and drink in the operating room, as required by the Surgical Services Policy.

7. **Professional Behavior**.

(a) Contractor shall ensure that its Providers comply with the Code of Professional Conduct for Medical Staff/Allied Staff and the Conduct Guidelines of Medical/Allied Staff Granted Privileges at Kaweah Delta Medical Center, each as adopted by the Medical Staff of Hospital.

(b) Contractor's Providers shall maintain professional behavior toward District's patients, patient's family members, Medical Staff members, visitors, and District staff as required by the Department of Anesthesia Policy and Procedure Manual, all related District Policies and the Medical Staff Bylaws.

(c) Providers shall arrive for scheduled cases at a reasonable time in order to allow for appropriate assessment, possible intervention, orders, etc., to avoid delays in surgery.

8. **Medication Management**. All Providers shall document and practice the following:

(a) Appropriate syringe labeling practices;

(b) Documentation of drugs received from Pyxis to ensure accountability of drug and restocking;

(c) Documentation of drug charges in collaboration with the Hospital pharmacy in appropriate systems;

(d) In collaboration with the District, Contractor shall achieve one hundred percent (100%) accountability for all drugs used and their disposition;

(e) Contractor shall achieve greater than an 85% initial charting accuracy compliance rate.

(f) Comply with District policies to ensure proper disposal of sharps and/or pharmaceutical waste in collaboration with the Hospital pharmacy;

(g) Comply with District Policy to ensure compliance, as applicable, with any compounding standards in collaboration with the Hospital pharmacy, such as aseptic techniques.

(h) Assure that Providers standardize their use of drug utilization with best practices, where feasible.

(i) When the mass transfusion protocol is in effect, Providers shall abide by the protocol until it is terminated.

9. **Anesthesia Business Indicators –** Unless specified differently, the following anesthesia business indicators will be monitored and reported quarterly and annually to the O.R. Policy Committee, O.R. Management, and Administration:

(a) **Anesthesia -** Staffing in comparison to anesthesia O.R. coverage schedule – will be reviewed quarterly with O.R. Management

(b) **Anesthetic Volume**

- By anesthetic location
- By anesthesia type
- By ASA class

(c) **Number of Clinicians**

- By type (Physician, Resident, CRNA, etc.)

(d) **Total Minutes (and Units) Billed**

- By anesthetic coverage location

(e) **Anesthesia Clinical Indicators.** The following anesthesia clinical indicators will be monitored and reported quarterly and annually to the Chief Medical Officer and Administration:

- Number of cases completed eventfully
- Occurrence of critical events (by location/service; definitions):
    - Death
    - Cardiac Arrest
    - Perioperative MI
    - Anaphylaxis
    - Malignant Hyperthermia
    - Transfusion Reaction
    - New Stroke
    - Visual Loss
    - Incorrect Surgical Site
    - Incorrect Patient
    - Medication Error
    - Unplanned Admission
    - Unplanned ICU Admission

- Intraoperative Awareness
- Unplanned Difficult Airway
- Unplanned Reintubation
- Dental Trauma
- Perioperative Aspiration
- Vascular Access Complication
- Pneumothorax
- Infection After Regional Anesthesia
- Epidural Hematoma
- High Spinal
- Postdural Puncture Headache
- Local Anesthetic Toxicity
- Peripheral Neurologic Deficit

10. **Performance Expectations**. In addition to the general service requirements of this Agreement, the Contractor shall use commercially reasonable efforts to ensure that its Providers meet specific performance expectations from time to time set by agreement by the parties. The performance expectations in effect on the Effective Date are as follows:

Indicators	
OB Patient Satisfaction (overall)[1]	>90%
Post Op PACU Pain Satisfaction	>90%
Anesthesia Related OR Case OR Delays[2]	<4%
On-time starts for Scheduled Surgery	>90%
On-time start for Scheduled Endoscopy, Electrophysiology Studies, AICD's, and Cardioversions	>90%

[1] As measured by MTC Health.

[2] Contractor and District to work together to establish a mutually agreeable definition.

EXHIBIT 4
COMPENSATION

1. Entire Compensation. Except as provided in this Agreement, neither District nor Contractor shall charge the other for Services provided pursuant to this Agreement.

2. Meet and Confer. The parties shall meet and confer at least quarterly to discuss the performance of the Contractor, including Provider recruitment and retention, billing and collection for Services, and Practice Expenses.

3. Billing and Collection of Fees for Services.

(a) Fee Schedule. Contractor shall prepare a schedule of fees representing its full professional charges for Services rendered to District patients under this Agreement. The fee schedule, and any change thereto, shall be approved in advance by District in order for District to ensure that fees are reasonable, fair and consistent with the basic commitment of District to provide adequate health care to all residents within the Service Area. The fee schedule shall, at all times, comply with all applicable laws, rules, regulations and payer agreements. The fees shall at all times be reasonable and competitive. Nothing herein shall be construed to cause Contractor to violate any federal or state laws concerning the establishment of fees. Contractor shall provide prompt notice to District of any and all proposed changes in Contractor's fee structures

(b) Documentation of Services. Contractor shall ensure that its Providers document all Services fully, completely, accurately and promptly in the District's electronic medical records, including entering appropriate billing codes, and provide such additional documentation as the District or the contracted billing company requires to ensure prompt billing of and payment for Contractor' Services.

(c) Billing Services. Contractor shall use the services of a qualified contractor approved by District for the billing and collection of claims for all Services provided during the term of this Agreement. The approved billing service provider is R1 RCM. Contractor shall obtain such assignments as are necessary to enable the services of its Providers to be billed in the name and for the account of Contractor. Contractor shall be responsible for ensuring that the billing service bills and collects claims for Contactor's services competently and diligently, and in accordance with commercial standards of practice.

(d) Provider Enrollment and Participation Agreements. Contractor shall diligently pursue and maintain, participation in good standing for Medicare, Medi-Cal and all managed care contracts for health care services in which District participates, e.g., health maintenance organizations (HMOs) and preferred provider organizations (PPOs), and shall ensure that its Subcontractors do the same. Contractor shall follow the same procedures for credentialing new Providers in order to obtain payment for Services in a timely manner.

(e) Global Contracts. To the extent that District enters into a contract with a health plan or other payor that does not permit Contractor and District to separately bill for their respective professional and technical services ("**Global Contract**"), Contractor shall look solely to District for payment and District shall compensate Contractor for such services by a mutually agreeable amount (to be set in advance in writing), but in no event shall the amount be less that the amount that Contractor would have received for such services, but for the Global Contract. Any such reimbursement shall be Program Collections for purposes of this Agreement.

(f) Collections.

(i) Program Collections. For purposes of this this Exhibit, "**Program Collections**" means revenues or receipts received by or on behalf of Contractor or any of its Providers during the applicable month from any and every source in any way related to Services performed at the District's facilities, including (without limitation) (i) payments under policies of business interruption insurance, and grants from government agencies relating to Services provided, lost revenues, or reimbursement of costs (except insofar as such grants are intended and used to cover unanticipated costs that are not reimbursable under this Agreement), and (ii)

Abandoned Collections, as defined below; but excluding Guarantee payments made by the District under this Agreement, and less refunds, recoupments, offsets, takebacks or withholds.

(ii) Audit; Abandoned Collections. District may at its sole discretion, audit, either internally or through an independent consultant, Contractor's documentation and coding practices. If, as a result of an audit or otherwise, District identifies claims that have not been billed (i) because of the failure of Contractor or a Provider to document or code its services promptly and appropriately in accordance with industry standards, or (ii) because of the failure of Contractor to reasonably cooperate with the District's efforts to establish its eligibility, or the eligibility of any Provider, for payment from any third-party payor, or to bill for and collect claims for services, and the billing contractor is not able to resubmit such claims to the payor by statute or payor requirements for timely claim submission ("Abandoned Collections"), the amount of Abandoned Collections, adjusted to reflect the Contractor's historical collections rate for the payor, shall be added to Contractor's Program Collections during the Term of this Agreement; provided that the Abandoned Collections shall not include the professional portion of any global rates that were billed and collected by District. For purposes of this Agreement, Abandoned Collections shall not include any charity care discount or other appropriate decision to reduce the charges to or payable by a Program patient; however, Abandoned Collections shall include any courtesy discount (including professional courtesy to a health provider or any family members of a health care provider) unrelated to individual need or appropriate exigent circumstances. The amount of Abandoned Collections identified subsequent to the expiration or termination of this Agreement that relate to Services performed by Contractor during the Term of this Agreement shall be promptly repaid by Contractor to District in an amount equal to, taking into consideration the historical collections rate for the payor, what would have been paid by the payor to Contractor had the collections not been abandoned.

(g) District Billing. District shall be responsible to bill and collect for all technical Hospital services provided to District patients during their Hospital stay.

(h) Billing Errors. The parties shall have reasonable access to records necessary to verify each party's compliance with this Agreement. Each party shall promptly correct or assist the other party in correcting any billing errors.

4. Submission of Pro Forma Estimates. On an annual basis, commencing three (3) months before each anniversary of this Agreement, Contractor shall provide to District (i) a pro forma estimate of the Program Collections, all Variable Provider Expenses (as defined below), by category, and all Practice Expenses (as defined by below (by Category) for the then current year, and (ii) a pro forma estimate of Program Collections, all Variable Provider Expenses (by category) and all Practice Expenses (by category) for the following year. At its option, District may request Contractor to provide information as necessary for District to evaluate the adequacy of the Practice Expenses.

5. Reports; Other Information.

(a) Documentation of Time. Medical Directors shall report their time through the District's Physician Time Study Database. All Clinical Providers shall be required to clock in and out via ADP Geo-fencing technology or other mutually agreed upon program. Medical Director, Practice Leadership and GME/Faculty hours (payable under a separate Agreement) may not be recorded for time spent while the Provider is providing clinical shifts, except as approved in advance by District, or on occasional instances where avoidance would be impractical.

(b) Monthly Reports. Within fifteen (15) days after the end of each month of this Agreement, Contractor shall submit to District an itemized report ("**Monthly Report**") setting forth the following in form and content reasonably satisfactory to the District, for the month just ended and for the Contract Year to date:

(i) The number of shifts and hours of Services performed each day of the month, with a description of the Services provided each day, and an indication of any variations from the staffing schedule set forth in the O.R. Schedule;

(ii) The number, identities and schedules of the individuals who provided Services during the month;

(iii) Contractor's billings for Services;

(iv) Program Collections;

(v) Abandoned Collections;

(vi) Refunds, recoupments and offsets of or to Program Collections, and any claims for any of these;

(vii) Accounts receivable, and an accounts receivable aging report;

(viii) A report on Contractor's performance during the month with respect to the goals set forth in Exhibit 4-2 (the "**Billing and Collection Targets**").

(ix) The Contractor's cost of Provider compensation and benefits ("**Variable Provider Expenses**")

(x) Other financial information maintained by Contractor or its billing agent as may be reasonably requested by District in order to determine its obligations under this Agreement or monitor compliance with this Agreement.

(c) The Contractor shall continue to submit the Monthly Report for each of the twelve (12) months following the termination or expiration of this Agreement for any cause or reason (the "**Tail Period**") in accordance with subsection (b), except that the reports for the Tail Period need contain only the information described in clauses (b)(iii) through (b)(vii) and (b)(x).

(d) Quarterly Report. As soon as practicable after the end of each quarter of each Contract Year, Contractor shall submit to District an itemized report ("**Quarterly Report**") for the prior quarter, setting forth the information required to be included in the Monthly Report, but aggregated for the quarter, in form and content reasonably satisfactory to the District.

(e) Annual Report. As soon as practicable after the end of each Contract Year, Contractor shall submit to District an itemized report ("**Annual Report**") for the prior Contract Year, setting forth the information required to be included in the Monthly Report, but aggregated for the Contract Year, in form and content reasonably satisfactory to the District.

(f) Other Information. In addition to the Monthly, Quarterly and Annual Reports, Contractor shall provide District with such additional reports and information as the District may reasonably request, including but not limited to collections activity, etc., with such frequency as the District may reasonably request.

(g) Production of Reports. If the District requests any report or information under this Section 5 that is not available as a standard report from the reporting systems of the Contractor or its contractors, the Contractor shall within fifteen (15) days of the District's request notify the District when the report may be available, or if the report is not available in the form or format requested by the District, how the Contractor proposes to make the information available to the District. The District shall not unreasonably withhold its approval of the Contractor's proposal, as long as the proposal would provide the information requested by the District in a timely manner. Once the parties have agreed upon the form and format of the report, the Contractor shall provide it in accordance with the District's request.

6. Compensation.

(a) Retention of Program Collections. Contractor shall retain all Program Collections, except as provided in Paragraph (f) (as to adjustments of estimated and actual Program Collections) and Paragraph (h) (as to Post-Termination Collections).

(b) Guaranty. Provided that Contractor submits Monthly, Quarterly and Annual Reports as required by Section 5, and subject to the provisions of this Exhibit, the District shall pay Contractor the amount, if any, by which Contractor's Total Allowed Expenses exceeds its Program Collections during the term of this Agreement on an aggregate term-to-date basis (the "**Guaranty**"). Payments in relation to the Guaranty shall be made as provided in subsection (e) below. For purposes of this Exhibit, "**Total Allowed Expenses**" means the aggregate of Contractor's actual and reasonable expenses incurred in in connection with the provision of Services, as set forth in (and not exceeding the amounts set forth in) Schedule 4 hereto. The expense limitations in Schedule 4 shall be applied on a line-item basis, not an aggregate basis.

(c) Contract Year. The amounts set forth in Schedule 4 are for a Contract Year, which means each year of the term of this Agreement commencing October 1 and ending September 30 of the following year (or sooner if this Agreement is terminated before the end of the current Contract Year); and the terms "per year" or "annually" mean for each Contract Year.

(d) Total Allowed Expenses. In determining Total Allowed Expenses:

(i) Except with the approval of the District, which it may give or withhold in its discretion:

(A) The number of FTE Providers whose compensation and benefit expense is included in Total Allowed Expenses shall not exceed the number in Schedule 4, or such lesser number as may be reasonably necessary to meet the coverage schedule from time to time set forth in the O.R. Schedule, as modified pursuant to Section 5.2.1 of the Agreement. The FTE status of Providers shall be determined in accordance with the criteria set forth in Schedule 4. The Parties acknowledge and agree that Contractor may, with the approval of District, deviate temporarily from the actual number of Providers set forth in Schedule 4, so long as the coverage set forth in the O.R. Schedule is provided and the deviation does not increase the District's expenses under this Agreement without its prior approval.

(B) For any period during which the CRNA Director does not provide the services required by this Agreement (except for regular time away from practice for vacation, continuing medical education and the like), upon prior notice the relevant expense for CRNA Leadership Stipends shall be reduced proportionately.

(ii) The District shall reimburse Contractor's cost of billing and collection directly to the Contractor's contracted billing service, and the costs of billing and collection shall not be Allowed Expenses.

(iii) The Total Allowed Expenses shall not include any expense, cost, charge, reduction, recoupment or offset incurred prior to the Effective Date, or arising from circumstances or events existing or occurring prior to the Effective Date, and the Contractor shall provide the District with such information as the District may reasonably request to satisfy itself that all charges and expenses included in the Monthly Reports arose or were incurred on or after the Effective .

(iv) The Total Allowed Expenses shall also include the cost to Contractor of sign-on bonuses not exceeding $10,000 for a new Provider, subject to the prior approval of the District in each case, and contingent upon a two-year service commitment by the Provider in form approved by the District.

(e) Payment Obligations and Reconciliation.

(i) Monthly Guarantee Payments. The District shall make the following payments to Contractor, each an "**Estimated Monthly Guarantee Payment**," and all of which shall be deemed to be "**Guarantee Payments**" for purposes of this Agreement, and which shall be reduced in the aggregate by the amount of Program Collections for the most recent month for which the Monthly Report is available, and shall be subject to periodic reconciliation as provided in Paragraph (ii) below:

(a) Clinical Services. By the fifth (5th) day of each month District will pay Contractor an amount equal to District's estimate of Contractor's expenses for the month for the salaries and benefits for the clinical services of Providers, based on budgeted Provider hours, adjusted to add or deduct any amount necessary to reflect any difference in actual hours, as reflected in the reports referred to in Section 5(a), as against estimated hours for the most recent month for which such reports are available, and based on the relevant hourly rate set forth in Schedule 4.

(b) Medical Director and CRNA Leadership Costs. By the twentieth (20th) day of each month District will pay Contractor the amount due for Medical Director Services and CRNA Leadership costs for the prior month. Payment for Medical Director and CRNA Leadership shall be in accordance with the hours documented via the Physician Time Study Database, at the hourly rates and subject to the monthly caps set forth in Schedule 4.

(c) Practice Expenses.

(i) As provided in Section 4 of this Exhibit 4, at least three (3) months before each anniversary of the Effective Date of this Agreement, Contractor shall provide District with a proposed budget for its expenses related solely to the performance of Services under this Agreement in the categories listed below, or such other categories as the parties may agree upon from time to time in connection with the process described in this paragraph ("**Practice Expenses**"). With the proposed budget, Contractor shall also provide such information concerning its historical expenses in each category of Practice Expense as the District may request in order to assess the proposed budget. In collaboration with Contractor, the District shall establish a final budget for Contractor's Practice Expenses for the ensuing year (the "**Practice Expense Budget**"), and shall provide Contractor a copy of the Practice Expense Budget before the start of the year. The District shall pay Contractor the amount of the Practice Expense Budget in twelve (12) equal monthly installments over the year. The Practice Expense Budget shall be updated annually and shall operate prospectively; provided that if the District fails to provide a budget for the current year for any reason other than delay by Contractor in the submission of its proposed budget, the Practice Expense Budget for the prior year shall continue in effect, pro rata, until the new one is provided by the District. The following categories of expense incurred by Contractor in connection with the performance of Services shall be included in the initial Practice Expense Budget; provided that the categories may be changed prospectively in connection with each annual budget:

- Bank Service Charges
- Computer Software & Internet
- Continuing Education
- Health Insurance
- Malpractice and Employment Insurance
- Worker's Compensation
- Meals and Entertainment
- Office Expense
- Office Supplies

- Payroll Expenses
- Payroll Fees
- Payroll Taxes
- Payroll Taxes (Federal)
- Payroll Taxes (State)
- Postage/Printing
- Professional Fees
- Accounting Fees
- Credentialing Fees
- Consulting/Management Fees
- Consulting/Management Travel
- Legal Fees
- State Tax
- Communications Expense
- Utilities
- Financial Planning and Retirement Fees
- Recruitment
- Additional Administrative Support deemed necessary by the contractor

(ii) The Contractor shall provide the District with any information that the District may reasonably request to document any Practice Expense.

(iii) In no event shall the Practice Expenses reimbursable under this Agreement exceed the aggregate amount set forth in the relevant Practice Expense Budget.

(ii) Periodic Reconciliation. Following delivery of the Quarterly Report and the Annual Report to the District, the District shall reconcile the Estimated Monthly Guarantee Payments over the term of this Agreement to date to the Contractor's actual Total Allowed Expenses and Program Collections over the term of this Agreement (each such reconciliation, a "**Reconciliation**"). If the amount determined by subtracting aggregate actual Program Collections for the quarter or the year from aggregate actual Total Allowed Expenses for the period (the "**Deficit**") exceeds the aggregate Guarantee Payments for the period, the District shall forthwith pay the excess to the Contractor by ACH transfer. If the aggregate Guarantee Payments for the period exceed the Deficit, the Contractor shall forthwith pay the excess to the District; provided that the District may in its discretion recover the excess by setting it off against future Estimated Monthly Guarantee Payments.

(iii) Cost of Locum Tenens Providers. Provided the conditions set forth in Section 4.4 of the Agreement are met, District shall pay the cost of locum tenens and Temporary Providers either to the Contractor or directly to the Providers, at the District's election. Contractor shall promptly forward invoices for the services to the District.

(f) Additional Information; Adjustments. The District may from time to time reasonably request supporting documentation for the Monthly Report or the Quarterly Report, and may from time to time, on not less than ten (10) days' prior written notice to Contractor, audit (through its employees or independent accountants) Contractor's books and records relating to the Services, the Program Collections, and the expenses for which Contractor has claimed reimbursement under this Agreement. If District determines that any Guarantee Payment has exceeded the amount to which Contractor is entitled, it shall give the Contractor written notice of its determination (an "**Overpayment Notice**"), and (subject to Contractor's right to dispute the determination) the excess shall be an obligation of Contractor to District, which District may recoup by deduction from future Guarantee Payments, or

otherwise. If Contractor disputes District's determination, it shall give the District written notice of the dispute within thirty (30) days of delivery of the Overpayment Notice, and if the parties are unable to settle the dispute informally it shall be resolved in accordance with Section 9.6 of the Agreement.

(g) Excess Collections. If in any month Contractor's Program Collections exceed its Total Allowed Expenses for the month, the excess shall be offset against the next Guarantee Payment; provided that the aggregate amount to be paid to the District under this paragraph over the term of this Agreement shall not exceed the aggregate amount of expenses reimbursed by the District over the term of this Agreement, plus the District's costs of billing for the Contractor's Services. If District determines that any Guarantee Payment was less than the amount to which Contractor is entitled, it shall give the Contractor written notice of its determination, and shall pay the deficit to the Contractor (less any amount owed to the District by the Contractor under this Agreement).

(h) Post-Termination Collections. Upon expiration or termination of this Agreement which is not superseded by an extended or new agreement between parties for Services, District shall determine the aggregate Guarantee Payments made to Contractor, plus the District's aggregate costs of billing services, that were not offset by Program Collections during the term **("Net Payments**"). The following shall apply so long as the District has Net Payments that have not been repaid by Contractor.

(i) Any Program Collections in excess of the Monthly Guarantee Payments as of the expiration or termination of the Agreement shall be remitted to the District within ten (10) days after the termination of the Agreement, but in no event shall Contractor remit to District any Program Collections that are greater than the amount of Net Payments then outstanding.

(ii) If there are still Net Payments then outstanding, District shall be entitled to Program Collections for Program Services rendered by Contractor prior to the expiration or termination date but not collected prior to the expiration or termination date ("**Post-Termination Collections**"). Throughout the Tail Period, Contractor shall (i) continue to bill and collect for the Post-Termination Collections with the same diligence as during the term of this Agreement; (ii) continue to submit to District the Monthly Report; and (iii) pay District the amount of the Post-Termination Collections, but in no event shall Contractor remit any Post-Termination Collections that are greater than the amount of Net Payments then outstanding. Contractor may deduct its actual costs related to managing billing and collection activities of the Post-Termination Collections.

Schedule 4

Allowable Expenses – CRNA Services

(Subject to the terms of the foregoing Agreement)

Clinical Compensation Terms:

1. Rate: $175.00
2. FTE Definition: 1,840 hours per FTE
3. FTE Base Compensation and Benefits: $322,000
4. FTE's Required: As agreed upon from time to time and documented in writing; at the commencement of this Agreement, the number is 22.6.
5. Payment Terms
    a. Payment based on hours worked (payroll reports) at $175.00
    b. Annual Increase – No increase in years 1 and 2. A 2% increase in year 3 (base compensation only)

Leadership – Annual Cap - $109,200

1. CRNA Medical Director and Group Leadership – Contractor to be paid $109,200 annually to provide at least 624 hours (annually) conducting CRNA Medical Director and Group Leadership duties. Amount subject to monthly attestation and will be paid in equal monthly payments (1/12 of total).

Practice Expenses

1. To be determined as provided in Section 6(e) of Exhibit 4.

Sign-on Bonus

1. $10,000 for new Full-Time CRNAs – 2 year commitment

Exhibit 5

PROVIDER ACKNOWLEDGEMENT

The undersigned, a CRNA providing anesthesia services within the Anesthesia Department at Kaweah Delta Medical Center (the "Hospital") pursuant to an Exclusive Provider Agreement for Anesthesia Services (the "Provider Agreement") between Kaweah Delta Health Care District (the "District"), and Kaweah Nurse Anesthesia Services, a California professional medical partnership (the "Contractor") agrees and acknowledges as follows:

(a) The Provider Agreement does not confer any contractual rights on the undersigned or any other individuals who currently are under contract with Contractor in any capacity.

(b) The status of the undersigned as an Advanced Practice Provider having clinical privileges or approvals to provide nurse anesthetist services in the Department shall forthwith terminate, without further action by or on behalf of the District or the Medical Staff, and without right of review, fair hearing or appeal (which the undersigned expressly waives), if (i) the Provider Agreement expires or is terminated for any cause or reason, or without cause, or (ii) if the undersigned is providing services under a subcontract with Contractor, the subcontract expires or is terminated for any cause or reason, or without cause, or (iii) the undersigned ceases, without cause or for any cause or reason, to be employed or contracted by Contractor to provide services under the Provider Agreement.

(c) Upon termination of the Provider Agreement or of his or her employment or service agreement with the Contractor, the undersigned shall immediately vacate the Department.

ACKNOWLEDGED:

_____
Sign

_____
Print Name

Date: _____

KAWEAH DELTA HEALTH CARE DISTRICT
EXCLUSIVE PROFESSIONAL SERVICES AGREEMENT

Regarding the Service of ANESTHESIOLOGY
[General Anesthesiology]

This Exclusive Professional Services Agreement ("**Agreement**") is entered into effective October 1, 2021 ("**Effective Date**"), by and between **KAWEAH DELTA HEALTH CARE DISTRICT** ("**District**"), a local health care district organized and existing under the laws of the State of California, Health and Safety Code §§ 32000 *et seq.* and **KAWEAH ANESTHESIOLOGIST SERVICES INC.** a California professional medical corporation ("**Contractor**"):

BACKGROUND

A. District is the operator of a general acute care Hospital known as Kaweah Delta Medical Center (the "Hospital") in Visalia, California, in which there is located and operated an Anesthesia Department (the "Department").

B. Contractor is a medical corporation whose shareholders and professional personnel are physicians licensed to practice medicine in the State of California and who are (or will be by the Effective Date) members in good standing of the Medical Staff of the Hospital (the "Medical Staff"), and who have been (or will by the Effective Date have been) approved by the administration and the appropriate Medical Staff committee to practice within the Hospital. The physicians providing services under this Agreement are referred to as "Providers." The services to be provided by the Providers under this Agreement are referred to as the "Services."

C. This is one of three contracts being entered into by the District for anesthesia services at the Hospital. The other contracts are with [Kaweah Nurse Anesthesia Services (the "CRNA Contractor" for the services of certified nurse anesthetists, and Kaweah Cardiac Anesthesia Professionals, Inc.(the "Cardiac Anesthesia Contractor") for cardiac anesthesia services. Contractor, the CRNA Contractor and the Cardiac Anesthesia Contractor are referred to collectively in this Agreement as the "Co-contractors."

D. District, in accordance with its Bylaws administered through its Board of Directors, has determined that the best interests of patients, insofar as the quality of medical care is concerned, and insofar as the future quality of medical care and the availability of anesthesia at Hospital are concerned, shall be served by having the Co-Contractors exclusively provide professional services within the Department as provided in Section 2.1 and in accordance with the Bylaws and Rules and Regulations of the Medical Staff ("Medical Staff Bylaws").

E. It is anticipated that the District's contracting exclusively with the Co-contractors will facilitate the administration of the Department and the training of personnel therein, enhance interdepartmental communications within District, simplify and permit more flexibility in scheduling, promote better availability of anesthesia services, enhance convenience to and safety of patients, encourage more efficient use of equipment and personnel, and ultimately lower the cost of anesthesia services for the patients of District.

F. In view of the foregoing, District desires that the Contractor, with the Co-contractors, shall have the full and exclusive right and obligation to provide professional services within the Department as provided in Section 5.1, and Contractor desires to accept such sole and exclusive rights and responsibilities, in cooperation with the other Co-contractors; it being agreed, however, that the District's contract with each Co-contractor is a separate contract; that the obligations of the Co-contractors under their respective contracts are individual and several, not joint; and that Contractor shall not be liable for any obligations or entitled to any of the rights of the other Co-contractors under their respective contracts.

G. District and Contractor desire to enter into this Agreement in order to provide a full statement of their respective rights and responsibilities in connection with the operation of the Department and the provision of professional general anesthesia services at District during the term of this Agreement.

THEREFORE, in consideration of the foregoing recitals, the mutual covenants, conditions and promises hereinafter set forth, and other good and valuable consideration, the sufficiency of which is hereby acknowledged, and intending to be legally bound, District and Contractor agree as follows:

Section 1. Term and Termination.

1.1. **Term**. This Agreement shall be effective on the Effective Date and shall continue in full force and effect until **September 30, 2024**. The execution and delivery of this Agreement is subject to approval by the District's Board of Directors. For purposes of this Agreement, a "**Contract Year**" is a twelve-month period beginning on the Effective Date or any anniversary of the Effective Date.

1.2. **Termination without Cause**. Either party may terminate this Agreement at any time, without cause, by providing not less than one hundred twenty (120) days' prior written notice stating the intended date of termination.

1.3. **Material Breach**. Either party may terminate this Agreement at any time in the event the other party engages in an act or omission constituting a material breach of any term or condition of this Agreement. The party electing to terminate this Agreement pursuant to this Section shall provide the breaching party with not less than ten (10) days prior written notice specifying the nature and extent of the material breach. The breaching party shall have ten (10) days from the date of the notice to remedy the breach and conform its conduct to this Agreement. If corrective action is not taken within the time specified to the satisfaction of the party giving the notice, this terminating party may terminate this Agreement upon written notice to the breaching party. For purposes of this Section, "**material breach**" shall mean any breach of the terms or conditions of this Agreement which is substantial and material to the stated purpose of this Agreement as set forth in the Recitals hereto.

1.4. **Termination by District.** District may terminate this Agreement on notice to Contractor upon the occurrence of any of the following:

1.4.1. The death, disability, termination or withdrawal of any Provider which materially impairs Contractor's ability to provide services under this Agreement, unless such Provider is replaced as soon as practicable, and in any event within thirty (30) days.

1.4.2. Any of the following events affecting a Provider, unless Contractor immediately causes the Provider to cease providing services under this Agreement, and continues to provide the services required by this Agreement:

1.4.2.1. The revocation or suspension of the license of a Provider to practice medicine as issued by the California Medical Board.

1.4.2.2. The revocation or suspension of the Drug Enforcement Administration (DEA) licensure of a Provider issued by the United States Department of Justice Drug Enforcement Administration for just cause.

1.4.2.3. The loss of or suspension from membership on the Medical Staff of Hospital of a Provider for just cause after appropriate hearing procedures in accordance with the Medical Staff Bylaws and other applicable rules and regulations and other applicable law.

1.4.2.4. Failure of any Provider to comply with any of the qualifications set forth or referred to in Section 4.2, unless the Provider is promptly removed from service under this Agreement without impairing Contractor's ability to fulfill its obligations hereunder.

1.4.3. Failure to comply with any of the representations set forth in Section 4.1 of this Agreement, which failure continues uncured for more than thirty (30) days following receipt of written notice from District of such failure, unless the failure relates to a particular Provider, and the Provider is promptly removed from service under this Agreement without impairing Contractor's ability to fulfill its obligations hereunder. Notice of failure shall specify with reasonable certainty the nature and extent of the failure.

1.4.4. Failure to provide any of the services and anesthesia coverage set forth in this Agreement, including the attached Exhibits, in accordance with the requirements of this Agreement, which failure continues uncured for more than thirty (30) days following receipt of written notice from District of such failure. Notice of failure shall specify with reasonable certainty the nature and extent of the failure.

1.4.5. Failure to use commercially reasonable efforts to manage its revenue cycle, except for causes beyond the reasonable control of Contractor or its agents or contractors, which failure is not cured within sixty (60) days following receipt of written notice from District of such failure.

1.4.6. Failure of Contractor to promptly address and resolve issues of non-performance or inappropriate conduct on the part of any of its Providers (which failure continues uncured for more than thirty (30) days following receipt of written notice from District of such failure. Notice of failure shall specify with reasonable certainty the nature and extent of the failure to comply) provided, however, that nothing contained in this Agreement is intended to supersede or supplant the role of the Chief of Staff, the MEC or the Medical Staff's Wellness Committee in addressing issues raised by the personal conduct of any of Contractor's Providers.

Termination for any of the reasons set forth above shall be considered as termination with cause.

1.5. **Termination of a Provider**. Upon request by District or Medical Staff's Medical Executive Committee ("**MEC**"), subject to any applicable cure period set forth in this section, Contractor shall remove from service under this Agreement any Provider: (i) who is convicted of a crime other than a minor traffic violation; (ii) who has a guardian or trustee of its person or estate appointed by a court of competent jurisdiction; (iii) who becomes permanently disabled so as to be unable to perform the duties required by this Agreement; (iv) who fails to maintain professional liability insurance required by this Agreement; (v) who has his/her license(s) and/or privileges required to provide services for the Department either suspended, revoked or otherwise limited; (vi) who discontinues services on a permanent basis; (vii) who is excluded, debarred or otherwise ineligible to participate in any federal health care program or in federal procurement or non-procurement programs or is convicted of or pleads no contest to a crime; (viii) who fails to comply with any of the terms and conditions of this Agreement after being given notice of that failure and a reasonable opportunity to comply; (ix) who fails to comply with the Standards and/or Codes described in Section 5.25; or (x) whose removal is requested pursuant to Section 4.7.1. For purposes of this Section 1.2, the term "permanently disabled" means the inability of a Provider, as a result of sickness or injury, to perform his or her duties under this Agreement for a period of more than one hundred eighty (180) days in the aggregate during any twenty-four (24) month period, despite reasonable accommodation.

1.6. **Immediate Termination**. District may terminate this Agreement immediately upon the occurrence of any of the following events:

1.6.1. Upon District's loss of certification as a Medicare provider;

1.6.2. Upon the closure of the Hospital or the Program; or

1.6.3. If Contractor is excluded, debarred or otherwise ineligible to participate in federal health care programs or in federal procurement or non-procurement programs or if Contractor is convicted of a crime. For purposes of this Paragraph, "**crime**" shall mean a felony as defined by the laws of the State of California or the United States of America punishable by imprisonment for a term of at least one (1) year.

1.7. **Tax-Exempt Financing**. If District is advised by its bond counsel that any amendment is required to this Agreement in order to establish or maintain the exemption from federal income tax of any obligations issued by or on behalf of the District, the parties shall, at the request of the District, cooperate to effect such amendment. If the parties fail to agree to such an amendment within thirty (30) days of the District's request, the District may terminate this Agreement on thirty (30) days' notice to Contractor. The Contractor agrees that it is not entitled to and will not take any tax position that is inconsistent with being a service provider to the District with respect to the Department. For example, the Contractor shall not to claim any depreciation or amortization deduction, investment tax credit, or deduction for any payment as rent with respect to the Department.

1.8. **Survival**. Upon any termination of this Agreement, neither party shall have further rights against, or obligations to, the other party except with respect to any rights or obligations accruing prior to the date and time of termination and any obligations, promises or arrangements which expressly extend beyond the termination, including, but not limited to, the following: Section 1 (Term and Termination); Section 5.24 (Books and Records); Section 5.27 (Confidentiality); Section 8 (Insurance and Indemnification); Section 9.6 (Dispute Resolution); Section 9.11 (HIPAA); and Paragraphs 3 (Billing and Collection), 5 (Reports), 6(f) (Audit) and 6(h) (Post-Termination Collections) of Exhibit 4.

1.9. **Effect of Termination on Medical Staff Membership and Clinical Privileges**. Contractor and each Provider agrees and acknowledges that: (a) upon termination of this Agreement without cause or for any cause or reason, the clinical privileges and Medical Staff membership of each Provider who provides Services that are exclusively granted under this Agreement shall be immediately terminated, without further action by or on behalf of the District or the Medical Staff, and without right of review, fair hearing or appeal; and (b) the clinical privileges and Medical Staff membership of any Provider to provide services in the Department shall similarly terminate if he/she ceases, without cause or for any cause or reason, to be contracted by Contractor to provide services under this Agreement. Upon termination of this Agreement, Contractor and its Providers shall immediately vacate the Department. Contractor shall obtain a written acknowledgement in the form attached hereto as Exhibit 5 from each Provider providing Services under this Agreement, and shall provide the acknowledgement to District before the Provider is assigned to provide services under this Agreement.

Section 2. Independent Contractor Relationship.

2.1. The parties acknowledge that, in performing the Service, (i) Contractor shall be an independent contractor with respect to District; (ii) this Agreement is not a contract of employment within the meaning of California Labor Code §2750, and no provider shall be an employee of District for any purpose; and (iii) nothing contained in this Agreement shall be construed to create a partnership, agency or joint venture between District and Contractor, or to authorize either District or Contractor to act as a general or special agent of the other in any respect, except as may be specifically set forth in this Agreement.

2.2. Contractor shall be solely responsible for all compensation, benefits and required employment-related taxes, contributions and insurance for all of the Providers. District shall have no obligation under this Agreement to compensate or pay taxes for, or provide employee benefits of any kind (including contributions to government

mandated, employment-related insurance and similar programs) to, or on behalf of, the Providers or any other person employed or retained by Contractor.

Section 3. Contractor's Representations. Contractor represents and warrants that:

3.1. Contractor is duly organized and operated in good standing as a professional medical corporation in the State of California;

3.2. Contractor is free to enter into this Agreement and is not violating any terms of any other agreement between Contractor and any third party by entering into this Agreement;

3.3. Contractor is a participating provider in the Medicare and Medi-Cal programs, and in other governmental health plans in which District participates, and conversely, is not an excluded, debarred or suspended provider for any federal health care program, federal procurement program or of the U.S. Food and Drug Administration;

3.4. Contractor is covered by one or more policies of professional liability insurance maintained by Contractor pursuant to Section 8.

3.5. No action, proceeding, inquiry, enforcement action, investigation, suit, claim or demand or legal, administrative, arbitration, or other method of settling disputes, whether legal or administrative or in mediation or arbitration (any of the foregoing, a "**Dispute**"), is pending or, to Contractor's knowledge, threatened against Contractor, or any of its officers, directors, employees, agents or contractors (collectively, **"Contractor's Personnel**") as a result of their activities hereunder as such, including (without limitation) (1) any Dispute concerning Contractor's or its Personnel's billing practices or alleging healthcare fraud or abuse on the part of Contractor or its Personnel, (2) any Dispute that relates in any way to Contractor's or its Personnel's services to or activities at the District or its facilities, (3) any dispute between Contractor and any of Contractor's Personnel relating to services provided under this Agreement, including any Dispute concerning Contractor's employment or contracting practices, or (4) any Dispute that could otherwise have a material adverse effect on Contractor's continued ability to perform any or all of its duties and obligations under this Agreement; nor is Contractor aware of any basis for any such Dispute. Contractor agrees to promptly notify the District's Compliance Officer in writing of the assertion or occurrence of any Dispute, and of any material change in status of any Dispute throughout the term of this Agreement.

Section 4. Providers.

4.1. Contractor represents and warrants to District, and agrees with District, as follows:

4.1.1. All Providers shall be employees or contractors of Contractor. The Providers providing services under this Agreement as of the Effective Date are mutually agreed upon by the parties. No person shall become a Provider thereafter without the approval of District, and without appropriate Medical Staff privileges.

4.1.2. All Providers meet, and shall continue to meet, the applicable requirements of Section 4.2.

4.1.3. Neither Contractor nor any Provider is bound by any agreement or arrangement which would preclude Contractor or any Provider from entering into, or from fully performing the services required under, this Agreement.

4.1.4. No Provider's license to practice medicine in the State or in any other jurisdiction or Drug Enforcement Agency number has ever been denied, suspended, revoked, terminated, relinquished under threat of disciplinary action, or restricted in any way.

4.1.5. No Provider's medical staff privileges at any health care facility have ever been denied, suspended, revoked, terminated, relinquished under threat of disciplinary action, or made subject to terms of probation or any other restriction.

4.1.6. Contractor and each Provider shall perform the services required by this Agreement in accordance with: (1) all applicable federal, state, and local laws, rules and regulations; (2) all applicable standards of the accreditation organizations and any other relevant accrediting organizations, and (3) all applicable bylaws, rules, regulations, procedures, and policies of Hospital and the Medical Staff.

4.1.7. Contractor and each Provider is or shall be a participant in Medicare and the State's Medicaid program.

4.1.8. Neither Contractor nor any Provider has in the past conducted, and is not presently conducting, its or his/her medical practice in such a manner as to cause Contractor or the Provider to be suspended, excluded, debarred or sanctioned under the Medicare or Medicaid Programs or by any government licensing agency, and has never been charged with or convicted of an offense related to health care, or listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation.

4.1.9. The compensation paid or to be paid by Contractor to any Provider is and shall, at all times during the term of the Agreement, be fair market value for services actually provided by such Provider, not taking into account the value or volume of referrals or other business generated by such Provider for District. Contractor represents to District that Contractor has and shall at all times maintain a written agreement with each Provider receiving compensation from Contractor, which written agreement is or shall be signed by the parties, and does or shall specify the services covered by the arrangement. Further, Contractor shall comply with all relevant claim submission and billing laws and regulations. Each of the representations and warranties set forth herein shall be continuing and in the event any such representation or warranty fails to remain true and accurate during the Term, Contractor shall immediately notify District.

4.1.10. Prior to the Effective Date, Contractor has submitted to District copies of all its contracts with Providers. Thereafter, if Contractor proposes to enter into a contract with a Provider in a form substantially different from the forms previously approved by the District, Contractor shall submit the form of agreement to District for approval at least thirty (30) days prior to execution the contract. Contractor shall not enter into any agreement with a Provider in a form substantially different from the approved form unless the form of agreement has been approved by District, which may grant or withhold its approval in its discretion, provided that District shall not unreasonably withhold its approval. Contractor shall provide District with copies of all its contracts with Providers from time to time upon request.

4.1.11. Contractor shall compensate Providers on a payer-neutral basis.

4.1.12. Contractor shall provide statistical analyses to its Providers on a periodic basis related to their productivity and performance under this Agreement.

4.1.13. Contractor and its Providers acknowledge and agree that the primary professional responsibility of Contractor and its full-time Providers is to provide services under this Agreement. Contractor shall not, and shall not permit its full-time Providers to, become involved in any other contracts or professional obligations that materially interfere with the ability of Contractor to honor all of the terms and conditions of this Agreement, including, but not limited to, the responsibilities detailed on the Exhibits attached to this Agreement.

4.1.14. Contractor shall ensure that each Provider complies with all terms and conditions contained herein. Providers shall also: (a) cooperate with District's employee health program and the designated employee health nurse in providing, reviewing and developing health services for employees who work at District; (b) attend any and all meetings within District that Providers are asked to attend by District's Chief Nursing Officer (the "CNO"); and (c) perform such other duties as may from time to time be reasonably requested by District's Governing Board, or Medical Staff, Chief Executive Officer (the "CEO") and/or CNO.

4.1.15. The foregoing representations and covenants (except for those relating expressly to the Effective Date) shall be deemed to continue throughout the term of this Agreement.

4.2. **Qualifications of Providers**. Each Provider who provides Services under this Agreement shall:

4.2.1. Maintain an unrestricted license to practice medicine in the State of California;

4.2.2. Be Board Certified by the American Board of Anesthesiology ("ABA"), or Board Eligible (defined as having an application filed for Board Certification with the ABA, and having been accepted into the process). If Board Eligible, the Physician shall obtain certification within five (5) years of acceptance into the process. If Board Certified, the Physician shall maintain Board Certification at all times during the performance of Services hereunder. Contractor shall provide proof of such certification or eligibility to District upon District's request;

4.2.3. Maintain membership on the Medical Staff with appropriate clinical privileges;

4.2.4. Be a participating provider in the Medicare and Medi-Cal programs, and in other government health plans in which District participates;

4.2.5. Participate in continuing education as necessary to maintain licensure, professional competence and skills commensurate with the standards of the medical community, as applicable, and as otherwise required by Contractor's continuing medical. education policy;

4.2.6. Be covered by the policy or policies of professional liability insurance maintained by Contractor or the Provider pursuant to Section 8.

4.3. **Acknowledgment**. Each Provider who provides Services under this Agreement shall have executed an acknowledgement in the form set forth in Exhibit 5 prior to the commencement of such Services.

4.4. **Use of Temporary Providers**. Contractor shall make commercially reasonable efforts to staff the Department with Providers who are dedicated to the Hospital, and will not rely on locum tenens and temporary anesthesia providers retained through third party staffing companies ("**Temporary Providers**") except with the prior approval of the District, and only as necessary to cover temporary absences of regularly scheduled Providers, or while Contractor is making commercially reasonable efforts to hire dedicated personnel. Such Temporary Providers must meet the qualifications set forth above, must be approved by the District prior to their assignment, and may not be retained beyond the period approved by the District. If Contractor's use of a Temporary Provider is expected to extend beyond the period approved by the District, Contractor shall notify the District promptly (and in any event no later than three (3) working days before the expiration of the period); provided that the District shall not be required to agree to any extension of the approved period.

4.5. **Composition of Providers**. Contractor, in cooperation with the other Co-contractors, shall be primarily responsible for determining the number of Providers necessary to meet anesthesia requirements of District's patient load. Contractor may, with the agreement of the other Co-contractors, change the composition of Providers to meet temporary needs so long as changes in the composition of Providers do not reduce coverage or cause disruption within the Department or increase the District's aggregate costs for anesthesia services; provided that (i) the compensation payable to Contractor under Exhibit 4 shall be adjusted to reflect any change in the number of FTEs provided by Contractor, and (ii) any sustained change shall require the approval of the District and the OR Policy Committee.

4.6. **Addition of Providers.** If Contractor proposes to add a new Provider, Contractor shall notify District not less than seven (7) days prior to contracting with the new Provider and provide to District, on request, the proposed contract with the Provider prior to its execution in order to verify that it is consistent with this Agreement and requires compliance by the Provider with terms and conditions of this Agreement. The addition of any new Provider shall require the prior approval of the District.

4.7. **Termination of Providers**.

4.7.1. At all times while this Agreement is in effect, the CEO or CNO of the District shall have the right to request removal in writing, with specification of cause, of any Provider from providing the Services hereunder for reasons related to clinical performance or failure to comply with this Agreement or with the policies, bylaws, rules, regulations or codes of conduct of the District or the Medical Staff. Contractor shall comply with such a request.

4.7.2. Contractor shall notify District not less than five (5) working days prior to Contractor's proposed termination of a Provider, whether with or without cause, which shall be subject to prior consultation with District. The notification shall include if the termination is for reasons related to clinical performance or compliance with clinical or conduct standards adopted by the Medical Staff. The notification need not be in writing, and the District shall keep the notification of the proposed termination confidential.

4.7.3. Contractor shall promptly notify District of the termination by a Provider of his or her contract with Contractor, or its expiration without extension or renewal.

4.7.4. Upon the termination of the contract between Contractor and a Provider, whether by the Provider or the Contractor, or automatically under the terms of the contract, the Provider shall be immediately removed by Contractor from the schedule for Services.

4.8. **Compensation of Providers**. All Guarantee Payments and other payments, other than the amounts for Practice Expense (as defined in Exhibit 4), shall be passed through to Contractor's providers as salary or benefits on an equitable basis, and shall not be retained or used by Contractor for administrative costs or profit. The District shall have the right from time to time upon request to review Contractor's agreements with its Personnel to determine their compensation and benefits.

4.9. **Exclusion Lists Screening**. Contractor shall screen all of its current and prospective owners, legal entities, officers, directors, employees, contractors, and agents ("**Screened Persons**") to ensure that none of the Screened Persons are currently excluded, debarred, suspended, or otherwise ineligible to participate in Federal healthcare programs or in Federal procurement programs, or have been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a), but have not yet been excluded, debarred, suspended, or otherwise declared ineligible (each, an "**Ineligible Person**"). If, at any time during the term of this Agreement any Screened Person becomes an Ineligible Person, Contractor shall immediately notify Hospital of the same. Screened Persons shall not include any employee, Contractor or agent who is not providing Services under this Agreement.

Section 5. Anesthesia Services.

5.1. **Coverage Schedule**.

5.1.1. Schedule. The District will establish an anesthesia committee (the "Anesthesia Committee") with responsibility for meeting regularly (as determined by the District) to assist the District and the O.R. Policy Committee to develop a schedule for anesthesia services (the "O.R. Schedule"), to modify and update the O.R. Schedule from time to time to address staffing needs and availability as the District expands its surgery services, and to review anesthesia services generally. Contractor shall participate actively on the Anesthesia Committee. The District shall be responsible for establishing the O.R. Schedule as provided in Section 5.2.6, and shall make the O.R. Schedule available to Contractor in writing (which may be on-line) in advance of its implementation. References in this Agreement to the O.R. Schedule refer to the O.R. Schedule as modified from time to time in accordance with this section and Section 5.2.6.

5.1.2. Endoscopy Coverage. In addition to the coverage set forth in the O.R. Schedule, Contractor shall, in cooperation with the other Co-contractors, provide up to of the mutually agreed anesthesia coverage

per month for Outpatient endoscopy, at variable hours confirmed by the Endoscopy Department and Contractor.

5.2. **Contractor's Services**.

5.2.1. Contractor shall cooperate with the other Co-contractors to provide all anesthesia services necessary for the proper operation of the Department, except for services provided by others pursuant to Section 5.2.2 of this Agreement. If any Provider is unable to staff the O.R. Schedule, Contractor shall communicate promptly with the District, including the Surgical Charge Nurse and O.R. Management, and shall use its best efforts to replace the Provider with a substitute Provider.

5.2.2. Contractor shall have the exclusive right and the responsibility to provide all professional anesthesiology services (other than the services of cardiac anesthesiologists and CRNAs) required for daily scheduled surgery at Hospital, except for: (1) consulting services requested by the admitting physician; and (2) local anesthetics administered by a treating physician (including for pain management), where such treating physician elects to do his or her own local anesthetic, if and when permissible pursuant to applicable Medical Staff Bylaws (the "Services"). Without limiting the foregoing, the Services include sedation integral to the performance of operative procedures in the surgery suites at the Hospital, and to obstetrical services performed in the Hospital's labor and delivery department and other departments of the Hospital as needed, needed, including but not limited to endoscopy, Cath Lab, Cardioversions, MRI sedations, emergency department, critical care and (subject to the exception set forth above) pain management for acute pain.

5.2.3. Notwithstanding anything to the contrary set forth in this Agreement, the parties acknowledge and agree that there may be certain members of the Medical Staff who are not affiliated with Contractor and currently or shall hold clinical privileges in pain management, acute and/or chronic, and that such clinical privileges shall not constitute a breach of Section 5.2.1.

5.2.4. Contractor shall have the ability to provide services to patients five years of age of age and older through appropriately trained and supervised Providers.

5.2.5. All Services shall be provided in accordance with all applicable laws, regulations, accreditation requirements, and Medical Staff Bylaws and standards. District and Contractor recognize that the treating physician or surgeon is the primary customer of the anesthesiologist along with the needs of the patient, and that anesthesia services are subject to the availability of sufficient anesthesia providers. Contractor shall devote its best efforts and sufficient time to provide for the proper management and operation of the Department.

5.2.6. Contractor shall cooperate with the other Co-contractors to provide, on premises, a sufficient number of anesthesiologists and CRNAs to cover the Services, on a twenty-four (24) hours per day basis, every day of the calendar year, with a sufficient number of Physicians and CRNAs physically present to provide full coverage the Services at all times as described in detail in the Schedule established pursuant to Section 5.1.1, as the Schedule may be modified from time to time, subject to reasonable and workable hours being established for elective surgery, and subject to the needs of the treating physician surgeon and the needs of the patients. The District, in consultation with the Medical Staff's O.R. Policy Committee ("O.R. Policy Committee") and Contractor, shall determine, and Contractor shall abide by, scheduling and coverage needs, including modification of the days and/or hours on the O.R. Schedule, provided that (i) in the event that the District increases the coverage obligations, Contractor shall be given a reasonable time (not exceeding fivemonths) to secure any additional staff necessary to meet the increased coverage obligations and District shall provide additional income support at the rate set forth in Exhibit 4; and (ii) to the extent practicable under the circumstances, the District shall give Contractor reasonable notice of any material reduction in required coverage.

5.2.7. It shall be the Contractor's responsibility to cooperate with the other Co-contractors to provide adequate numbers of Providers to fulfill the coverage requirements from time to time set forth in the O.R. Coverage Schedule, in compliance with all applicable laws, regulations, accreditation requirements, and Medical Staff Bylaws and standards.

5.2.8. Contractor shall cooperate with the other Co-contractors to ensure that the ratio of CRNAs to Physicians providing services under this Agreement shall not exceed 3:1 based on total hours worked, except for occasional variations from schedule to accommodate vacancies, volumes unexpected events or preferences of the medical staff.

5.3. **Emergency OR Call Coverage**.

5.3.1. Contractor shall cooperate with the other Co-contractors to provide first call emergency anesthesiology coverage twenty-four (24) hours per day, seven (7) days per week, including holidays. This call emergency coverage shall not be "in house" coverage, but rather shall be on-call coverage and Contractor shall exercise all reasonable efforts to have an appropriate anesthesiologist at Hospital within thirty (30) minutes from the time a Contractor is paged for the on-call physician. At the request of the District, Contractor will make all reasonable attempts to provide an additional anesthesiologist to provide call coverage on Saturdays and Sundays given sufficient notice.

5.3.2. When a third (3rd) call room is made available to the Co-contractors, the Contractor will cooperate with the other Co-contractors to provide in-house first call emergency anesthesiology coverage twenty-four (24) hours per day, seven (7) days per week, including holidays. The Contractor shall exercise all reasonable efforts to have an appropriate anesthesiologist report to the Operating Room immediately from the time a Contractor is paged for the on-call physician. The District will make reasonable efforts to provide this call room as soon as possible, and the Co-contractors shall be the first recipient of an available Call Room prior to all other entities providing services for the District.

5.3.3. If an emergency C-Section occurs at the Hospital, Contractor will cooperate with the other Co-contractors to ensure that an anesthesiologist or CRNA will come to the Hospital to continue epidurals and be available for another simultaneous emergency C Section. If a trauma or emergency surgery occurs simultaneously during these obstetrical emergencies, Contractor will cooperate with the other Co-contractors to ensure that an anesthesiologist or CRNA will come to the Hospital, and another an anesthesiologist or CRNA will come in if there is a further emergency, which constitutes the fourth anesthetizing location.

5.4. **On-Call Requirement – No Discrimination**. In accordance with California Health and Safety Code §1317.3(b), Contractor shall provide on-call emergency services without discrimination to patients based on: race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, HIV status, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

5.5. **Obstetrical Coverage**.

5.5.1. Contractor shall cooperate with the other Co-contractors to provide all necessary obstetrical anesthesiology coverage for obstetrical (OB) cases at Hospital, including, but not limited to, epidural administration, twenty-four (24) hours per day, seven (7) days per week, including holidays. Contractor cooperate with the other Co-contractors to have an anesthesiologist or CRNA physically present in Hospital within thirty (30) minutes after a call is placed to Contractor for emergency OB anesthesia services. The opinion of the responsible obstetrician that an emergency exists shall be conclusive.

5.5.2. Contractor shall cooperate with the other Co-contractors to include the obstetrical call schedule with their regular operating room call schedule. This schedule shall be posted with Operating Room

Management and locations requested by District, and Co-contractors shall notify District of any changes as soon as possible.

5.6. **Unscheduled Surgeries**.

5.6.1. Contractor agrees to respond to unscheduled surgeries in an expeditious manner. The O.R. Policy Committee has established standardized policies regarding unscheduled surgeries, which shall be adhered to by the Contractor, as modified by the O.R. Policy Committee from time to time. Contractor shall provide the surgeon who shall be performing the unscheduled procedure, with an approximate time for the procedure and that time shall be adhered to insofar as possible. During normal surgery hours as set forth on the O.R. Schedule, add-on cases shall be scheduled pursuant to existing policies. Unscheduled cases shall be divided into three categories: emergent surgery, urgent surgery, and routine add-on surgery.

5.6.2. An emergent surgery (e.g., ruptured AAA, post-operative bleeding, C-Section for fetal distress) shall be done in the first available room by the first available Provider even if this requires interrupting a scheduled room and another surgeon.

5.6.3. An urgent surgery (e.g., appendectomy, open fracture, etc.) shall be done in an appropriate room within one (1) to three (3) hours of the patient being available for surgery. Contractor shall make a good-faith effort not to interrupt a scheduled room, but the parties acknowledge that on occasion this may be necessary. When it is necessary to interrupt a scheduled room, the interrupted surgeon shall be notified by the interrupting surgeon, in accordance with the policy of the O.R. Policy Committee.

5.6.4. A routine add-on surgery shall be done in the first available room with the first available anesthesiologist or CRNA as soon as he/she is done with his/her elective schedule. A routine add-on shall not interrupt a scheduled room and shall not inconvenience scheduled cases. Upon receiving an add-on request, Contractor and the charge nurse shall promptly provide the surgeon requesting the add-on with an approximate time for the surgery. Routine add-ons shall be accommodated in the same order in which the requests are received by Contractor. If a request is made after normal surgery hours as reflected on the O.R. Schedule, it shall be accommodated at the discretion of Contractor. Rooms shall be made available for add-ons consistent with current requirements set by the O.R. Policy Committee working in consultation with Contractor and consistent with the days and hours set forth on the O.R. Schedule.

5.6.5. Contractor shall respond in a courteous, timely, professional manner to requests to do these non-scheduled cases.

5.7. **Phone Number for Requesting Anesthesia Services**. As part of the increased efficiency to be realized through this exclusive provider arrangement, Contractor shall be available for contact by District's House Supervisor through the PBX Operator twenty-four (24) hours per day, seven (7) days per week, including holidays. District's House Supervisor through the PBX Operator shall contact Contractor by making a direct telephone call to the anesthesiologist on-call, as is the current practice. District's PBX number shall be the only number which a physician or District representative (other than the PBX Operator) shall be required to call to make a request of Contractor for anesthesia coverage. The Nursing Supervisor through District's PBX Operator shall promptly relay the request for anesthesia services to Contractor by means of the telephone number, which Contractor has provided, to District's PBX Operator for the date and time of the call. In contacting Contractor, the House Supervisor through District's PBX Operator shall be required only to communicate to the authorized representative of Contractor who answers the call, the identity of the physician who requested anesthesia coverage and whether the physician identified the need for anesthesia services as an emergency. Once this number has been called and the request relayed by the House Supervisor through District's PBX Operator, Contractor shall be deemed paged for the purposes of this Agreement.

5.8. **Responses to Requests for Anesthesia Services**. Contractor agrees to respond to calls for anesthesia services by having a Provider in Hospital ready to perform the procedure within the following times:

5.8.1. Hospital Emergency: As soon as possible but no later than thirty (30) minutes;

5.8.2. Emergency Obstetrical Call: As soon as possible but no later than thirty (30) minutes;

5.8.3. Urgent Case Call: One (1) to three (3) hours.

5.8.4. The medical judgment of the responsible surgeon at the time of surgery shall be conclusive as to the classification of the case as emergency, urgent, or non-urgent. Retrospectively, any disagreements with the classification used by the surgeon should be brought to the attention of the O.R. Policy Committee. Contractor agrees to have a Provider physically present at Hospital within these designated response times.

5.9. **Assignments for Scheduled Surgery**.

5.9.1. Contractor acknowledges that it is the desire of District that surgeons at Hospital retain the ability to request which of the Providers employed or engaged by Contractor shall provide anesthesiology services during a scheduled surgical procedure. Therefore, every reasonable effort shall be made to honor a surgeon's request for a specific Provider, as well as any of the following:

5.9.1.1. A bona fide request by a surgeon for the expertise of a particular Provider;

5.9.1.2. A specific patient request; or

5.9.1.3. A request for legitimate patient care needs based on the careful following of protocols and/or clinical pathways that have been pre-established to eliminate variabilities.

5.9.2. It is further acknowledged by Contractor that patient care is enhanced by a surgeon knowing, in advance, which of the Providers shall provide anesthesia services during a scheduled surgical procedure. Therefore, Contractor agrees to post the surgical assignments for the Providers in the Operating Room Scheduling Office before the start of that day's scheduled surgery and thereafter to endeavor to accommodate reasonable requests by surgeons to adjust those assignments.

5.10. **Membership of the Department**. All Providers who provide anesthesia services at Hospital shall be members of the Department of Anesthesia, and all anesthesia services contemplated by this Agreement shall be provided by Providers in their capacity as members of the Department of Anesthesia. With the approval of District administration, Providers with locum tenens privileges (granted by Contractor and the Medical Staff) may also provide services under this Agreement.

5.11. **Department Premises**. During the term of this Agreement, District shall continue to provide to or on behalf of Contractor, at District's sole cost and expense, the use of the Department's premises located in, on, or about the Hospital as currently used in connection with the Department and as expanded or relocated as may in the determination of the District be reasonably necessary in the future for the safe and efficient operation of the Department and the provision of anesthesia to patients at the Hospital. Contractor shall inform District as to future increased needs for Department premises. The District shall, at no cost to Contractor, provide two (2) offices suitable for an on-site administrator and the Medical Director of Anesthesia Services, and three (3) on-call rooms (one for OB, one for Surgery, and one for OR Call when available).

5.12. **Use of Premises**. Contractor shall use the Department's premises solely for the practice of anesthesia, pain management and related procedures provided by the Department under this Agreement, and the administrative and clerical activities attendant to that practice. Use of the premises by Contractor shall be limited to Contractor's Providers and administrative staff. No part of the premises shall be used at any time by Contractor,

nor shall Contractor permit anyone else to use the premises, as an office for the private practice of medicine unless a separate agreement in writing is reached by the parties to that effect.

5.13. **Professional Standards**. Contractor and its Providers shall perform their duties under this Agreement in accordance with the rules of ethics of the medical profession. Contractor and its Providers also shall perform their duties under this Agreement in accordance with the appropriate standard of care for their respective professions and specialties including the guidelines of the American Society of Anesthesiologists and the Medical Staff Bylaws.

5.14. **Medical Direction and Administration**.

5.14.1. Spokesperson.

5.14.1.1. Contractor shall designate a spokesperson (the "**Spokesperson**") for Contractor, and may change its designation from time to time on prior notice to the District. The Spokesperson shall communicate in all matters involving the terms and conditions of this Agreement. Contractor shall arrange for the Spokesperson to be available to consult with District or its designees at reasonable times on a regular basis to discuss any matters concerning this Agreement or the administration or operation of the Department.

5.14.1.2. In addition, the Spokesperson shall act as the facilitator to ensure that the duties of Contractor described in this Agreement are met in a timely manner. Communications by District or its designee made to the Spokesperson shall be considered as made to Contractor and the Spokesperson shall be responsible for the forwarding of all such communications by District to the appropriate boards, committees, or Providers of Contractor. Statements made by the Spokesperson regarding this Agreement or the administration or operation of the Department shall be deemed by District as the statements of Contractor.

5.14.2. Medical Director. Contractor shall provide a Physician who is Board Certified by the American Board of Anesthesiology, approved by the District and the MEC, and otherwise meets the qualifications required by this Agreement to provide the services of Medical Director for Anesthesia Services (the "**Medical Director**"), subject to the approval of District. During the term of this Agreement, each party reserves the right to remove an existing Medical Director, in which case the proposed substitute Medical Director shall be subject to District approval, and shall be a Physician who (i) has Medical Staff clinical privileges at Hospital, (ii) is employed by or contracted with Contractor to provide Services under this Agreement; and (iii) is subject to the requirements set forth in this Agreement, including the duties for the Medical Director as set forth in Exhibit 2 to this Agreement. Contractor shall ensure that the Medical Directors, or his/her designee, is on-call to respond to operational issues during off-hours, weekends and holidays. The Medical Director shall serve as the Chief of the Anesthesia Department, subject to the adoption of revisions to the Medical Staff Bylaws and MEC approval.

5.14.3. Director for OB Anesthesia. Contractor shall provide a Director for OB Anesthesia (the "**OB Anesthesia Director**"), who is approved by the District and the MEC. The OB Anesthesia Director shall be credentialed in OB anesthesia. The OB Anesthesia Director shall be responsible under the Director for the provision of Anesthesia Services for obstetrical surgery, and shall perform the duties set forth in Exhibit 2.

5.14.4. Practice Leadership. The Contractor shall provide the services of one or more licensed anesthesia providers to provide practice leadership services, consisting of meeting attendance, policy review, personnel matters, scheduling, recruitment, and other administrative duties as appropriate.

5.15. **Additional Services**. In addition to the above coverage, Contractor agrees, in the operation of the Department, to provide to District the additional services listed on the attached Exhibit 3, it being understood by both parties that these additional services are a material part of the consideration for this Agreement.

5.16. **Service Obligations**. Contractor shall provide the Services in accordance with the Service obligations set forth in **Exhibit B** to this Agreement.

5.17. **Services to Medicare and Other Patients**. Contractor shall provide Services in a manner consistent with District's charitable purpose of providing medical service to a broad class of patients in the Service Area, maintaining Medicare and Medi-Cal provider status and treating Medicare and Medi-Cal inpatients in a nondiscriminatory manner throughout the term of this Agreement. Contractor shall provide uncompensated care to patients as reasonably requested by District throughout the term of this Agreement. District and Contractor shall cooperate in designating the patient recipients of uncompensated care.

5.18. **Reports**. Contractor shall prepare such administrative and business records and reports related to the Service in such format and upon such intervals as District may reasonably require.

5.19. **Conflicts of Interest**. Contractor shall inform District of any other arrangements which may present a conflict of interest or materially interfere in the performance of its duties under this Agreement. In the event Contractor or any Provider pursues conduct which constitutes a conflict of interest or which materially interferes with (or is reasonably anticipated to interfere with) Contractor's performance under this Agreement, District may exercise its rights and privileges under Section 1.

5.20. **Use of Hospital**. Contractor shall use the Department's premises solely for the practice of anesthesia, pain management and related procedures provided by the Department under this Agreement, and the administrative and clerical activities attendant to that practice. Use of the premises by Contractor shall be limited to Contractor's Providers and administrative staff. Contractor shall not use, or permit any Provider to use, any part of the Hospital or other District facility for any purpose other than the performance of Services under this Agreement. Without limiting the generality of the foregoing, Contractor agrees that no part of the premises of Hospital shall be used at any time as an office for private practice and delivery of care for non-Hospital patients. This provision shall not apply to any office for private practice at any professional building owned by District or any of its affiliates, pursuant to a separate lease agreement, or other private patients and practices of Contractor independent of this Agreement.

5.21. **Authority**. Neither Contractor nor any Provider may enter into any contract in the name of District or otherwise bind District in any way without the express consent of District.

5.22. **Compliance with Laws**. Contractor shall perform all services under this Agreement in accordance with any and all requirements and accreditation standards applicable to District and the Service, including, without limitation, those requirements imposed by the California Departments of Health Care Services and Public Health, The Joint Commission and the Medicare/Medicaid conditions of participation.

5.23. **Compliance with District Policies and Bylaws**. Contractor and Physicians shall at all times comply with the bylaws, rules and regulations, policies and directives of District and the Medical Staff.

5.24. **Books and Records**.

5.24.1. Record-Keeping and Auditing. Contractor shall maintain current and detailed records of all its Services, its billing and collection activities and results, its personnel services and costs of compensation and benefits, and all other expenses that are included in the expenses guaranteed in Exhibit 4, in accordance with accepted accounting and record-keeping practices, and sufficient to document and support such expenses and the Monthly Reports to be provided pursuant to Exhibit 4. District may at its sole discretion audit, either internally or through an independent consultant, Contractor's coding, billing and collection activities, and its compensation records relating to Services provided under this Agreement by Contractor's employees and independent contractors. Without limiting the foregoing, District shall have access to Contractor's records relating to billing, collection, accounting, timekeeping, payroll and independent contractor services and compensation. At District's request, Contractor shall provide copies of any records described in this paragraph.

5.24.2. Access. Upon written request of the Secretary of Health and Human Services, the Comptroller General or any of their duly authorized representatives, Contractor shall make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such services. If Contractor carries out any of the duties of this Agreement through a subcontract with a value of ten thousand dollars ($10,000.00) or more over a twelve (12) month period with a related individual or organization, Contractor agrees to include this requirement in any such subcontract. This Section is included pursuant to and is governed by the requirements of 42 C.F.R. §§ 300-304. No attorney-client, accountant-client or other legal privilege shall be deemed to be waived by District or Contractor by virtue of this Agreement. This Section shall survive the termination or expiration of this Agreement.

5.25. **Compliance Program**. Contractor and each Provider shall (i) comply with all District policies, procedures and codes of conduct ("**Standards**"); (ii) sign and adhere to any disclosures or attestations related to District's compliance program (the "**Compliance Program**"); and (iii) participate in and support the Compliance Program. With respect to Contractor's and each Provider's business dealings with District and their performance of the Services, neither Contractor nor any Provider shall act in any manner that conflicts with or violates the Standards, nor cause another person to act in any manner which conflicts with or violates the Standards. Contractor and each Physician shall comply with the Standards (as they may be revised in the future), as they relate to Contractor's business relationship with District and its affiliates, employees, agents, contractors, and suppliers. Contractor further acknowledges and agrees that, pursuant to the Compliance Program, Contractor shall be subject to routine monitoring and review, and, potentially, external audit (limited to Contractor's office(s) used in the performance of this Agreement). Contractor agrees to cooperate fully in any such review conducted in connection with the administration of the Compliance Program

5.26. **Notification of Certain Events**. Contractor shall notify District, in writing, promptly (and where feasible, within twenty-four (24) hours) of the occurrence of any of the following: (i) Contractor or any Provider becomes the subject of, or otherwise materially involved in, any government investigation regarding business practices, the provision of Services pursuant to this Agreement or the provision of professional services, including, without limitation, being served with a search warrant in connection with such activities; (ii) the Medical Staff membership or clinical privileges of a Provider at any hospital are denied, suspended, restricted, revoked or voluntarily relinquished, regardless of the availability of civil or administrative hearing rights or judicial review with respect thereto; (iii) Contractor or any Provider becomes the subject of any suit, action or other legal proceeding arising out of Contractor's professional services and/or the Service provided pursuant to this Agreement; (iv) Contractor or any Provider is required to pay damages or any other amount in any professional liability (malpractice) action by way of judgment or settlement; (v) any Provider become the subject of any disciplinary proceeding or action before any state's medical board or similar agency responsible for professional standards or behavior; (vi) any Provider becomes incapacitated or disabled from providing the Services, or voluntarily or involuntarily retire from the practice of medicine; (vii) any Provider's license to practice medicine in the State of California is restricted, suspended or terminated, regardless of the availability of civil or administrative hearing rights or judicial review with respect thereto; (viii) Contractor or any Provider becomes the subject of any disciplinary proceeding or action before any state's medical board or similar agency responsible for professional standards or behavior; (ix) any Provider changes his/her medical specialty; (x) any Provider is charged with or convicted of a criminal offense other than an infraction; (xi) the federal Drug Enforcement Agency Number of any Provider is revoked; (xii) any event or occurrence which has a material adverse effect on a Provider's ability to perform any or all of the Service under this Agreement; (xiii) Contractor or any of Provider is debarred, suspended or otherwise ineligible to participate in any federal or state health care program, (xiv) Contractor or any Provider is charged with or convicted of a felony, or any criminal offense related to the provision of health care, (xv) any act of nature or any other event occurs which has a material adverse effect on Contractor's or any Provider's ability to perform the Services, (xvi) any Provider ceases to meet the requirements set forth in Section 4, or (xvii) Contractor gives notice of termination to any Provider for reasons relating to clinical performance or compliance with clinical standards or standards of conduct adopted by the Medical Staff.

5.27. **Confidentiality**. Contractor understands and acknowledges that Contractor shall have access to confidential information ("**Confidential Information**") concerning District's business and that Contractor has a duty at all times not to use such information in competition with District or to disclose such information or permit such information to be disclosed to any other person, firm, corporation, entity or third party, during the term of this Agreement or at any time thereafter. For purposes of this Agreement, Confidential Information shall include, without limitation, any and all secrets or confidential technology, proprietary information, customer or patient lists, trade secrets, records, notes, memoranda, data, ideas, processes, methods, techniques, systems, formulas, patents, models, devices, programs, computer software, writings, research, personnel information, customer or patient information, plans or any other information of whatever nature in the possession or control of District that is not generally known or available to members of the general public or the medical profession, including any copies, worksheets or extracts from any of the above. Contractor further agrees that if this Agreement is terminated for any reason, it will neither take nor retain, without prior written authorization from District, originals or copies of any records, papers, programs, computer software, documents, x-rays or other imaging materials, slides, medical data, medical records, patient lists, fee books, files or any other matter of whatever nature which is or contains Confidential Information. This Section shall survive the termination or expiration of this Agreement.

5.28. **Quality**. Contractor shall provide Services in accordance with high professional standards of care in the area and consistent with the quality standards of District, as determined by the applicable oversight committee, the standards of The Joint Commission and District's quality assurance/ performance improvement programs and in compliance with all laws and regulations. Contractor shall, upon reasonable notice by District, make available to District the examination of its records and data with respect to the Services, including all quality data. Contractor shall, upon reasonable notice by District, permit District to audit and inspect all such records and data necessary to ensure compliance with the terms of this Agreement.

5.29. **Medical Residency Programs**. Contractor acknowledges that District is a teaching facility accredited by the Accreditation Council for Graduate Medical Education (ACGME) for teaching and training of medical residents, including residency programs in anesthesiology, family medicine, emergency medicine, behavioral medicine, general surgery and transitional year. Contractor further acknowledges that the resident physicians are trainees practicing on a progressive continuum of independence and authority, and accordingly the residents must have collegial access to attending staff and medical directors for consultation and teaching, and that all patient care services provided by the residents are supervised by attending physicians. Contractor (i) acknowledges the present and future participation (after consultation with Contractor) of its employees and contractors as Core Faculty Members, Faculty Members and Program Director for the Program; (ii) will support and accommodate the Core Faculty Members, Faculty Members and Program Director in providing Faculty Services and otherwise meeting their Program duties, including supervision of the residents in the operating rooms and other locations; (iii) will provide prior notice and an opportunity to meet and confer with the District before terminating or restricting surgery room or other assignments of a participating anesthesiologist who is the Program Director or a Core Faculty Member or Faculty Member of the Program; and (iv) will otherwise support and facilitate the Program and the performance of services by the anesthesiology residents in the operating rooms and other hospital departments that are covered by this Agreement, provided that this provision shall not require Contractor to accommodate any faculty activities that would impair its ability to provide services under this Agreement, and provided, further, Contractor will not be required to incur any material cost in connection with such support.

5.29.1 Kaweah Health has an established Anesthesiology Residency **training program**. The group shall ensure that resident physicians are provided with the educational experiences, both clinical and non clinical time, required by the ACGME. The group must ensure residents clinical duties and expectations do not exceed the allowable duty hours and do not exceed the abilities of each individual resident. Supervision ratios and levels of supervision, as defined by the ACGME and Kaweah Health's GME Committee (GMEC), must be followed at all times. At the discretion of the program director, anesthesiology residents may be requested to perform clinical services during protected educational time if the educational value of the service is determined to be significant. This discretion can be exercised for only a single patient case. The residency

program must track and report these instances and justifications to the office of GME regularly.

Section 6. District's Obligations. District shall perform the following undertakings:

6.1. **Compensation**. The compensation terms are set forth in Exhibit 4 to this Agreement.

6.2. **Facilities and Service Provided by District**.

6.2.1. District shall provide on District premises the space designated by District for the Department, plus expendable supplies, equipment and services necessary for the proper operation of the Department.

6.2.2. District shall employ all technical and clerical personnel it deems necessary for the proper operation of the Department. District, with input from Contractor and Providers, shall direct and supervise the technical work and services of such Department personnel, with District retaining full administrative control and responsibility for all non-physician Service personnel. All personnel furnished by District shall be subject to the direction of Contractor while performing any clinical work or duties in the Department; however, all such personnel are not and shall not be made or considered to be agents of Contractor, but rather shall remain employees of District and under its general supervision and report to the management of the Surgery Department.

6.2.3. District agrees to provide, at its expense, a Practice Manager to oversee the day-to-day operations of Contractor within the Department, and at least one full-time on-site Administrative Analyst for the Service.

6.3. **District's Professional and Administrative Responsibilities**. To the extent required by Title 22, California Code of Regulations §70713, District shall retain the professional and administrative responsibility for the Service. District's retention of these responsibilities shall not alter or modify, in any way, the hold harmless, indemnification, insurance or independent contractor provisions set forth in this Agreement. Contractor shall apprise District of recommendations, plans for implementation and continuing assessment through dated and signed reports, which shall be retained by District for follow-up action and evaluation of performance.

Section 7. Change of Circumstances. In the event (i) Medicare, Medicaid, any third party payor or any federal, state or local legislative or regulatory authority adopts any law, rule, regulation, policy, procedure, or interpretation thereof which establishes a material change in the method or amount of reimbursement or payment for services under this Agreement, or if (ii) any or all such payors/authorities impose requirements which require a material change in the manner of either party's operations under this Agreement and/or costs related thereto, then, upon the request of either party materially affected by any such change in circumstances, the parties shall enter into good faith negotiations for the purpose of establishing such amendments or modifications as may be appropriate in order to accommodate the new requirements and change of circumstances while preserving the original intent of this Agreement to the greatest extent possible. If, after thirty (30) days of such negotiations, the parties are unable to reach an agreement as to how or whether this Agreement shall continue, either party may terminate this Agreement upon thirty (30) days' prior written notice.

Section 8. Insurance and Indemnification.

8.1. **Contractor's Coverage**. Contractor shall ensure that Contractor and each Provider maintains professional liability insurance coverage with such insurance companies, issued upon such forms and containing such terms and limitations as required by the Medical Staff and as reasonably acceptable to District. The insurance coverage shall provide District defense for claims arising solely on the basis of vicarious liability or ostensible or apparent agency, for the act or inaction of Contractor or its Providers. As a minimum, the insurance shall provide coverage in the amount of one million dollars ($1,000,000.00) per occurrence, three million dollars ($3,000,000.00) in the aggregate. If the insurance is maintained on a claims-made basis, the insurance shall continue throughout the term of this Agreement; and upon the termination of this Agreement, or the expiration or cancellation of the insurance, Contractor shall ensure that it and/or each Provider purchases, or arranges for the purchase of, either (i) an extended reporting endorsement ("**Tail Coverage**") for the maximum period that may be purchased from its

insurer (ii) "Prior Acts" coverage from the new insurer with a retroactive date on or prior to the date Contractor (or a Provider, as the case may be) began performing services at Hospital under this Agreement or (iii) maintain continuous coverage with the same carrier for the period of the statute of limitations for personal injury. In the event Contractor is unable to obtain the required insurance for or on behalf of Providers, Contractor shall require Providers to keep and maintain such insurance coverage individually. All such insurance shall be kept and maintained without cost or expense to District. In the event neither Contractor nor Providers purchase required coverage, District, in addition to other rights it may have under the terms of this Agreement or under law, shall be entitled, but not obligated to purchase such coverage. District shall be entitled to immediate reimbursement from Contractor for the cost thereof. District may enforce its right of reimbursement through set-off against any sums otherwise payable to Contractor or any Provider who failed to maintain the required coverage. Contractor shall provide District with one or more certificates of insurance certifying the existence of all coverages required hereunder. Contractor and Providers shall require their insurance carrier to provide District with not less than thirty (30) days' prior written notice in the event of a change in the professional liability policies of Contractor or Providers.

8.2. **District's Coverage**. District shall maintain, at its sole cost and expense, professional and general liability coverage for the acts and omissions of District, its officers, directors, employees and agents (excluding Contractor and Providers should it or they be deemed to be agents notwithstanding the contrary intent of the parties). The District's coverage may be provided through one or more programs of self-insurance.

8.3. **Indemnification**.

8.3.1. District shall defend, indemnify, and hold Contractor, its shareholders and Providers harmless from and against any and all liability, loss, expense, attorneys' fees, or claims for injury or damages arising out of the performance of this Agreement but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of District, its officers, directors, employees, or agents.

8.3.2. Contractor shall defend, indemnify, and hold District, its officers, directors, and employees harmless from and against any and all liability, loss, expense, attorneys' fees, or claims (i) for injury or damages arising out of the performance of this Agreement but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of Contractor, its shareholders, officers, Providers, contractors, employees, or agents, (ii) any claim, loss or liability arising out of or with respect to its obligations to its employees or contractors for compensation or benefits, or arising from Contractor's failure to withhold or pay required employment-related taxes or compensation, and (iii) any claim, action and cause of action arising out of, or in any way connected to, a claim by a Provider, or other contractor or employee of Contractor, that he or she has in any way been treated wrongfully by Contractor or any of its present or future officers, directors, shareholders, contractors or employees.

8.3.3. Contractor shall be solely responsible for compliance will all employment-related laws and regulations with respect to Providers, including California Assembly Bill 5 of 2019, and shall indemnify, defend and hold the District harmless against any claim, cost or liability arising from any claim that any Provider is or was an employee of the District. Without limiting the foregoing, if District is required to compensate or pay taxes for, or provide employee compensation or benefits of any kind (including contributions to government mandated, employment-related insurance and similar programs) to, or on behalf of, any Provider or any other person employed or retained by Contractor, or to pay any costs or penalties resulting from its failure to pay any such compensation, benefits or other amount, the amount of all such costs, claims and liabilities shall be an obligation of Contractor to District, for which Contractor shall reimburse District within thirty (30) calendar days after being notified thereof; provided that District may, at its option, set off the amount of the obligation against any sums otherwise due to Contractor under this Agreement.

8.3.4. The provisions of this Section 8.3 shall survive termination of this Agreement.

Section 9. Miscellaneous Provisions.

9.1. **Notice**. Any notice required or desired to be given in respect to this Agreement shall be deemed to be given upon the earlier of (i) actual delivery to the intended recipient or its agent, or (ii) upon the third business day following deposit in the United States mail, postage prepaid, certified or registered mail, return receipt requested. Notice to either party may be given by the other party, in writing, personally delivered, or deposited in the United States mail, postage prepaid and addressed to the appropriate party, as follows:

If to District:
Kaweah Delta Health Care District
Attn: Gary Herbst, CEO
400 West Mineral King Avenue
Visalia, California 93291-6263

If to Contractor:
Kaweah Anesthesiologist Services Inc.
Attn: _____
400 West Mineral King Avenue
Visalia, California 93291

With copies to each of the following:
Herr Pedersen Berglund
Attn: Rachele Berglund
100 Willow Plaza, Suite 300
Visalia, California 93291

Attn: Peter Zeitler
5260 North Palm, Suite 421
Fresno, California 93704

With a copy to:
Benjamin Cripps, Chief Compliance Officer
Kaweah Delta Health Care District
400 West Mineral King Avenue
Visalia, California 93291-6263

9.2. **Entire Agreement**. This Agreement contains the entire agreement of the parties hereto and supersedes all prior agreements, contracts and understandings, whether written or otherwise, between the parties relating to the subject matter hereof.

9.3. **Partial Invalidity**. In the event any provision of this Agreement is found to be legally invalid or unenforceable for any reason, the remaining provisions of the Agreement shall remain in full force and effect provided the fundamental rights and obligations remain reasonably unaffected.

9.4. **Assignment**. Because this is a personal service contract, Contractor may not assign or subcontract any of its rights or obligations hereunder without the prior written consent of District. District may assign this Agreement to any successor to all, or substantially all, of District's operating assets or to any affiliate of District. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors and permitted assigns.

9.5. **Regulatory Requirements**. The parties expressly agree that nothing contained in this Agreement shall require Contractor or any Provider to refer or admit any patients to, or order any goods or services from, District. Notwithstanding any unanticipated effect of any provision of this Agreement, neither party shall knowingly or intentionally act in such a manner as to violate the prohibition against fraud and abuse in connection with the Medicare and Medicaid programs (42 U.S.C. §1320a-7b).

9.6. **Dispute Resolution**. The parties firmly desire to resolve all disputes arising hereunder without resort to litigation in order to protect their respective business reputations and the confidential nature of certain aspects of their relationship. Accordingly, any controversy or claim arising out of or relating to this Agreement, or breach thereof, shall first be addressed by and between Contractor and the District's Vice President responsible

for the administrative oversight of the Service. If still unresolved to the mutual satisfaction of the parties, the dispute shall be referred to the Board of Directors for final resolution, subject to receiving the recommendation of the MEC to the extent required under the Medical Staff Bylaws. The Board of Directors shall, within a reasonable time, notify Contractor of its decision in accordance with the requirements of this Section. The parties expressly agree litigation may not be commenced regarding the terms and conditions of this Agreement or any controversy or dispute hereunder unless and until the contractual procedures and remedies described in this Section are exhausted. Nothing in this Section 9.6, however, shall require either party to complete the pre-litigation dispute resolution process in this Section 9.6 prior to exercising its respective rights under Section 1 to terminate this Agreement.

9.7. **Third Party Beneficiaries**. This Agreement is entered into for the sole benefit of District and Contractor. Nothing contained herein or in the parties' course of dealing shall be construed as conferring any third party beneficiary status on any person or entity not a party to this Agreement, including any Provider.

9.8. **Governing Law**. This Agreement shall be governed by the laws of the State of California.

9.9. **Approvals**. Neither this Agreement nor any amendment of or modification hereto shall be effective or legally binding upon either party unless it is set forth in a written document executed by the parties hereto.

9.10. **Attorneys' Fees**. If any legal action at law or in equity or any arbitration proceeding, is brought for the interpretation or enforcement of this Agreement or any part hereof, or because of an alleged dispute, breach, default or misrepresentation in connection with any of the provisions of this Agreement, the prevailing party shall be entitled to recover its reasonable attorneys' fees and other costs incurred in that action or arbitration proceeding, in addition to any other relief to which it may be entitled.

9.11. **HIPAA**. The parties acknowledge that they are part of an "organized health care arrangement" for purposes of the privacy provisions of the Health Information Portability and Accountability Act of 1996 ("**HIPAA**"). Contractor and each Provider shall perform the Services in accordance with (i) applicable state and federal laws and regulations relating to health information privacy and security, including the California Confidentiality of Medical Information Act (Civil Code § 56 and following), and regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA); (ii) the District's policies and procedures relating to health information privacy and security; and (iii) the District's notice of privacy practices.

9.12. **Cross Referenced Agreements**. According to regulations implementing 42 U.S.C. §1395nn *et seq.*, respecting the prohibition of physician referrals to entities with which those physicians or their family members have financial arrangements, all arrangements shall be cross referenced for audit purposes. In accordance with 42 CFR §411.357(d)(ii), any arrangements between Contractor and District, or between any Group Physician of Contractor and District, are listed in a master list of contracts that is maintained by District and updated centrally, preserves the historical record of contracts and is available for review by the Secretary of Health and Human Services upon request.

9.13. **Modification**. This Agreement may be modified only by a signed, written instrument.

9.14. **Compliance with Laws.** District and Contractor agree to comply with all applicable statutes and regulations, both state and federal, governing the operation and administration of District, as well as standards set forth by the Joint Commission.

9.14.1. In addition to the obligations of the parties to comply with applicable federal, state and local laws respecting the conduct of their respective businesses and professions, District and Contractor each acknowledge that they are subject to certain federal and state laws governing the referral of patients which are in effect or will become effective during the term of this Agreement. These laws include:

9.14.1.1. Prohibition on payments for referral or to induce the referral of patients (California Business and Professions Code §650; California Labor Code §3215; and the Medicare/Medicaid Fraud and Abuse Law, §1128B of the Social Security Act); and

9.14.1.2. Prohibition on the referral of patients by a physician for certain designated health care services to an entity with which the physician (or his/her immediate family) has a financial relationship including (California Business and Professions Code §§650.01 and 650.02, and §1877 of the Social Security Act).

9.14.2. Nothing in this Agreement is intended or shall be construed to require either party to violate the California or federal laws described in Section 9.14.1, and this Agreement shall not be interpreted to:

9.14.2.1. Require any Provider to make referrals to District, be in a position to make or influence referrals to District, or otherwise generate business for the District.

9.14.2.2. Restrict any Provider from establishing staff privileges at, referring any patient to, or from otherwise generating any business for any other entity of the Provider's choosing.

9.14.2.3. Provide for payments in excess of the fair market value or comparable compensation paid to physicians for similar services in comparable locations and circumstances.

9.14.3. In the event of any changes in law or regulations implementing or interpreting the Internal Revenue Act or the Medicare and Medicaid Patient Protection Act of 1987, including the adoption or amendment of Medicare Fraud and Abuse Safe Harbor Regulations, or to any other Federal or State law relating to the subject matter of such Acts, to fraud and abuse, or to payment-for-patient referral, including the laws referenced in Section 7.14.1, the Parties shall use all reasonable efforts to revise this Agreement to conform and comply with such changes.

9.15. **Force Majeure**. Neither party shall be liable nor deemed to be in default for any delay or failure in performance under the Agreement or other interruption of service or employment deemed resulting, directly or indirectly, from: Acts of God; acts of civil or military authority; acts of terrorism, bioterrorism, or public enemy; bomb threats; computer virus; epidemic/pandemic, power outage; acts of war; accidents; fires; explosions; earthquakes; floods; failure of transportation, machinery, or supplies; vandalism; strikes or other work interruptions by District's employees; or any similar or dissimilar cause beyond the reasonable control of either party. Both parties shall, however, make good faith efforts to perform under this Agreement in the event of any such circumstance. This force majeure provision shall not relieve aa party of the obligation to make any monetary payments provided for hereunder.

9.16. **Counterparts**. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same agreement.

9.17. **Legal Counsel**. Each party understands the advisability of seeking legal counsel and financial/tax advice and has exercised its own judgment in this regard.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement effective on the date first set forth above. This Agreement shall be binding when all signatories listed below have executed this Agreement.

DISTRICT: **KAWEAH DELTA HEALTH CARE DISTRICT**

By: _____
Gary K. Herbst, Chief Executive Officer

CONTRACTOR: _____
a California professional medical corporation

By: _____
_____, President

EXHIBIT 1

[RESERVED]

EXHIBIT 2
MEDICAL DIRECTORS FOR ANESTHESIA SERVICES

1. The Medical Director for Anesthesia Services shall be responsible for the professional direction of the Department. His or her duties shall include:

(a) Participating in the educational programs conducted by District and the Medical Staff in order to assure Hospital's overall compliance with accreditation and licensing requirements, and performing such other reasonable teaching functions as District may request;

(b) Directing non-physician personnel in the performance of professional services for patients;

(c) Advising District with respect to the selection, retention and termination of all personnel who may be required for the proper performance of anesthesia services; provided, however, that District shall retain the ultimate decision-making authority regarding the selection, retention and termination of all such personnel;

(d) Establishing schedules for all services provided by Providers in accordance with the terms of this Agreement;

(e) Supervising the development and implementation of Hospital quality assurance and quality improvement programs and procedures relative to the Services;

(f) Assisting District in the preparation and conduct of surveys by The Joint Commission and/or any other national, state or local agency relating to the Anesthesia Service and the Services provided under this Agreement; and

(g) Performing any other duties related to the Anesthesia Services contemplated herein that District's Governing Board, Medical Staff and/or the CNO may reasonably request.

2. The OB Anesthesia Director shall be responsible under the Medical Director for the provision of Anesthesia Services for obstetrical surgery, and shall perform the duties set forth above, as they pertain to obstetrical surgery.

EXHIBIT 3
ADDITIONAL SERVICE AND STAFFING REQUIREMENTS

Contractor, in cooperation with the other Co-contractors, shall meet the following service and staffing requirements, all of which shall be considered material requirements of this Agreement, as provided in Section 5.15 of the Agreement:

1. **General Requirements**:

(a) An adequate number of anesthesia providers shall be qualified to perform epidural, spinal, regional, MAC, total intravenous anesthesia (TIVA), central line placement, double lumen endotracheal tube intubation, fiber-optic bronchoscopy, use of glide scope, and general anesthesia to support institutional demand.

(b) Two dedicated CV Anesthesiologists shall be assigned to CV Surgery. Call is dedicated primarily to this area, but the anesthesiologists may respond to emergent needs in other areas.

(c) The OB Anesthesia Director shall be dedicated primarily to Obstetrics & Gynecology on 2 East, but the anesthesiologists may respond to emergent needs in the main OR and other areas.

(d) Contractor shall be responsible for the monitoring of medication administration and correction of medication charge errors to ensure billing compliance for District.

(e) All Providers shall be ACLS certified as of the Effective Date, except for new Providers and Providers who have served less than one year under this Agreement, who shall be certified within one (1) year of commencing Services under this Agreement.

(f) Contractor shall actively participate with all hospital quality or improvement initiatives related to Surgical Services and Anesthesia Services

(g) Contractor shall exert commercially reasonable efforts to improve Physician Satisfaction results year-over-year as related to Surgical Services and Anesthesia.

(h) Contractor shall strive to improve Patient Satisfaction (HCAHPS) scores year-over-year as related to Anesthesia. Contractor shall cooperate with Hospital's Perioperative Medical Director on initiatives to improve quality and service in the main operating room and Surgical Center.

(i) Contractor shall participate in and cooperate with Hospital's OR Policy Committee, and shall collaborate with Hospital's surgical medical director.

(j) Contractor shall actively support Hospital's Quality initiatives, including the reduction of anesthesia-related OR case delays by assuring that patients have been interviewed and are ready on time for their scheduled surgical start times and that all anesthesiologists are consistently on time.

(k) Contractor shall conduct a minimum of one post-anesthesia evaluation on all inpatients and outpatients.

(l) Contractor, through a designated member, shall reasonably participate in the medical and paramedical educational programs conducted by District.

(m) Contractor shall comply with regulations and standards as outlined by The Joint Commission and California Code of Regulations ("CCR") Title 22, the State Board of Pharmacy, CMS Conditions of Participation and other agencies having authority over the Hospital and the Department, to include medication safety and control,

appropriate documentation in the medical record, pre-induction assessments, and full compliance with all hazardous waste streams and HIPAA regulations, or as otherwise set forth in the Agreement.

(n) The Medical Director for Anesthesia Services shall assure that anesthesia section meetings are held regularly, that minutes are reported to the appropriate medical staff committees in accordance with the Medical Staff Bylaws, that appropriate quality indicators are reviewed at each meeting with corrective action taken, and that the quality indicators and actions taken are subsequently reported to the Medical Care Review Committee, Quality Council or O.R. Policy Committee as appropriate.

(o) Contractor shall be responsible for and have authority to ensure District's compliance with anesthesia requirements of accrediting bodies such as the American Medical Association, The Joint Commission and California Department of Public Health, to include active participation in the Department and District-wide quality monitoring activities.

(p) Contractor shall on an ongoing basis participate through the Cardiac Anesthesia Medical Director or his/her designee, at meetings of all required Performance Improvement committees and assigned activities.

(q) Contractor shall make available to the Performance Improvement Department on a consistent and systematic basis all relevant information in the computerized or paper patient record for collection, display, and analysis.

(r) Contractor shall comply on an ongoing basis with all of The Joint Commission requirements, including dating and timing of pre-induction physicals.

(s) Contractor shall have bi-monthly Department meetings, and shall maintain, on an ongoing basis, Departmental minutes which accurately reflect appropriate and consistent involvement in the Performance Improvement process.

(t) Contractor shall on an ongoing basis demonstrate a multi-Departmental team approach to solving quality problems that involve multi-Departmental processes.

(u) Contractor shall on an ongoing basis demonstrate responsibility and accountability in the protection of the patient and with respect to unsolved problems that involve interdepartmental responsibility.

(v) Contractor shall maintain, on an ongoing basis, bi-monthly Departmental minutes which accurately reflect review of data, problems, mortality, and outcomes, with analysis and action appropriate to the solution of problems in a timely and effective manner.

(w) Contractor shall collaborate to support educational programs as requested by the District.

(x) Contractor shall direct and arrange for anesthesiologists proctoring per applicable Medical Staff Bylaws.

(y) Contractor and its Providers shall participate actively in the affairs of the Medical Staff, including, without limitation, serving on committees and discharging such other obligations as may be requested by the Medical Staff, or any duly appointed officer or committee thereof.

(z) Contractor and its Providers shall conform to any and all lawful administrative directive issued from time to time by the CEO, Vice President of Cardiac and Surgical Services, and/or CMO, provided that such directives are consistent with the scope and principles of this Agreement.

2. **Monthly Meeting**. The Medical Director shall meet with District's Medical Director for Surgical Services and Director for Surgical Services at the monthly meeting to review performance of services identified in this Exhibit 3 and any other operational issues of concern.

3. **Quality Assurance**. Specific anesthesia criteria shall be developed by the Department of Anesthesia ("Department") that shall identify variances in Hospital practice/medical care (e.g. difficult intubations, OPs admitted to Hospital due to N & V, etc.) A medical record review shall be conducted by the Department when a patient's criteria are not satisfied. This information accompanied with any corrective action implemented shall be reported monthly to the O.R. Policy Committee and Medical Care Review Committee.

4. **Documentation Requirements**. Contractor shall promptly complete all records, forms and reports reasonably required by District and the Medical Staff. District has developed an integrated computerized information system so as to more efficiently interface and collate medical data for patient care and billing. Contractor shall actively utilize District's electronic medical records technology and tools. It is expected that anesthesia records, both computerized and written, prepared by Providers shall be accurate, complete and timely in accordance with Title 22.

5. **Qualifications**. In order to assure and enhance present and on-going clinical qualifications of Contractor and its Providers:

(a) Contractor shall ensure that any Provider providing pediatric anesthesiology shall have training in pediatric anesthesiology and PALs certification. Pediatric definition by age to be determined by Surgery, Anesthesia, and Pediatrics Departments.

(b) All Providers, to the extent eligible, shall be trained, privileged and expected to place arterial/central lines and fiber optic difficult intubations.

(c) Whenever possible, all staffing assignments by Contractor shall be based on Provider competency in the required skills.

(d) Contractor or Contractor's representatives shall acknowledge receipt all complaints within two (2) business days or sooner after receipt of notification.

6. **Dress Code**. All Providers shall adhere to the OR attire/dress code and the prohibitions on food and drink in the operating room, as required by the Surgical Services Policy.

7. **Professional Behavior**.

(a) Contractor shall ensure that its Providers comply with the Code of Professional Conduct for Medical Staff/Allied Staff and the Conduct Guidelines of Medical/Allied Staff Granted Privileges at Kaweah Delta Medical Center, each as adopted by the Medical Staff of Hospital.

(b) Contractor's Providers shall maintain professional behavior toward District's patients, patient's family members, Medical Staff members, visitors, and District staff as required by the Department of Anesthesia Policy and Procedure Manual, all related District Policies and the Medical Staff Bylaws.

(c) Providers shall arrive for scheduled cases at a reasonable time in order to allow for appropriate assessment, possible intervention, orders, etc., to avoid delays in surgery.

8. **Medication Management**. All Providers shall document and practice the following:

(a) Appropriate syringe labeling practices;

(b) Documentation of drugs received from Pyxis to ensure accountability of drug and restocking;

(c) Documentation of drug charges in collaboration with the Hospital pharmacy in appropriate systems;

(d) In collaboration with the District, Contractor shall achieve one hundred percent (100%) accountability for all drugs used and their disposition;

(e) Contractor shall achieve greater than an 85% initial charting accuracy compliance rate.

(f) Comply with District policies to ensure proper disposal of sharps and/or pharmaceutical waste in collaboration with the Hospital pharmacy;

(g) Comply with District Policy to ensure compliance, as applicable, with any compounding standards in collaboration with the Hospital pharmacy, such as aseptic techniques.

(h) Assure that Providers standardize their use of drug utilization with best practices, where feasible.

(i) When the mass transfusion protocol is in effect, Providers shall abide by the protocol until it is terminated.

9. **Anesthesia Business Indicators –** Unless specified differently, the following anesthesia business indicators will be monitored and reported quarterly and annually to the O.R. Policy Committee, O.R. Management, and Administration:

(a) **Anesthesia -** Staffing in comparison to anesthesia O.R. coverage schedule – will be reviewed quarterly with O.R. Management

(b) **Anesthetic Volume**

- By anesthetic location
- By anesthesia type
- By ASA class

(c) **Number of Clinicians**

- By type (Physician, Resident, CRNA, etc.)

(d) **Total Minutes (and Units) Billed**

- By anesthetic coverage location

(e) **Anesthesia Clinical Indicators.** The following anesthesia clinical indicators will be monitored and reported quarterly and annually to the Chief Medical Officer and Administration:

- Number of cases completed eventfully
- Occurrence of critical events (by location/service; definitions):
    - Death
    - Cardiac Arrest
    - Perioperative MI

- Anaphylaxis
- Malignant Hyperthermia
- Transfusion Reaction
- New Stroke
- Visual Loss
- Incorrect Surgical Site
- Incorrect Patient
- Medication Error
- Unplanned Admission
- Unplanned ICU Admission
- Intraoperative Awareness
- Unplanned Difficult Airway
- Unplanned Reintubation
- Dental Trauma
- Perioperative Aspiration
- Vascular Access Complication
- Pneumothorax
- Infection After Regional Anesthesia
- Epidural Hematoma
- High Spinal
- Postdural Puncture Headache
- Local Anesthetic Toxicity
- Peripheral Neurologic Deficit

The Medical Director for Anesthesia Services shall review the performance of these staffing and services requirements with the CEO or the CNO (or designee) at least quarterly.

10. **Performance Expectations**. In addition to the general service requirements of this Agreement, the Contractor shall use commercially reasonable efforts to ensure that its Providers meet specific performance expectations from time to time set by agreement by the parties. The performance expectations in effect on the Effective Date are as follows:

Indicators	
OB Patient Satisfaction (overall)[1]	>90%
Post Op PACU Pain Satisfaction	>90%
Anesthesia Related OR Case OR Delays[2]	<4%
On-time starts for Scheduled Surgery	>90%

On-time start for Scheduled Endoscopy, Electrophysiology Studies, AICD's, and Cardioversions	>90%

[1] As measured by MTC Health.

[2] Contractor and District to work together to establish a mutually agreeable definition.

EXHIBIT 4
COMPENSATION

1. Entire Compensation. Except as provided in this Agreement, neither District nor Contractor shall charge the other for Services provided pursuant to this Agreement.

2. Meet and Confer. The parties shall meet and confer at least quarterly to discuss the performance of the Contractor, including Provider recruitment and retention, billing and collection for Services, and Practice Expenses.

3. Billing and Collection of Fees for Services.

(a) Fee Schedule. Contractor shall prepare a schedule of fees representing its full professional charges for Services rendered to District patients under this Agreement. The fee schedule, and any change thereto, shall be approved in advance by District in order for District to ensure that fees are reasonable, fair and consistent with the basic commitment of District to provide adequate health care to all residents within the Service Area. The fee schedule shall, at all times, comply with all applicable laws, rules, regulations and payer agreements. The fees shall at all times be reasonable and competitive. Nothing herein shall be construed to cause Contractor to violate any federal or state laws concerning the establishment of fees. Contractor shall provide prompt notice to District of any and all proposed changes in Contractor's fee structures

(b) Documentation of Services. Contractor shall ensure that its Providers document all Services fully, completely, accurately and promptly in the District's electronic medical records, including entering appropriate billing codes, and provide such additional documentation as the District or the contracted billing company requires to ensure prompt billing of and payment for Contractor' Services.

(c) Billing Services. Contractor shall use the services of a qualified contractor approved by District for the billing and collection of claims for all Services provided during the term of this Agreement. The approved billing service provider is R1 RCM. Contractor shall obtain such assignments as are necessary to enable the services of its Providers to be billed in the name and for the account of Contractor. Contractor shall be responsible for ensuring that the billing service bills and collects claims for Contactor's services competently and diligently, and in accordance with commercial standards of practice.

(d) Provider Enrollment and Participation Agreements. Contractor shall diligently pursue and maintain, participation in good standing for Medicare, Medi-Cal and all managed care contracts for health care services in which District participates, e.g., health maintenance organizations (HMOs) and preferred provider organizations (PPOs), and shall ensure that its Subcontractors do the same. Contractor shall follow the same procedures for credentialing new Providers in order to obtain payment for Services in a timely manner.

(e) Global Contracts. To the extent that District enters into a contract with a health plan or other payor that does not permit Contractor and District to separately bill for their respective professional and technical services ("**Global Contract**"), Contractor shall look solely to District for payment and District shall compensate Contractor for such services by a mutually agreeable amount (to be set in advance in writing), but in no event shall the amount be less that the amount that Contractor would have received for such services, but for the Global Contract. Any such reimbursement shall be Program Collections for purposes of this Agreement.

(f) Collections.

(i) Program Collections. For purposes of this this Exhibit, "**Program Collections**" means revenues or receipts received by or on behalf of Contractor or any of its Providers during the applicable month from any and every source in any way related to Services performed at the District's facilities, including (without limitation) (i) payments under policies of business interruption insurance, and grants from government agencies relating to Services provided, lost revenues, or reimbursement of costs (except insofar as such grants are intended and used to cover unanticipated costs that are not reimbursable under this Agreement), and (ii)

Abandoned Collections, as defined below; but excluding Guarantee payments made by the District under this Agreement, and less refunds, recoupments, offsets, takebacks or withholds.

(ii) Audit; Abandoned Collections. District may at its sole discretion, audit, either internally or through an independent consultant, Contractor's documentation and coding practices. If, as a result of an audit or otherwise, District identifies claims that have not been billed (i) because of the failure of Contractor or a Provider to document or code its services promptly and appropriately in accordance with industry standards, or (ii) because of the failure of Contractor to reasonably cooperate with the District's efforts to establish its eligibility, or the eligibility of any Provider, for payment from any third-party payor, or to bill for and collect claims for services, and the billing contractor is not able to resubmit such claims to the payor by statute or payor requirements for timely claim submission ("Abandoned Collections"), the amount of Abandoned Collections, adjusted to reflect the Contractor's historical collections rate for the payor, shall be added to Contractor's Program Collections during the Term of this Agreement; provided that the Abandoned Collections shall not include the professional portion of any global rates that were billed and collected by District. For purposes of this Agreement, Abandoned Collections shall not include any charity care discount or other appropriate decision to reduce the charges to or payable by a Program patient; however, Abandoned Collections shall include any courtesy discount (including professional courtesy to a health provider or any family members of a health care provider) unrelated to individual need or appropriate exigent circumstances. The amount of Abandoned Collections identified subsequent to the expiration or termination of this Agreement that relate to Services performed by Contractor during the Term of this Agreement shall be promptly repaid by Contractor to District in an amount equal to, taking into consideration the historical collections rate for the payor, what would have been paid by the payor to Contractor had the collections not been abandoned.

(g) District Billing. District shall be responsible to bill and collect for all technical Hospital services provided to District patients during their Hospital stay.

(h) Billing Errors. The parties shall have reasonable access to records necessary to verify each party's compliance with this Agreement. Each party shall promptly correct or assist the other party in correcting any billing errors.

4. Submission of Pro Forma Estimates. On an annual basis, commencing three (3) months before each anniversary of this Agreement, Contractor shall provide to District (i) a pro forma estimate of the Program Collections, all Variable Provider Expenses (as defined below), by category, and all Practice Expenses (as defined by below (by Category) for the then current year, and (ii) a pro forma estimate of Program Collections, all Variable Provider Expenses (by category) and all Practice Expenses (by category) for the following year. At its option, District may request Contractor to provide information as necessary for District to evaluate the adequacy of the Practice Expenses.

5. Reports; Other Information.

(a) Documentation of Time. Medical Directors shall report their time through the District's Physician Time Study Database. With the exception of CV Anesthesiologists, all Clinical Providers shall be required to clock in and out via ADP Geo-fencing technology or other mutually agreed upon program. Medical Director, Practice Leadership and GME/Faculty hours (payable under a separate Agreement) may not be recorded for time spent while the Provider is providing clinical shifts, except as approved in advance by District, or on occasional instances where avoidance would be impractical.

(b) Monthly Reports. Within fifteen (15) days after the end of each month of this Agreement, Contractor shall submit to District an itemized report ("**Monthly Report**") setting forth the following in form and content reasonably satisfactory to the District, for the month just ended and for the Contract Year to date:

(i) The number of shifts and hours of Services performed each day of the month, with a description of the Services provided each day, and an indication of any variations from the staffing schedule set forth in the O.R. Schedule;

(ii) The number, identities and schedules of the individuals who provided Services during the month;

(iii) Contractor's billings for Services;

(iv) Program Collections;

(v) Abandoned Collections;

(vi) Refunds, recoupments and offsets of or to Program Collections, and any claims for any of these;

(vii) Accounts receivable, and an accounts receivable aging report;

(viii) A report on Contractor's performance during the month with respect to the goals set forth in Exhibit 4-2 (the "**Billing and Collection Targets**").

(ix) The Contractor's cost of Provider compensation and benefits ("**Variable Provider Expenses**")

(x) Other financial information maintained by Contractor or its billing agent as may be reasonably requested by District in order to determine its obligations under this Agreement or monitor compliance with this Agreement.

(c) The Contractor shall continue to submit the Monthly Report for each of the twelve (12) months following the termination or expiration of this Agreement for any cause or reason (the "**Tail Period**") in accordance with subsection (b), except that the reports for the Tail Period need contain only the information described in clauses (b)(iii) through (b)(vii) and (b)(x).

(d) Quarterly Report. As soon as practicable after the end of each quarter of each Contract Year, Contractor shall submit to District an itemized report ("**Quarterly Report**") for the prior quarter, setting forth the information required to be included in the Monthly Report, but aggregated for the quarter, in form and content reasonably satisfactory to the District.

(e) Annual Report. As soon as practicable after the end of each Contract Year, Contractor shall submit to District an itemized report ("**Annual Report**") for the prior Contract Year, setting forth the information required to be included in the Monthly Report, but aggregated for the Contract Year, in form and content reasonably satisfactory to the District.

(f) Other Information. In addition to the Monthly, Quarterly and Annual Reports, Contractor shall provide District with such additional reports and information as the District may reasonably request, including but not limited to collections activity, etc., with such frequency as the District may reasonably request.

(g) Production of Reports. If the District requests any report or information under this Section 5 that is not available as a standard report from the reporting systems of the Contractor or its contractors, the Contractor shall within fifteen (15) days of the District's request notify the District when the report may be available, or if the report is not available in the form or format requested by the District, how the Contractor proposes to make the information available to the District. The District shall not unreasonably withhold its approval of the Contractor's proposal, as long as the proposal would provide the information requested by the District in a timely manner. Once the parties have agreed upon the form and format of the report, the Contractor shall provide it in accordance with the District's request.

6. Compensation.

(a) Retention of Program Collections. Contractor shall retain all Program Collections, except as provided in Paragraph (f) (as to adjustments of estimated and actual Program Collections) and Paragraph (h) (as to Post-Termination Collections).

(b) Guaranty. Provided that Contractor submits Monthly, Quarterly and Annual Reports as required by Section 5, and subject to the provisions of this Exhibit, the District shall pay Contractor the amount, if any, by which Contractor's Total Allowed Expenses exceeds its Program Collections during the term of this Agreement on an aggregate term-to-date basis (the "**Guaranty**"). Payments in relation to the Guaranty shall be made as provided in subsection (e) below. For purposes of this Exhibit, "**Total Allowed Expenses**" means the aggregate of Contractor's actual and reasonable expenses incurred in in connection with the provision of Services, as set forth in (and not exceeding the amounts set forth in) Schedule 4 hereto. The expense limitations in Schedule 4 shall be applied on a line-item basis, not an aggregate basis.

(c) Contract Year. The amounts set forth in Schedule 4 are for a Contract Year, which means each year of the term of this Agreement commencing October 1 and ending September 30 of the following year (or sooner if this Agreement is terminated before the end of the current Contract Year); and the terms "per year" or "annually" mean for each Contract Year.

(d) Total Allowed Expenses. In determining Total Allowed Expenses:

(i) Except with the approval of the District, which it may give or withhold in its discretion:

(A) The number of FTE Providers whose compensation and benefit expense is included in Total Allowed Expenses shall not exceed the number in Schedule 4, or such lesser number as may be reasonably necessary to meet the coverage schedule from time to time set forth in the O.R. Schedule, as modified pursuant to Section 5.2.1 of the Agreement. The FTE status of Providers shall be determined in accordance with the criteria set forth in Schedule 4. The Parties acknowledge and agree that Contractor may, with the approval of District, deviate temporarily from the actual number of Providers set forth in Schedule 4, so long as the coverage set forth in the O.R. Schedule is provided and the deviation does not increase the District's expenses under this Agreement without its prior approval.

(B) For any period during which the Medical Director or the OB Anesthesia Director does not provide the services required by this Agreement (except for regular time away from practice for vacation, continuing medical education and the like), upon prior notice the relevant expense for MD Leadership Stipends shall be reduced proportionately.

(ii) The District shall reimburse Contractor's cost of billing and collection directly to the Contractor's contracted billing service, and the costs of billing and collection shall not be Allowed Expenses.

(iii) The Total Allowed Expenses shall not include any expense, cost, charge, reduction, recoupment or offset incurred prior to the Effective Date, or arising from circumstances or events existing or occurring prior to the Effective Date, and the Contractor shall provide the District with such information as the District may reasonably request to satisfy itself that all charges and expenses included in the Monthly Reports arose or were incurred on or after the Effective .

(iv) The Total Allowed Expenses shall also include the cost to Contractor of sign-on bonuses not exceeding $30,000 for a new Provider, subject to the prior approval of the District in each case, and contingent upon a two-year service commitment by the Provider in form approved by the District.

(e) Payment Obligations and Reconciliation.

(i) Monthly Guarantee Payments. The District shall make the following payments to Contractor, each an "**Estimated Monthly Guarantee Payment**," and all of which shall be deemed to be "**Guarantee Payments**" for purposes of this Agreement, and which shall be reduced in the aggregate by the amount of Program Collections for the most recent month for which the Monthly Report is available, and shall be subject to periodic reconciliation as provided in Paragraph (ii) below:

(a) Clinical Services. By the fifth (5th) day of each month District will pay Contractor an amount equal to District's estimate of Contractor's expenses for the month for the salaries and benefits for the clinical services of Providers, based on budgeted Provider hours, adjusted to add or deduct any amount necessary to reflect any difference in actual hours, as reflected in the reports referred to in Section 5(a), as against estimated hours for the most recent month for which such reports are available, and based on the relevant hourly rate set forth in Schedule 4.

(b) Medical Director and Physician Leadership Costs. By the twentieth (20th) day of each month District will pay Contractor the amount due for Medical Director Services and Physician Leadership costs for the prior month. Payment for Medical Director and Physician Leadership shall be in accordance with the hours documented via the Physician Time Study Database, at the hourly rates and subject to the monthly caps set forth in Schedule 4.

(c) Practice Expenses.

(i) As provided in Section 4 of this Exhibit 4, at least three (3) months before each anniversary of the Effective Date of this Agreement, Contractor shall provide District with a proposed budget for its expenses related solely to the performance of Services under this Agreement in the categories listed below, or such other categories as the parties may agree upon from time to time in connection with the process described in this paragraph ("**Practice Expenses**"). With the proposed budget, Contractor shall also provide such information concerning its historical expenses in each category of Practice Expense as the District may request in order to assess the proposed budget. In collaboration with Contractor, the District shall establish a final budget for Contractor's Practice Expenses for the ensuing year (the "**Practice Expense Budget**"), and shall provide Contractor a copy of the Practice Expense Budget before the start of the year. The District shall pay Contractor the amount of the Practice Expense Budget in twelve (12) equal monthly installments over the year. The Practice Expense Budget shall be updated annually and shall operate prospectively; provided that if the District fails to provide a budget for the current year for any reason other than delay by Contractor in the submission of its proposed budget, the Practice Expense Budget for the prior year shall continue in effect, pro rata, until the new one is provided by the District. The following categories of expense incurred by Contractor in connection with the performance of Services shall be included in the initial Practice Expense Budget; provided that the categories may be changed prospectively in connection with each annual budget:

- Bank Service Charges
- Computer Software & Internet
- Continuing Education
- Health Insurance
- Malpractice and Employment Insurance
- Worker's Compensation
- Meals and Entertainment
- Office Expense
- Office Supplies

- Payroll Expenses
- Payroll Fees
- Payroll Taxes
- Payroll Taxes (Federal)
- Payroll Taxes (State)
- Postage/Printing
- Professional Fees
- Accounting Fees
- Credentialing Fees
- Consulting/Management Fees
- Consulting/Management Travel
- Legal Fees
- State Tax
- Communications Expense
- Utilities
- Financial Planning and Retirement Fees
- Recruitment
- Additional Administrative Support deemed necessary by the contractor

(ii) The Contractor shall provide the District with any information that the District may reasonably request to document any Practice Expense.

(iii) In no event shall the Practice Expenses reimbursable under this Agreement exceed the aggregate amount set forth in the relevant Practice Expense Budget.

(ii) Periodic Reconciliation. Following delivery of the Quarterly Report and the Annual Report to the District, the District shall reconcile the Estimated Monthly Guarantee Payments over the term of this Agreement to date to the Contractor's actual Total Allowed Expenses and Program Collections over the term of this Agreement (each such reconciliation, a "**Reconciliation**"). If the amount determined by subtracting aggregate actual Program Collections for the quarter or the year from aggregate actual Total Allowed Expenses for the period (the "**Deficit**") exceeds the aggregate Guarantee Payments for the period, the District shall forthwith pay the excess to the Contractor by ACH transfer. If the aggregate Guarantee Payments for the period exceed the Deficit, the Contractor shall forthwith pay the excess to the District; provided that the District may in its discretion recover the excess by setting it off against future Estimated Monthly Guarantee Payments.

(iii) Cost of Locum Tenens Providers. Provided the conditions set forth in Section 4.4 of the Agreement are met, District shall pay the cost of locum tenens and Temporary Providers either to the Contractor or directly to the Providers, at the District's election. Contractor shall promptly forward invoices for the services to the District.

(f) Additional Information; Adjustments. The District may from time to time reasonably request supporting documentation for the Monthly Report or the Quarterly Report, and may from time to time, on not less than ten (10) days' prior written notice to Contractor, audit (through its employees or independent accountants) Contractor's books and records relating to the Services, the Program Collections, and the expenses for which Contractor has claimed reimbursement under this Agreement. If District determines that any Guarantee Payment has exceeded the amount to which Contractor is entitled, it shall give the Contractor written notice of its determination (an "**Overpayment Notice**"), and (subject to Contractor's right to dispute the determination) the excess shall be an obligation of Contractor to District, which District may recoup by deduction from future Guarantee Payments, or

otherwise. If Contractor disputes District's determination, it shall give the District written notice of the dispute within thirty (30) days of delivery of the Overpayment Notice, and if the parties are unable to settle the dispute informally it shall be resolved in accordance with Section 9.6 of the Agreement.

(g) Excess Collections. If in any month Contractor's Program Collections exceed its Total Allowed Expenses for the month, the excess shall be offset against the next Guarantee Payment; provided that the aggregate amount to be paid to the District under this paragraph over the term of this Agreement shall not exceed the aggregate amount of expenses reimbursed by the District over the term of this Agreement, plus the District's costs of billing for the Contractor's Services. If District determines that any Guarantee Payment was less than the amount to which Contractor is entitled, it shall give the Contractor written notice of its determination, and shall pay the deficit to the Contractor (less any amount owed to the District by the Contractor under this Agreement).

(h) Post-Termination Collections. Upon expiration or termination of this Agreement which is not superseded by an extended or new agreement between parties for Services, District shall determine the aggregate Guarantee Payments made to Contractor, plus the District's aggregate costs of billing services, that were not offset by Program Collections during the term **("Net Payments**"). The following shall apply so long as the District has Net Payments that have not been repaid by Contractor.

(i) Any Program Collections in excess of the Monthly Guarantee Payments as of the expiration or termination of the Agreement shall be remitted to the District within ten (10) days after the termination of the Agreement, but in no event shall Contractor remit to District any Program Collections that are greater than the amount of Net Payments then outstanding.

(ii) If there are still Net Payments then outstanding, District shall be entitled to Program Collections for Program Services rendered by Contractor prior to the expiration or termination date but not collected prior to the expiration or termination date ("**Post-Termination Collections**"). Throughout the Tail Period, Contractor shall (i) continue to bill and collect for the Post-Termination Collections with the same diligence as during the term of this Agreement; (ii) continue to submit to District the Monthly Report; and (iii) pay District the amount of the Post-Termination Collections, but in no event shall Contractor remit any Post-Termination Collections that are greater than the amount of Net Payments then outstanding. Contractor may deduct its actual costs related to managing billing and collection activities of the Post-Termination Collections.

Schedule 4

Allowable Expenses – General Anesthesia Services

(Subject to the terms of the foregoing Agreement)

Clinical Compensation Terms:

1. FTE Definition: 2,080 hours per FTE
2. FTE Base Compensation and Benefits: $572,000.00
3. FTEs Required: As agreed upon from time to time and documented in writing; at the commencement of this Agreement, the number is 10.5.
4. Payment Terms
    a. Payment based on hours worked (payroll reports) at $275.00 per hour.
    b. Annual Increase – 2% increase in base compensation (only)

Leadership – Annual Cap - $181,516

1. OR Anesthesia Medical Director – OR Anesthesia Medical Director to be paid up to $50,050 annually to provide up to 182 annual hours. Payment subject to documentation submitted via the Physician Time Study Database.
2. OB Anesthesia Medical Director – OB Anesthesia Medical Director to be paid $25,000 annually to provide at least 90 hours (annually) conducting duties for OB Anesthesia. Amount subject to monthly attestation and will be paid in equal monthly payments (1/12 of total).
3. Group Leadership – Contractor to be paid $114,400 annually to provide at least 416 hours (annually) conducting Group Leadership Duties for Main OR Anesthesia. Amount subject to monthly attestation and will be paid in equal monthly payments (1/12 of total).

Practice Expenses

1. To be determined as provided in Section 6(e) of Exhibit 4.

Sign-on Bonus

1. $30,000 for new Full-Time Physicians – 2 year commitment

Exhibit 5

PROVIDER ACKNOWLEDGEMENT

The undersigned, a Physician providing anesthesia services within the Anesthesia Department at Kaweah Delta Medical Center (the "Hospital") pursuant to an Exclusive Provider Agreement for Anesthesia Services (the "Provider Agreement") between Kaweah Delta Health Care District (the "District"), and Kaweah Anesthesiologist Services, INC professional medical corporation (the "Contractor") agrees and acknowledges as follows:

(a) The Provider Agreement does not confer any contractual rights on the undersigned or any other individuals who currently are under contract with Contractor in any capacity.

(b) The clinical privileges of the undersigned to provide services in the Department that are exclusively assigned under the Provider Agreement (and if these are the only clinical privileges of the undersigned, his or her Medical Staff membership also) shall forthwith terminate, without further action by or on behalf of the District or the Medical Staff, and without right of review, fair hearing or appeal (which the undersigned expressly waives), if (i) the Provider Agreement expires or is terminated for any cause or reason, or without cause, or (ii) if the undersigned is providing services under a subcontract with Contractor, the subcontract expires or is terminated for any cause or reason, or without cause, or (iii) the undersigned ceases, without cause or for any cause or reason, to be employed or contracted by Contractor to provide services under the Provider Agreement.

(c) Upon termination of the Provider Agreement or of his or her employment or service agreement with the Contractor, the undersigned shall immediately vacate the Department.

ACKNOWLEDGED:

_____

Sign

_____

Print Name

Date: _____

Allowable Expenses – Kaweah Anesthesiologist Services INC.
(Subject to the terms of the foregoing Agreement)

Practice Expenses

1. To be determined as provided in Section 6(e) of Exhibit 4.

Kaweah Health
MORE THAN MEDICINE. LIFE.

September 27, 2021

Sent via Certified Mail
No. 70160340000002570001
Return Receipt Required

Nicholas R. Ruiz
Williams Brodersen Pritchett Burke LLP
2222 West Main Street
Visalia, CA 93291

RE: Notice of Rejection of Claim of Dennis Hundsforfer, Beverly Hundsdorfer, Erin Moody, Estate of Dennis Hundsdorfer vs. Kaweah Health

Notice is hereby given that the claim, which you presented to the Board of Directors of Kaweah Health on August 31, 2021, was rejected on its merits by the Board of Directors on September 27, 2021

WARNING

Subject to certain exceptions, you have only six (6) months from the date this notice was personally delivered or deposited in the mail to file a court action on this claim. See Government Code Section 945.6. You may seek the advice of an attorney of your choice in connection with this matter. If you desire to consult an attorney, you should do so immediately.

Sincerely,

Garth Gipson
Secretary/Treasurer, Board of Directors

cc: Richard Salinas, Attorney at Law

September 27, 2021

Sent via Certified Mail
No. 70160340000002566622
Return Receipt Required

Bryant Whitten, LLP
Attorneys at Law
8050 N. Palm Avenue, Suite 210
Fresno, CA 93711

RE: Notice of Rejection of Claim of Victoria Vital vs. Kaweah Delta Health Care District

Notice is hereby given that the claim, which you presented to the Board of Directors of Kaweah Health on August 20, 2021, was rejected on its merits by the Board of Directors on September 27, 2021

WARNING

Subject to certain exceptions, you have only six (6) months from the date this notice was personally delivered or deposited in the mail to file a court action on this claim. See Government Code Section 945.6. You may seek the advice of an attorney of your choice in connection with this matter. If you desire to consult an attorney, you should do so immediately.

Sincerely,

Garth Gipson
Secretary/Treasurer, Board of Directors

cc: Rachele Berglund, Attorney at Law

Kaweah Delta
MORE THAN MEDICINE. LIFE.

RESOLUTION 2142

WHEREAS, Byron Mendenhall, M.D. has served as the Chief of the Medical Staff of Kaweah Delta Health Care District from 2019-2021 and;

WHEREAS, in that capacity Dr. Mendenhall has provided excellent leadership for the Medical Staff and supported the mission of the hospital through two years of great achievements and growth, and;

WHEREAS, Dr. Mendenhall has always been available, attentive and responsive to the Board, Medical Staff, and Executive Team of the District in carrying out the duties of his position, and;

WHEREAS, Dr. Mendenhall has been an effective leader of the Medical Staff in areas of accreditation, self-governance, peer review, and improvement of patient care.

NOW THEREFORE, BE IT RESOLVED, that the Board of Directors of the Kaweah Delta Health Care District on behalf of themselves, the Hospital Staff, and the Community they represent, hereby extend their appreciation to Byron Mendenhall, M.D. and in recognition thereof, have caused this resolution to be spread upon the minutes of this meeting.

PASSED AND ADOPTED by unanimous vote of those present at a regular meeting of the Board of Directors of the Kaweah Delta Health Care District on the 27th day of September 2021.

_____
President, Kaweah Delta Health Care District

ATTEST:

_____
Secretary/Treasurer, Kaweah Delta Health Care District and of the Board of Directors thereof

Quality Improvement for Institutions

AMERICAN COLLEGE of CARDIOLOGY

Kaweah Health Medical Center PCI Data Quality Analysis

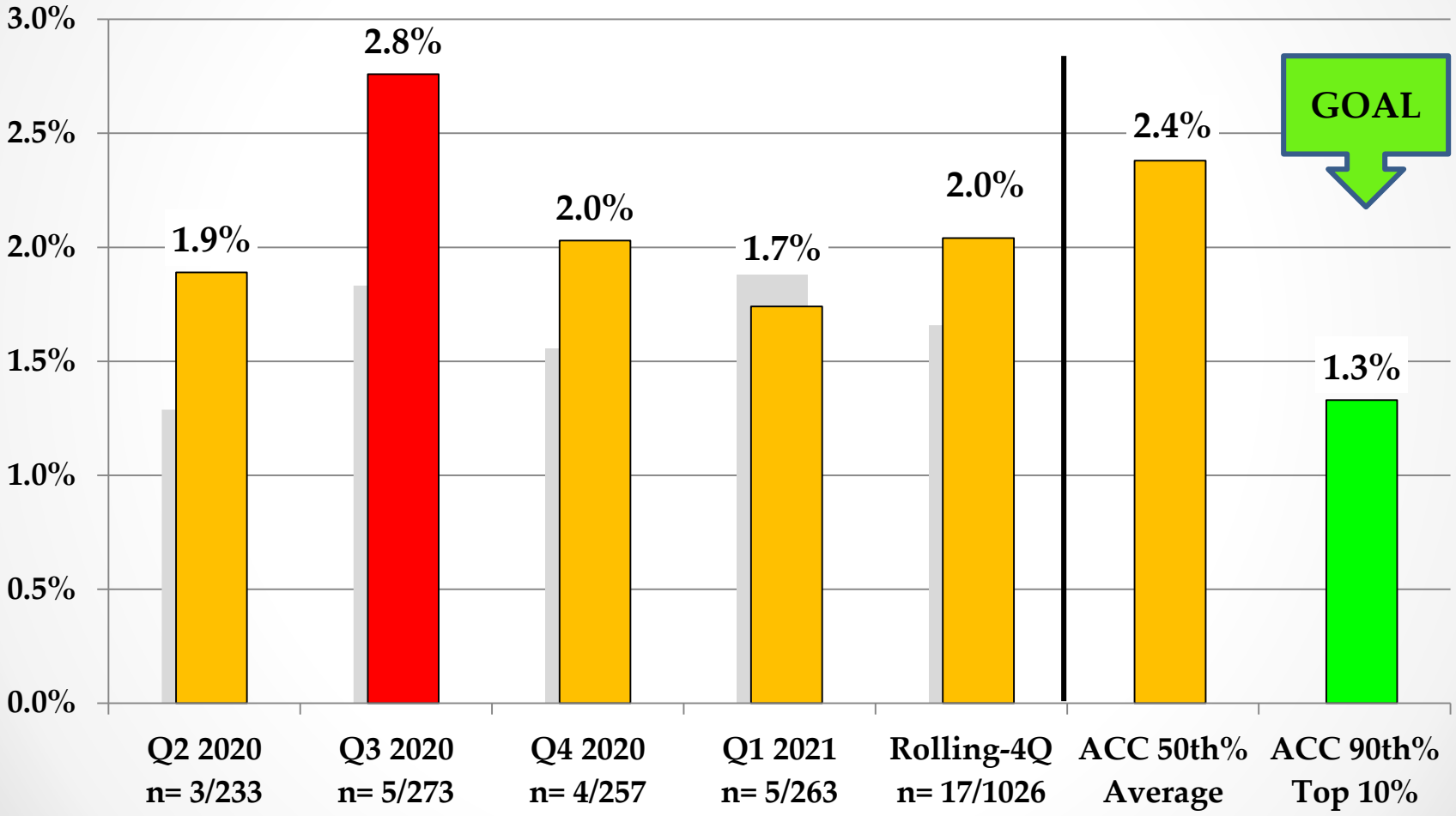
Q2 2020 – Q1 2021

Green = In the Top 10% of the Nation
Yellow = Better or Equal to the National Average
Red = Worse than National Average
Gray = Non-Risk Adjusted Value (for Reference only)

***Comparison reporting period Varies per Metric**

PCI In-Hospital Mortality Rate[1]

Risk Adjusted[InColor] (All patients)



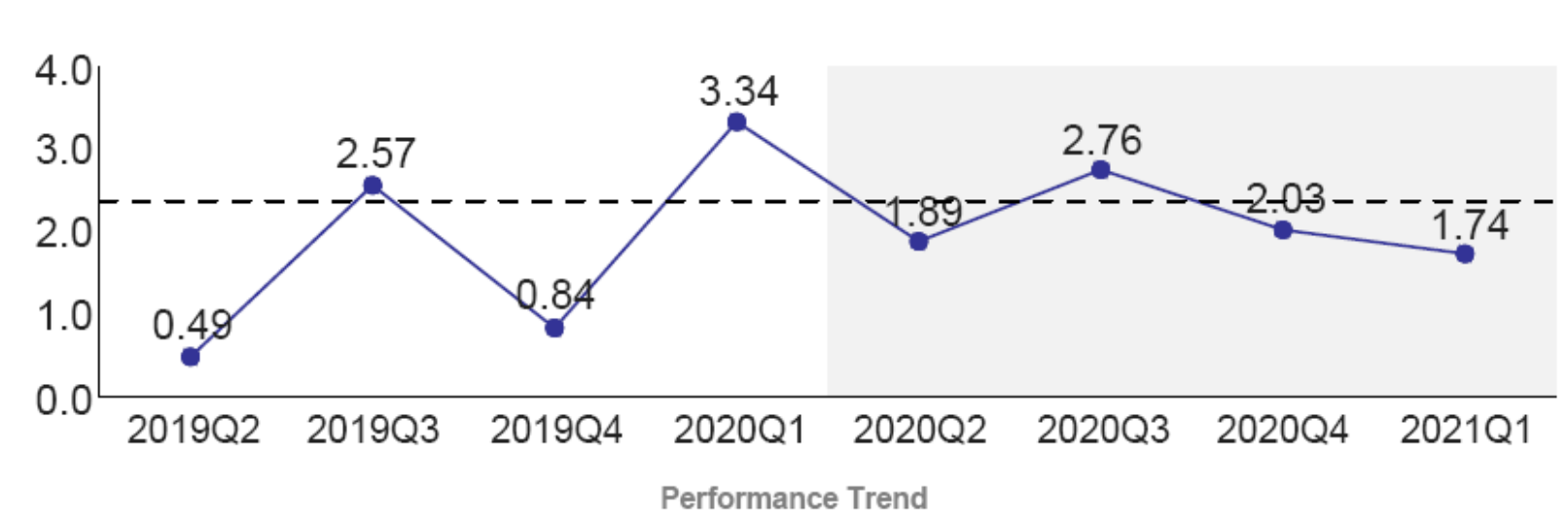
R4Q Risk Adjusted O/E = 0.9

[1] PCI in-hospital mortality rate for all patients, risk adjusted. Exclusions include patients with a discharge location of "other acute care hospital." (ref: 4739, 4736)

***Comparison reporting period is 04/01/20 through 03/31/21**

PCI In-Hospital Mortality Rate[1]
Risk Adjusted (All patients)

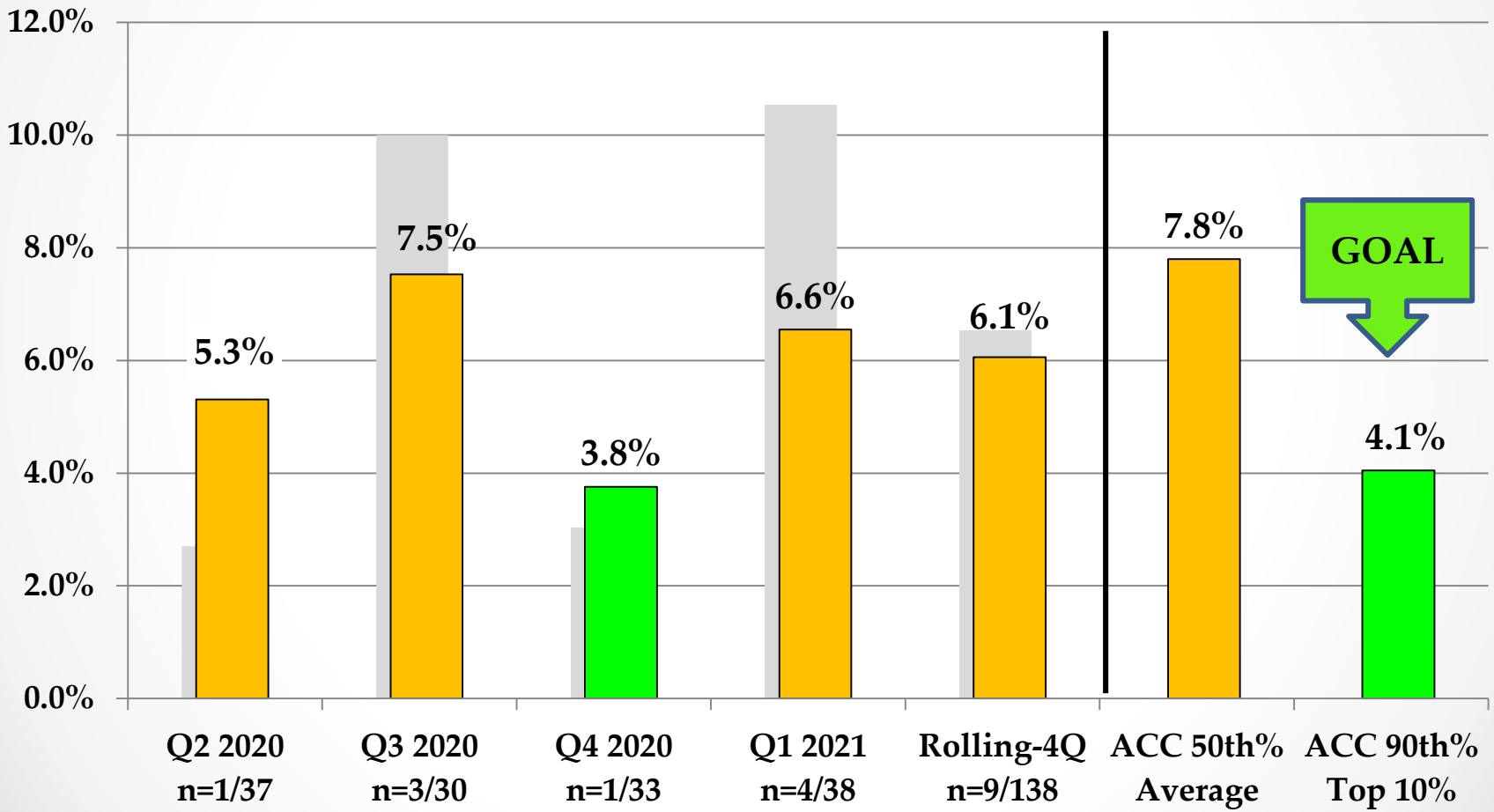
- TWO-YEAR TRENDING



[1] PCI in-hospital mortality rate for all patients, risk adjusted. Exclusions include patients with a discharge location of "other acute care hospital." (ref: 4739, 4736)

PCI In-Hospital Mortality Rate[1]

Risk Adjusted[InColor] (STEMI patients)



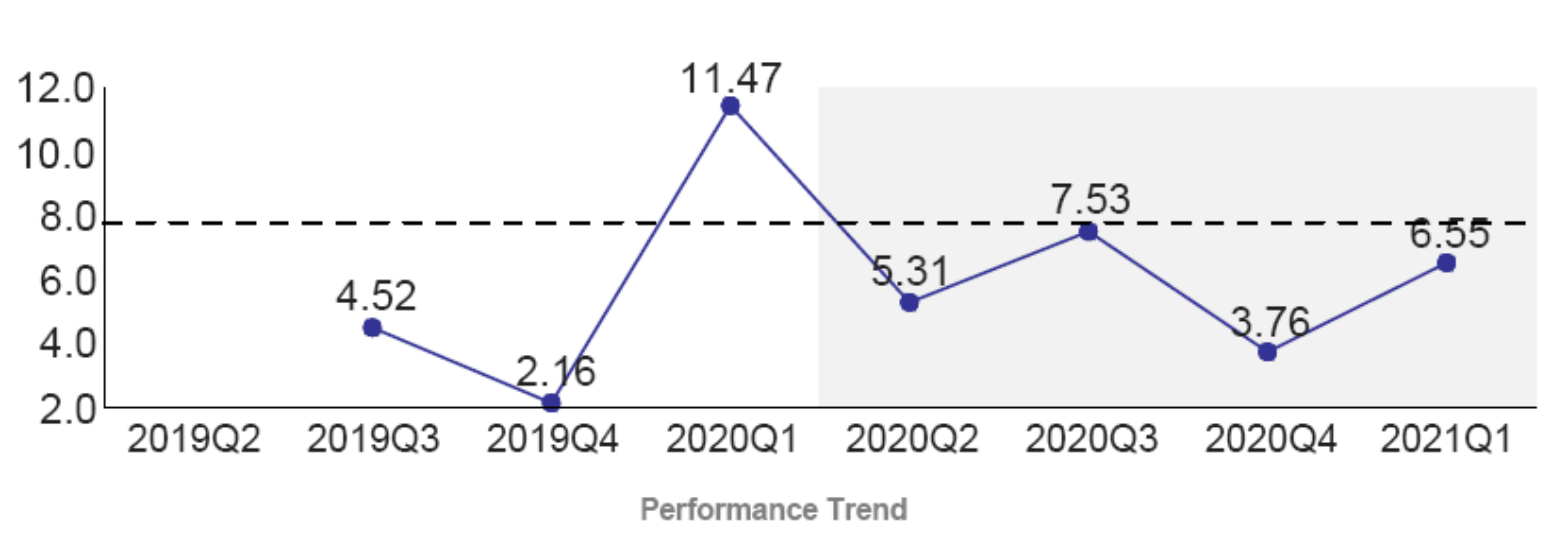
R4Q Risk Adjusted O/E = 0.85

[1] PCI in-hospital mortality rate for STEMI Pt.'s. (ref: 4740, 4734)

*** Comparison reporting period is 04/01/20 through 03/31/21**

PCI In-Hospital Mortality Rate[1]
Risk Adjusted (STEMI patients)

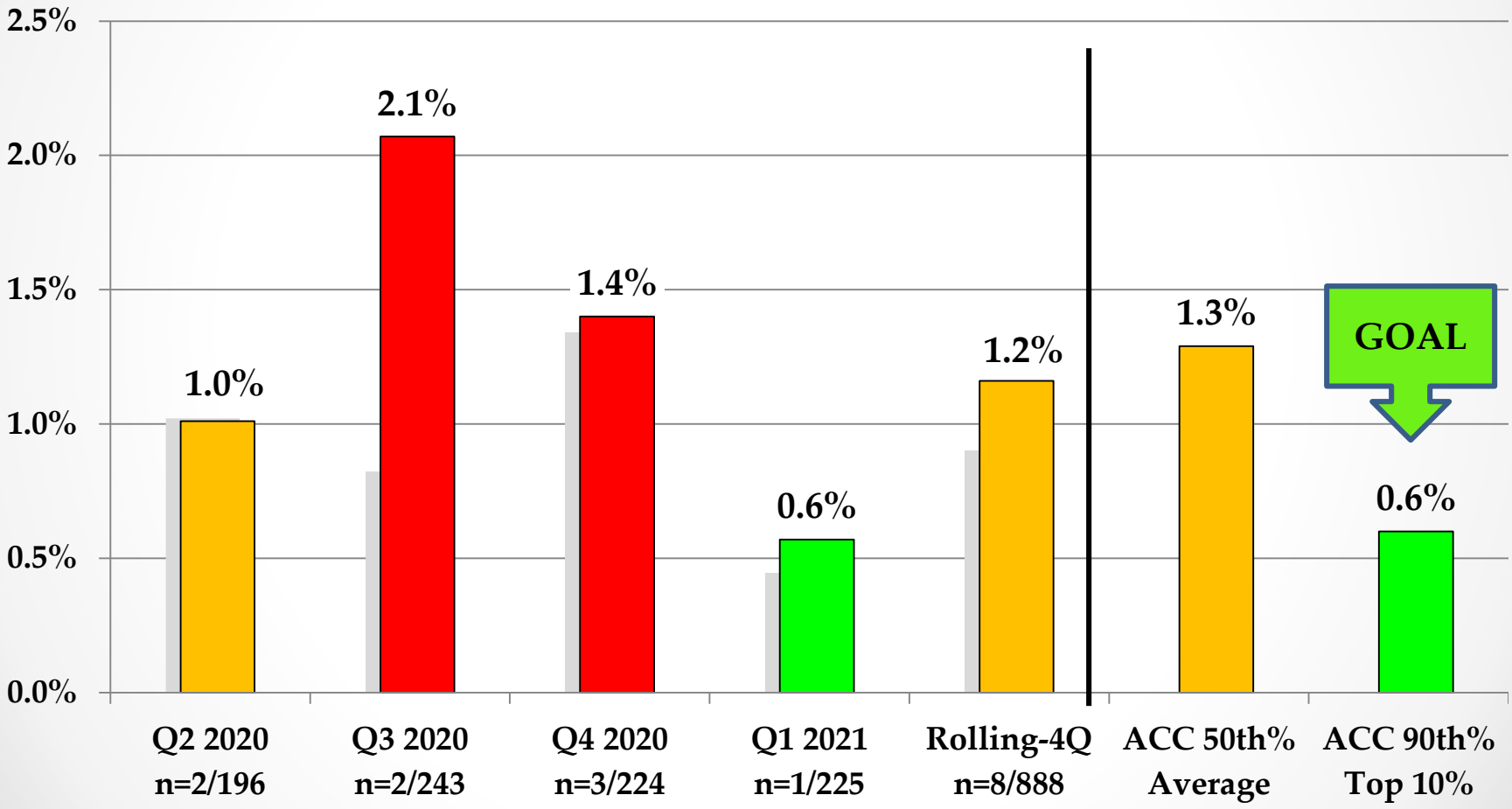
- TWO-YEAR TRENDING



[1] PCI in-hospital mortality rate for STEMI Pt.'s. (ref: 4740, 4734)

PCI In-Hospital Mortality Rate[1]

Risk Adjusted[InColor] (NSTEMI, unstable angina, electives)



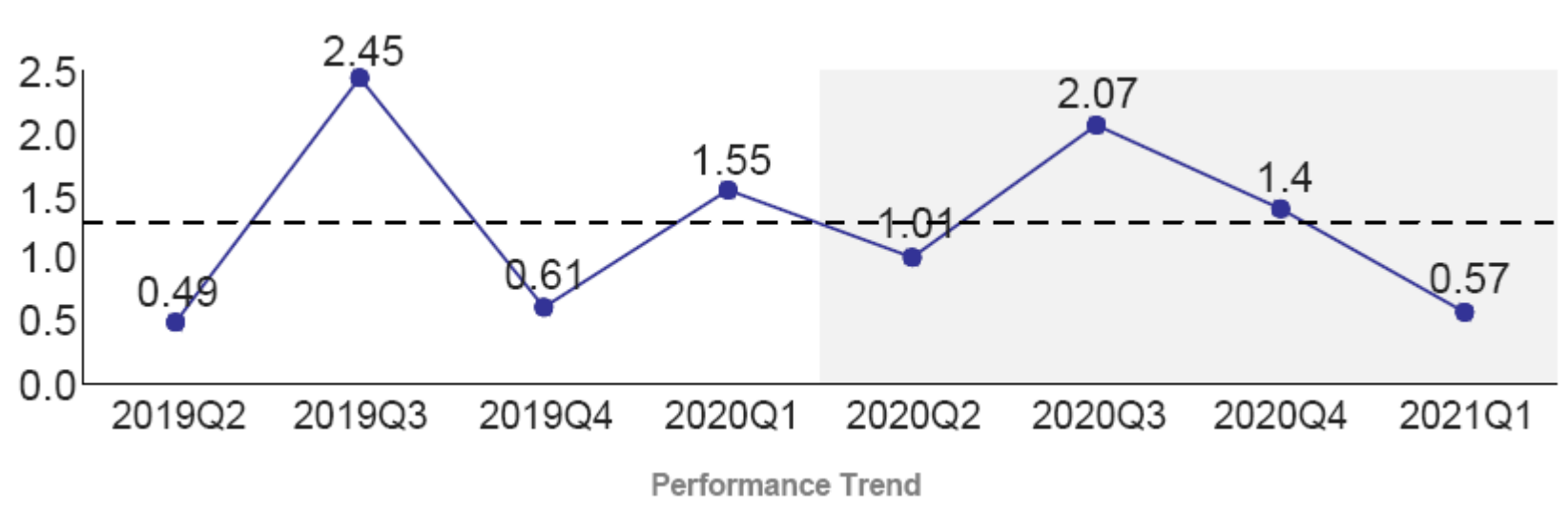
R4Q Risk Adjusted O/E = 1.02

[1] PCI in-hospital mortality rate for all patients Excluding STEMI. Exclusions include patients with a discharge location of "other acute care hospital." (ref: 4741, 4735)

*** Comparison reporting period is 04/01/20 through 03/31/21**

PCI In-Hospital Mortality Rate[1]
Risk Adjusted (NSTEMI, unstable angina, electives)

- TWO-YEAR TRENDING



[1] PCI in-hospital mortality rate for all patients Excluding STEMI. Exclusions include patients with a discharge location of "other acute care hospital." (ref: 4741, 4735)

STEMI Triage Guidelines
Thoughtful Pause

- Should go to CVICU first, not the Cath Lab
  - Cardiac Arrest with CPR ≥ 20 minutes and un/minimally responsive
  - Cardiogenic Shock, age ≥ 80
  - STEMI ≥ 24 hours without Chest Pain
  - Excess risk of bleeding (e.g. active internal bleed, ICH <3 mos, Hct <22, PLT <30K)
  - Altered Mental Status
  - Apparent sepsis or other conditions (other than pure cardiogenic shock) that would markedly increase the risk of dying within 30 days
  - Pre-existing DNR / No Code Status

  ❖ Consider lytic agents for symptoms < 3 hours, anticipated DTB time > 120 minutes and low risk of bleeding

  ❖ These are intended as guidelines, not to supersede clinical judgement

Adopted from The Cleveland Clinic Heart Institute: Triage Guidelines for STEMI patients.

Predicted Mortality Risk Factors

- STEMI
- Age >70
- BMI
- Cerebral Vasc. Disease
- Peripheral Vasc. Disease
- Chronic Lung Disease
- Previous PCI
- NIDDM
- IDDM
- GFR
- Renal Failure / Dialysis
- Ejection Fraction
- Cardiogenic Shock
- NYHA Class I/II/III
- NYHA Class IV
- Cardiac Arrest
- Thrombosis w/in 1 month
- PCI of Prox LAD
- PCI of LM
- >=2VD
- Total Chronic Occlusion

*Risk Factors taken from the American College of Cardiology inclusion list for their Risk Model for Predicted Mortality: version 4.4

Quality Initiative:

Treatment Algorithm for Invasive Cardiac Procedures

- Targeted Temperature Management
  - Immediate hypothermia measures to be implemented on cardiac arrest patients
- 12-Lead ECG must be done within 10 minutes of arrival to hospital
- ACT initiated – (Do not delay cooling measures)
  - Assessment for unfavorable resuscitation features
  - Consultation between ED, Critical Care and Cardiology physicians
  - Transport to CathLab urgently when consensus reached

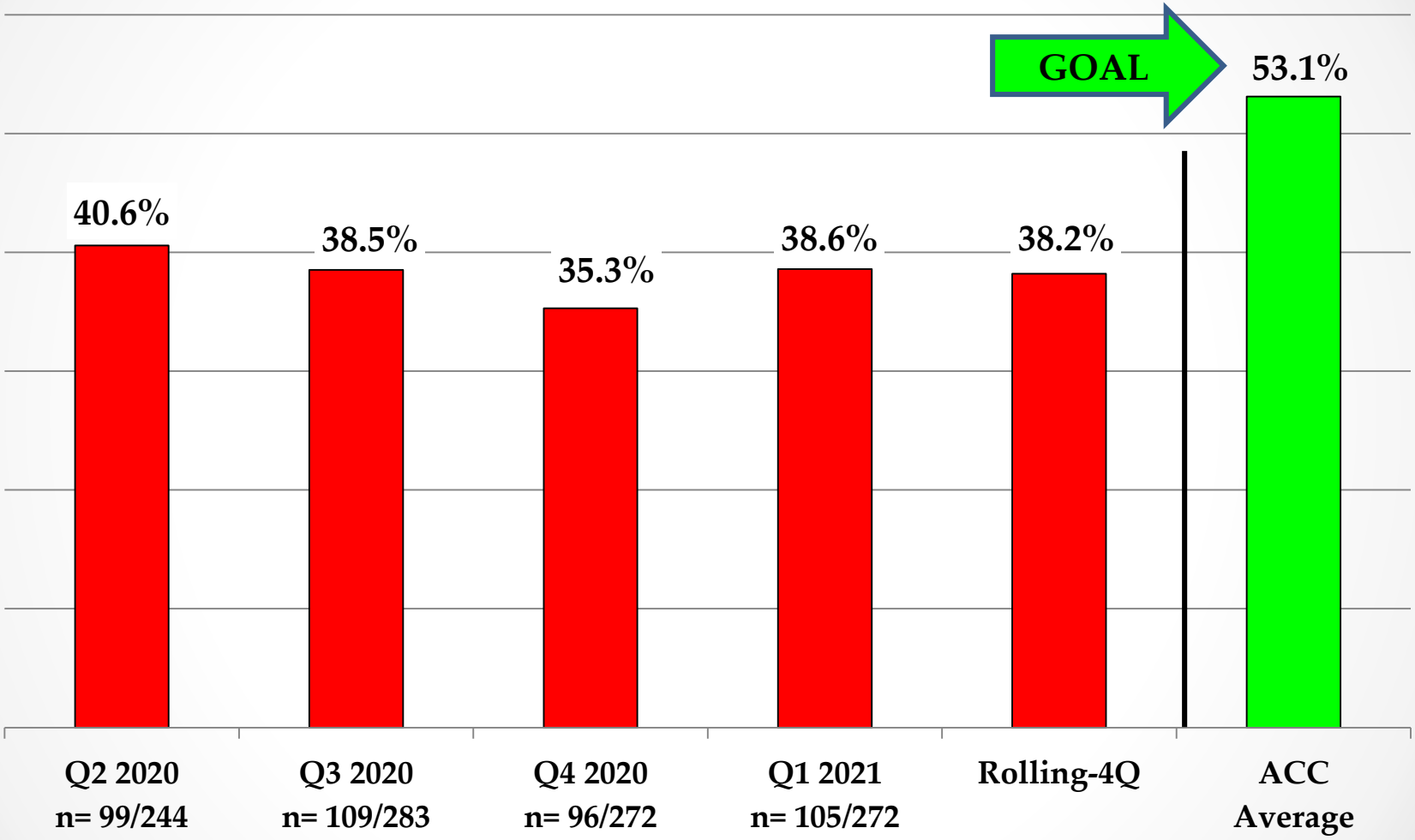
Rab, Tanveer, and Karl B. Kern. "Cardiac Arrest A Treatment Algorithm for Emergent Invasive Cardiac Procedures in the Resuscitated Comatose Patient." *Journal of the American College of Cardiology* 66.1 (2015): 62-73.

Quality Initiative:
Vitally Important Steps

- Physician collaboration & coordination between departments is required
- Cardiologist must participate in all thoughtful pause discussions
- ED physician and Cardiologist will consult with an Intensivist as needed for difficult cases
- Intensivist will respond to the ED for thoughtful pauses as requested
- Thoughtful pause must be documented in patient's EMR by a physician
- Families must be given aggressive treatment options with their corresponding prognosis or futility
- Honest communication between all parties required to maintain transparency and trust

Rab, Tanveer, and Karl B. Kern. "Cardiac Arrest A Treatment Algorithm for Emergent Invasive Cardiac Procedures in the Resuscitated Comatose Patient." *Journal of the American College of Cardiology* 66.1 (2015): 62-73.

PCI Radial Artery Access

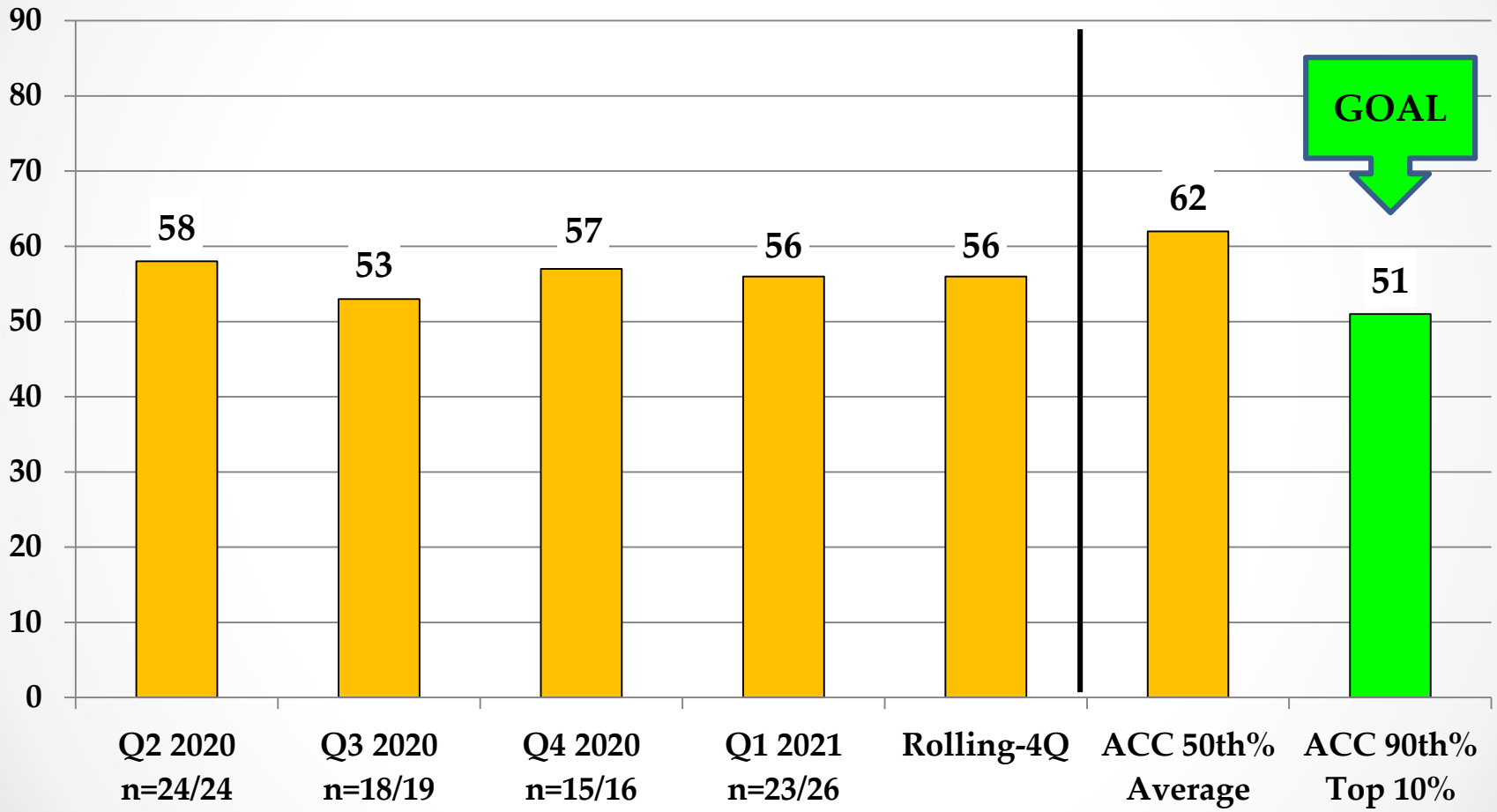


R4Q O/E = 0.7

(ref: NCDR Detail Line 4163)

*** Comparison reporting period is 04/01/20 through 03/31/21**

Immediate PCI for STEMI
(in minutes)[1]

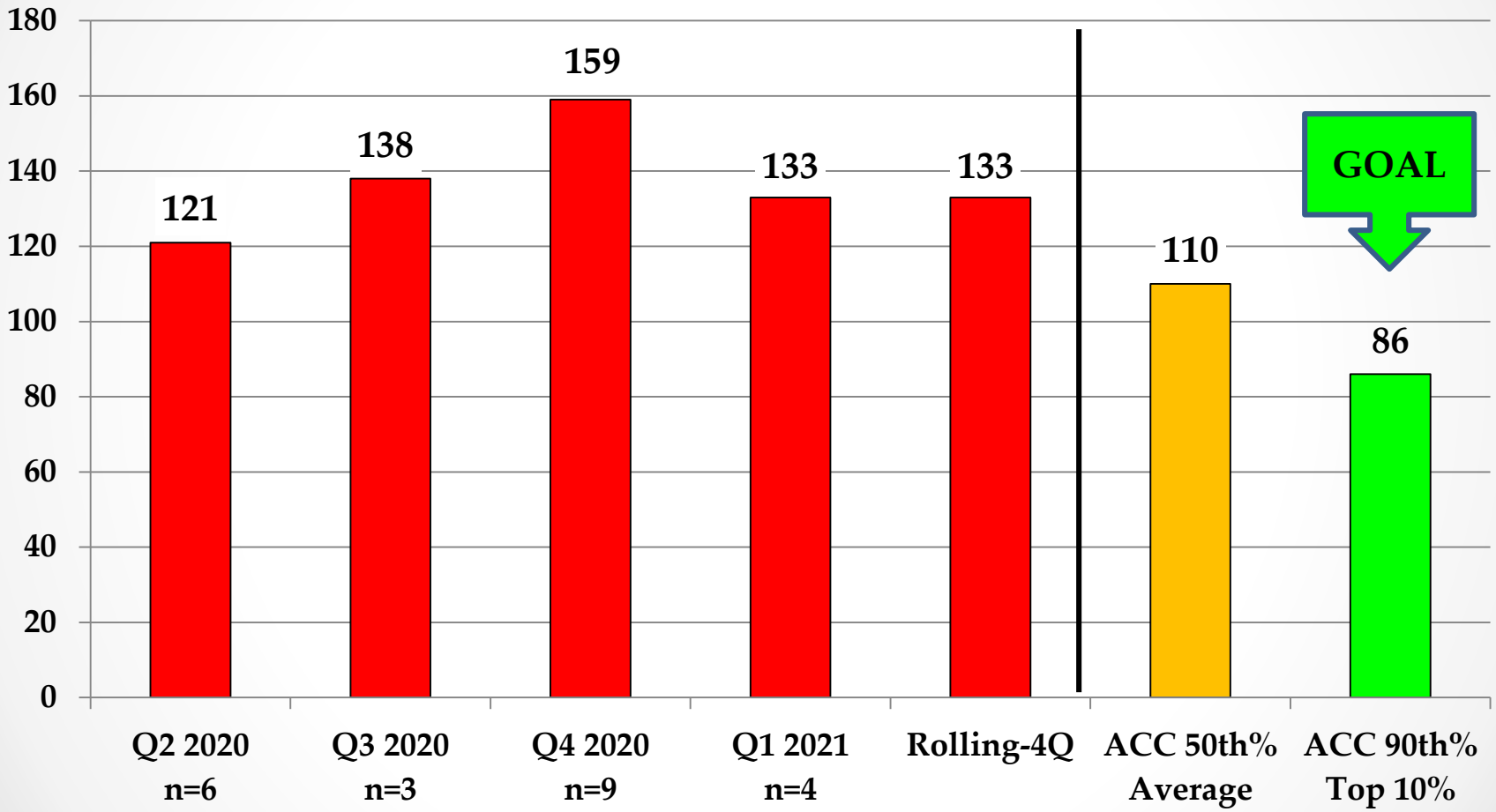


R4Q O/E = 0.9

[1] Median time frame from hospital arrival to immediate PCI for STEMI pts in minutes. Exclusions: Patients transferred in from another acute care facility; Reasons for delay does not equal none. N= pt.'s receiving PCI within 90 minutes. (ref:4448)

*** Comparison reporting period is 04/01/20 through 03/31/21**

Immediate PCI for STEMI Transfers
(in minutes)[1]



R4Q O/E = 1.2

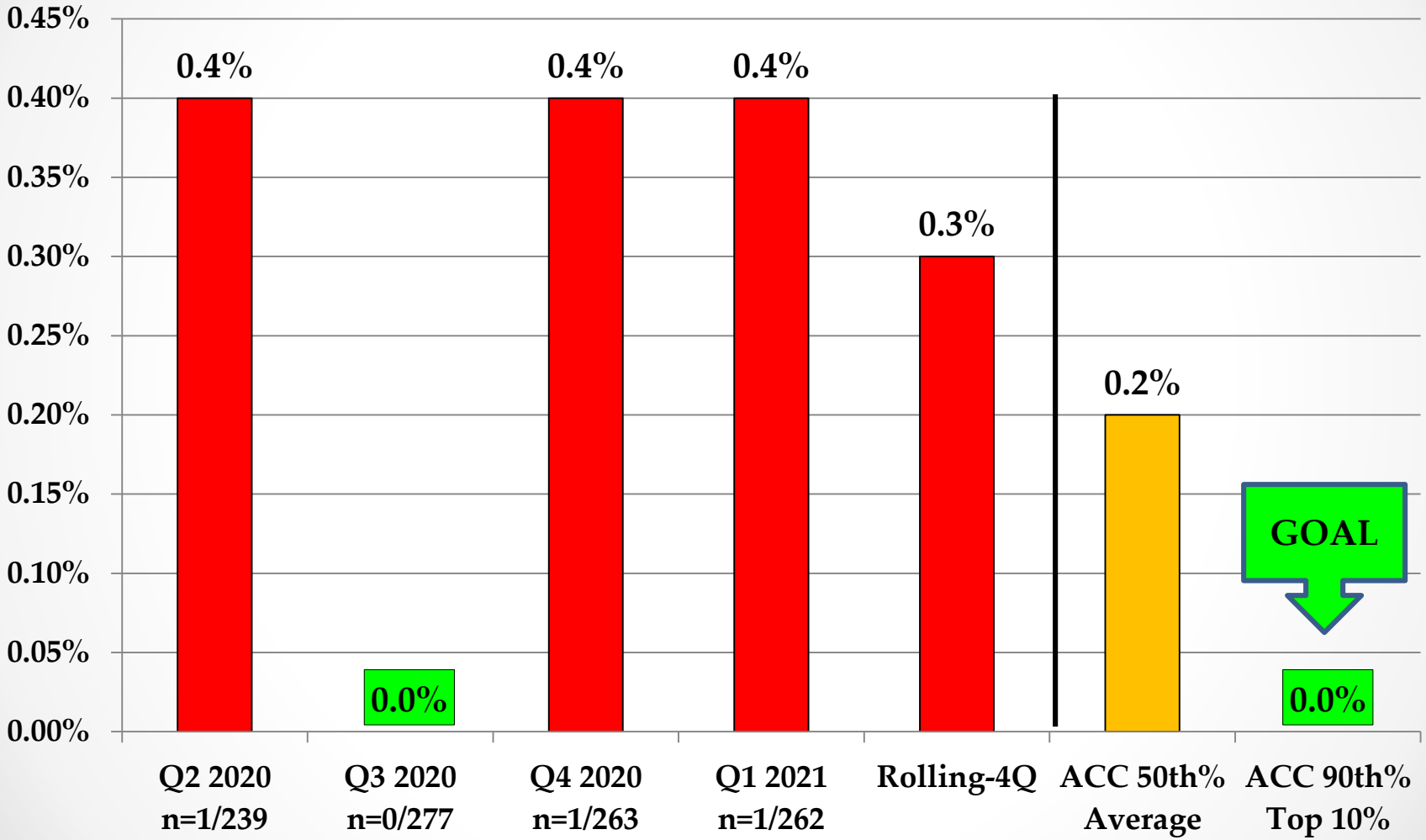
[1] Median time from ED arrival at STEMI transferring facility to immediate PCI at STEMI receiving facility among transferred patients (excluding reason for delays); Reasons for delay does not equal none. (ref:4452, 10888)

*** Comparison reporting period is 04/01/20 through 03/31/21**

Quality Initiative:
Best Practice in Door to Balloon

- 4 Staff on call at all times with crew response time of 20 minutes
- Recognition of staff with a monthly fastest Door to Balloon award to incentivize staff
- Cardiac Alerts to be called at the time of leaving transferring hospitals
- ED EKG to be placed in EMR or Tracemaster
- STEMI taskforce with ED, Quality, Cath Lab to review ED STEMI hand off including STEMIs called in the field and from other facilities
- Cardiac Alerts called within 10 minutes of ED arrival unless Thoughtful Pause is documented in the EMR

Stroke Post PCI[1]



R4Q O/E = 1.4

[1] Exclusions: Patients with an Intervention this admission (Surgery, EP, Other); Pt's discharged to *Other Acute Care Facility* (ref: 4235) *** Comparison reporting period is 04/01/20 through 03/31/21**

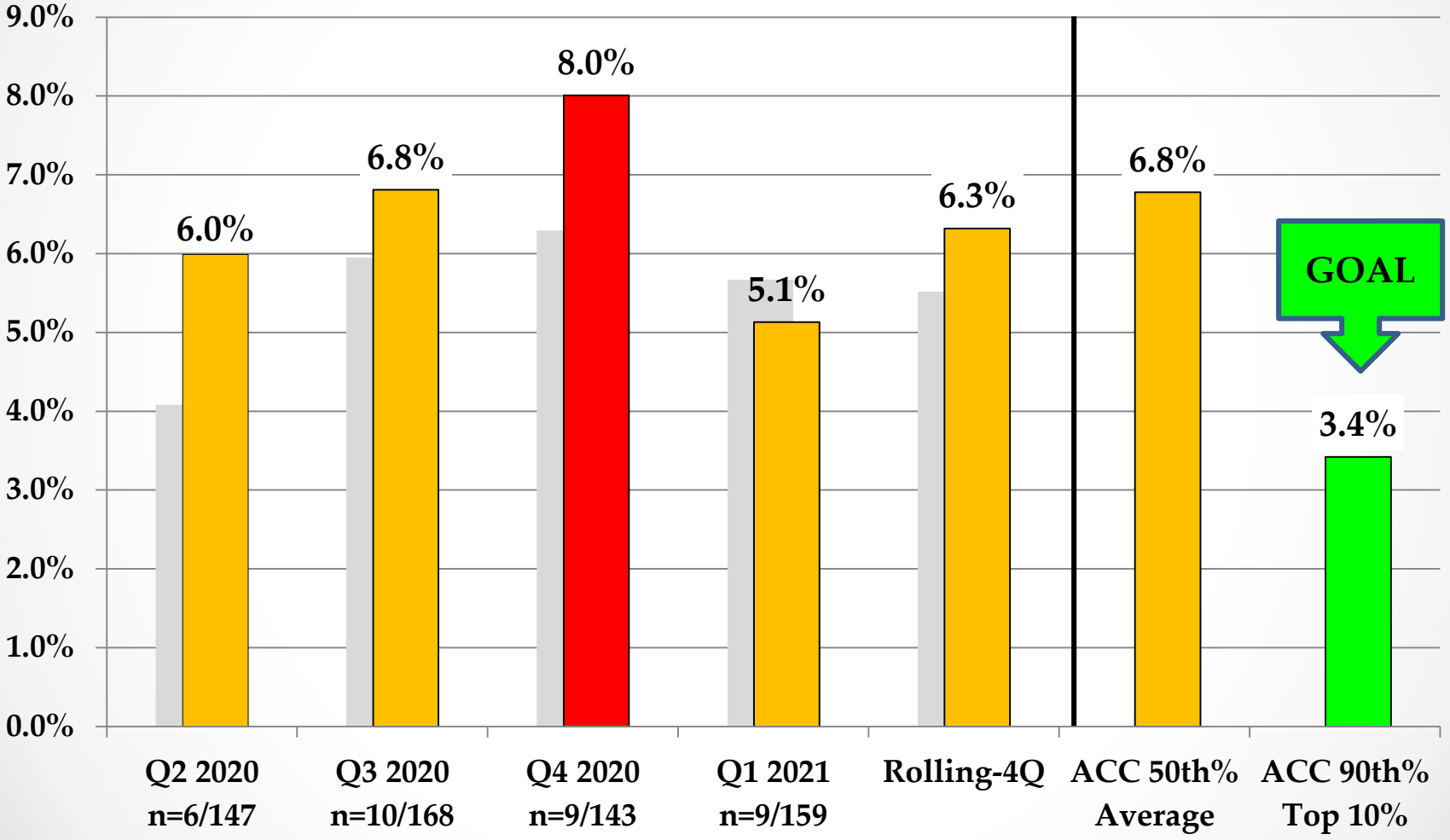
Quality Initiative:

Stroke Recognition and Treatment

- Assess Stroke Risk factors in PCI for each patient
  - Age, gender, history of CVA, End Stage Renal Disease, Diabetes, Hypertension, Peripheral Vascular Disease, Smoking, Congestive Heart Failure, Atrial Fibrillation, CABG surgery or emergent PCI
- Rapid recognition of stroke symptoms in Cath Lab
- Use of the clear protocol for recognition and interventions will facilitate efficient care in the unlikely event of a stroke in Cath Lab

Acute Kidney Injury[1] Post PCI

Risk Adjusted InColor



R4Q Risk Adjusted O/E = 0.86

[1] Proportion of pt's with a rise of serum creatinine of > 50% or ≥0.3 mg/dL over the pre-procedure baseline; all pt's w/ New Requirement for Dialysis. Exclusions: pt's on dialysis pre-procedure; pt's second PCI within this episode of care; same day discharges. (ref: 4882) *** Comparison reporting period is 04/01/20 through 03/31/21**

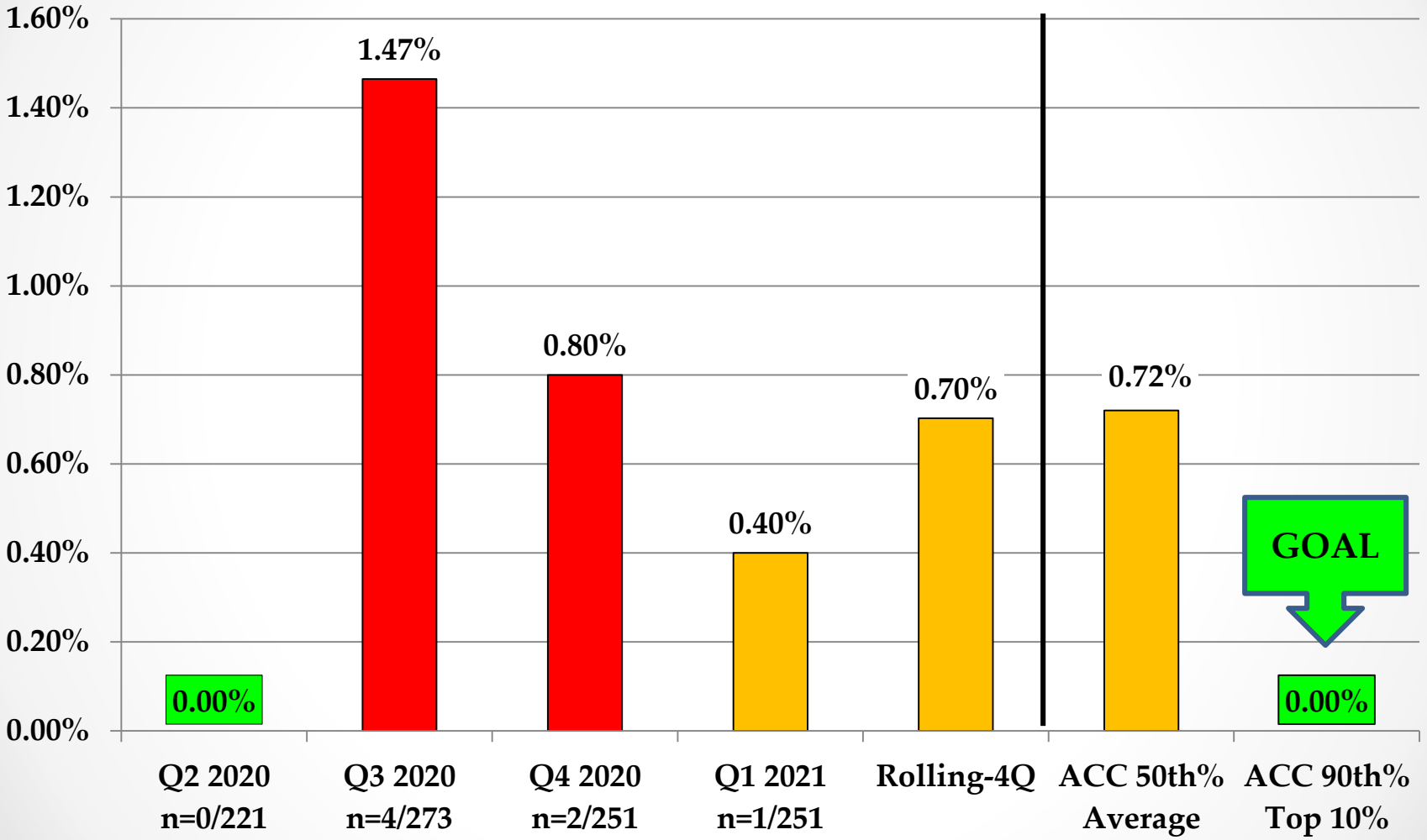
Quality Initiative:

Contrast Induced Nephropathy

- Renal impairment = estimated glomerular filtration rate ≤ 60mL/min
- Hydration Needs
  - Pre procedure: Normal Saline at 250 ml/hour to be started upon arrival
  - Intra procedure:
    - LVEDP <18 → NS 500 mL/hr for 4 hours
    - LVEDP >19 → NS 250 mL/hr for 4 hours
  - Post procedure: Normal Saline at 250 ml/hour for 6-24 hours
- For outpatients, an increase in oral hydration is encouraged the day before arrival. The patients are encouraged to drink clear liquid up to 2 hours before procedure
- Post procedure labs must be ordered
- Metabolic panel ordered one day post procedure
- Track and Report contrast utilization for Diagnostic and Interventional procedures

*Merschen, Richard. "An Overview of Chronic Kidney Disease and Useful Strategies for Clinical Management." *Cath Lab Digest* Mar. 2012 http://www.cathlabdigest.com/articles/Overview-Chronic-Kidney-Disease-Useful-Strategies-Clinical-Management

Transfusion Post-PCI of RBCs[1]



R4Q O/E = 1.0

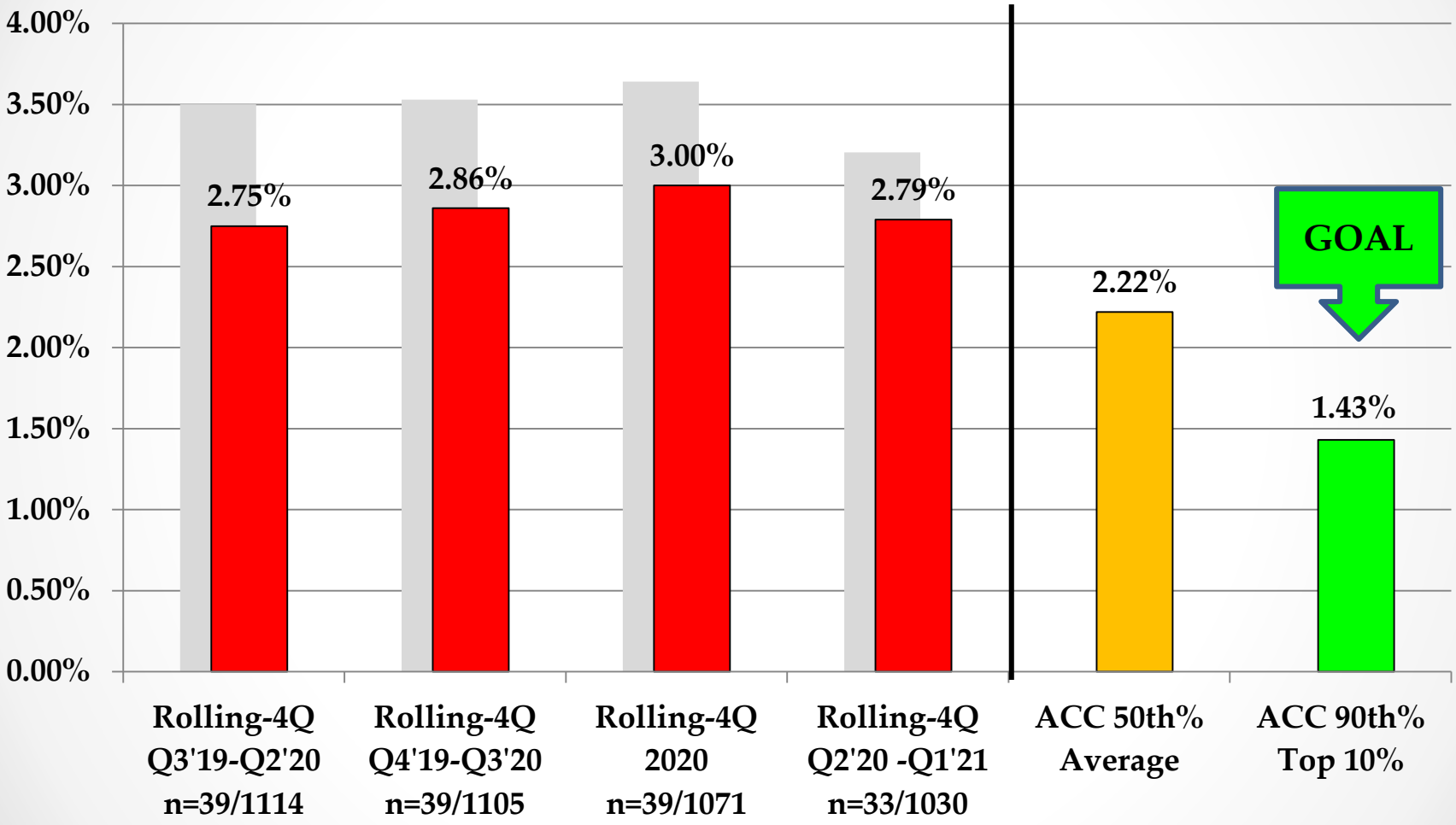
[1] Proportion of pt's who receive a transfusion of whole blood or RBCs during or after, but within 72 hours of PCI procedure. Exclusions: Patients on dialysis; EP study or CABG or other major surgery during the same admission; Pt.'s with a pre-procedure hemoglobin <8g/dL or no value. (ref: 4288) *** Comparison reporting period is 04/01/20 through 03/31/21**

APPROPRIATE USE OF RED BLOOD CELLS

A. Pre-transfusion hematocrit of less than 24% or hemoglobin less than 8 grams/dl.

B. Transfusion may be administered when hemoglobin levels are 8-10 grams/dl in the following circumstances:
    1. Acute Blood Loss/Active Bleed
    2. Presence of Symptomatic Anemia
    3. HGB <9 w/ Chemotherapy
    4. HGB <10 w/ Radiation Treatment

Risk Standardized Bleeding Rate[1]



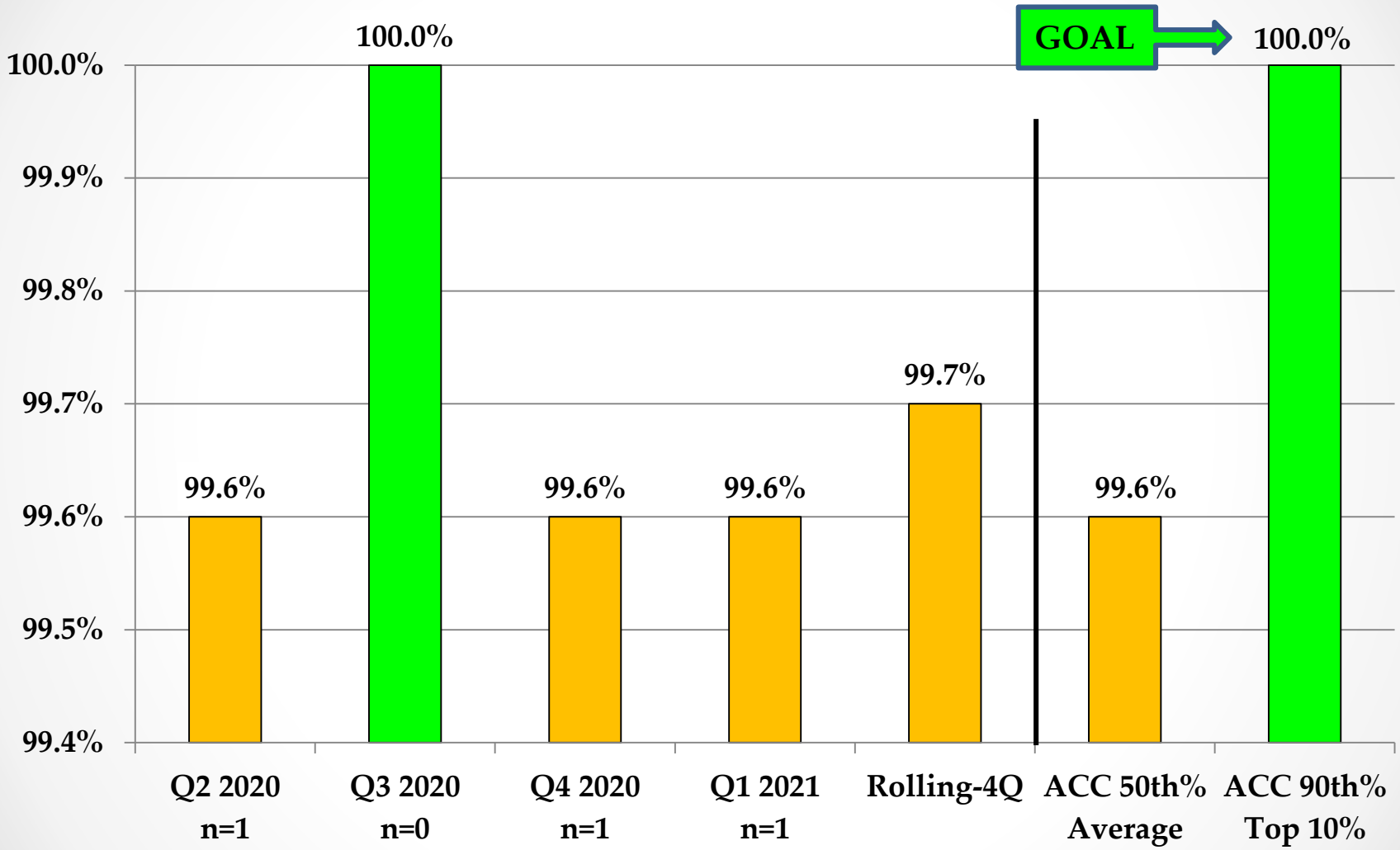
R4Q O/E = 1.4 [1] Pt's with a Bleeding event defined as 1) occurring within 72 hours of procedure (Bleeding at access site, hematoma at access site, retroperitoneal bleed, GI, GU or any transfusion) 2) occurring during hospitalization (hemorrhagic stroke, tamponade, Hgb drop ≥4 g/dL requiring transfusion, or a procedural intervention/surgery to reverse/stop or correct the bleeding) Exclusions: subsequent PCI procedures, death w/in 24 hours, CABG this hospitalization, transfusion in presence of mechanical support. (ref: 4934) *** Comparison reporting period is 04/01/20 through 03/31/21**

Quality Initiative:

Bleeding Protocol

- Establish a vascular site protocol in accordance with SCAI safe femoral access guidelines
    1. Radial first
    2. Use of ultrasound guidance
    3. Use of fluoroscopy to mark the femoral head
    4. Use of micro puncture needle

ASA Prescribed at DC[1]

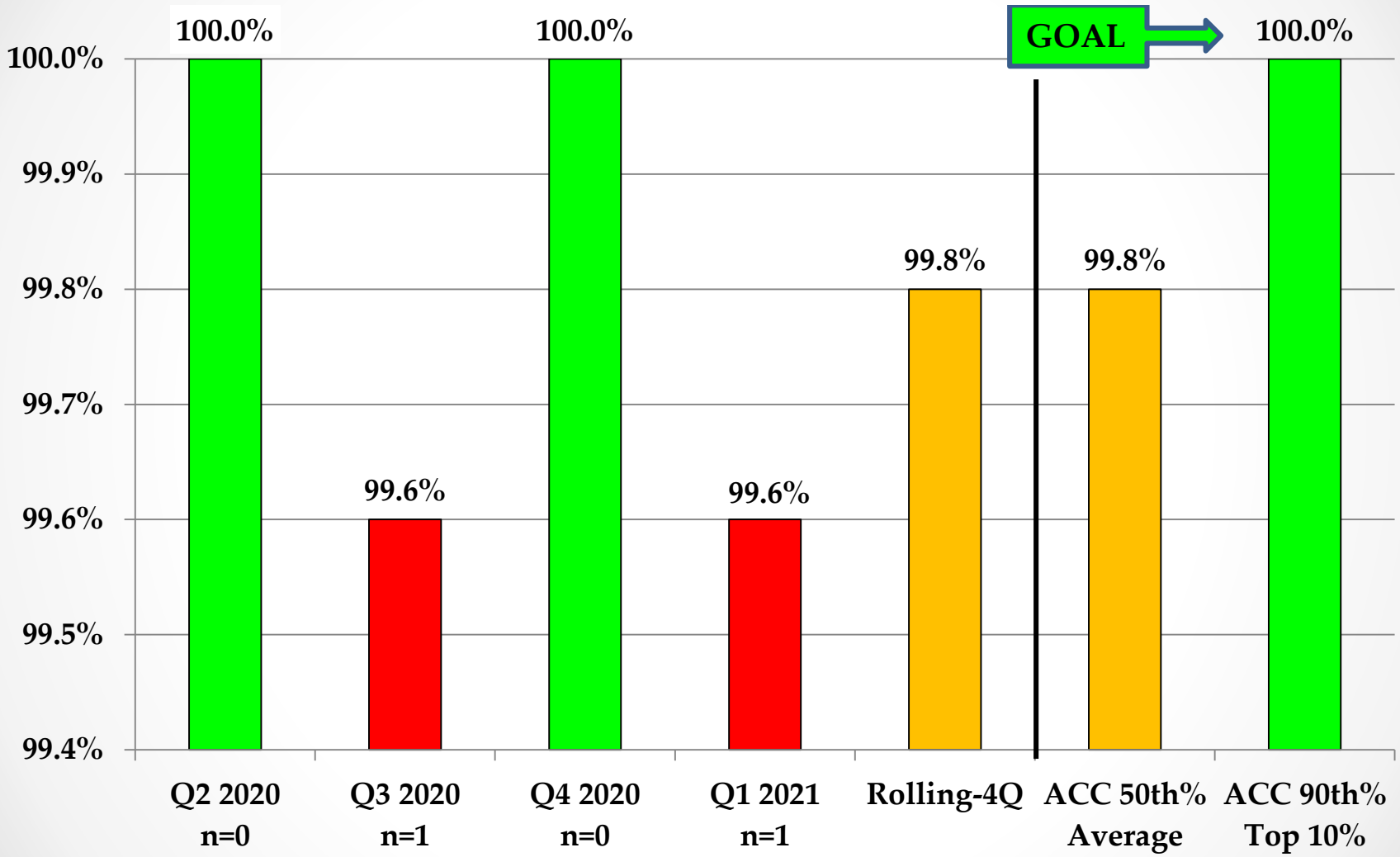


R4Q O/E = 1.0

[1] Proportion of pt.'s (without a documented contraindication) with a PCI attempted or performed that were prescribed aspirin at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths. (ref: 4702)

*** Comparison reporting period is 04/01/20 through 03/31/21**

P2Y12 Inhibitor Prescribed at DC[1]

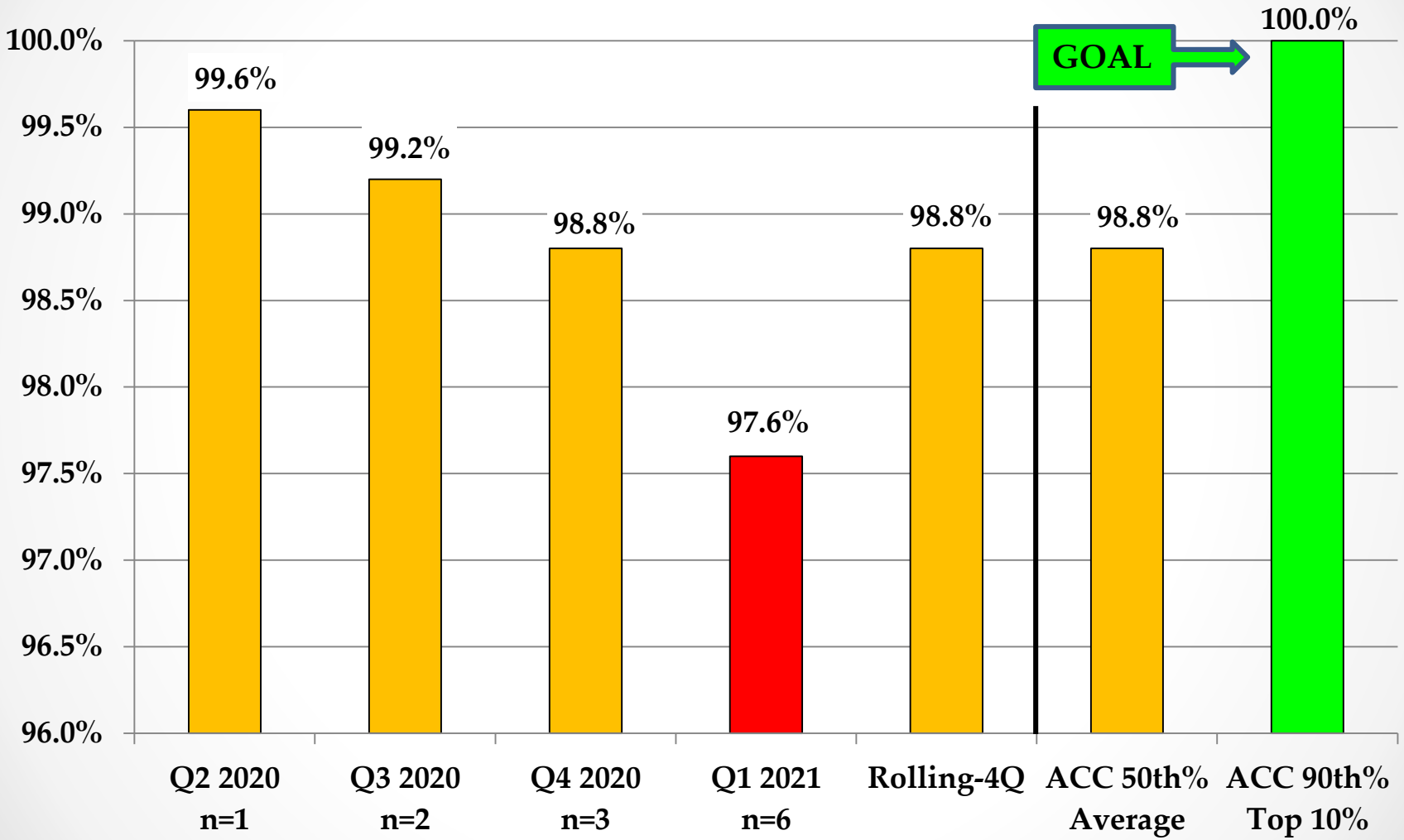


R4Q O/E = 1.0

[1] Proportion of pt.'s (without a documented contraindication) with a cardiac stent placed that were prescribed a thienopyridine/P2Y12 inhibitor at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths (ref: 4711)

*** Comparison reporting period is 04/01/20 through 03/31/21**

Statins Prescribed at DC[1]



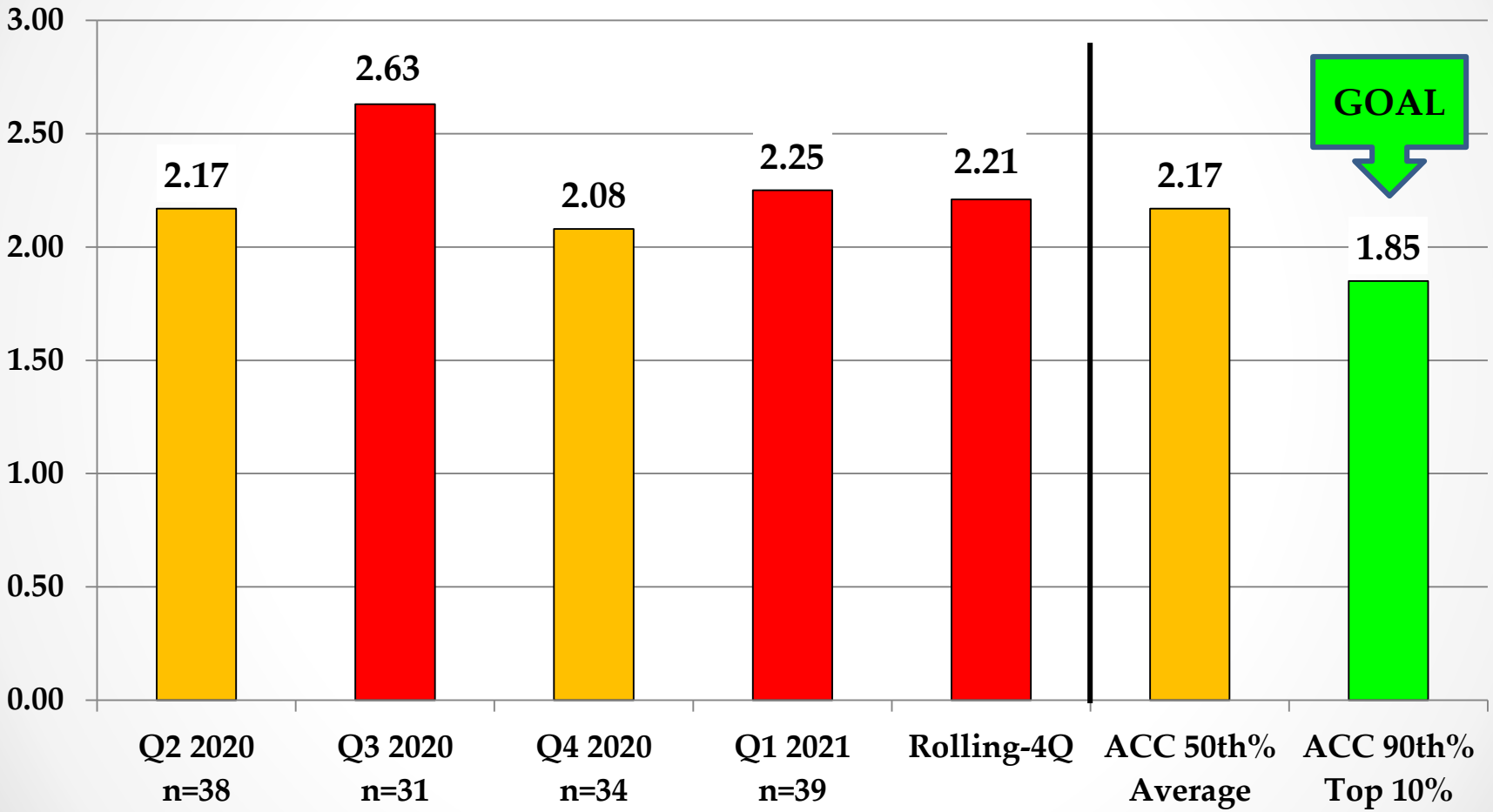
R4Q O/E = 1.0

[1] Proportion of pt.'s (without a documented contraindication) with a PCI attempted or performed that were prescribed a statin at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths. (ref: 4707) *** Comparison reporting period is 04/01/20 through 03/31/21**

Quality Initiative:
Discharge Medications

- Develop and implement PCI specific discharge order set
- Re-educate Hospitalists and Nurse Practitioners on importance of specific discharge medications in this patient population and utilization of new Order Set.
- Track utilization of order set
- Contact Lead Hospitalist or Nurse Practitioner with all fallouts and track
- Improving Clinical documentation in the Discharge Summary of any contraindications
- Improving Clinical documentation in the Discharge Summary clarifying any pending diagnosis (i.e. possible NSTEMI, possible MI)

Post-PCI Length of Stay[1] – STEMI

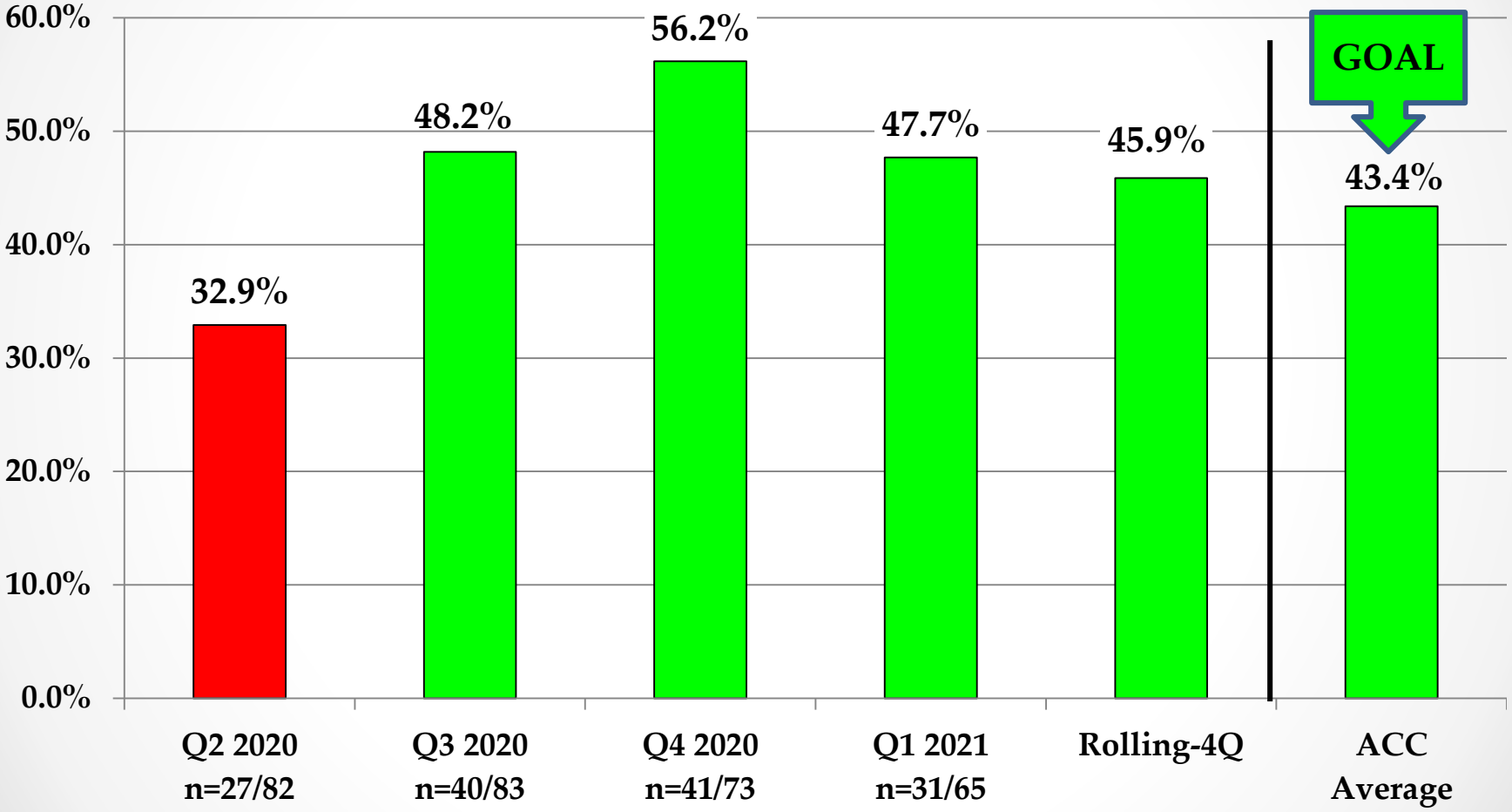


R4Q O/E = 1.0

[1] Median Post-procedure length of stay in STEMI patients. Exclusions: pt.'s discharged to Another Acute Care Facility; death during procedure (ref:4340, 10894)

*** Comparison reporting period is 04/01/20 through 03/31/21**

Post-PCI Same Day Discharge - Electives



R4Q O/E = 1.1

[1] Elective patients discharged on the same day as procedure. Exclusions: mortalities and pt.'s discharged to Another Acute Care Facility or AMA (ref:4971)

*** Comparison reporting period is 04/01/20 through 03/31/21**

Diversion Prevention Committee Update September 2021

What is Drug Diversion?

Drug Diversion is a term used when an individual removes, takes, or finds medication(s) that are prescribed or ordered for someone else and uses them for him/herself.

Examples:

- A patient is prescribed two pills – the person gives one pill to the patient and keeps one for themselves
- A person uses an empty syringe to remove medicine from an IV tubing to inject into themselves
- A person finds a medication and takes it home

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- **Problem Statement**: The organization has strong processes for gathering data and dissemination of reports to monitor control of drugs. We are missing a standardized expectation of follow-up on those reports by the managers and medical staff. We also have an opportunity to broaden awareness of concerning behaviors and build a culture of escalating observations of strange behaviors.

SCOPE:

Education – Organization Wide (Orientation and Annual)

Accountability - Standardization of use of reports and follow-up with team members

Sustainability – Identify best course for ongoing reporting and follow-up with organization action items.

Committee as part of the organizational Quality Assessment Performance Improvement (QAPI) program reports to

Patient Safety Committee and Med Safety Committee

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Purpose and Goals

- Develop organizational program to build awareness of and response to behaviors suspicious for drug diversion.
- Build a culture within the organization of attention to drug diversion prevention.
- Implement education into orientation and annual training related to drug diversion and awareness for all health care professionals.
- Ensure accountability for action items related to routine audits and medication related reports by department leaders.
- Use technology and automation to ensure reporting is routine and applicable.
- Determine expected actions to be taken and communicate those actions to department leaders when abnormal reports are shared.

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Initial Performance Measures

- Implementation of annual education, orientation education for employees and medical staff related to drug diversion. COMPLETE
- Interviews of KDHCD team members and medical staff to determine understanding of the education and organizational expectations. NEXT STEP
- Development of a supervisor/leadership training program to provide enhanced skills for detecting and preventing diversion activities. READY
- Compliance with audits outlined in CMS plan of correction. COMPLETE
- Monthly review of audit dashboard reveals improvements in audit outcomes. PROCESS IN PLACE
- Timely follow-up by organizational leaders for action plans and identified improvements. PROCESS IN PLACE

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EDUCATION - Organization

- Five Education Plans Developed and Deployed
- Audiences Varied - created education specific to the groups' needs
  - High Risk Licensed, All licensed, All providers and residents, House Supervisors/Managers, All Employees
- Delivered to all Employees and Providers
- Incorporated Education into Annual Spring Training
- Continue to Develop future Education based on identified needs.
  - Committee will continue to look for opportunities based on interviews, audit reports and assessments.

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EDUCATION - Leadership

- Focus on monitoring expectations
- Explain what we do and why we do it with audits, monitoring and reports.
- Review signs/symptoms (s/sx) as well as actions to take if s/sx reported or observed.
- Plan to roll out to leadership in October 2021.
  - Incorporate into orientation
  - Annual review in leadership modules.

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CURRENT AUDITS UPDATE –May to July 2021

• Revenue Integrity Technician Audits Monitoring	June and July 100% compliant
• Monitoring of Diluted Controlled Substance and Fentanyl Waste	
• Monitoring Plan –Decreased Dilution of Controlled Substances	June and July 100% compliant
• Monitoring Plan –Fentanyl and Diluted Controlled Substances Waste	June and July 100% compliant
• PHARMACY: Spot Check Pyxis Formulary Changes	Ongoing/Real time review and changes
• Patient's Own Med Storage Monitoring – Controlled Substances	June 96% and July 100% compliant
• Lorazepam (Ativan) IV Bulk Storage Monitoring	May, June and July 100% compliant
• Follow-up on Drug Losses from Manufacturer	June and July 100% compliant
• Short Case Reviews Monitoring	June and July 100% compliant
• Validation of Pharmacy Technician Competence Monitoring	May, June and July 100% compliant
• Stop Orders Monitoring	July 100% compliant
• Staff Practices - Clean Compounding Room Monitoring	Quarterly audits – pending report September 2021
• Monitoring of Room Temperature Monitoring	July 100% compliant
• Expired Medications Monitoring	June 100% and July 99.7% compliant

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Next Steps

- Informal interviews of Front Line team members
  - Effectiveness of education
  - Understanding of prevention strategies
- Review of routine audits and reports – improvements and action plans from managers
- Leadership Education Roll-out
- Implementation of Blue Sight – Diversion Prevention Software
- Expand Goals for the Committee through event reporting, trends and noted improvements

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Health is our passion. Excellence is our focus. Compassion is our promise.

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CFO Financial Report
September 21, 2021

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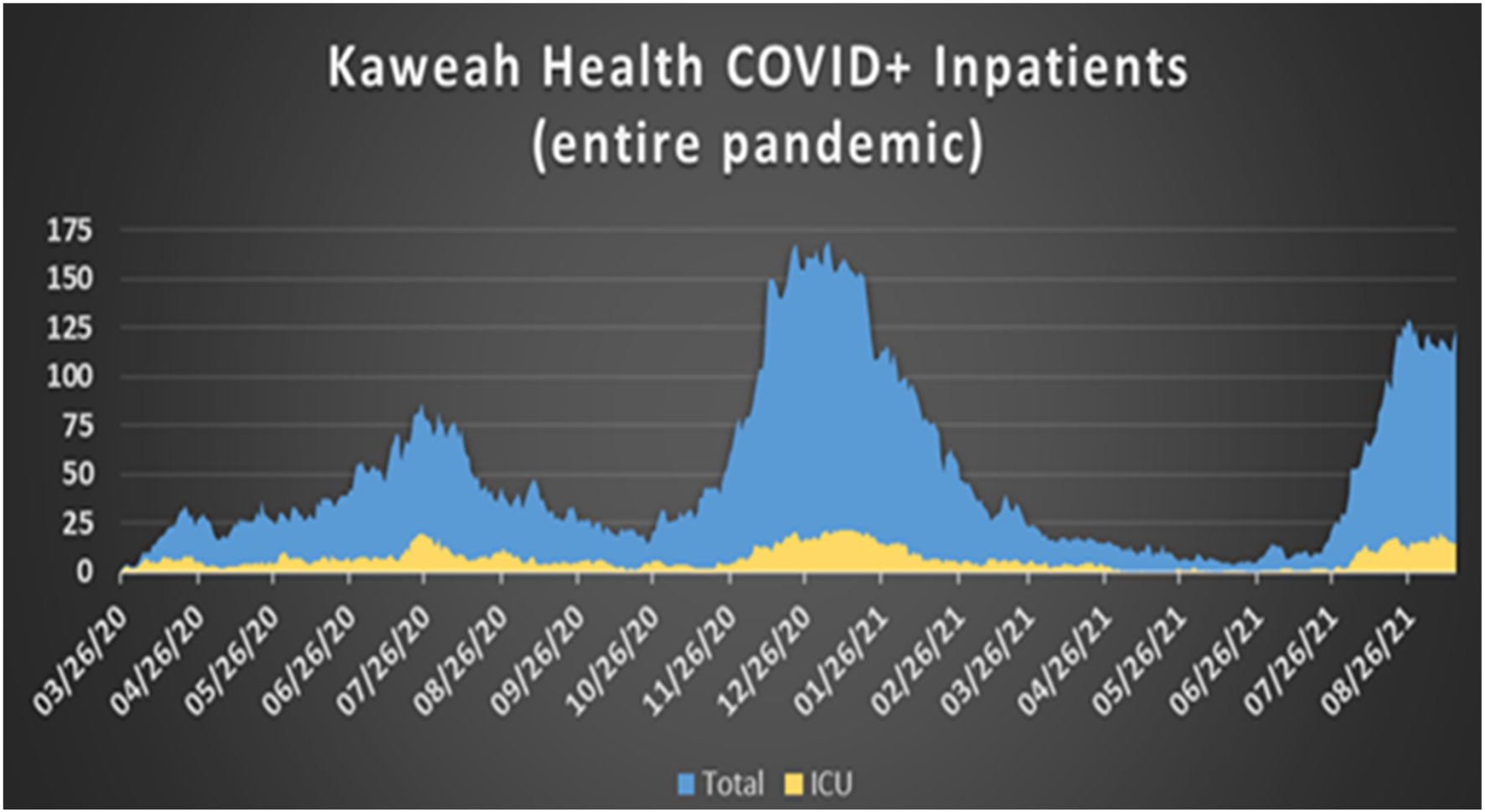

Kaweah Health COVID+ Inpatients
(entire pandemic)
175
150
125
100
75
50
25
0
03/26/20
04/26/20
05/26/20
06/26/20
07/26/20
08/26/20
09/26/20
10/26/20
11/26/20
12/26/20
01/26/21
02/26/21
03/26/21
04/26/21
05/26/21
06/26/21
07/26/21
08/26/21
Total
ICU

COVID-19 Financial Activity – **Round 4 Stimulus Funds**

On Friday September 10th, the U.S. Department of Health and Human Services announced it will allocate $25.5 billion in additional COVID-19 relief funding for Providers

Allocation method

$17B from the Provider Relief Fund

- 75% will be based on Revenue Losses and COVID-19 related expenses: Large providers will receive minimum payment amount that is based on their loss revenues and expenses. (Qtrs.3&4 2020 & Qtr.1 2021) Medium and small providers will receive a base payment plus a supplement
- 25% will be used for bonus payments to providers based on the amount and type of services delivered to Medicaid, Children's Health Insurance Program, and Medicare patients. Providers who serve any patients living in rural areas and who meet the eligibility requirement will receive a minimum payment

$8.5B from the American Rescue Plan

- Providers who service Medicaid, CHIP and Medicare patients who live in rural communities, as defined by the Federal Office of Rural Health Policy are eligible. Payments will be based on the amount and type of services provided to rural patients.

COVID-19 Financial Activity

Stimulus Funds Received

Red indicates changes since last reviewed

Stimulus Funds – Kaweah Delta	$11,420,930	Received 4/11/20
Stimulus Funds – KDMF	$684,104	Received 4/11/20
Stimulus Funds – KD 2nd payment	$1,225,939	Received 4/24/20
Stimulus Funds – KDMF 2nd payment	$198,091	Received 5/26/20
California Hospital Association - PPE	$28,014	Received 6/3 and 6/9/20
Stimulus Funds – 4 Physician Groups	$332 017	Received April 2020
Stimulus Funds -Testing at RHC	$197,846	Received 5/20/20
Stimulus Funds - Skilled Nursing Facility	$225,000	Received 5/22/20
Stimulus Funds – Rural Providers	$413,013	Received 6/25/20
Stimulus Funds – Due to servicing Rural Areas	$813,751	Received 7/21/20
Stimulus Funds – High Impact Areas	$10,900,000	Received 7/29/20
California Hospital Association – PPE II	$150,243	Received 8/25/20
Stimulus Funds – Skilled Nursing Facility	$111,500	Received 8/27/20
Stimulus Funds – Skilled Nursing Facility	$184,388	Received 5 out of 5 payments
Stimulus Funds – KD 3rd wave of federal payments	$11,120,347	Received 1/27/21
Stimulus Funds – KDMF 3rd wave of federal payments	$920,477	Received 4/16/21
Business Interruption Insurance	$125,000	Received 5/25/21
Stimulus Funds – RHC Testing and Mitigation	$400,000	Received 6/10/21
Impact to Net Revenue	**$39,118,643**	

COVID-19 Financial Activity - **Reimbursement and In Kind Impact**

Red indicates changes since last reviewed

20% increase in Medicare inpatient payments	$ 1,350,000	Public health emergency extended through April 20, 2021
6.2% increase in FMAP - IGT matching	$ 1,200,000	Extended through the 1st quarter in which emergency ends
10% increase in Medi-Cal rates in SNF payments	$ 997,000	Calendar year 2020
5% increase Blue Shield rates for certain procedures	$ 12,000	4 Month Estimate
Uninsured COVID Patients – Medicare Rates	**$ 1,266,823**	**Payments through 9/8/21**
Department of Defense	$ 250,000	In kind clinical support staff
2% sequestration	$ 2,100,000	Calendar year 2020 – extended through March 31, 2021
Unemployment benefit costs ½ covered	$ 1,057,000	4 quarters – extended through Mar 14th 2021
5 County agreements – Lab testing, PPE, Pharmaceuticals, vaccination	**$ 5,866,573**	$8,578,800 max , the County will cover related costs as we submit invoices
COVID Payer Grants	$ 3,065,000	October deposit
Repayment period of Medicare Advanced Payments extended - Initial funding $46.6M (4/7/2020)	Balance must be repaid in full 29 months from the first payment.	Medicare payments will be reduced by 25% for the first 11 months and 50% during the next 6 months.
Additional payments received from **Medicare Advanced Payments** Program - $40.2M (10/28/20) Total to date $86.8M	**($15.1M) recouped in April-Sept 13, 2021.**	10/28/20 We received $40,173,945 additional funds to be repaid in 1 year
Social Security Tax Deferral – $13.5M		Repayment of 50% due 12/31/21 and 50% 12/31/22
DSH cuts were delayed through FFY2023 - $5,200,000 in FY2021		DSH cuts were delayed through FFY2023
Impact to Bottom Line	**$ 17,164,396**	

Financial Analysis - COVID-19 Inpatients

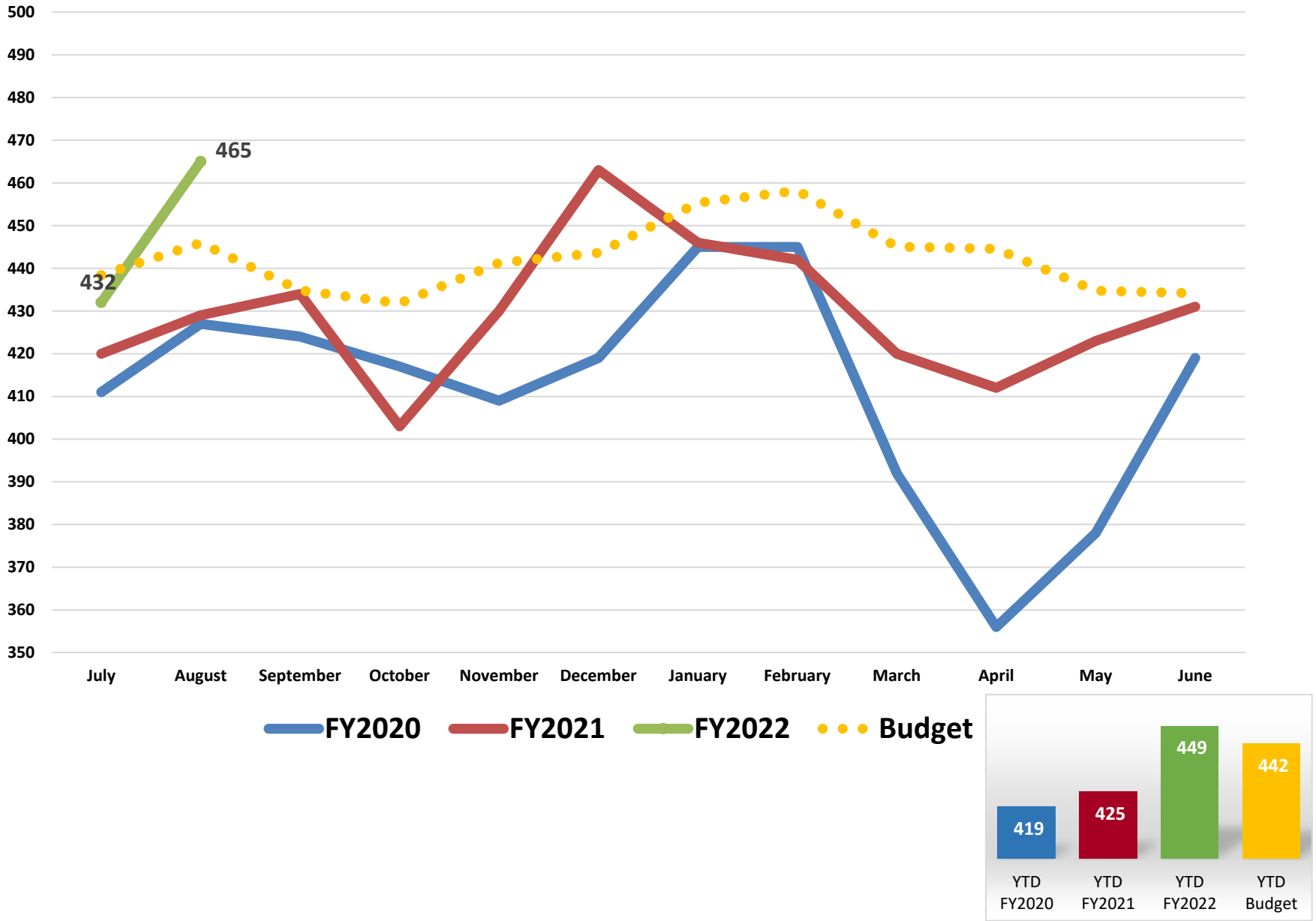
January 2020 - August 2021 Discharged COVID Inpatients

Payer Group	Patient Volume	% of Total Visits	ALOS	GMLOS	Est. Net Revenue	Direct Cost	Contribution Margin	Net Income
Medicare	1472	49%	10.3	5.7	$32,825,005	$32,225,707	$599,298	($8,679,351)
Medi-Cal Managed Care	613	20%	8.8	5.5	$13,848,465	$12,651,731	$1,196,734	($2,394,323)
Commercial/Other	587	20%	9.2	5.9	$18,687,245	$12,664,922	$6,022,322	$2,439,434
Medi-Cal	272	9%	11.3	5.5	$4,214,222	$5,804,794	($1,590,571)	($3,285,360)
Work Comp	27	1%	11.4	7.1	$875,726	$922,707	($46,981)	($297,965)
Cash Pay	24	1%	5.3	5.3	$8,082	$277,585	($269,503)	($347,271)
Tulare County	1	0%	7.0	4.9	$9,219	$6,658	$2,561	$380
Grand Total	**2,996**	**100%**	**9.8**	**5.7**	**$70,467,963**	**$64,554,104**	**$5,913,859**	**($12,564,457)**
			Typical Contribution Margin on 2,996 Inpatient visits				**$7,546,924**	
			LOS GAP	**4.2**		**Difference**	**($1,633,065)**	

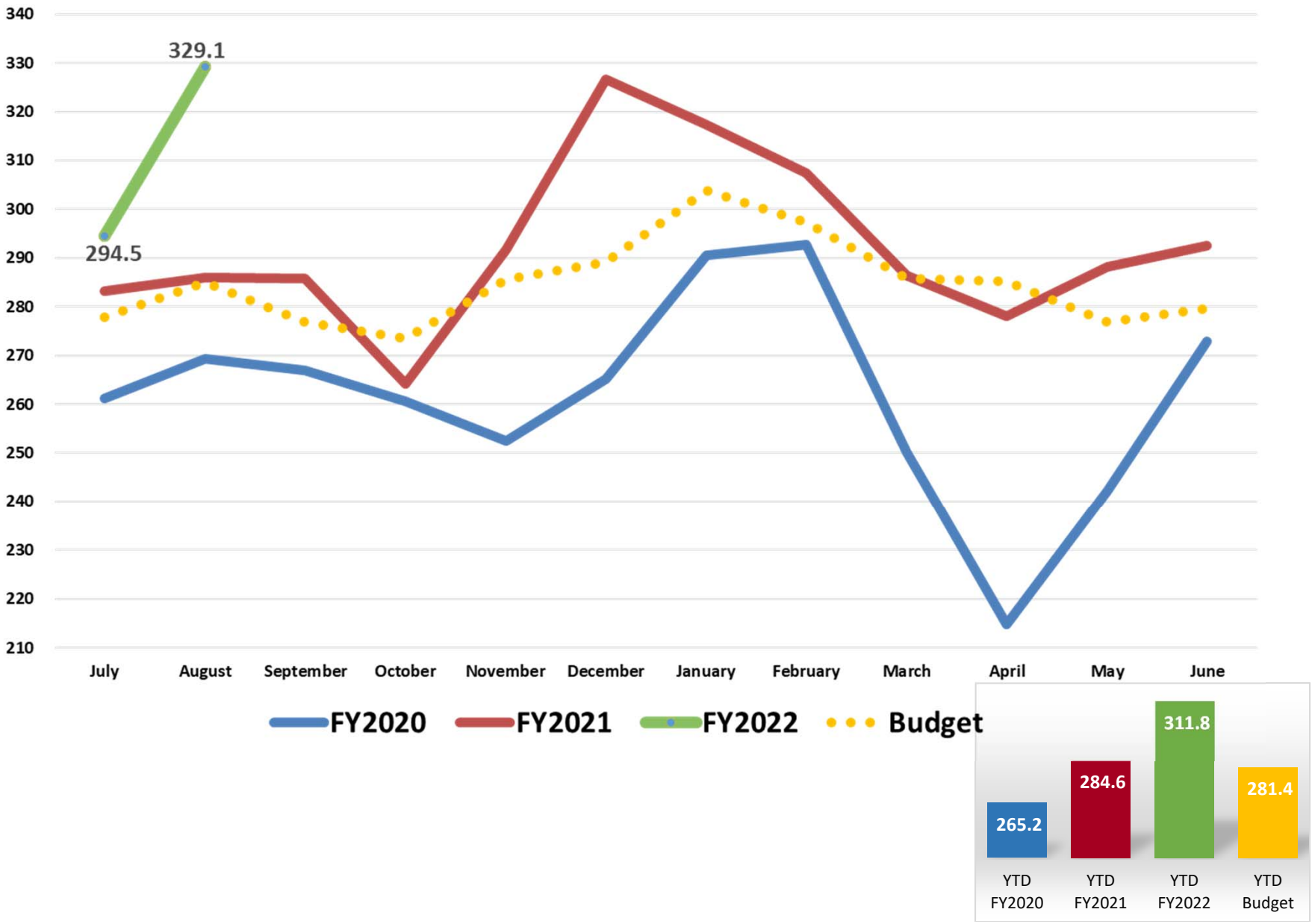
COVID IMPACT (000's)

	March 2020 - Aug 2021
Operating Revenue	
Net Patient Service Revenue	**$851,052**
Supplemental Gov't Programs	85,047
Prime Program	20,021
Premium Revenue	86,385
Management Services Revenue	51,822
Other Revenue	32,740
Other Operating Revenue	276,015
Total Operating Revenue	**1,127,065**
Operating Expenses	
Salaries & Wages	483,964
Contract Labor	14,353
Employee Benefits	85,578
Total Employment Expenses	**583,896**
Medical & Other Supplies	193,822
Physician Fees	144,968
Purchased Services	28,469
Repairs & Maintenance	39,214
Utilities	10,696
Rents & Leases	9,304
Depreciation & Amortization	47,711
Interest Expense	10,238
Other Expense	30,596
Humana Cap Plan Expenses	49,016
Management Services Expense	51,369
Total Other Expenses	**615,402**
Total Operating Expenses	**1,199,297**
Operating Margin	**($72,232)**
Stimulus Funds	$47,865
Operating Margin after Stimulus	**($23,567)**
Nonoperating Revenue (Loss)	15,773
Excess Margin	**($8,593)**

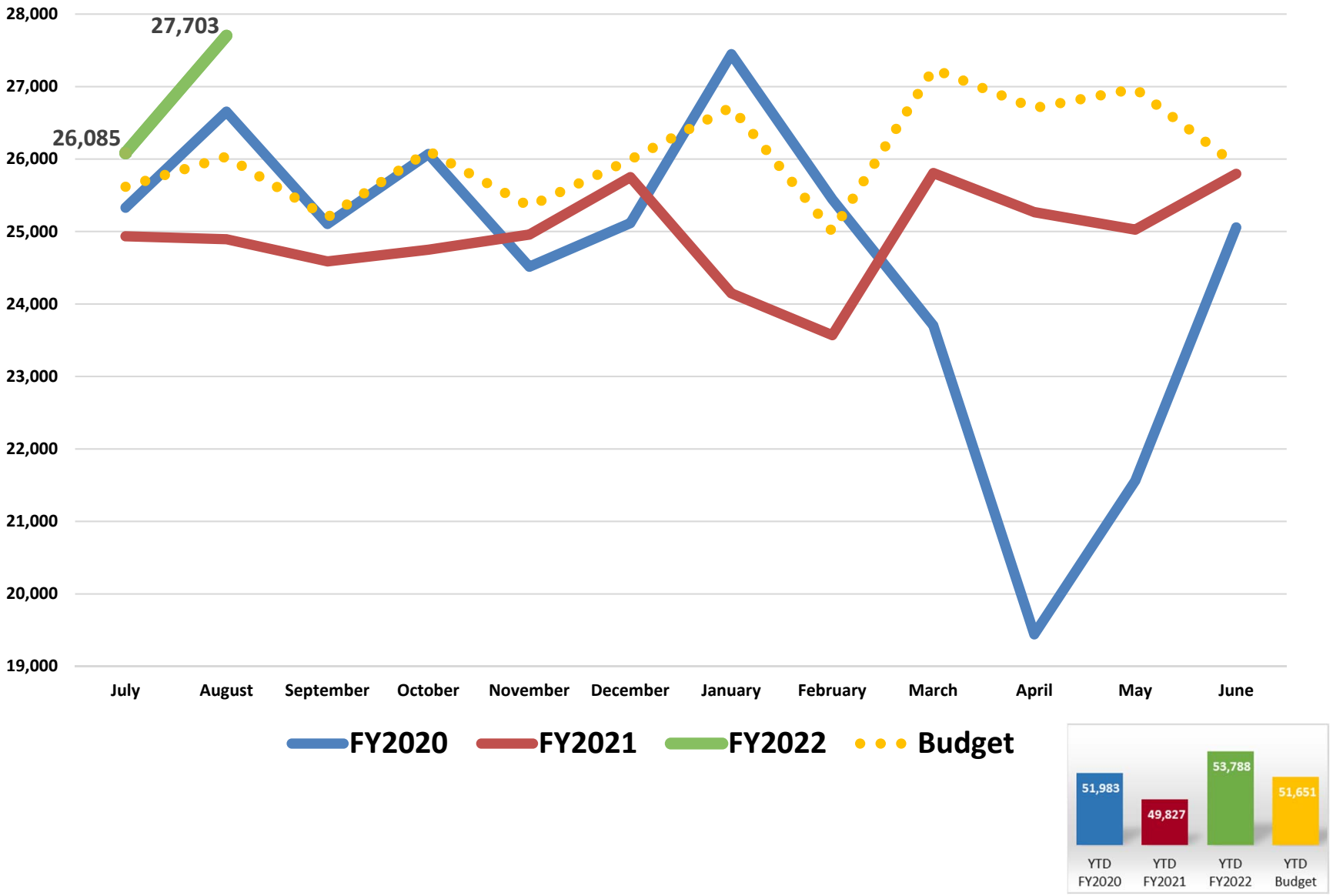
Average Daily Census



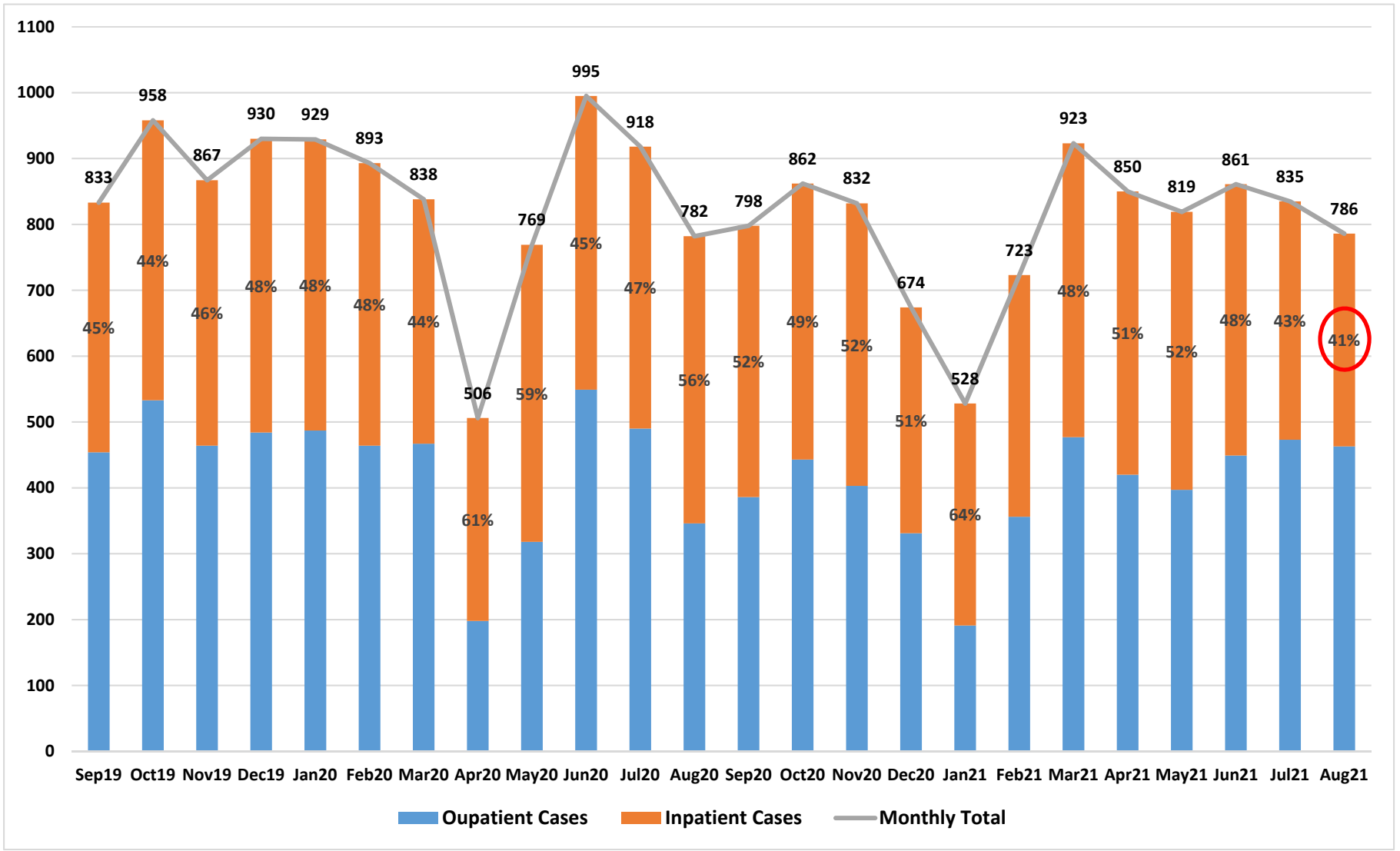
Medical Center – Average Daily Census



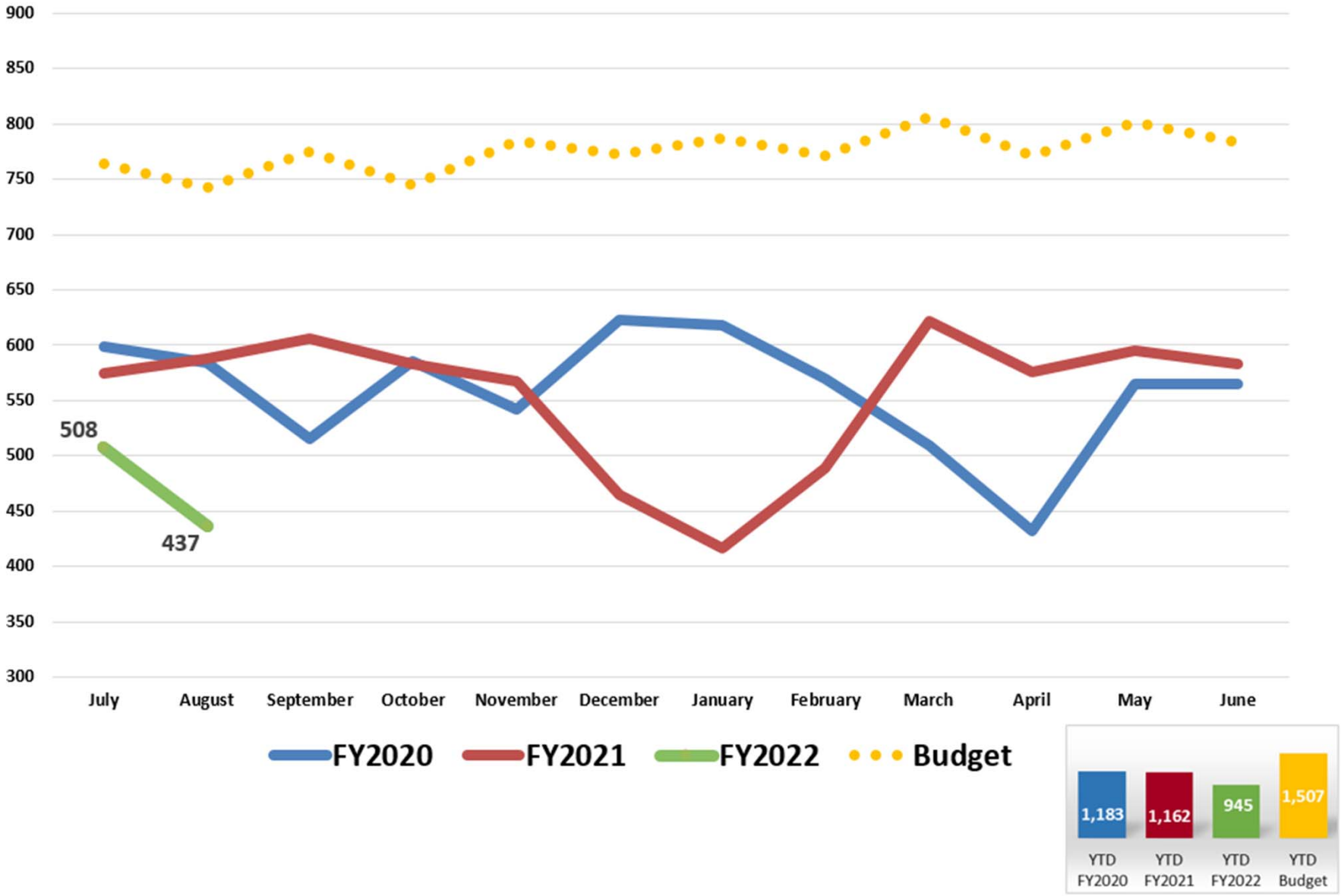
Adjusted Patient Days



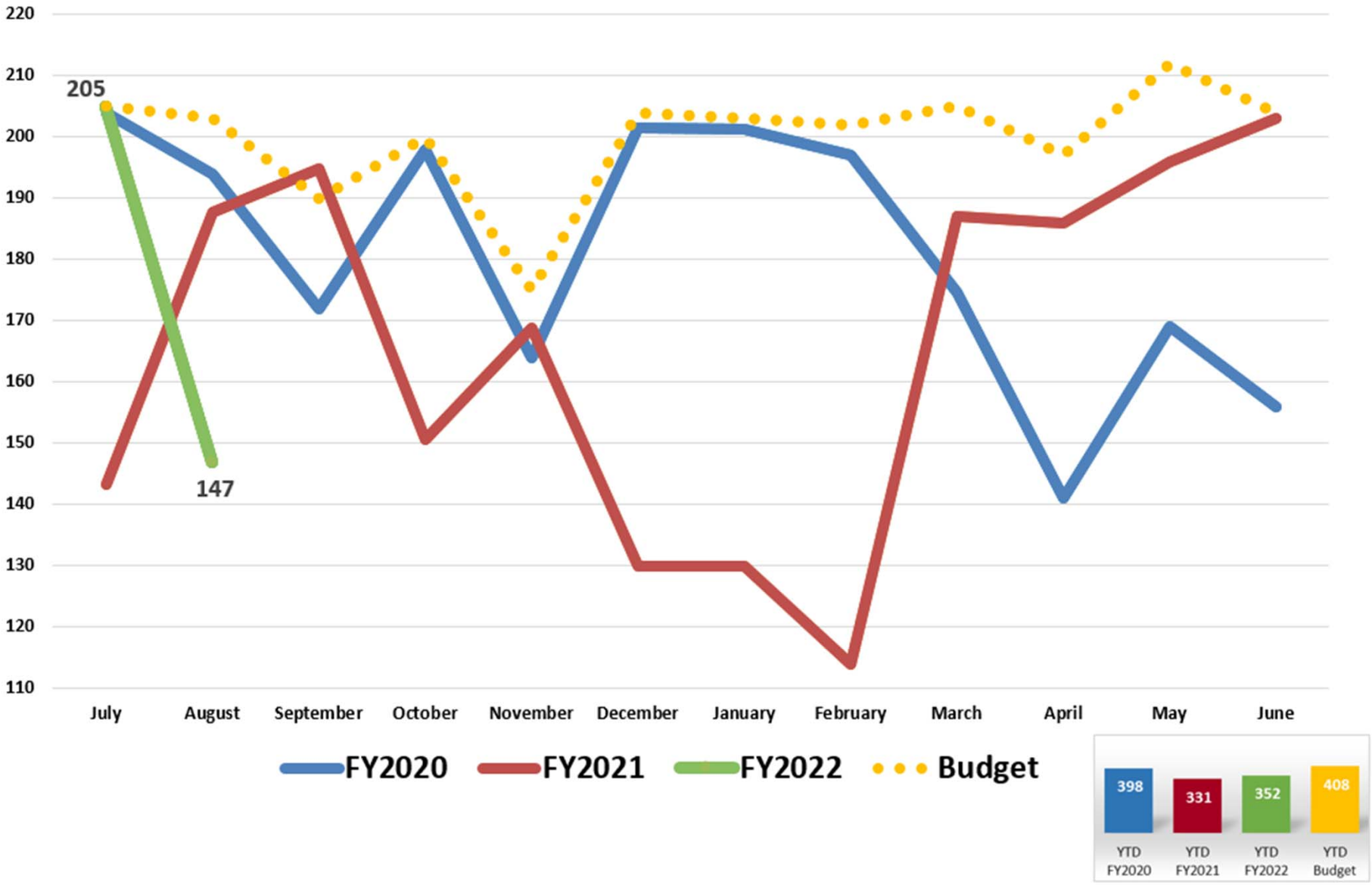
Surgery Volume



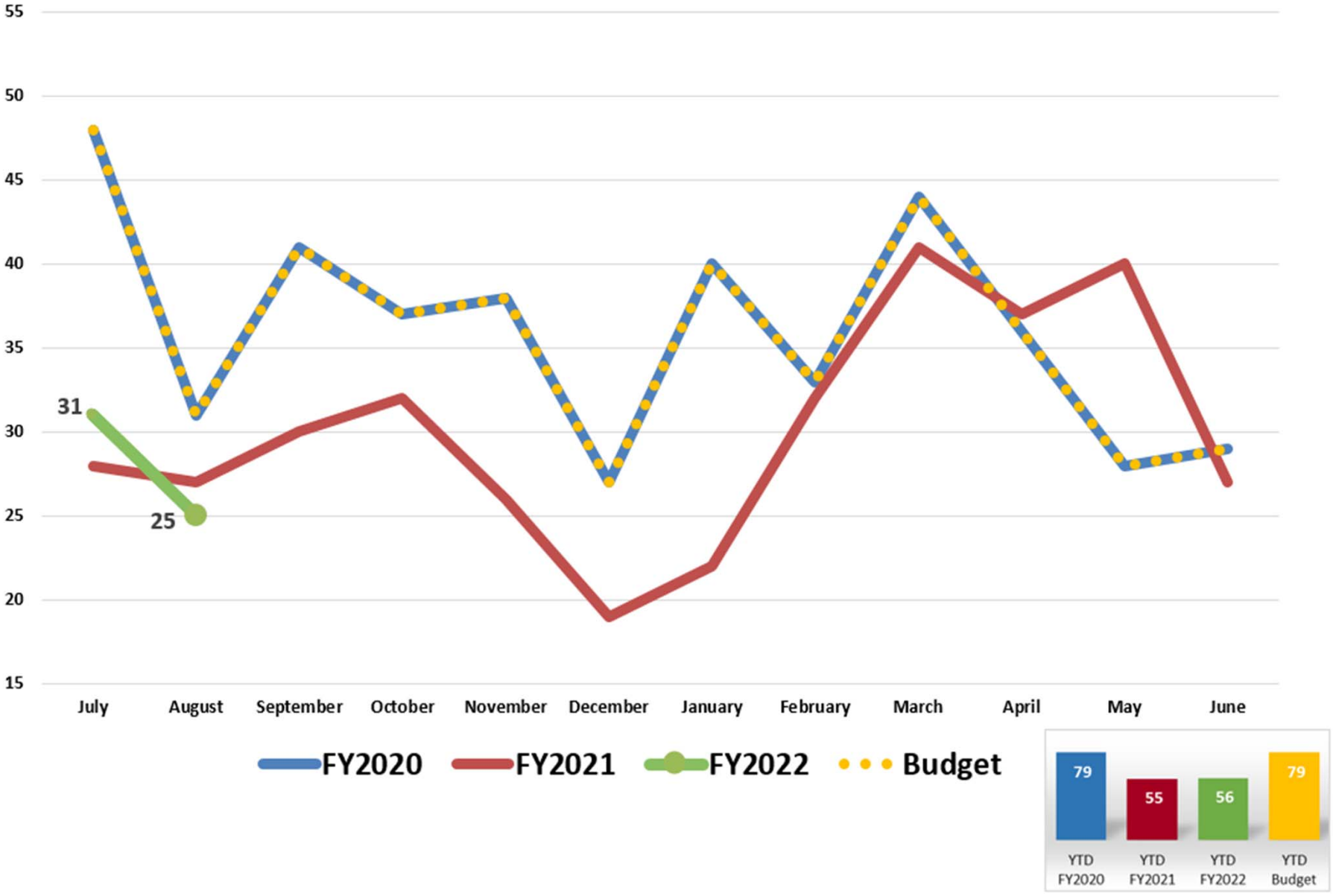
Surgery (IP Only) – 100 Min Units



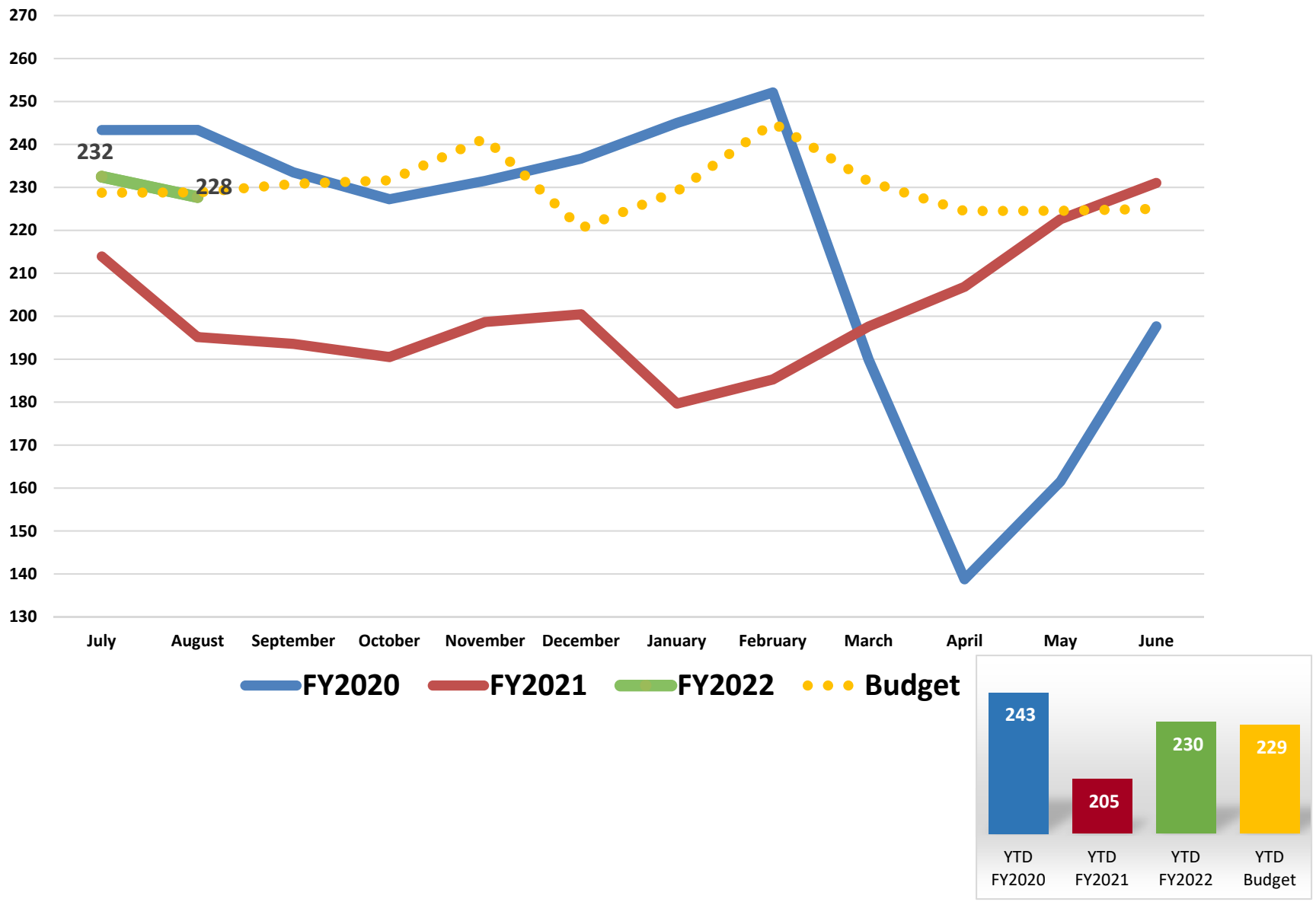
Cath Lab (IP Only) – 100 Min Units



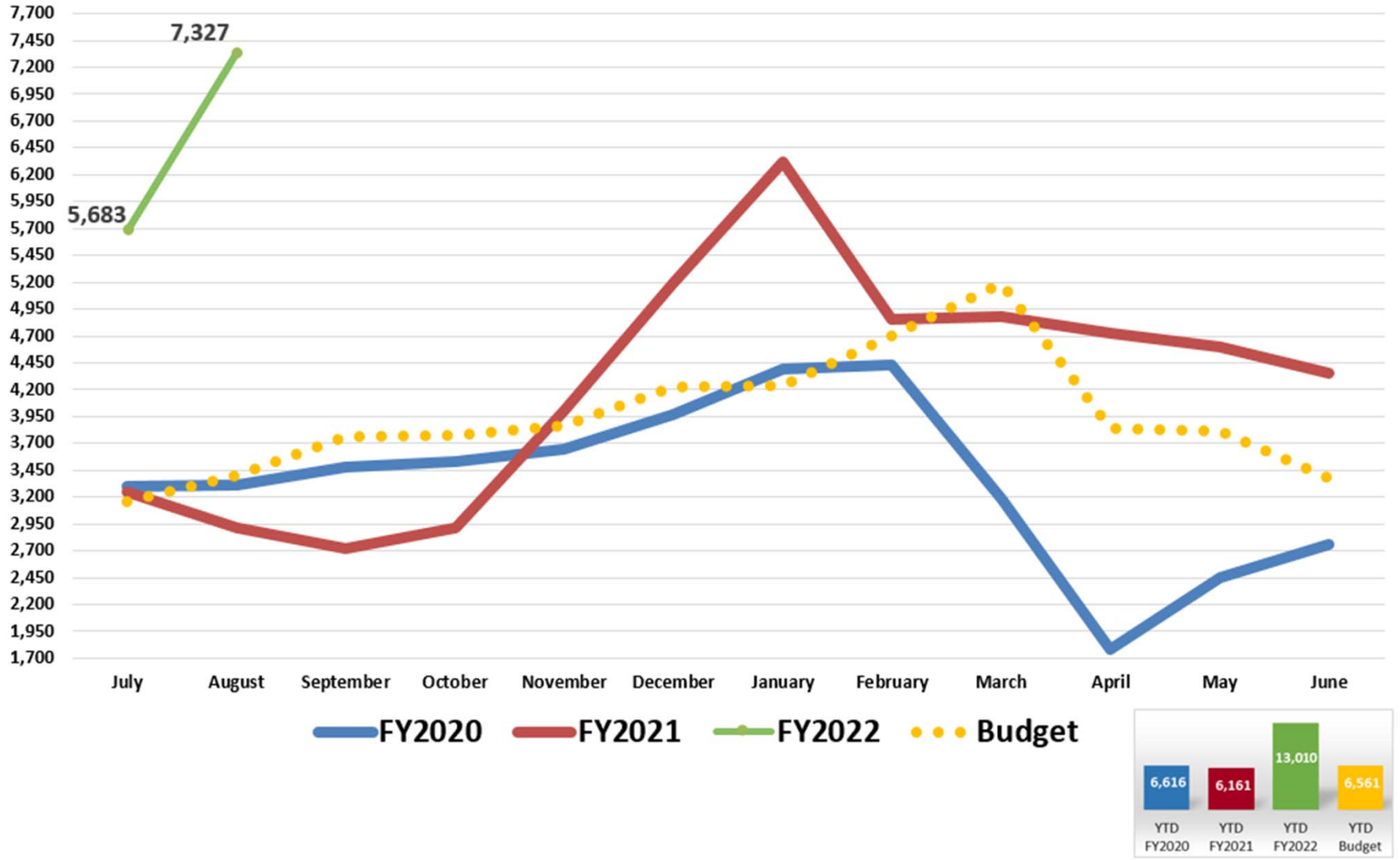
Cardiac Surgery – Cases



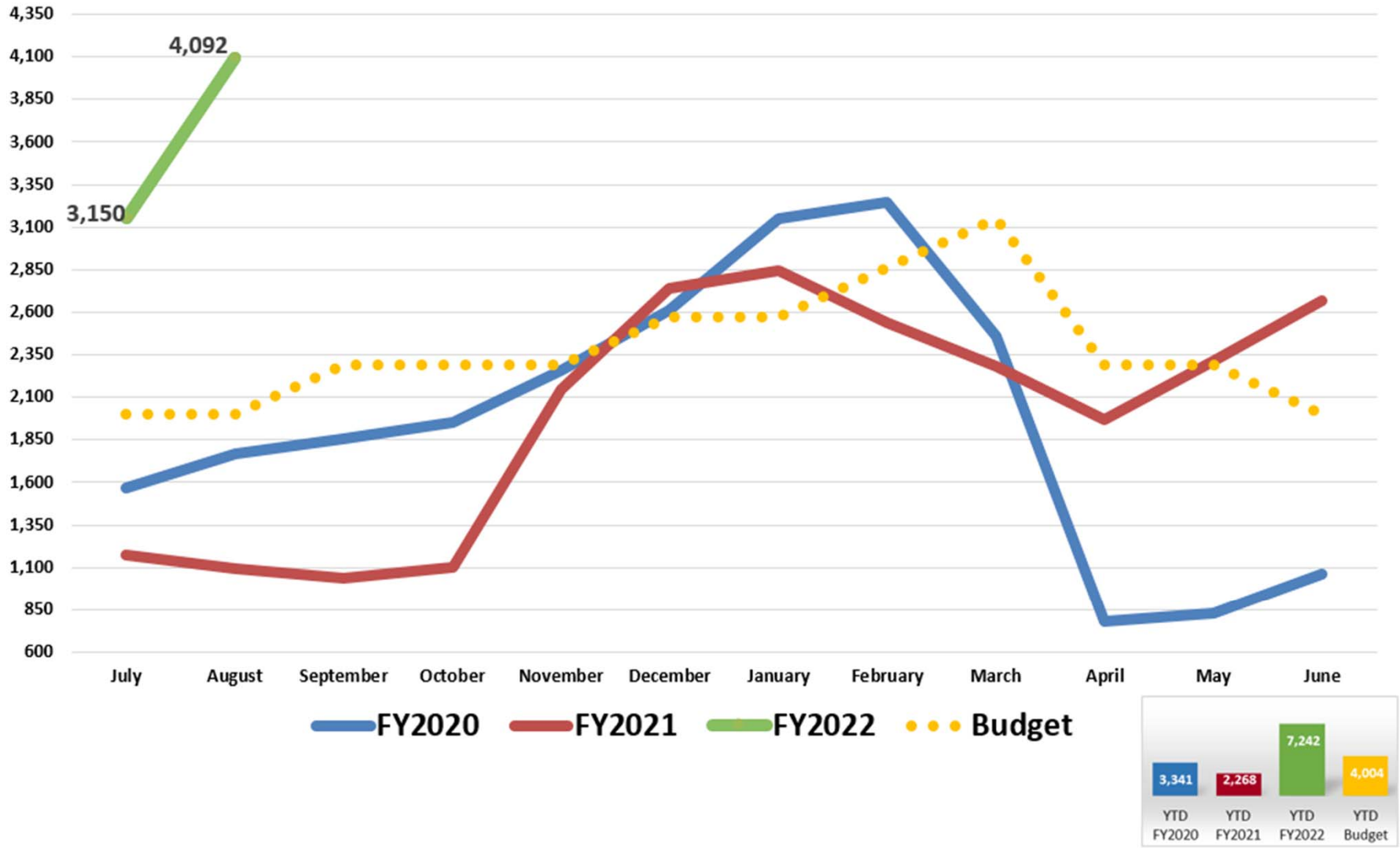
Emergency Department – Average # Treated Per Day



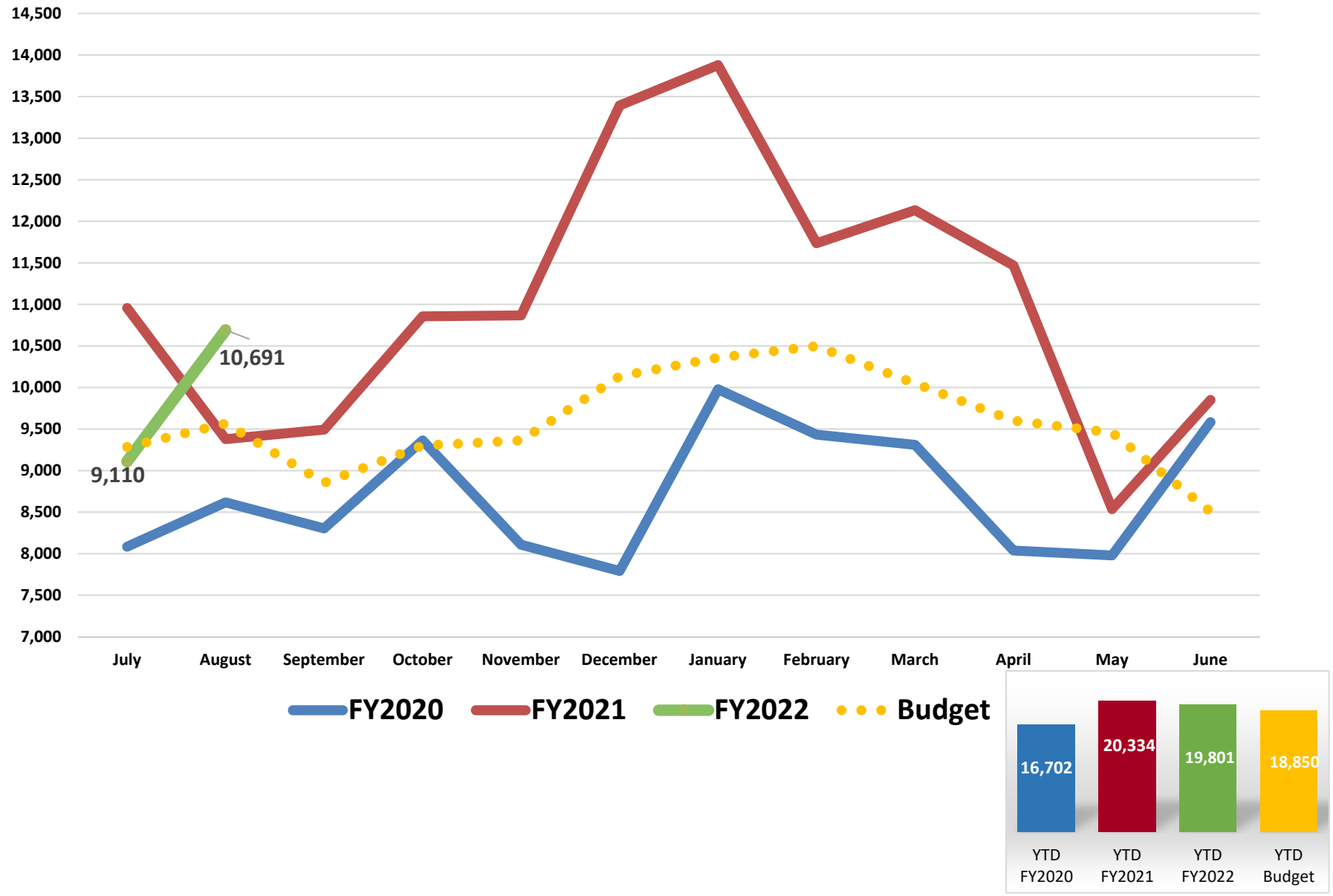
Urgent Care – Court Total Visits



Urgent Care – Demaree Total Visits



Rural Health Clinic Registrations



Statistical Results – Fiscal Year Comparison (Aug)

	Actual Results			Budget	Budget Variance	
	Aug 2020	Aug 2021	% Change	Aug 2021	Change	% Change
Average Daily Census	**429**	**465**	**8.3%**	**446**	**19**	**4.2%**
KDHCD Patient Days:						
Medical Center	8,863	10,203	15.1%	8,836	1,367	15.5%
Acute I/P Psych	1,431	1,137	(20.5%)	1,459	(322)	(22.1%)
Sub-Acute	921	819	(11.1%)	951	(132)	(13.9%)
Rehab	354	467	31.9%	568	(101)	(17.8%)
TCS-Ortho	387	402	3.9%	419	(17)	(4.1%)
TCS	407	267	(34.4%)	520	(253)	(48.7%)
NICU	447	550	23.0%	453	97	21.4%
Nursery	486	556	14.4%	618	(62)	(10.0%)
Total KDHCD Patient Days	**13,296**	**14,401**	**8.3%**	**13,824**	**577**	**4.2%**
Total Outpatient Volume	**39,277**	**49,569**	**26.2%**	**47,657**	**1,912**	**4.0%**

Statistical Results – Fiscal Year Comparison (Jul-Aug)

	Actual Results			Budget	Budget Variance	
	FYTD 2021	FYTD 2022	% Change	FYTD 2022	Change	% Change
Average Daily Census	**424**	**448**	**5.6%**	**442**	**6**	**1.4%**
KDHCD Patient Days:						
Medical Center	17,643	19,334	9.6%	17,449	1,885	10.8%
Acute I/P Psych	2,857	2,200	(23.0%)	2,920	(720)	(24.7%)
Sub-Acute	1,825	1,648	(9.7%)	1,902	(254)	(13.4%)
Rehab	739	1,000	35.3%	1,146	(146)	(12.7%)
TCS-Ortho	588	786	33.7%	832	(46)	(5.5%)
TCS	823	676	(17.9%)	1,034	(358)	(34.6%)
NICU	913	1,083	18.6%	913	170	18.6%
Nursery	924	1,062	14.9%	1,218	(156)	(12.8%)
Total KDHCD Patient Days	**26,312**	**27,789**	**5.6%**	**27,414**	**375**	**1.4%**
Total Outpatient Volume	**84,537**	**95,728**	**13.2%**	**95,313**	**415**	**0.4%**

Other Statistical Results – Fiscal Year Comparison (Aug)

	Actual Results				Budget	Budget Variance	
	Aug 2020	Aug 2021	Change	% Change	Aug 2021	Change	% Change
Adjusted Patient Days	**24,893**	**27,703**	**2,810**	**11.3%**	**27,220**	**483**	**1.8%**
Outpatient Visits	**39,277**	**49,569**	**10,292**	**26.2%**	**47,657**	**1,912**	**4.0%**
Urgent Care - Demaree	1,097	4,092	2,995	**273.0%**	2,002	2,090	**104.4%**
Urgent Care - Court	2,919	7,327	4,408	**151.0%**	3,404	3,923	**115.2%**
Infusion Center	244	456	212	**86.9%**	349	107	**30.7%**
ED Total Registered	6,095	7,224	1,129	**18.5%**	7,094	130	**1.8%**
OB Deliveries	375	438	63	**16.8%**	432	6	**1.4%**
Radiology/CT/US/MRI Proc (I/P & O/P)	14,645	16,900	2,255	**15.4%**	15,398	1,502	**9.8%**
RHC Registrations	9,378	10,691	1,313	**14.0%**	9,566	1,125	**11.8%**
KDMF RVU	32,879	36,380	3,501	**10.6%**	36,379	1	**0.0%**
Hospice Days	3,879	4,257	378	**9.7%**	3,879	378	**9.7%**
O/P Rehab Units	19,214	20,349	1,135	**5.9%**	20,577	(228)	**(1.1%)**
Physical & Other Therapy Units	16,701	17,333	632	**3.8%**	19,195	(1,862)	**(9.7%)**
GME Clinic visits	1,211	1,251	40	**3.3%**	1,332	(81)	**(6.1%)**
Home Health Visits	3,027	2,921	(106)	**(3.5%)**	2,897	24	**0.8%**
Endoscopy Procedures (I/P & O/P)	497	479	(18)	**(3.6%)**	562	(83)	**(14.8%)**
Surgery Minutes- General & Robotic (I/P & O/P)	1,003	956	(47)	**(4.7%)**	1,321	(365)	**(27.6%)**
Radiation Oncology Treatments (I/P & O/P)	2,369	2,205	(164)	**(6.9%)**	2,448	(243)	**(9.9%)**
Dialysis Treatments	1,845	1,645	(200)	**(10.8%)**	1,911	(266)	**(13.9%)**
Cath Lab Minutes (IP & OP)	356	303	(53)	**(14.9%)**	406	(103)	**(25.4%)**

Other Statistical Results – Fiscal Year Comparison (Jul-Aug)

	Actual Results				Budget	Budget Variance	
	FY 2021	FY 2022	Change	% Change	FY 2022	Change	% Change
Adjusted Patient Days	**49,834**	**53,797**	**3,963**	**8.0%**	**54,154**	**(357)**	**(0.7%)**
Outpatient Visits	**84,537**	**95,728**	**11,191**	**13.2%**	**95,313**	**415**	**0.4%**
Infusion Center	592	889	297	**50.2%**	706	183	**25.9%**
Urgent Care - Demaree	2,268	7,242	4,974	**219.3%**	4,004	3,238	**80.9%**
Urgent Care - Court	6,161	13,010	6,849	**111.2%**	6,561	6,449	**98.3%**
Physical & Other Therapy Units	33,135	36,139	3,004	**9.1%**	38,453	(2,314)	**(6.0%)**
OB Deliveries	717	819	102	**14.2%**	823	(4)	**(0.5%)**
Radiology/CT/US/MRI Proc (I/P & O/P)	29,955	33,823	3,868	**12.9%**	31,234	2,589	**8.3%**
ED Total Registered	12,764	14,531	1,767	**13.8%**	14,185	346	**2.4%**
Endoscopy Procedures (I/P & O/P)	1,002	1,017	15	**1.5%**	1,033	(16)	**(1.5%)**
Hospice Days	8,129	8,565	436	**5.4%**	7,758	807	**10.4%**
O/P Rehab Units	38,965	39,846	881	**2.3%**	39,642	204	**0.5%**
GME Clinic visits	2,464	2,454	(10)	**(0.4%)**	2,710	(256)	**(9.4%)**
Dialysis Treatments	3,618	3,338	(280)	**(7.7%)**	3,712	(374)	**(10.1%)**
Surgery Minutes – General & Robotic (I/P & O/P)	2,141	2,025	(116)	**(5.4%)**	2,629	(604)	**(23.0%)**
Home Health Visits	6,127	5,786	(341)	**(5.6%)**	5,794	(8)	**(0.1%)**
Radiation Oncology Treatments (I/P & O/P)	4,652	4,215	(437)	**(9.4%)**	4,953	(738)	**(14.9%)**
KDMF RVU	66,482	64,805	(1,677)	**(2.5%)**	72,222	(7,417)	**(10.3%)**
RHC Registrations	20,334	19,801	(533)	**(2.6%)**	18,850	951	**5.0%**
Cath Lab Minutes (IP & OP)	691	670	(21)	**(3.0%)**	797	(127)	**(15.9%)**

Trended Financial Comparison (000's)

Kaweah Delta Health Care District
Trended Income Statement (000's)

	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Adjusted Patient Days	*24,893*	*24,587*	*24,749*	*24,958*	*25,750*	*24,148*	*23,570*	*25,807*	*25,268*	*25,026*	*25,797*	*26,085*	*27,703*
Operating Revenue													
Net Patient Service Revenue	**$48,393**	**$48,769**	**$51,454**	**$50,994**	**$50,409**	**$49,949**	**$44,505**	**$56,144**	**$52,593**	**$50,531**	**$43,233**	**$51,502**	**$49,714**
Supplemental Gov't Programs	3,979	3,979	3,980	3,979	3,979	4,822	5,279	5,279	4,990	4,990	6,845	4,286	4,286
Prime Program	429	429	429	429	429	713	358	715	4,872	715	721	667	667
Premium Revenue	4,561	4,351	4,408	4,271	4,318	4,690	5,027	4,894	4,710	5,036	6,584	4,902	5,425
Management Services Revenue	2,684	3,072	2,396	2,569	2,583	2,867	2,430	3,303	3,301	2,877	3,251	3,172	3,298
Other Revenue	1,686	1,716	1,871	1,471	2,008	1,022	1,425	2,915	1,810	2,074	2,188	2,009	2,348
Other Operating Revenue	13,339	13,548	13,083	12,719	13,317	14,115	14,519	17,106	19,684	15,692	19,589	15,036	16,024
Total Operating Revenue	**61,732**	**62,317**	**64,537**	**63,713**	**63,726**	**64,064**	**59,024**	**73,250**	**72,277**	**66,223**	**62,822**	**66,537**	**65,737**
Operating Expenses													
Salaries & Wages	26,671	26,449	27,583	25,984	28,026	28,111	25,134	28,879	26,741	27,786	26,249	27,474	28,198
Contract Labor	372	336	488	242	303	226	1,404	887	1,694	1,169	2,080	1,116	1,358
Employee Benefits	5,160	6,053	5,314	4,998	5,969	5,671	5,027	5,739	8,650	5,087	(7,812)	4,087	3,878
Total Employment Expenses	**32,203**	**32,837**	**33,385**	**31,225**	**34,298**	**34,008**	**31,565**	**35,505**	**37,084**	**34,042**	**20,517**	**32,678**	**33,434**
Medical & Other Supplies	10,720	11,619	10,713	10,999	11,492	12,014	9,685	10,923	11,011	10,170	11,772	9,596	13,004
Physician Fees	8,699	6,871	7,746	8,079	8,024	8,421	8,484	8,278	8,320	7,754	8,207	7,922	8,527
Purchased Services	1,518	988	1,685	1,592	1,628	1,935	1,507	1,538	1,520	1,383	2,697	1,100	1,368
Repairs & Maintenance	2,022	1,965	2,166	2,091	2,146	2,192	2,115	2,019	2,544	2,282	2,319	2,074	2,425
Utilities	606	646	644	491	439	537	467	523	630	729	1,175	688	740
Rents & Leases	516	517	529	543	504	546	519	487	535	489	504	475	519
Depreciation & Amortization	2,582	2,518	2,509	2,473	2,458	2,451	2,423	2,412	2,413	2,923	3,924	2,635	2,632
Interest Expense	555	557	556	555	555	555	555	555	555	555	666	555	646
Other Expense	1,347	1,266	1,747	1,863	1,610	1,808	1,280	2,762	1,840	1,537	2,053	1,450	1,466
Humana Cap Plan Expenses	3,040	3,137	2,750	2,677	2,935	2,217	2,707	3,164	3,771	3,780	3,018	3,472	2,503
Management Services Expense	2,559	3,050	2,447	2,553	2,876	2,860	2,256	3,531	3,088	2,892	3,521	2,768	3,115
Total Other Expenses	**34,163**	**33,133**	**33,491**	**33,915**	**34,668**	**35,536**	**31,998**	**36,191**	**36,227**	**34,493**	**39,856**	**32,735**	**36,945**
Total Operating Expenses	**66,366**	**65,971**	**66,876**	**65,140**	**68,965**	**69,544**	**63,562**	**71,696**	**73,310**	**68,535**	**60,373**	**65,413**	**70,379**
Operating Margin	**($4,634)**	**($3,654)**	**($2,339)**	**($1,427)**	**($5,240)**	**($5,480)**	**($4,538)**	**$1,554**	**($1,033)**	**($2,312)**	**$2,449**	**$1,124**	**($4,642)**
Stimulus Funds	$3,745	$3,633	$4,538	$1,724	$0	$5,758	$3,460	$3,449	$920	$1,076	$525	$0	$438
Operating Margin after Stimulus	**($889)**	**($21)**	**$2,199**	**$297**	**($5,240)**	**$278**	**($1,078)**	**$5,003**	**($113)**	**($1,236)**	**$2,974**	**$1,124**	**($4,204)**
Nonoperating Revenue (Loss)	699	(495)	638	1,083	1,963	605	513	(1,182)	1,725	753	248	582	552
Excess Margin	**($191)**	**($515)**	**$2,837**	**$1,380**	**($3,276)**	**$883**	**($565)**	**$3,821**	**$1,612**	**($483)**	**$3,222**	**$1,706**	**($3,651)**

August Financial Comparison (000's)

	Actual Results		Budget	Budget Variance	
	Aug 2020	Aug 2021	Aug 2021	Change	% Change
Operating Revenue					
Net Patient Service Revenue	**$48,392**	**$49,714**	**$52,946**	**($3,233)**	**(6.1%)**
Other Operating Revenue	13,339	16,024	14,845	1,179	7.9%
Total Operating Revenue	**61,732**	**65,737**	**67,791**	**(2,053)**	**(3.0%)**
Operating Expenses					
Employment Expense	32,203	33,434	33,247	187	0.6%
Other Operating Expense	34,163	36,945	34,311	2,634	7.7%
Total Operating Expenses	**66,366**	**70,379**	**67,557**	**2,822**	**4.2%**
Operating Margin	**($4,634)**	**($4,642)**	**$233**	**($4,875)**	**(1358%)**
Stimulus Funds	3,745	438	101	337	334%
Operating Margin after Stimulus	**($889)**	**($4,204)**	**$334**	**($4,538)**	**(1358%)**
Non Operating Revenue (Loss)	699	552	542	11	2.0%
Excess Margin	**($191)**	**($3,651)**	**$876**	**($4,527)**	**(517%)**

Operating Margin %	**(7.5%)**	**(7.1%)**	**0.3%**
OM after Stimulus%	**(1.4%)**	**(6.4%)**	**0.5%**
Excess Margin %	**(0.3%)**	**(5.5%)**	**1.3%**
Operating Cash Flow Margin %	**(2.4%)**	**(2.1%)**	**4.8%**

YTD (July-Aug) Financial Comparison (000's)

	Actual Results FYTD Jul-Aug		Budget FYTD	Budget Variance	FYTD
	FYTD2021	FYTD2022	FYTD2022	Change	% Change
Operating Revenue					
Net Patient Service Revenue	**$95,794**	**$101,216**	**$106,119**	**($4,903)**	**(4.6%)**
Other Operating Revenue	26,947	31,058	30,724	131	0.4%
Total Operating Revenue	**122,741**	**132,274**	**137,046**	**(4,772)**	**(3.5%)**
Operating Expenses					
Employment Expense	64,417	66,112	66,077	35	0.1%
Other Operating Expense	65,508	69,680	69,286	394	0.6%
Total Operating Expenses	**129,925**	**135,792**	**135,363**	**429**	**0.3%**
Operating Margin	**($7,184)**	**($3,518)**	**$1,683**	**($5,201)**	**(309%)**
Stimulus Funds	7,378	438	203	235	116%
Operating Margin after Stimulus	**$194**	**($3,080)**	**$1,683**	**($4,763)**	**(283%)**
Nonoperating Revenue (Loss)	1,608	1,134	1,083	51	4.7%
Excess Margin	**$1,802**	**($1,946)**	**$2,766**	**($4,712)**	**(170%)**

Operating Margin %	**(5.9%)**	**(2.7%)**	**1.1%**
OM after Stimulus%	**0.2%**	**(2.3%)**	**1.2%**
Excess Margin %	**1.4%**	**(1.5%)**	**2.0%**
Operating Cash Flow Margin %	**(0.8%)**	**2.2%**	**5.5%**

August Financial Comparison (000's)

	Actual Results			Budget	Budget Variance	
	Aug 2020	Aug 2021	% Change	Aug 2021	Change	% Change
Operating Revenue						
Net Patient Service Revenue	**$48,393**	**$49,714**	**2.7%**	**$52,946**	**($3,233)**	**(6.1%)**
Supplemental Gov't Programs	3,979	4,286	7.7%	4,426	(139)	(3.1%)
Prime Program	429	667	55.4%	679	(13)	(1.9%)
Premium Revenue	4,561	5,425	18.9%	4,571	854	18.7%
Management Services Revenue	2,684	3,298	22.9%	3,082	216	7.0%
Other Revenue	1,686	2,348	39.3%	2,086	261	12.5%
Other Operating Revenue	13,339	16,024	**20.1%**	14,845	1,179	7.2%
Total Operating Revenue	**61,732**	**65,737**	**6.5%**	**67,791**	**(2,053)**	**(3.0%)**
Operating Expenses						
Salaries & Wages	26,671	28,198	5.7%	28,132	66	0.2%
Contract Labor	372	1,358	264.9%	529	829	156.8%
Employee Benefits	5,160	3,878	(24.9%)	4,586	(708)	(15.4%)
Total Employment Expenses	**32,203**	**33,434**	**3.8%**	**33,247**	**187**	**0.6%**
Medical & Other Supplies	10,720	13,004	21.3%	10,456	2,548	24.4%
Physician Fees	8,699	8,527	(2.0%)	8,182	346	4.2%
Purchased Services	1,518	1,368	(9.9%)	910	458	50.4%
Repairs & Maintenance	2,022	2,425	19.9%	2,398	27	1.1%
Utilities	606	740	22.2%	761	(21)	(2.8%)
Rents & Leases	516	519	0.5%	510	9	1.7%
Depreciation & Amortization	2,582	2,632	1.9%	2,432	200	8.2%
Interest Expense	555	646	16.5%	614	32	5.2%
Other Expense	1,347	1,466	8.9%	1,920	(454)	(23.6%)
Humana Cap Plan Expenses	3,040	2,503	(17.7%)	3,079	(576)	(18.7%)
Management Services Expense	2,559	3,115	21.7%	3,049	66	2.2%
Total Other Expenses	**34,163**	**36,945**	**8.1%**	**34,311**	**2,634**	**7.7%**
Total Operating Expenses	**66,366**	**70,379**	**6.0%**	**67,557**	**2,822**	**4.2%**
Operating Margin	**($4,634)**	**($4,642)**	**(0.2%)**	**$233**	**($4,875)**	**(2090%)**
Stimulus Funds	3,745	438	(88.3%)	101	337	334%
Operating Margin after Stimulus	**($889)**	**($4,204)**	**(373%)**	**$334**	**($4,538)**	**(1358%)**
Nonoperating Revenue (Loss)	699	552	(20.9%)	542	11	2.0%
Excess Margin	**($191)**	**($3,651)**	**(1816%)**	**$876**	**($4,527)**	**(517%)**

Operating Margin %	**(7.5%)**	**(7.1%)**		**0.3%**
OM after Stimulus%	**(1.4%)**	**(6.4%)**		**0.5%**
Excess Margin %	**(0.3%)**	**(5.5%)**		**1.3%**
Operating Cash Flow Margin %	**(2.4%)**	**(2.1%)**		**4.8%**

YTD Financial Comparison (000's)

	Actual Results FYTD Jul-Aug			Budget FYTD	Budget Variance	FYTD
	FYTD2021	FYTD2022	% Change	FYTD2022	Change	% Change
Operating Revenue						
Net Patient Service Revenue	**$95,794**	**$101,216**	**5.7%**	**$106,119**	**($4,903)**	**(4.6%)**
Supplemental Gov't Programs	7,958	8,573	7.7%	8,851	(278)	(3.1%)
Prime Program	858	1,333	55.4%	1,359	(26)	(1.9%)
Premium Revenue	8,800	10,327	17.3%	10,178	149	1.5%
Management Services Revenue	5,518	6,469	17.2%	6,164	305	4.9%
Other Revenue	3,813	4,356	14.3%	4,172	184	4.4%
Other Operating Revenue	26,947	31,058	**15.3%**	30,724	334	1.1%
Total Operating Revenue	**122,741**	**132,274**	**7.8%**	**136,843**	**(4,569)**	**(3.3%)**
Operating Expenses						
Salaries & Wages	53,211	55,673	4.6%	55,864	(191)	(0.3%)
Contract Labor	948	2,475	160.9%	1,045	1,430	136.9%
Employee Benefits	10,258	7,965	(22.4%)	9,169	(1,204)	(13.1%)
Total Employment Expenses	**64,417**	**66,112**	**2.6%**	**66,077**	**35**	**0.1%**
Medical & Other Supplies	20,756	22,600	8.9%	21,167	1,433	6.8%
Physician Fees	16,506	16,449	(0.3%)	16,489	(40)	(0.2%)
Purchased Services	2,756	2,467	(10.5%)	2,257	210	9.3%
Repairs & Maintenance	4,305	4,499	4.5%	4,796	(298)	(6.2%)
Utilities	1,111	1,428	28.5%	1,367	61	4.5%
Rents & Leases	1,019	993	(2.6%)	1,019	(26)	(2.6%)
Depreciation & Amortization	5,143	5,267	2.4%	4,864	403	8.3%
Interest Expense	1,110	1,201	8.2%	1,229	(28)	(2.3%)
Other Expense	2,825	2,916	3.2%	3,840	(924)	(24.1%)
Humana Cap Plan Expenses	4,602	5,976	29.9%	6,158	(182)	(3.0%)
Management Services Expense	5,374	5,883	9.5%	6,098	(215)	(3.5%)
Total Other Expenses	**65,508**	**69,680**	**6.4%**	**69,286**	**394**	**0.6%**
Total Operating Expenses	**129,925**	**135,792**	**4.5%**	**135,363**	**429**	**0.3%**
Operating Margin	**($7,184)**	**($3,518)**	**51.0%**	**$1,480**	**($4.998)**	**(338%)**
Stimulus Funds	7,378	438	(94.1%)	203	235	116%
Operating Margin after Stimulus	**$194**	**($3,080)**	**(1687%)**	**$1,683**	**($4,763)**	**(283%)**
Nonoperating Revenue (Loss)	1,608	1,134	(29.5%)	1,083	51	4.7%
Excess Margin	**$1,802**	**($1,946)**	**(208%)**	**$2,766**	**($4,712)**	**(170%)**

Operating Margin %	**(5.9%)**	**(2.7%)**		**1.1%**
OM after Stimulus%	**0.2%**	**(2.3%)**		**1.2%**
Excess Margin %	**1.4%**	**(1.5%)**		**2.0%**
Operating Cash Flow Margin %	**(0.8%)**	**2.2%**		**5.5%**

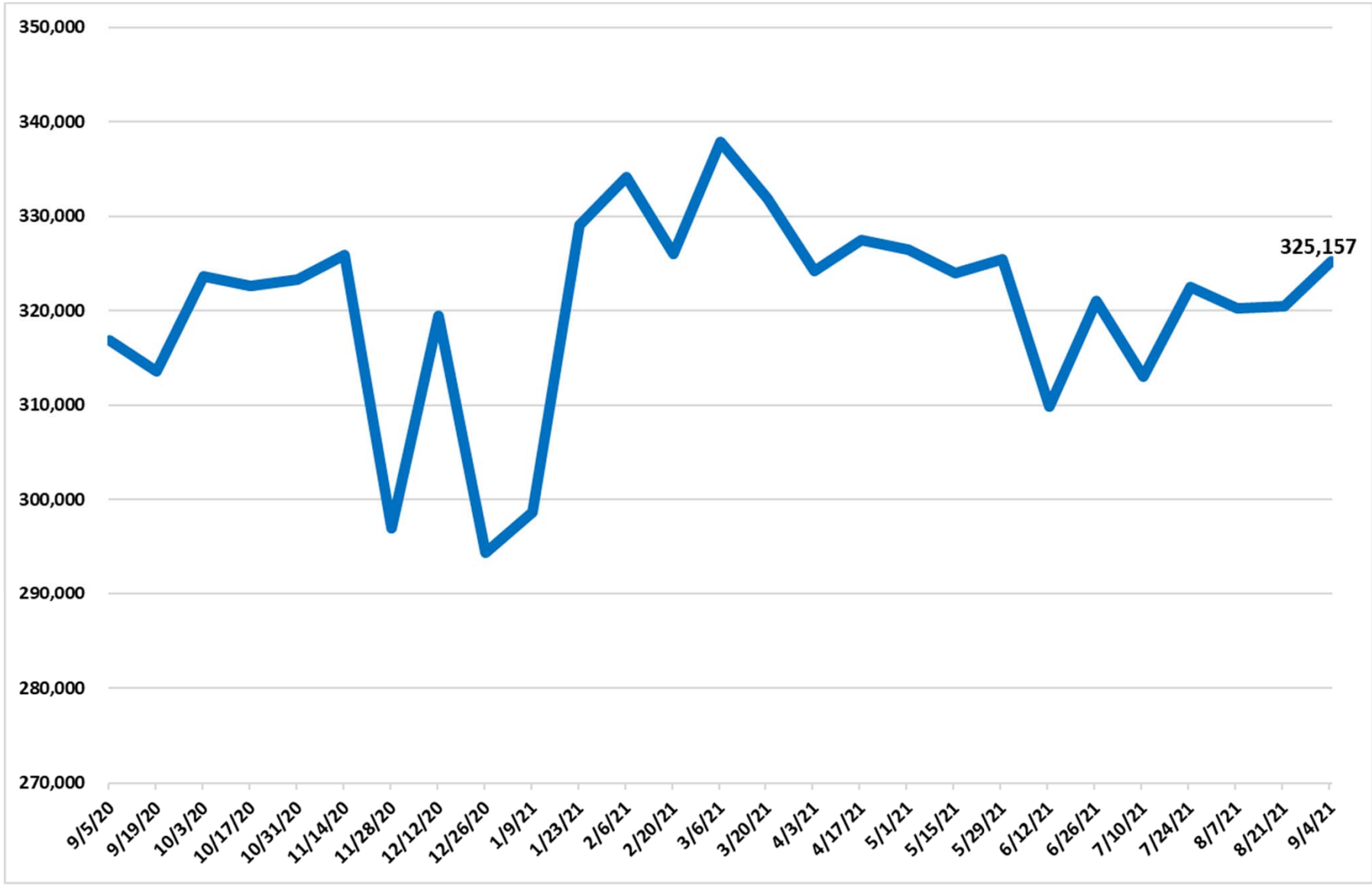
Kaweah Health Medical Group
Fiscal Year Financial Comparison (000's)

	Actual Results FYTD July - Aug			Budget FYTD	Budget Variance	FYTD
	Aug 2020	Aug 2021	% Change	Aug 2021	Change	% Change
Operating Revenue						
Net Patient Service Revenue	**$7,552**	**$7,267**	**(3.8%)**	**$8,432**	**($1,165)**	**(13.8%)**
Other Operating Revenue	66	159	140.0%	143	16	11.2%
Total Operating Revenue	**7,618**	**7,425**	**(2.5%)**	**8,575**	**(1,149)**	**(13.4%)**
Operating Expenses						
Salaries & Wages	1,858	1,949	4.9%	2,097	(148)	(7.1%)
Contract Labor	0	0	0.0%	0	0	0.0%
Employee Benefits	334	332	(0.5%)	342	(10)	(3.0%)
Total Employment Expenses	**2,192**	**2,281**	**4.1%**	**2,440**	**(158)**	**(6.5%)**
Medical & Other Supplies	865	1,153	33.3%	1,160	(7)	(0.6%)
Physician Fees	4,394	4,620	5.1%	4,925	(306)	(6.2%)
Purchased Services	126	160	26.6%	144	16	11.2%
Repairs & Maintenance	405	346	(14.7%)	457	(111)	(24.3%)
Utilities	96	82	(13.8%)	99	(16)	(16.7%)
Rents & Leases	440	417	(5.1%)	433	(16)	(3.6%)
Depreciation & Amortization	209	134	(35.9%)	184	(50)	(27.0%)
Interest Expense	1	0	(57.5%)	0	0	76.4%
Other Expense	178	181	1.8%	286	(105)	(36.7%)
Total Other Expenses	**6,714**	**7,093**	**5.7%**	**7,687**	**(594)**	**(7.7%)**
Total Operating Expenses	**8,906**	**9,375**	**5.3%**	**10,127**	**(752)**	**(7.4%)**
Stimulus Funds	0	0	0.0%	0	0	0.0%
Excess Margin	**($1,287)**	**($1,949)**	**(51.4%)**	**($1,552)**	**($397)**	**(25.6%)**
Excess Margin %	**(16.9%)**	**(26.3%)**		**(18.1%)**		

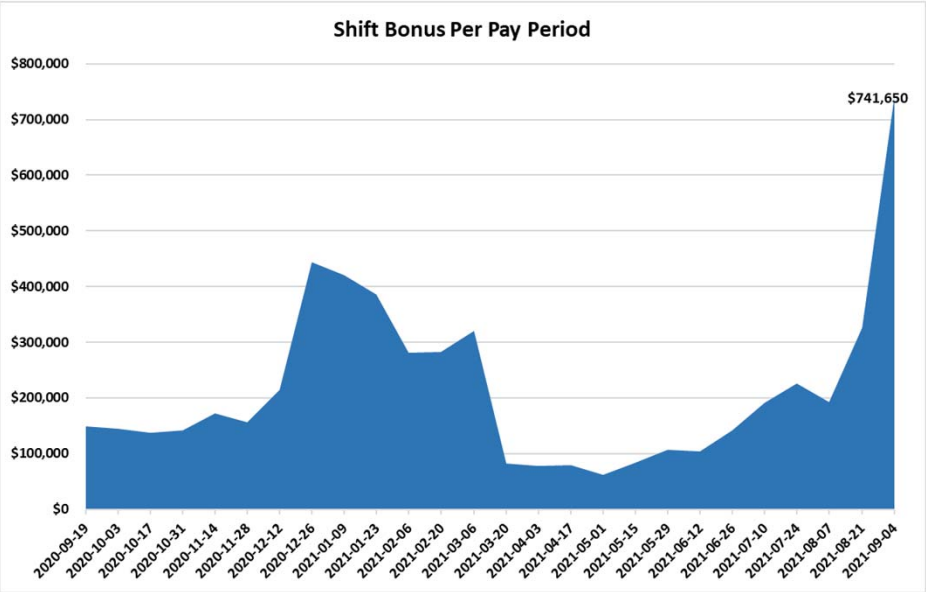
Month of August - Budget Variances

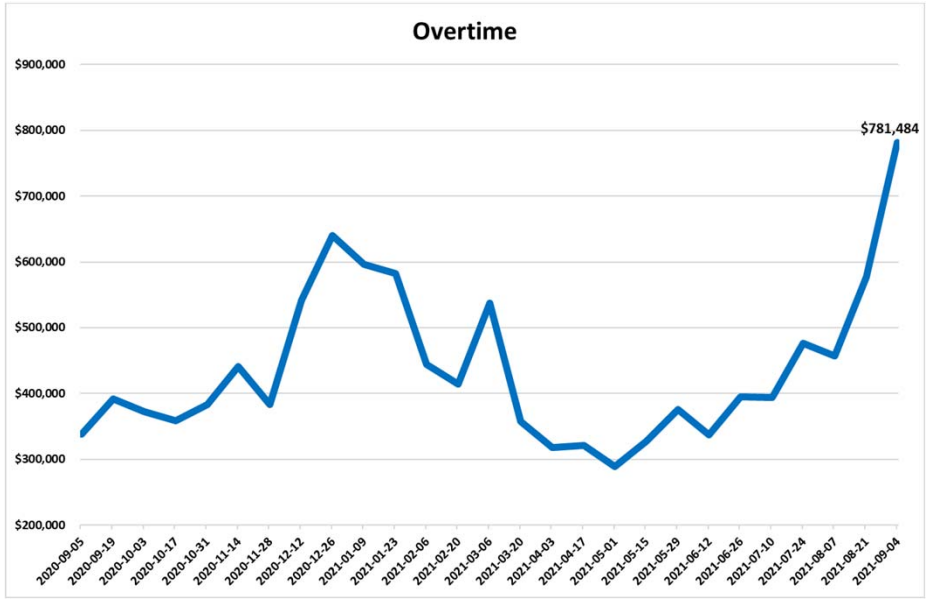
- **Net Patient Revenues:** Net patient revenue fell short of budget expectations by $3.2M (6.1%). Inpatient days (4.2% increase) and outpatient volume (4.0% increase) both exceeded budget expectations but the mix of patient volumes (more medical than surgical), impacted net revenues.
- **Other Operating Revenues:** Other Revenue was $1.2M more than budget mainly due to Humana premiums, grant funds received, and contributions received by the Hospital Foundation.
- **Salaries and Contract Labor**: We experienced an unfavorable budget variance of $895K in August. The unfavorable variance is primarily due to the rates associated with contract labor hours, shift bonuses ($515K) and COVID supplemental pay ($245K).
- **Employee Benefits:** Employee benefit costs were under budget by $708K in August primarily due to employee health insurance cost being lower than budget.
- **Medical Supplies:** The $2.5M unfavorable budget variance is mainly due to supplies purchases for COVID ($1.2M), and an increase in pharmacy and lab costs.
- **Physician Fees:** Physician fees were over budget by $346K in August due to lower collections in some areas, increased stipends, and timing of payments.
- **Other Expense:** The $454K favorable budget variance is mainly due to recruiting, travel, marketing and other areas that were under budget in August due to timing of these expenses.
- **Humana Cap Plan Expenses:** The $576K favorable variance resulted from lower utilization of non-Kaweah medical care provided to members during the month of August.

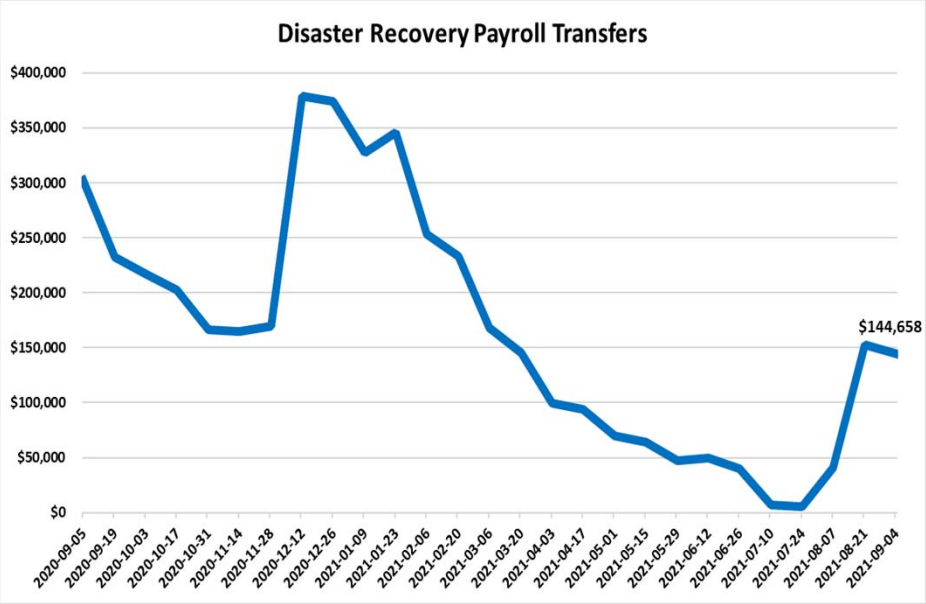
Productive Hours

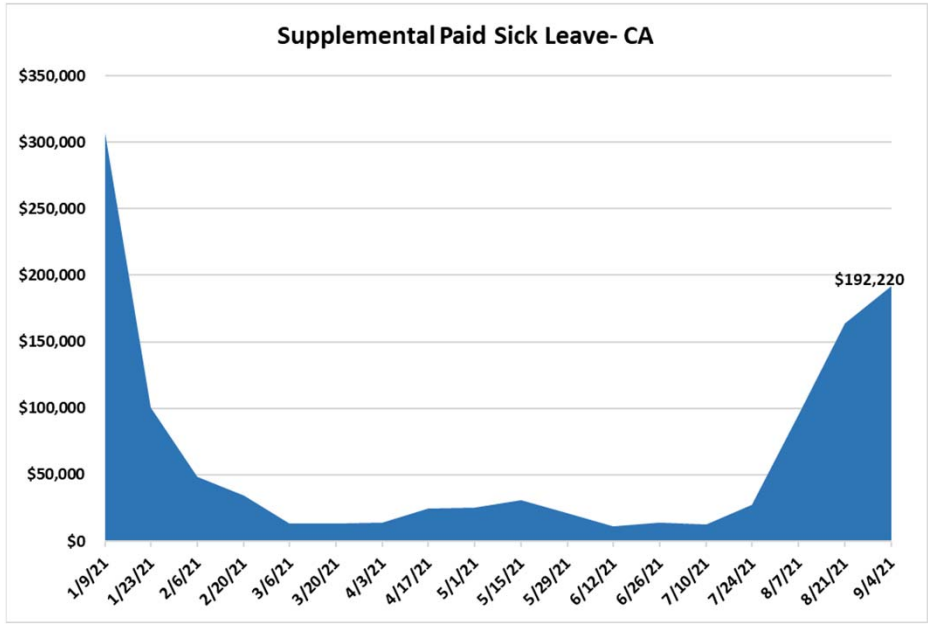


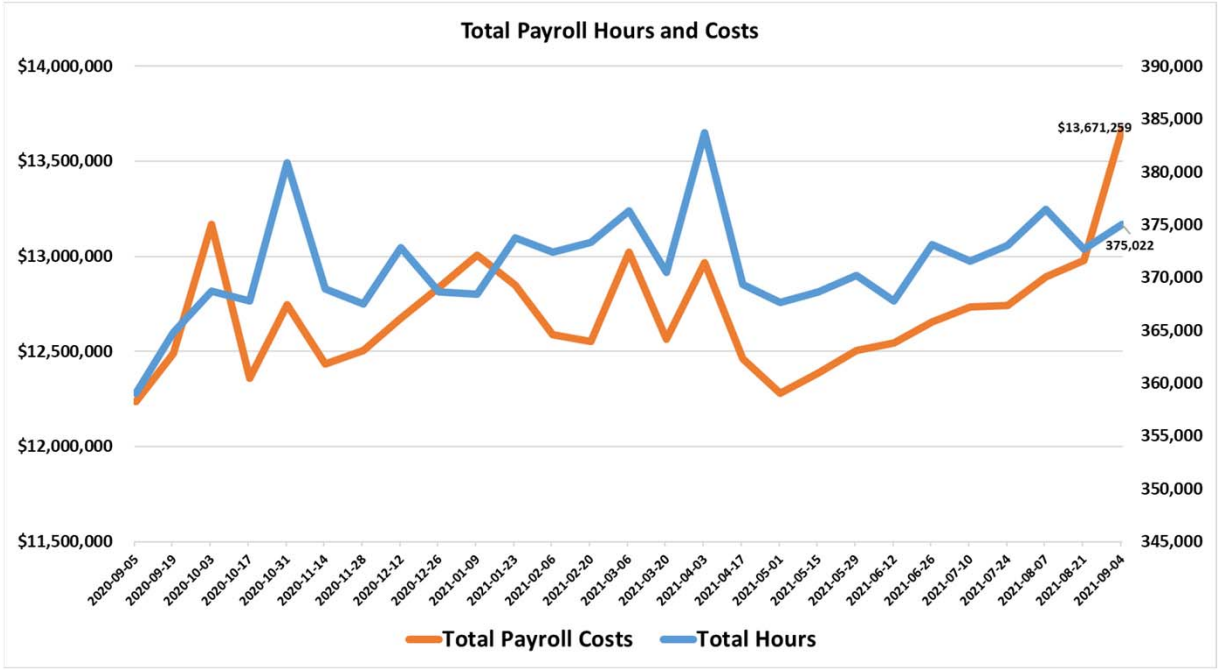
Premium & Extra Pay

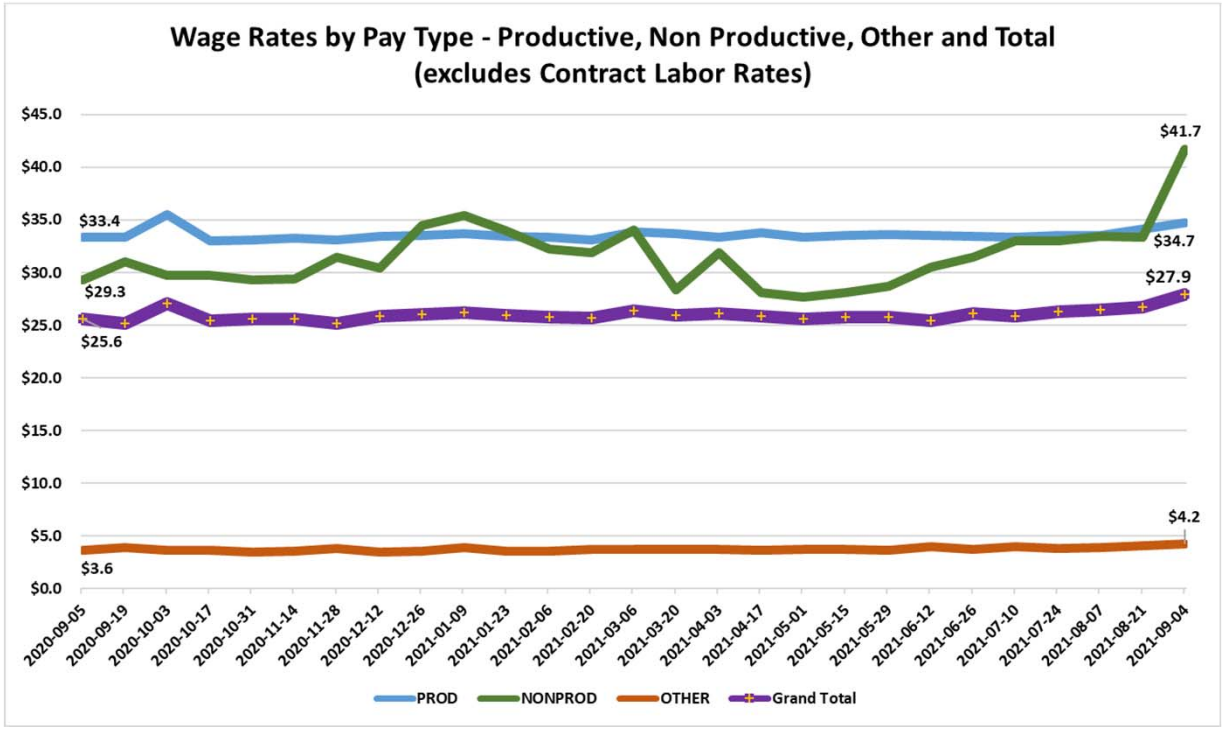




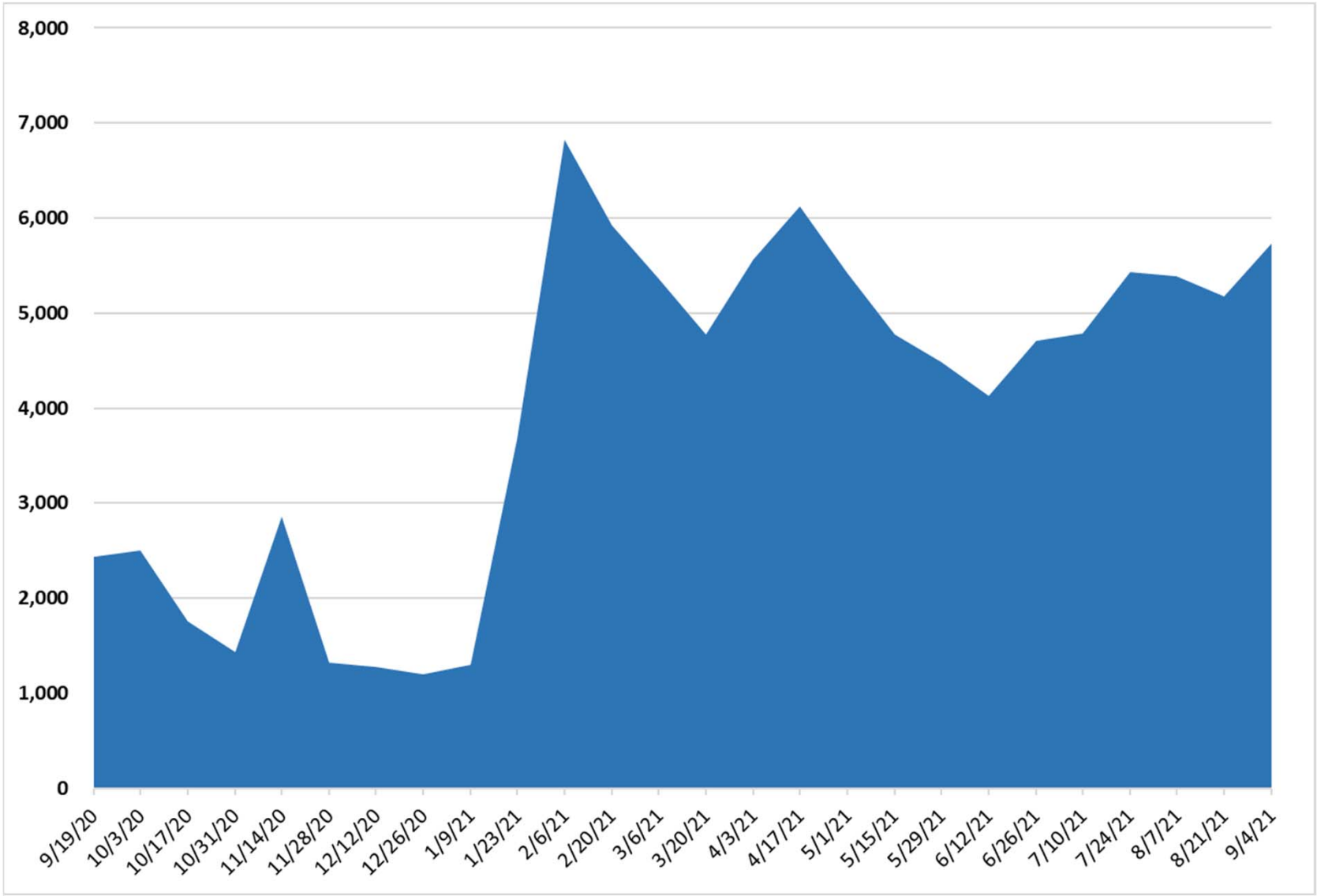




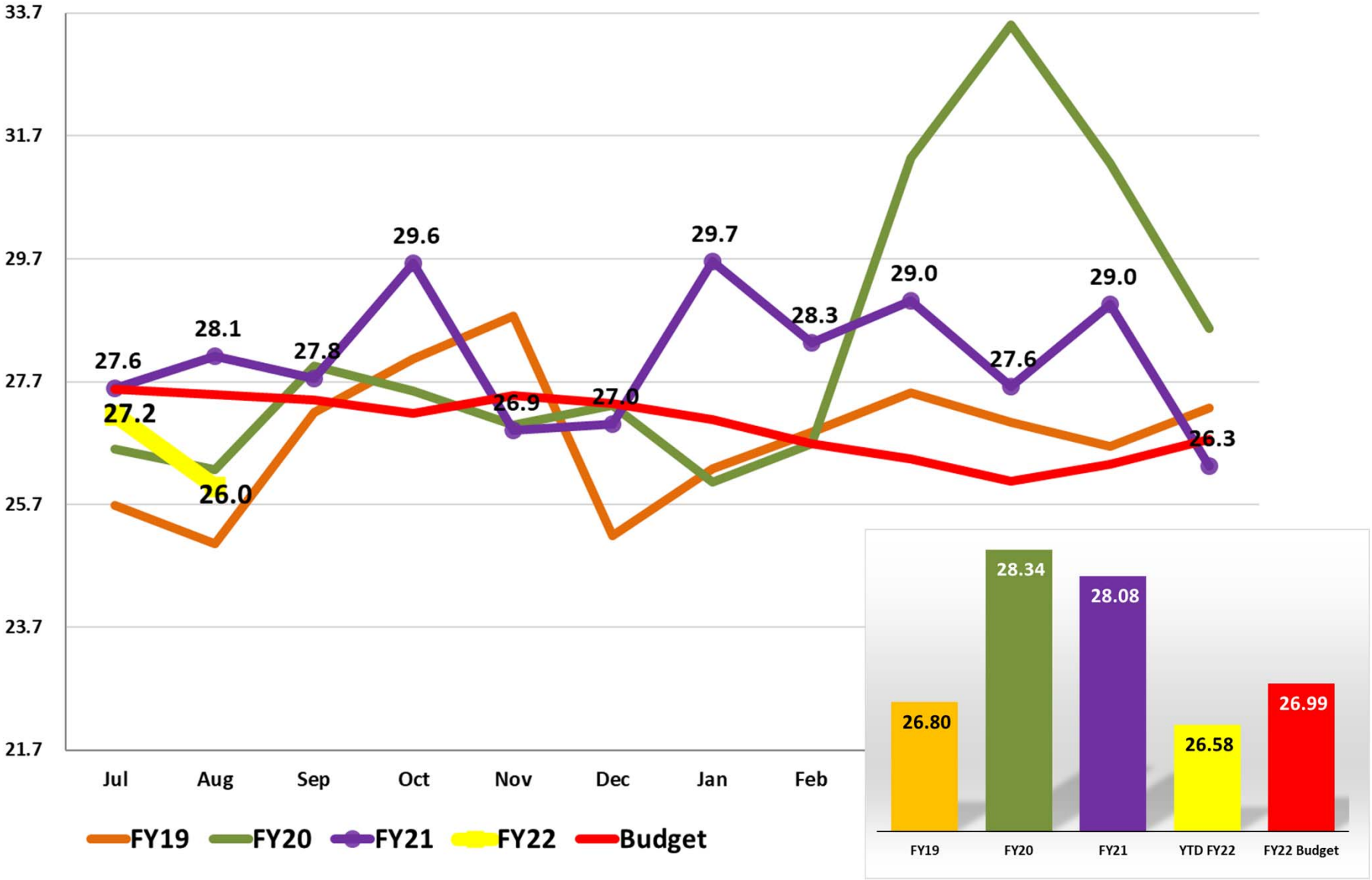

Total Payroll Hours and Costs
$14,000,000
$13,500,000
$13,000,000
$12,500,000
$12,000,000
$11,500,000
390,000
385,000
380,000
375,000
370,000
365,000
360,000
355,000
350,000
345,000
$13,671,259
375,022
2020-09-05
2020-09-19
2020-10-03
2020-10-17
2020-10-31
2020-11-14
2020-11-28
2020-12-12
2020-12-26
2021-01-09
2021-01-23
2021-02-06
2021-02-20
2021-03-06
2021-03-20
2021-04-03
2021-04-17
2021-05-01
2021-05-15
2021-05-29
2021-06-12
2021-06-26
2021-07-10
2021-07-24
2021-08-07
2021-08-21
2021-09-04
Total Payroll Costs
Total Hours

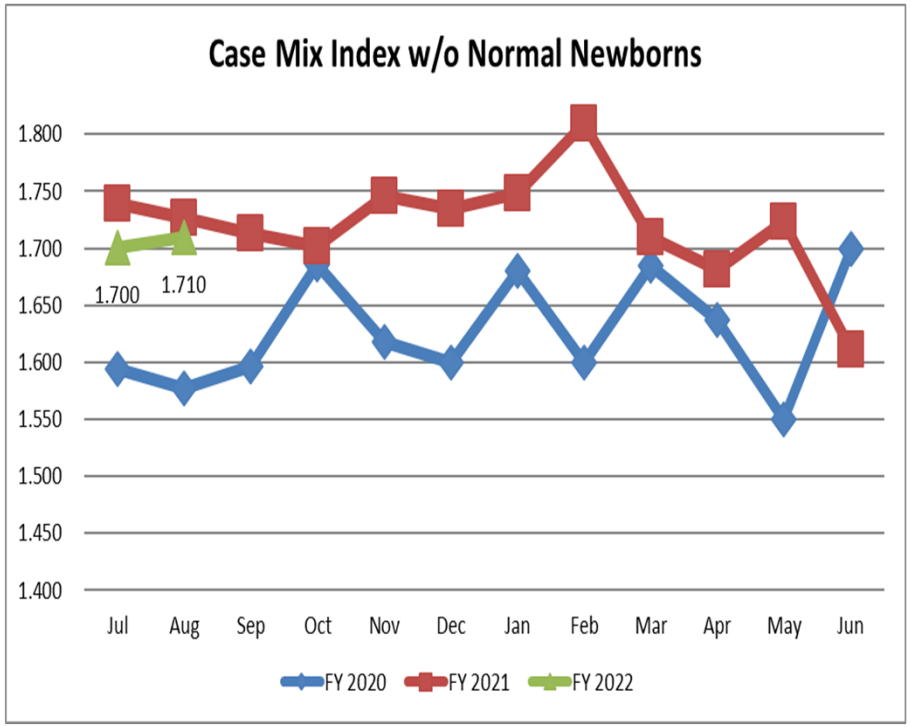

Wage Rates by Pay Type - Productive, Non Productive, Other and Total
(excludes Contract Labor Rates)
$45.0
$40.0
$35.0
$30.0
$25.0
$20.0
$15.0
$10.0
$5.0
$0.0
$41.7
$33.4
$34.7
$29.3
$27.9
$25.6
$4.2
$3.6
2020-09-05
2020-09-19
2020-10-03
2020-10-17
2020-10-31
2020-11-14
2020-11-28
2020-12-12
2020-12-26
2021-01-09
2021-01-23
2021-02-06
2021-02-20
2021-03-06
2021-03-20
2021-04-03
2021-04-17
2021-05-01
2021-05-15
2021-05-29
2021-06-12
2021-06-26
2021-07-10
2021-07-24
2021-08-07
2021-08-21
2021-09-04
PROD
NONPROD
OTHER
Grand Total

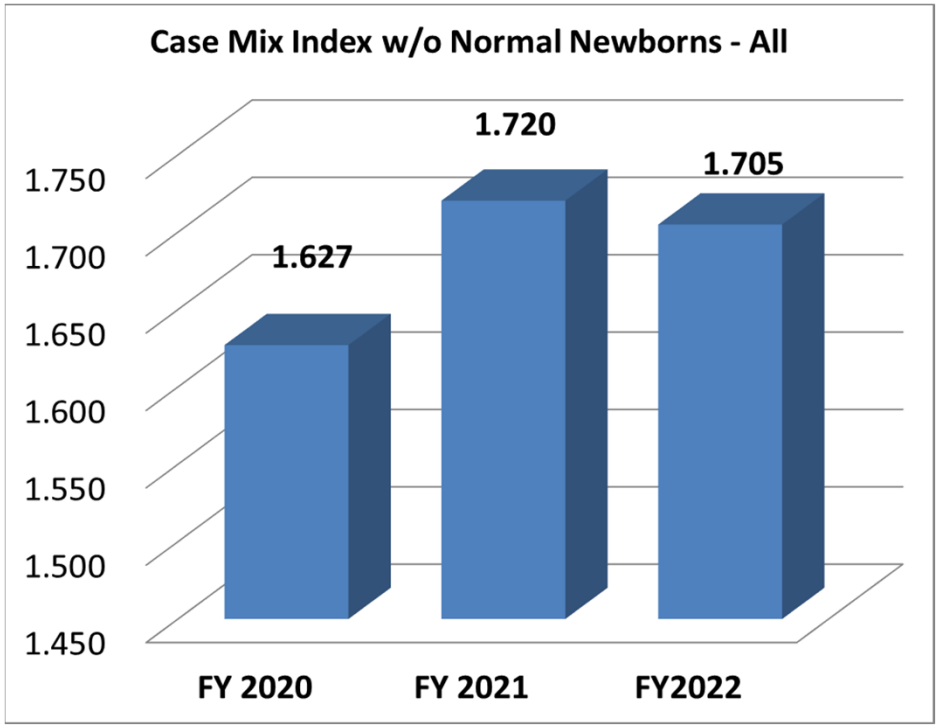
Contract Labor Hours

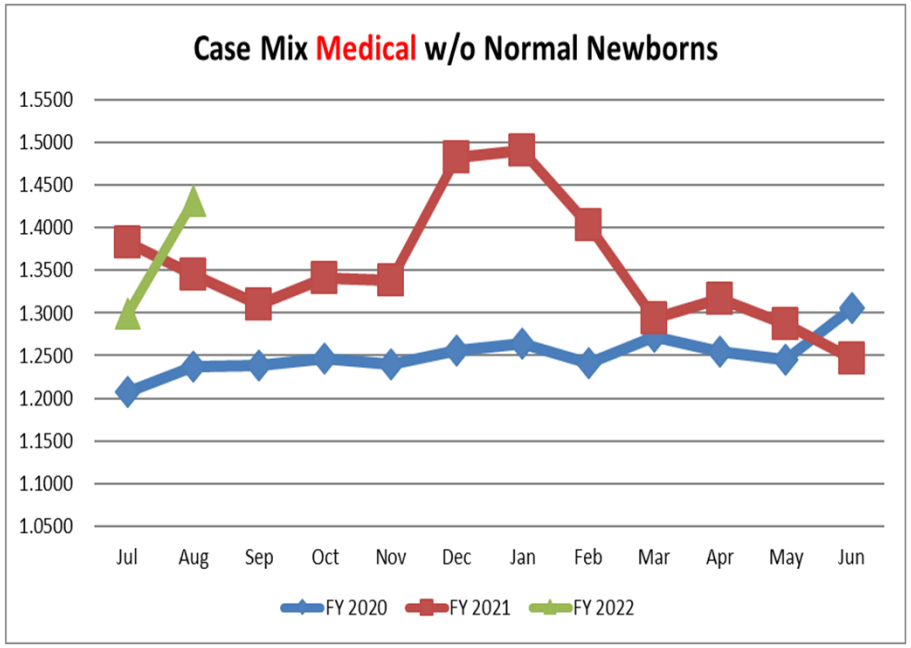


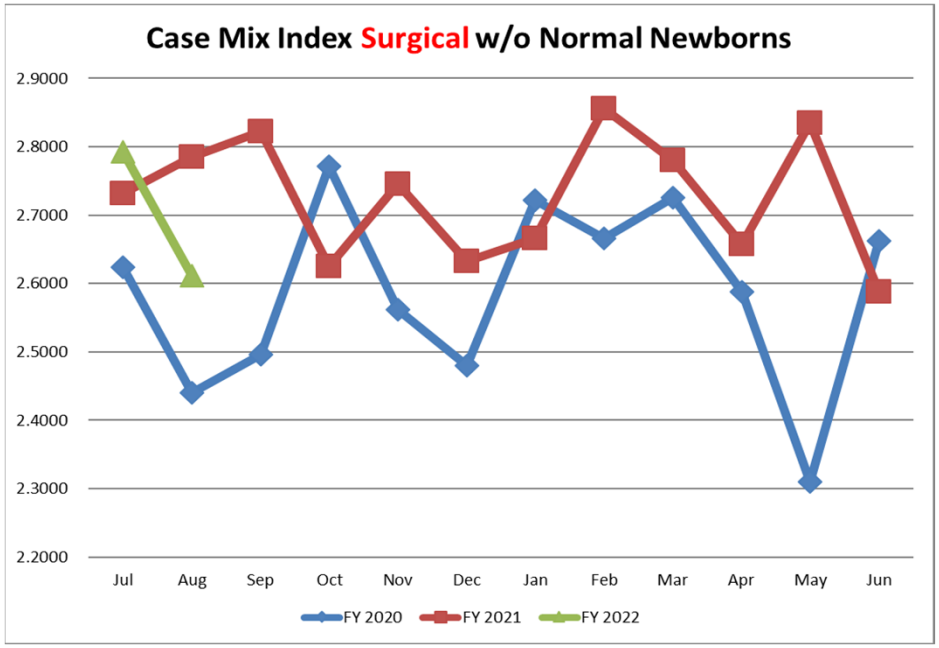
Productivity: Worked Hours/Adjusted Patient Days



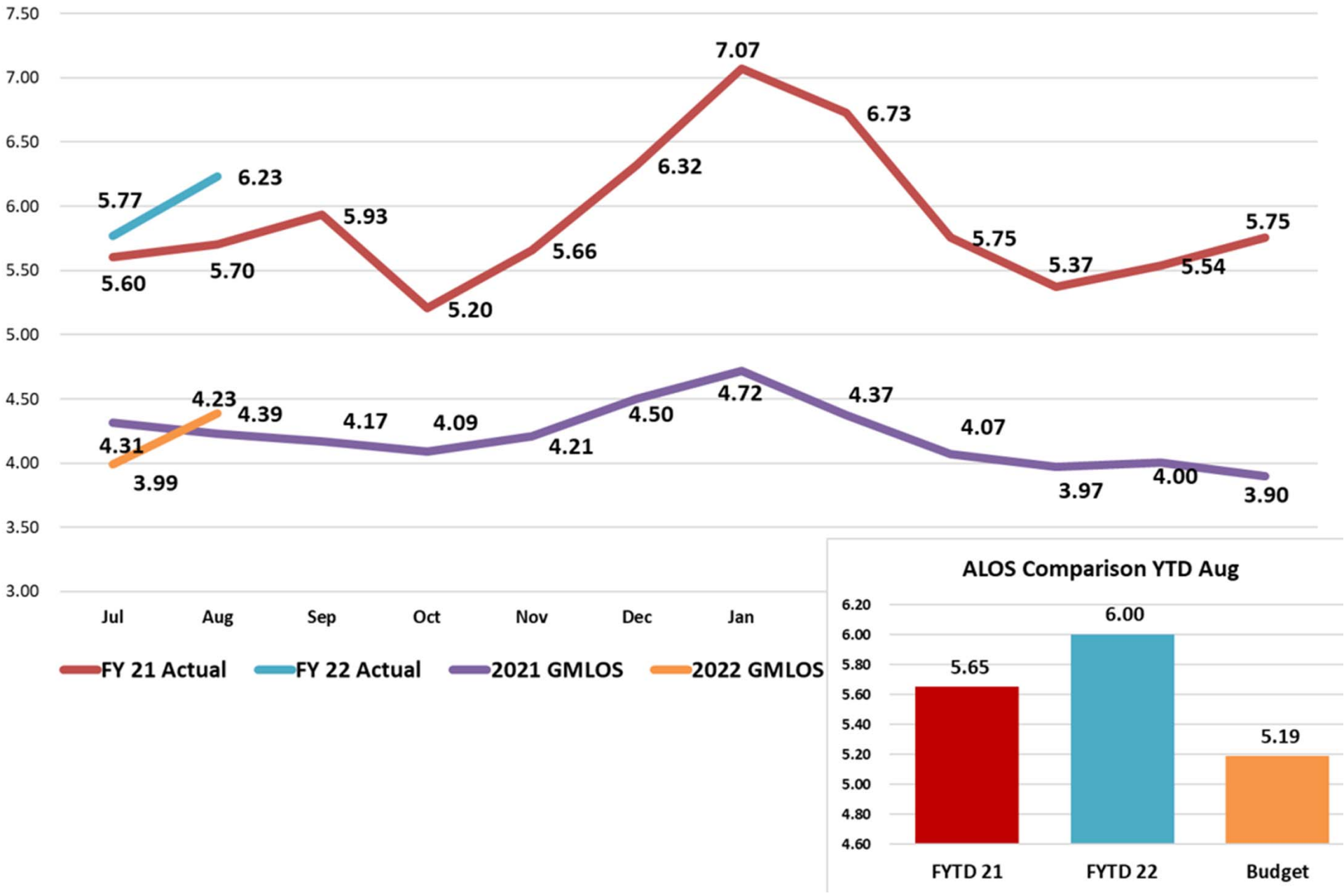

Case Mix Index w/o Normal Newborns
1.800
1.750
1.700
1.650
1.600
1.550
1.500
1.450
1.400
1.700
1.710
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2020
FY 2021
FY 2022


Case Mix Index w/o Normal Newborns - All
1.750
1.700
1.650
1.600
1.550
1.500
1.450
1.627
1.720
1.705
FY 2020
FY 2021
FY2022


Case Mix Medical w/o Normal Newborns
1.5500
1.5000
1.4500
1.4000
1.3500
1.3000
1.2500
1.2000
1.1500
1.1000
1.0500
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2020
FY 2021
FY 2022

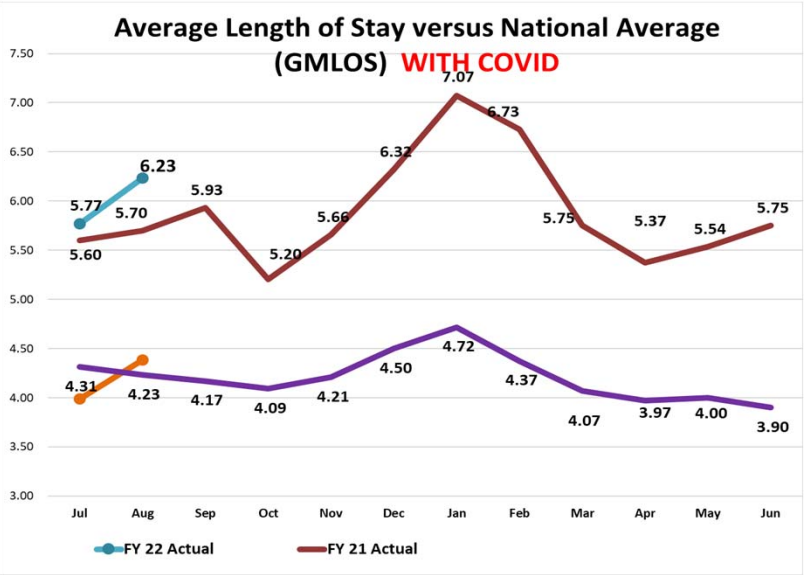

Case Mix Index Surgical w/o Normal Newborns
2.9000
2.8000
2.7000
2.6000
2.5000
2.4000
2.3000
2.2000
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2020
FY 2021
FY 2022

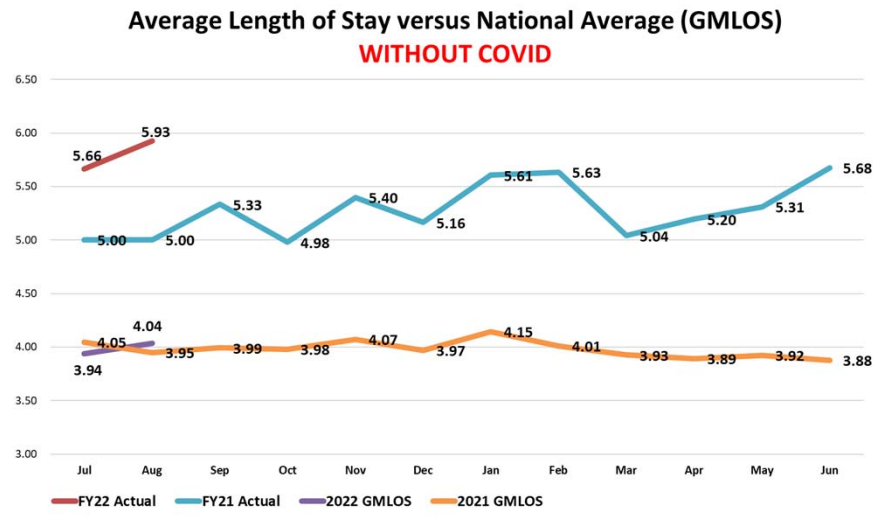
Average Length of Stay versus National Average (GMLOS)



Average Length of Stay versus National Average (GMLOS)

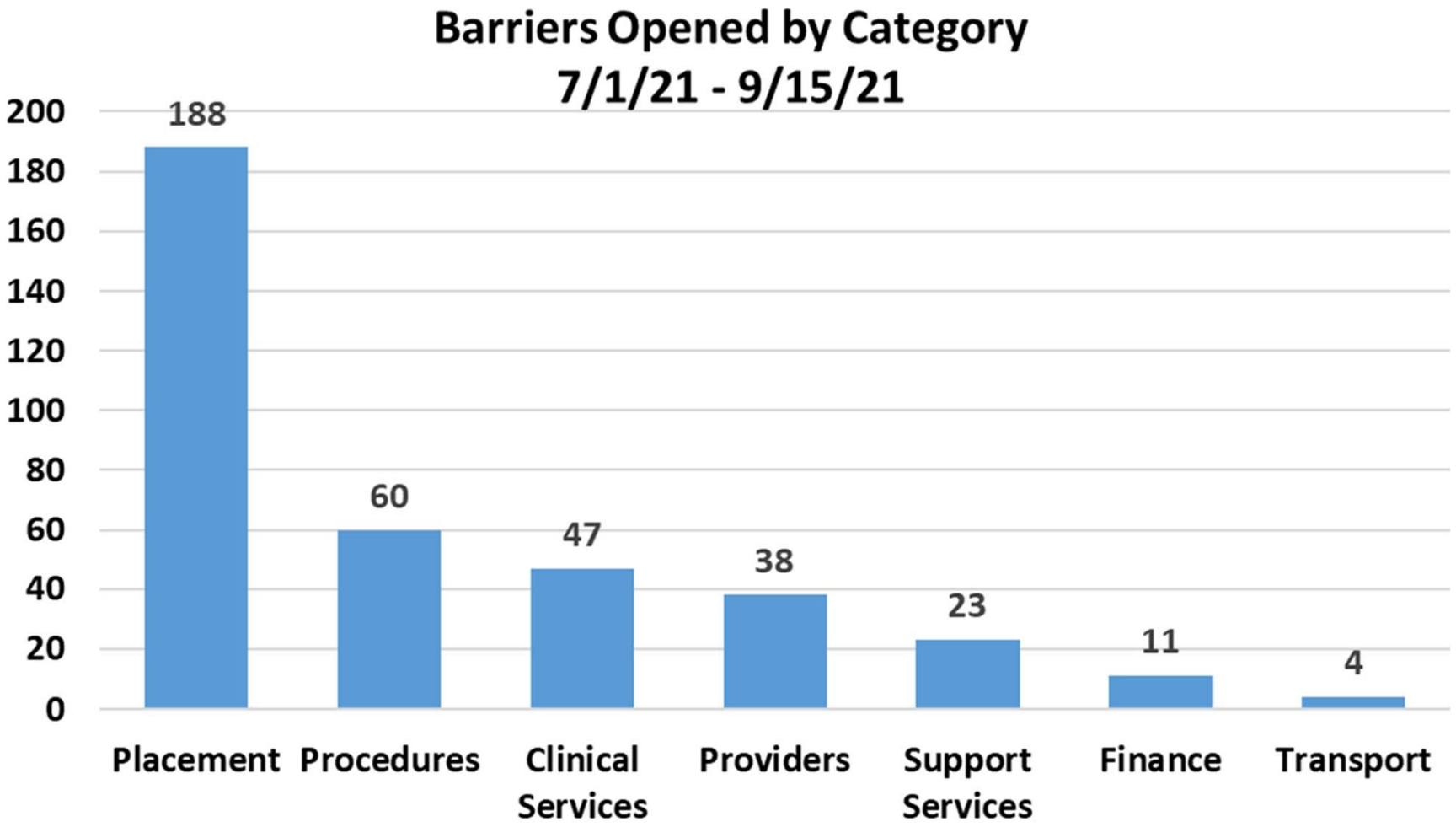
	Including COVID Patients			Excluding COVID Patients				
	ALOS	GMLOS	GAP	ALOS	GMLOS	GAP	Gap Diff	%
Mar-20	5.20	4.04	1.16	5.16	4.03	1.13	0.03	2%
Apr-20	5.30	4.25	1.05	5.19	4.17	1.03	0.02	2%
May-20	5.25	4.16	1.09	4.74	4.06	0.68	0.40	37%
Jun-20	5.61	4.11	1.50	4.98	3.95	1.03	0.47	31%
Jul-20	5.60	4.31	1.29	5.00	4.05	0.96	0.33	26%
Aug-20	5.70	4.23	1.47	5.00	3.95	1.05	0.42	28%
Sep-20	5.93	4.17	1.76	5.33	3.99	1.34	0.42	24%
Oct-20	5.20	4.09	1.11	4.98	3.98	1.00	0.11	10%
Nov-20	5.66	4.21	1.45	5.40	4.07	1.33	0.12	8%
Dec-20	6.32	4.50	1.82	5.16	3.97	1.20	0.62	34%
Jan-21	7.07	4.72	2.35	5.61	4.15	1.46	0.89	38%
Feb-21	6.73	4.37	2.36	5.63	4.01	1.62	0.73	31%
Mar-21	5.75	4.07	1.68	5.04	3.92	1.12	0.56	33%
Apr-21	5.37	3.97	1.39	5.20	3.89	1.31	0.09	6%
May-21	5.54	4.00	1.54	5.31	3.92	1.39	0.15	10%
Jun-21	5.75	3.90	1.85	5.68	3.88	1.80	0.05	3%
Jul-21	5.77	3.99	1.78	5.66	3.94	1.72	0.06	3%
Aug-21	6.23	4.39	1.84	5.93	4.04	1.89	(0.05)	-3%
Average	**5.78**	**4.19**	**1.58**	**5.28**	**4.00**	**1.28**	**0.30**	**19%**



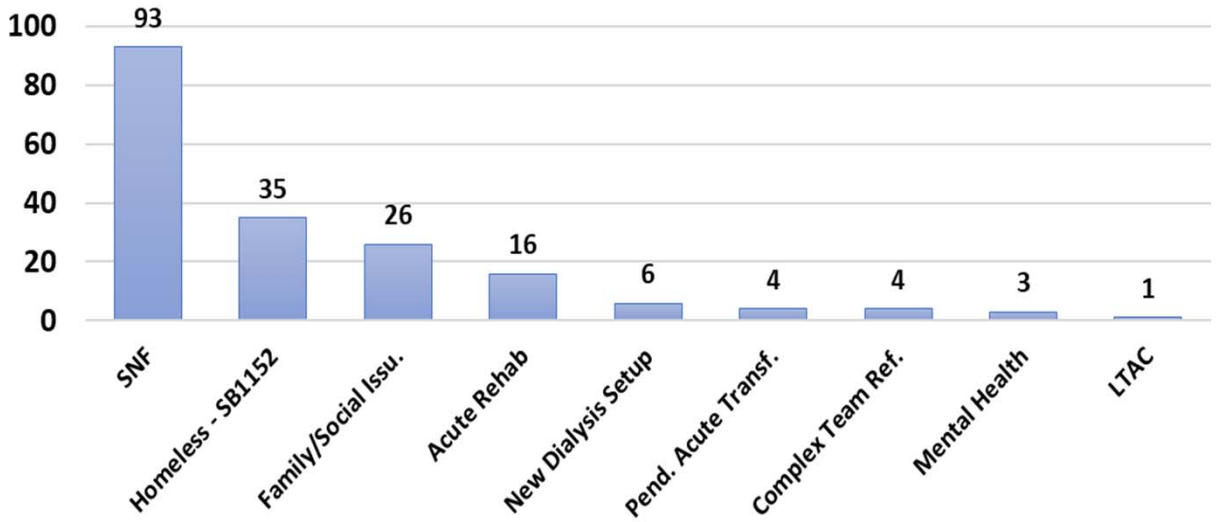


Opportunity Cost of Reducing LOS to National Average - $62.7M FY21

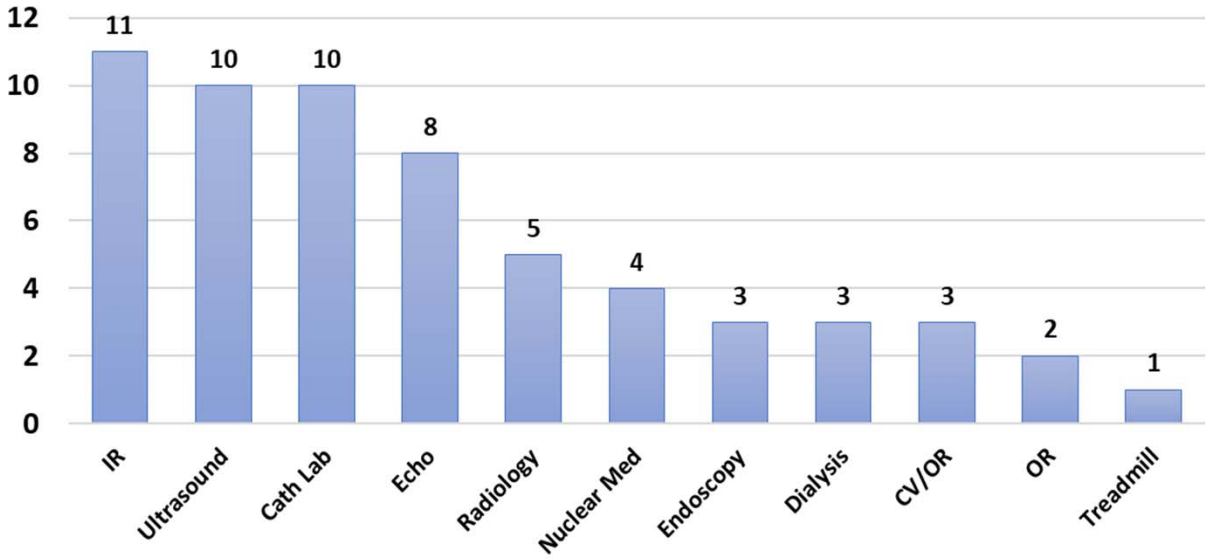
Throughput Rounding Tool (TRT)



Open Throughput Barriers by Category and Delay Reason 7/1/21-9/15/21

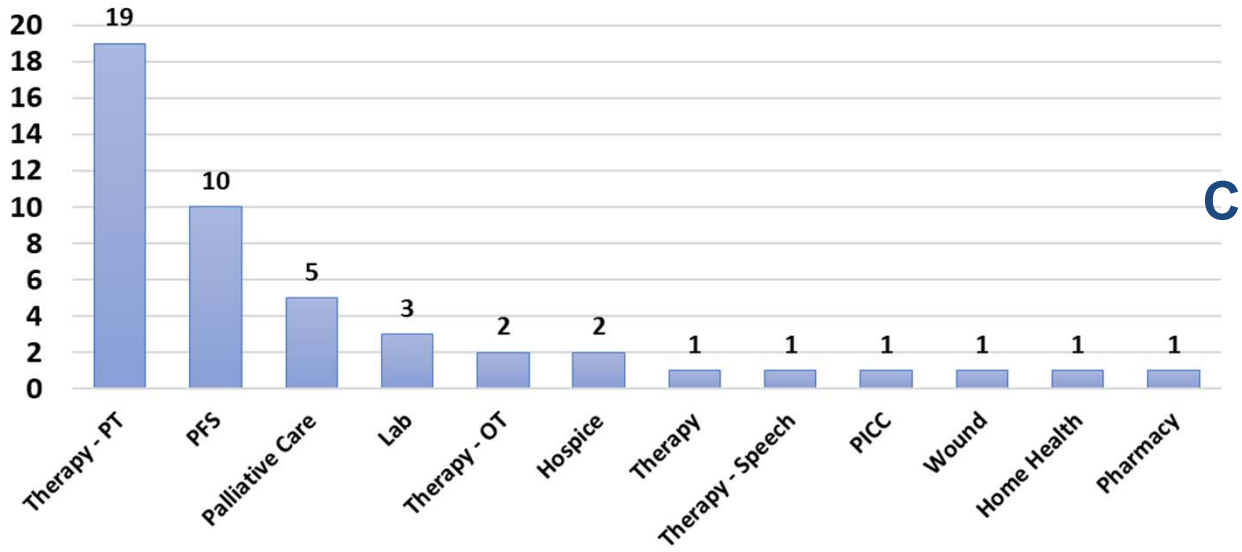


Placement Barriers

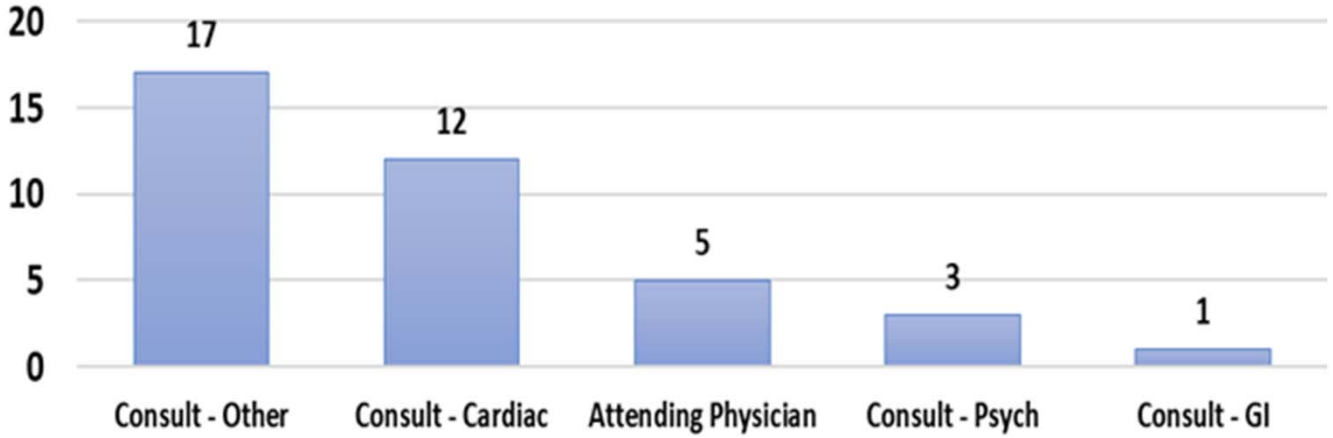


Procedure Barriers

Open Throughput Barriers by Category and Delay Reason 7/1/21-9/15/21

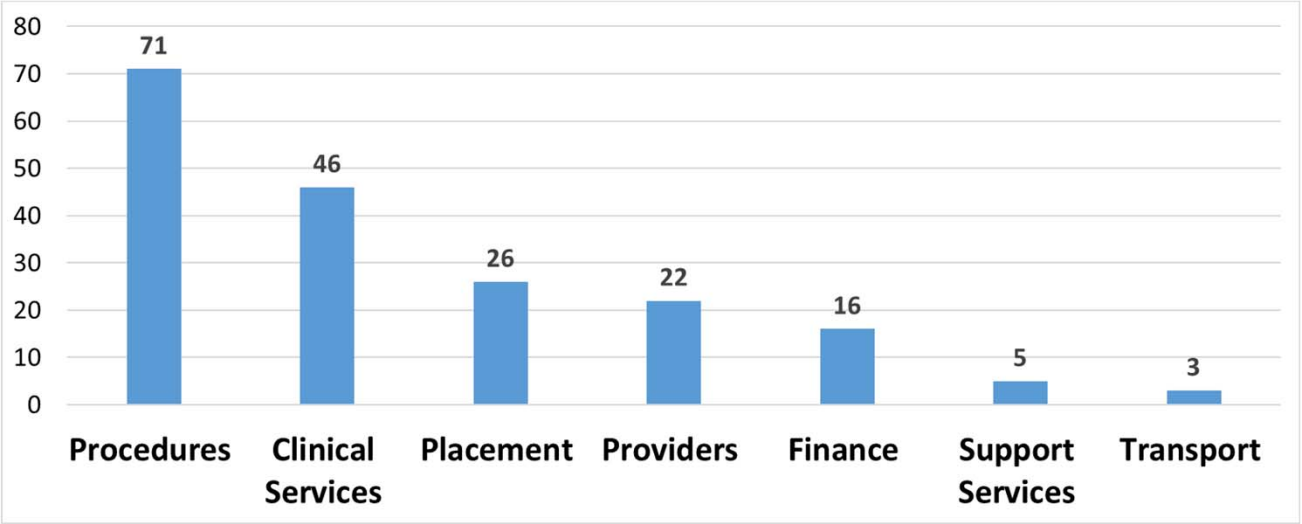


Clinical Services Barriers



Provider Barriers

Escalations by Barrier Category 7/1/21-9/15/21



Escalated Delay Reason	Escalated Barrier	Count of ecd_no
Cath Lab	Procedures	26
Echo	Procedures	15
Therapy - Physical Therapy	Clinical Services	11
Skilled Nursing Facility	Placement	10
Patient Financial Services	Clinical Services	8
Consult - Psych	Providers	8
Radiology	Procedures	7
Consult - Other	Providers	7
Ultrasound	Procedures	7
Interventional Radiology	Procedures	6
Ins pending	Finance	6
Auth pndg	Finance	6
Lab	Clinical Services	6
Palliative Care	Clinical Services	5
Home Health	Clinical Services	5
Hospice	Clinical Services	5
Consult - Neurosurgery	Providers	4
Family/Social Issues	Placement	4
Durable Medical Equipment	Support Services	3
Therapy	Clinical Services	3
Endoscopy	Procedures	3
Nuclear Med	Procedures	3
Other	Finance	2
SNF Behavioral	Placement	2
Environmental Services	Support Services	2
Family delays	Transport	2
OR	Procedures	2
Attending Physician	Providers	2
New Dialysis Setup	Placement	2
Homeless – Board and Care	Placement	2
Acute Rehab	Placement	2
SNF Long Term	Placement	1
Homeless - SB1152 in program	Placement	1
American Ambulance	Transport	1
Pharmacy	Clinical Services	1
Consult - Cardiac	Providers	1
Dialysis	Procedures	1
Wound	Clinical Services	1
Respiratory	Clinical Services	1
Treadmill	Procedures	1
Self Pay-Change Insurance	Finance	1
Long Term Acute Care	Placement	1
No Income Source	Placement	1
Insurance Auth	Finance	1
Grand Total		189

2020-2021 Surgical Services Dashboard

Overall Surgical Services Throughput Initiatives	Goal	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21
First Case Delay Minutes in O.R.	650	1385	1507	925	594	757	429	715	926	719	695	800	777	1107
Block Utilization	60%	53%	46%	53%	53%	40%	22%	41%	51%	52%	54%	53%	44%	48%
O.R. Efficiency	Goal	Minutes												
Surgeon (Non-Op) Wait Time	70	83	85	82	78	86	83	80	86	73	73	79	77	77

Better than target
Within 10% of target
Does not meet target

1. First case delay minutes in O.R.: Problem Statement: Kaweah Health needs to reduce the daily average minutes related to first case delays in the Main OR from the baseline of 650 minutes.

a. **Goal**: Decrease the daily average minutes related to first case delays by 10 minutes
b. **August:** 1,107 minutes in first case delays
    i. In the month of August we had 169 first case starts and out of that 169 cases we had 106 cases with some type of a delay.
    ii. **Delay reasons:** Surgeon late, paperwork issues (consent or H&P), Anesthesia delays (anesthesia late, patient interview, pre-op block), Patient delays (pt. up to bathroom, pt. wanting to speak to surgeon), ASC delays (labs, manipulating cancelations), and Surgery dept. delays (difficult room set up, staffing challenges, cases not picked properly, and cancelations).
c. **Critical issues:** Surgeons late and Surgeon needing to complete paperwork prior to proceeding with procedure. This accounted for 642 minutes of the first case delays, 58% of the delay reasons.
d. **Next Steps:**
    i. O.R. Governance will reviews June, July, and August data and determine surgeons who fall out of compliance.
    ii. Morning block will be removed from surgeons for trends of delaying first cases.
    iii. Moring blocks that were removed will be filled with surgeons who need more time.

2020-2021 Surgical Services Dashboard

2 . Block Utilization: Problem Statement: Kaweah Health needs to increase Block Time Utilization in the Main OR

a. **Goal:** Increase Block utilization to 60%.

b. **August:** 48% of the block was utilized.

i. August 2021 we had a total of 763 main O.R. Procedures.
ii. August 2020 we had 760 main O.R. Procedures.
iii. August 2019 we had 981 main O.R. Cases.

c. **Critical Issues:**

i. Surgery and Anesthesia Staffing challenges.
ii. In the month of July we had 3 O.R. rooms and 3 storage rooms down (Could not use). Currently have 1 O.R. room down and 2 . Storage rooms down. Storage rooms will be back up the end of September and the O.R. room will be up at the end of October.
iii. In July we had air conditioning issues in 2 operating rooms and the PACU. We had to close the 2 rooms until we received a rental HVAC unit to supply appropriate air to the room. We are still utilizing the rental HVAC.
iv. Scheduling is impacted due to COVID. We are only able to have 3 admissions due to the hospital census. Prior to COVID would be admitting 10-15 cases a day. .

d. **Next Steps:**

i. 7/13/21- An updated letter will be send to the surgeons.
ii. 9/21/21- O.R. Governance will review surgeons block utilization and decide if any surgeons will lose block.
iii. 9/29/21- Surgeons will receive August block utilization numbers
iv. 10/1/21- Surgeons will receive a letter of any changes.

2020-2021 Surgical Services Dashboard

3. **Physician Non-Operative "Wait Times":** Problem Statement: Kaweah Health needs to reduce the physician wait times between cases, as defined by surgery stop time in previous case to start time of the next case.

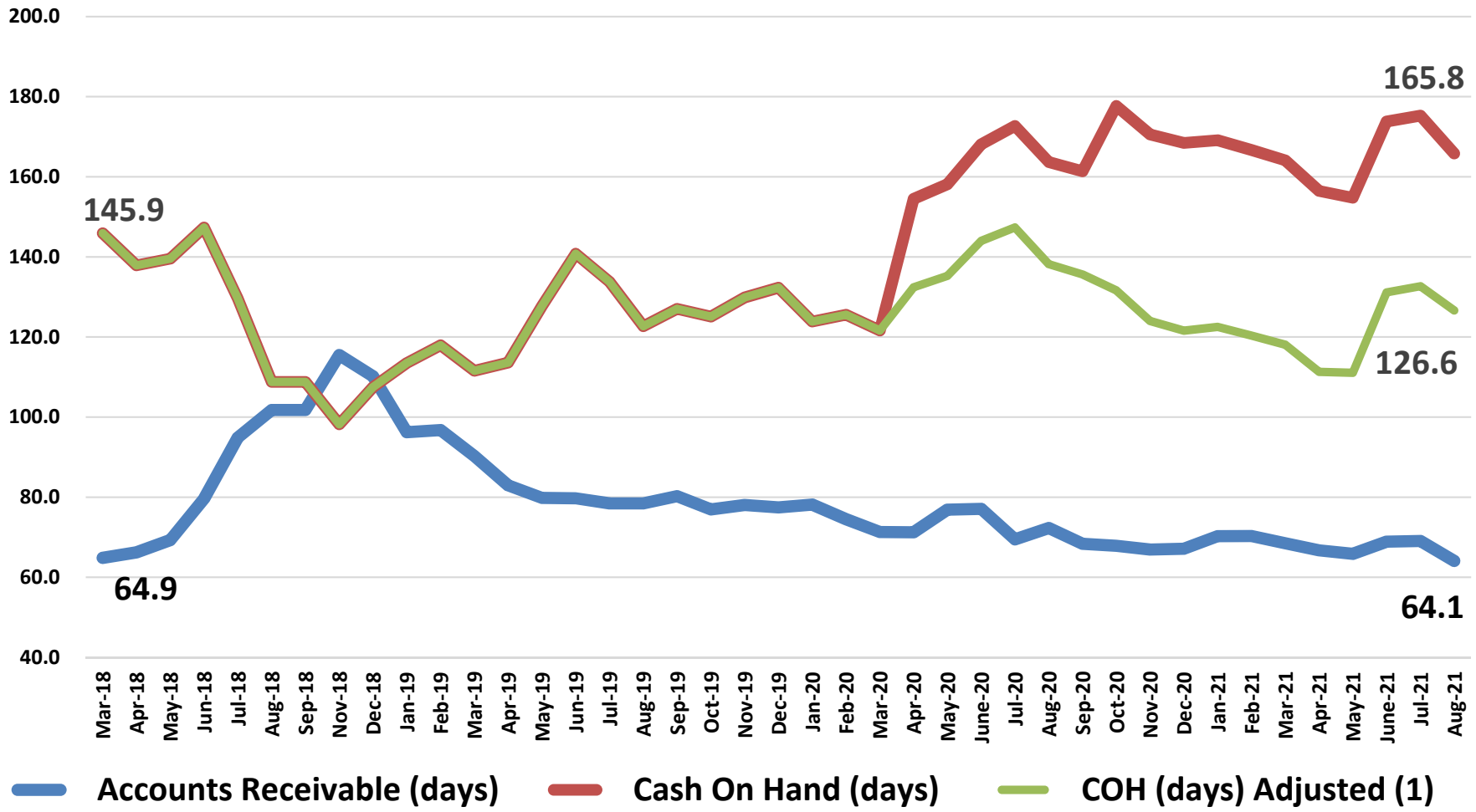
   a. **Goal: Decrease physician wait times between cases by 10% with a baseline of 86 minutes.**
   b. **August:** 77 minute non-operative "wait time".
      i. This data is based on the time the surgeon finishes one case and when he/she starts the next case.
   c. **Critical Issues:**
      i. In the month of July we had 3 rooms and 3 storage rooms down (Could not use). Currently have 1 room down and 2 storage rooms down. Storage rooms will be back up the end of September and the room will be up at the end of October.

      - The old sterile processing is currently a surgery storage room. This has been taken away for 4-8 months due to the Acequia Sterile Processing Construction. Sterile processing will have to use the Old SPD until the project is completed.
      - If rooms are down, we cannot flip surgeons out to a second room to save on turnover time.
      - If storage rooms are down, staff do not have equipment or supply nearby which can cause a delay.
      - Do not have enough nearby storage, the OR and storage rooms are spread out from one another.

      i. Air conditioning issues in 2 operating rooms and the PACU. We had to close the 2 rooms until we received a rental HVAC unit mid-July to supply appropriate air to the room. These areas still have a rental HVAC
      ii. Anesthesia Staffing and Surgery staffing. Very few applicants and no travelers.
      iii. Sterile Processing is across the hospital: We have hired 4 runners who run supply and instrumentation back and forth from sterile processing to surgery (this has been a huge benefit).

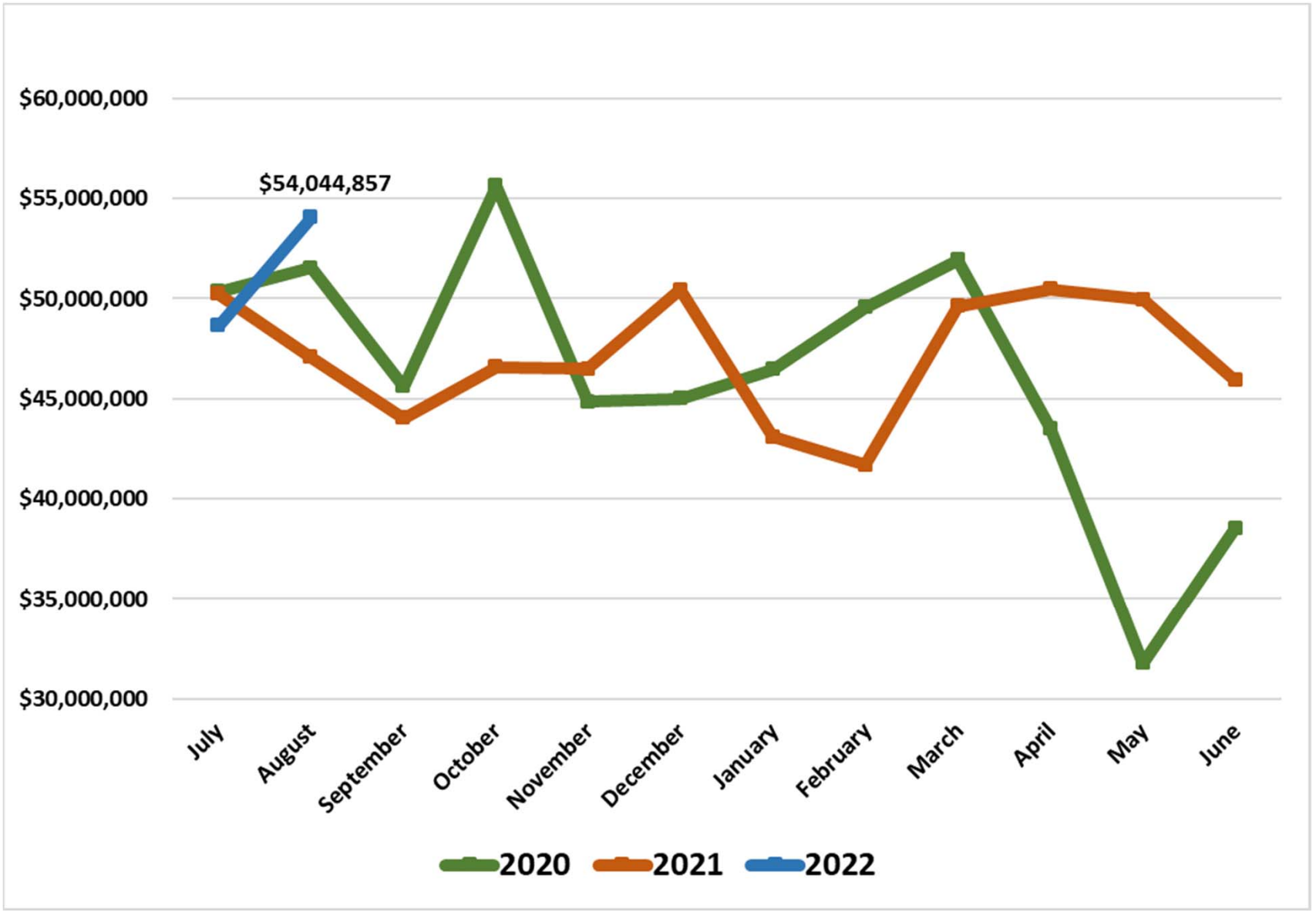
   d. **Next Steps:**
      i. Breaking data down to case specifics and develop an average goal that can be reached by staff . This is partially a manual process. Orthopedics, Neuro surgery, Vascular and Robotics will be the focus because they are bigger cases with more supply and equipment.
      ii. Meet with specialty groups to come to a consensus on what each cases non-operative goal should be.
      iii. Focus only on cases that tend to have longer non-operative "wait times" to see what can be standardized to decrease the time.

Trended Liquidity Ratios



(1) Adjusted for Medicare accelerated payments and the deferral of employer portion of FICA as allowed by the CARES act.

Trended Patient Collections (Soarian System – excludes Medicare recoupments)



KAWEAH DELTA HEALTH CARE DISTRICT

CONSOLIDATED INCOME STATEMENT (000's)

FISCAL YEAR 2021 & 2022

	Operating Revenue			Operating Expenses									
Fiscal Year	Net Patient Revenue	Other Operating Revenue	Operating Revenue Total	Personnel Expense	Physician Fees	Supplies Expense	Other Operating Expense	Operating Expenses Total	Operating Income	Non-Operating Income	Net Income	Operating Margin %	Excess Margin
2021													
Jul-20	47,402	13,608	61,009	32,213	7,807	10,036	13,502	63,559	(2,550)	4,542	1,993	(4.2%)	3.0%
Aug-20	48,393	13,339	61,732	32,203	8,699	10,720	14,744	66,366	(4,634)	4,444	(191)	(7.5%)	(0.3%)
Sep-20	48,769	13,548	62,317	32,837	6,871	11,619	14,643	65,971	(3,654)	3,138	(515)	(5.9%)	(0.8%)
Oct-20	51,454	13,083	64,537	33,385	7,746	10,713	15,033	66,876	(2,339)	5,177	2,837	(3.6%)	4.1%
Nov-20	50,994	12,719	63,713	31,225	8,079	10,999	14,837	65,140	(1,427)	2,807	1,380	(2.2%)	2.1%
Dec-20	50,409	13,317	63,726	34,298	8,024	11,492	15,152	68,965	(5,240)	1,963	(3,276)	(8.2%)	(5.0%)
Jan-21	49,949	14,115	64,064	34,008	8,421	12,014	15,101	69,544	(5,480)	6,363	883	(8.6%)	1.3%
Feb-21	44,505	14,519	59,024	31,565	8,484	9,685	13,829	63,562	(4,538)	3,973	(565)	(7.7%)	(0.9%)
Mar-21	56,144	17,106	73,250	35,505	8,278	10,923	16,990	71,696	1,554	2,267	3,821	2.1%	5.1%
Apr-21	52,593	19,684	72,277	37,084	8,320	11,011	16,895	73,310	(1,033)	2,645	1,612	(1.4%)	2.2%
May-21	50,531	15,692	66,223	34,042	7,754	10,170	16,569	68,535	(2,312)	1,829	(483)	(3.5%)	(0.7%)
Jun-21	43,233	19,589	62,822	20,517	8,207	11,772	19,877	60,373	2,449	773	3,222	3.9%	5.1%
2021 FY Total	**$ 594,375**	**$ 180,319**	**$ 774,694**	**$ 388,882**	**$ 96,690**	**$ 131,154**	**$ 187,172**	**$ 803,898**	**$ (29,204)**	**$ 39,921**	**$ 10,717**	**(3.8%)**	**1.3%**
2022													
Jul-21	51,502	15,035	66,537	32,678	7,922	9,596	15,217	65,413	1,124	582	1,706	1.7%	2.5%
Aug-21	49,714	16,024	65,737	33,434	8,527	13,004	15,414	70,379	(4,642)	990	(3,651)	(7.1%)	(5.5%)
2022 FY Total	**$ 101,216**	**$ 31,058**	**$ 132,274**	**$ 66,112**	**$ 16,449**	**$ 22,600**	**$ 30,631**	**$ 135,792**	**$ (3,518)**	**$ 1,572**	**$ (1,946)**	**(2.7%)**	**(1.5%)**
FYTD Budget	**106,119**	**30,927**	**137,046**	**66,077**	**16,489**	**21,167**	**31,629**	**135,363**	**1,683**	**1,083**	**2,766**	**1.2%**	**2.0%**
Variance	**$ (4,903)**	**$ 131**	**$ (4,772)**	**$ 35**	**$ (40)**	**$ 1,433**	**$ (998)**	**$ 429**	**$ (5,201)**	**$ 489**	**$ (4,712)**		
Current Month Analysis													
Aug-21	**$ 49,714**	**$ 16,024**	**$ 65,737**	**$ 33,434**	**$ 8,527**	**$ 13,004**	**$ 15,414**	**$ 70,379**	**$ (4,642)**	**$ 990**	**$ (3,651)**	**(7.1%)**	**(5.5%)**
Budget	**52,946**	**14,946**	**67,892**	**33,247**	**8,182**	**10,456**	**15,673**	**67,557**	**334**	**542**	**876**	**0.5%**	**1.3%**
Variance	**$ (3,233)**	**$ 1,078**	**$ (2,154)**	**$ 187**	**$ 346**	**$ 2,548**	**$ (259)**	**$ 2,822**	**$ (4,976)**	**$ 449**	**(4,527)**		

KAWEAH DELTA HEALTH CARE DISTRICT

FISCAL YEAR 2021 & 2022

Fiscal Year	Patient Days	ADC	Adjusted Patient Days	I/P Revenue %	DFR & Bad Debt %	Net Patient Revenue/ Ajusted Patient Day	Personnel Expense/ Ajusted Patient Day	Physician Fees/ Ajusted Patient Day	Supply Expense/ Ajusted Patient Day	Total Operating Expense/ Ajusted Patient Day	Personnel Expense/ Net Patient Revenue	Physician Fees/ Net Patient Revenue	Supply Expense/ Net Patient Revenue	Total Operating Expense/ Net Patient Revenue
2021														
Jul-20	13,016	420	24,934	52.2%	76.8%	1,901	1,292	313	403	2,549	68.0%	16.5%	21.2%	134.1%
Aug-20	13,296	429	24,893	53.4%	75.7%	1,944	1,294	349	431	2,666	66.5%	18.0%	22.2%	137.1%
Sep-20	13,024	434	24,587	53.0%	75.6%	1,984	1,336	279	473	2,683	67.3%	14.1%	23.8%	135.3%
Oct-20	12,478	403	24,749	50.4%	74.2%	2,079	1,349	313	433	2,702	64.9%	15.1%	20.8%	130.0%
Nov-20	12,898	430	24,958	51.7%	74.0%	2,043	1,251	324	441	2,610	61.2%	15.8%	21.6%	127.7%
Dec-20	14,346	463	25,750	55.7%	75.2%	1,958	1,332	312	446	2,678	68.0%	15.9%	22.8%	136.8%
Jan-21	13,817	446	24,148	57.2%	75.5%	2,068	1,408	349	498	2,880	68.1%	16.9%	24.1%	139.2%
Feb-21	12,384	442	23,570	52.5%	77.3%	1,888	1,339	360	411	2,697	70.9%	19.1%	21.8%	142.8%
Mar-21	13,023	420	25,807	50.5%	74.9%	2,176	1,376	321	423	2,778	63.2%	14.7%	19.5%	127.7%
Apr-21	12,361	412	25,268	48.9%	75.8%	2,081	1,468	329	436	2,901	70.5%	15.8%	20.9%	139.4%
May-21	13,115	423	25,026	52.4%	76.4%	2,019	1,360	310	406	2,739	67.4%	15.3%	20.1%	135.6%
Jun-21	12,916	431	25,797	50.1%	80.5%	1,676	795	318	456	2,340	47.5%	19.0%	27.2%	139.6%
2021 FY Total	**156,674**	**429**	**299,648**	**52.3%**	**76.0%**	**1,984**	**1,298**	**323**	**438**	**2,683**	**65.4%**	**16.3%**	**22.1%**	**135.3%**
2022														
Jul-21	13,388	432	26,085	51.3%	76.2%	1,974	1,253	304	368	2,508	63.4%	15.4%	18.6%	127.0%
Aug-21	14,401	465	27,703	52.0%	77.3%	1,795	1,207	308	469	2,540	67.3%	17.2%	26.2%	141.6%
2022 FY Total	**27,789**	**448**	**53,797**	**51.7%**	**76.7%**	**1,881**	**1,229**	**306**	**420**	**2,524**	**65.3%**	**16.3%**	**22.3%**	**134.2%**
FYTD Budget	**27,414**	**442**	**54,154**	**50.6%**	**75.4%**	**1,960**	**1,220**	**304**	**391**	**2,516**	**62.3%**	**15.5%**	**19.9%**	**127.6%**
Variance	**375**	**6**	**(357)**	**1.0%**	**1.3%**	**(78)**	**9**	**1**	**29**	**8**	**3.1%**	**0.7%**	**2.4%**	**6.6%**
Current Month Analysis														
Aug-21	**14,401**	**465**	**27,703**	**52.0%**	**77.3%**	**1,795**	**1,207**	**308**	**469**	**2,540**	**67.3%**	**17.2%**	**26.2%**	**141.6%**
Budget	**13,824**	**446**	**27,220**	**50.8%**	**75.5%**	**1,945**	**1,221**	**301**	**384**	**2,439**	**62.8%**	**15.5%**	**19.7%**	**127.6%**
Variance	**577**	**19**	**483**	**1.2%**	**1.7%**	**(151)**	**(15)**	**7**	**85**	**102**	**4.5%**	**1.7%**	**6.4%**	**14.0%**

KAWEAH DELTA HEALTH CARE DISTRICT
RATIO ANALYSIS REPORT
AUGUST 31, 2021

	Current Month Value	Prior Month Value	June 30, 2021 Unaudited Value	2019 Moody's Median Benchmark		
				Aa	A	Baa
LIQUIDITY RATIOS						
Current Ratio (x)	1.3	1.2	1.2	1.5	**1.8**	1.9
Accounts Receivable (days)	64.1	69.1	66.7	48.2	**46.2**	46.6
Cash On Hand (days)	165.8	175.3	173.6	276.1	**215.1**	162.5
Cushion Ratio (x)	21.8	22.2	22.9	37.8	**23.5**	14.6
Average Payment Period (days)	83.1	89.6	93.1	74.6	**60.5**	61.1
CAPITAL STRUCTURE RATIOS						
Cash-to-Debt	156.2%	158.8%	164.4%	244.9%	**176.8%**	121.2%
Debt-To-Capitalization	31.5%	31.3%	31.3%	24.4%	**30.9%**	38.4%
Debt-to-Cash Flow (x)	9.0	4.0	4.7	2.1	**2.7**	4.0
Debt Service Coverage	1.5	3.3	2.8	8.2	**5.5**	3.4
Maximum Annual Debt Service Coverage (x)	1.5	3.3	2.8	7.1	**4.7**	3.1
Age Of Plant (years)	14.0	13.9	13.5	10.6	**12.0**	12.2
PROFITABILITY RATIOS						
Operating Margin	(2.7%)	1.7%	(3.8%)	4.4%	**2.7%**	0.5%
Excess Margin	(1.5%)	2.5%	1.3%	7.6%	**5.2%**	2.6%
Operating Cash Flow Margin	2.2%	6.5%	1.2%	10.0%	**8.7%**	6.3%
Return on Assets	(1.2%)	2.1%	1.1%	5.3%	**4.4%**	2.6%

KAWEAH DELTA HEALTH CARE DISTRICT
CONSOLIDATED STATEMENTS OF NET POSITION (000's)

	Aug-21	Jul-21	Change	% Change	Jun-21
					(Unaudited)
ASSETS AND DEFERRED OUTFLOWS					
CURRENT ASSETS					
Cash and cash equivalents	$ 20,706	$ 20,002	$ 704	3.52%	$ 30,081
Current Portion of Board designated and trusted assets	14,800	13,394	1,405	10.49%	13,695
Accounts receivable:					
Net patient accounts	110,332	120,495	(10,163)	-8.43%	119,553
Other receivables	11,025	10,022	1,003	10.01%	14,616
	121,357	130,517	(9,160)	-7.02%	134,169
Inventories	11,855	11,620	235	2.02%	11,095
Medicare and Medi-Cal settlements	40,142	35,941	4,202	11.69%	37,339
Prepaid expenses	12,320	13,036	(716)	-5.49%	12,210
Total current assets	221,180	224,510	(3,330)	-1.48%	238,589
NON-CURRENT CASH AND INVESTMENTS -					
less current portion					
Board designated cash and assets	340,668	347,800	(7,132)	-2.05%	349,986
Revenue bond assets held in trust	22,288	22,275	12	0.06%	22,271
Assets in self-insurance trust fund	2,080	2,077	3	0.14%	2,073
Total non-current cash and investments	365,036	372,153	(7,117)	-1.91%	374,331
CAPITAL ASSETS					
Land	17,542	17,542	-	0.00%	17,542
Buildings and improvements	384,399	384,399	-	0.00%	384,399
Equipment	316,636	316,636	-	0.00%	316,636
Construction in progress	55,611	54,593	1,018	1.86%	53,113
	774,188	773,170	1,018	0.13%	771,690
Less accumulated depreciation	431,761	429,208	2,553	0.59%	426,652
	342,428	343,963	(1,535)	-0.45%	345,038
Property under capital leases -					
less accumulated amortization	(405)	(342)	(63)	18.40%	(279)
Total capital assets	342,023	343,621	(1,598)	-0.47%	344,759
OTHER ASSETS					
Property not used in operations	1,627	1,631	(4)	-0.26%	1,635
Health-related investments	5,262	5,137	126	2.44%	5,066
Other	11,862	11,858	5	0.04%	11,569
Total other assets	18,751	18,625	126	0.68%	18,270
Total assets	946,990	958,909	(11,919)	-1.24%	975,949
DEFERRED OUTFLOWS	8,830	8,865	(35)	-0.39%	8,900
Total assets and deferred outflows	**$ 955,821**	**$ 967,774**	**$ (11,953)**	**-1.24%**	**$ 984,849**

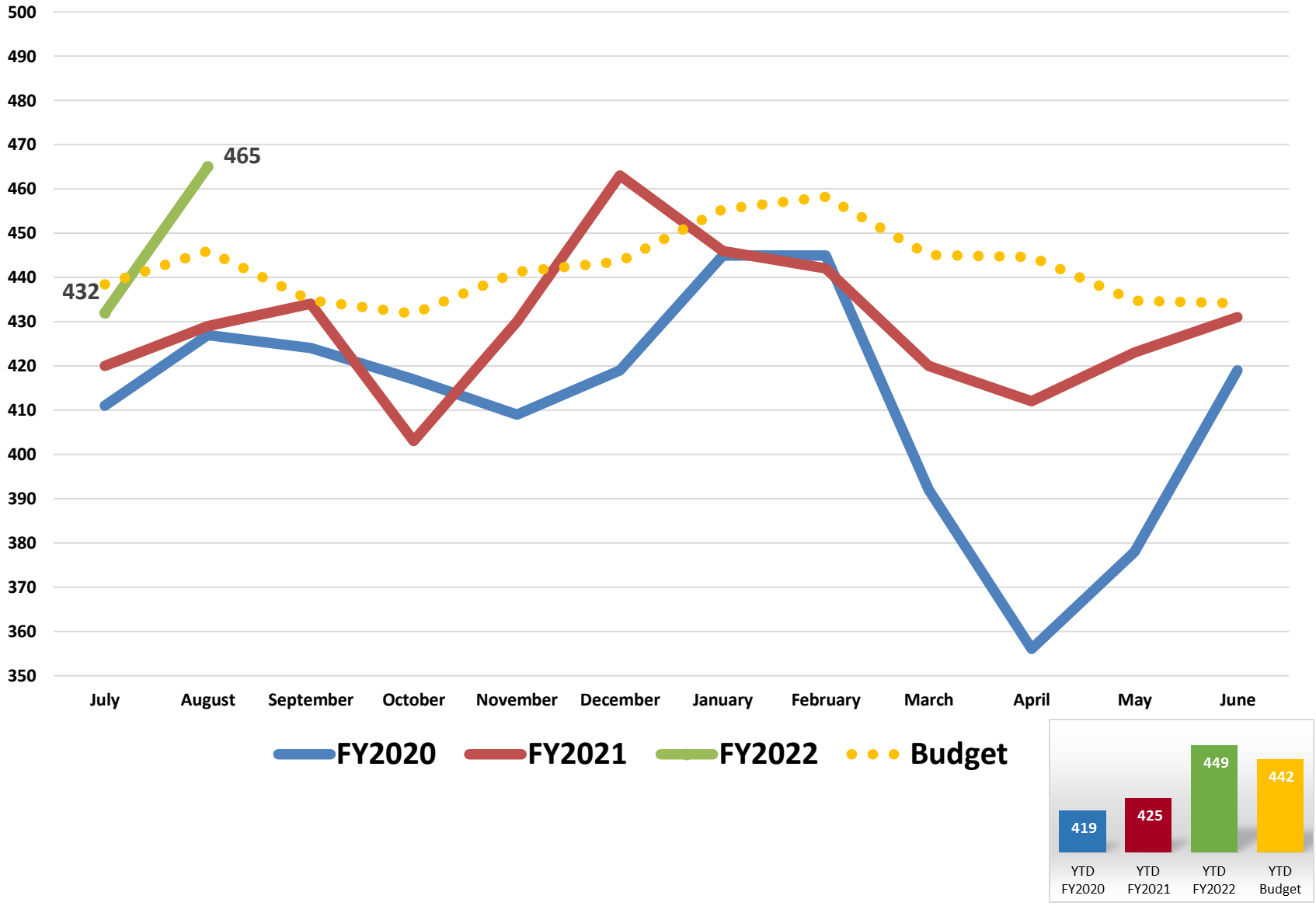
KAWEAH DELTA HEALTH CARE DISTRICT

CONSOLIDATED STATEMENTS OF NET POSITION (000's)

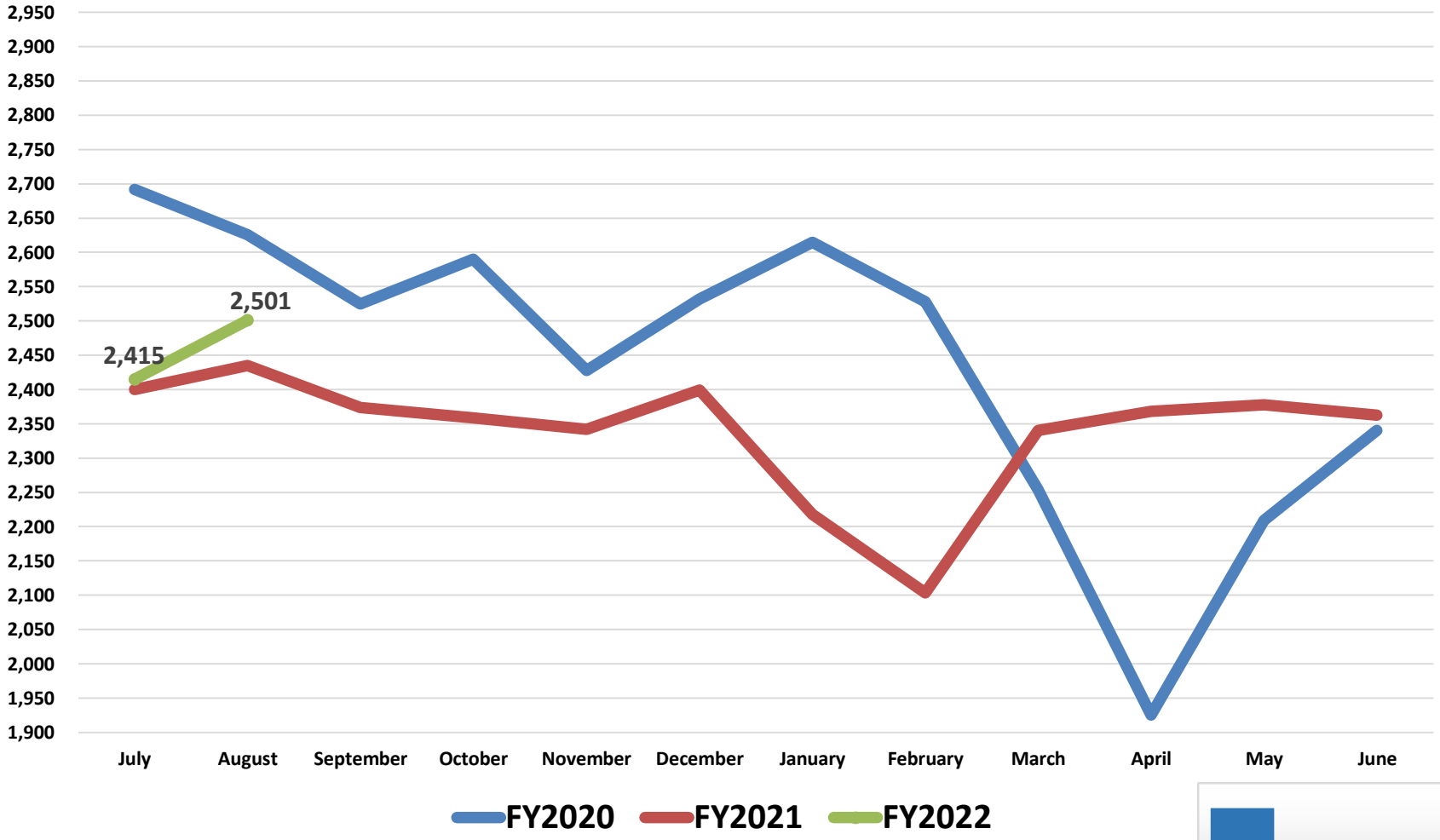
	Aug-21	Jul-21	Change	% Change	Jun-21
					(Unaudited)
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES					
Accounts payable and accrued expenses	$ 99,175	$ 104,532	$ (5,357)	-5.13%	$ 114,405
Accrued payroll and related liabilities	64,545	65,746	(1,202)	-1.83%	71,537
Long-term debt, current portion	11,257	11,257	-	0.00%	11,128
Total current liabilities	174,976	181,535	(6,559)	-3.61%	197,070
LONG-TERM DEBT, less current portion					
Bonds payable	248,648	248,705	(57)	-0.02%	250,675
Capital leases	117	123	(6)	-4.75%	123
Total long-term debt	248,764	248,827	(63)	-0.03%	250,797
NET PENSION LIABILITY	17,336	19,377	(2,041)	-10.53%	21,418
OTHER LONG-TERM LIABILITIES	31,887	31,578	310	0.98%	30,894
Total liabilities	472,964	481,317	(8,353)		500,179
NET ASSETS					
Invested in capital assets, net of related debt	107,074	108,627	(1,553)	-1.43%	107,949
Restricted	32,944	31,490	1,454	4.62%	31,885
Unrestricted	342,839	346,341	(3,502)	-1.01%	344,836
Total net position	482,857	486,457	(3,600)	-0.74%	484,670
Total liabilities and net position	**$ 955,821**	**$ 967,774**	**$ (11,953)**	**-1.24%**	**$ 984,849**

Statistical Report
September 2021

Average Daily Census



Admissions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1,900
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October
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December
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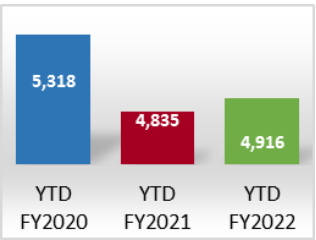
May
June
FY2020
FY2021
FY2022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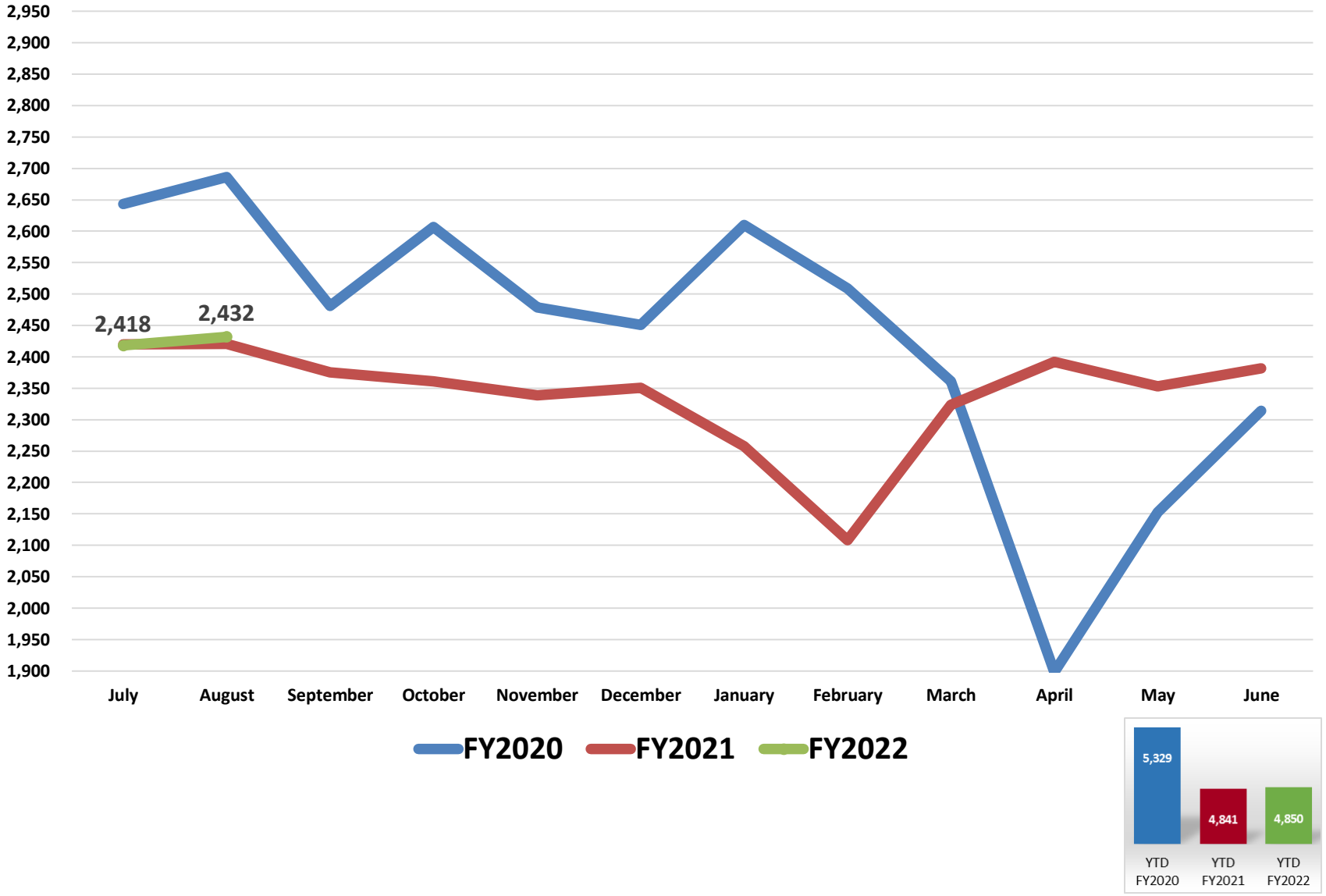
YTD FY2020
YTD FY2021
YTD FY2022

Discharges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July
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September
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November
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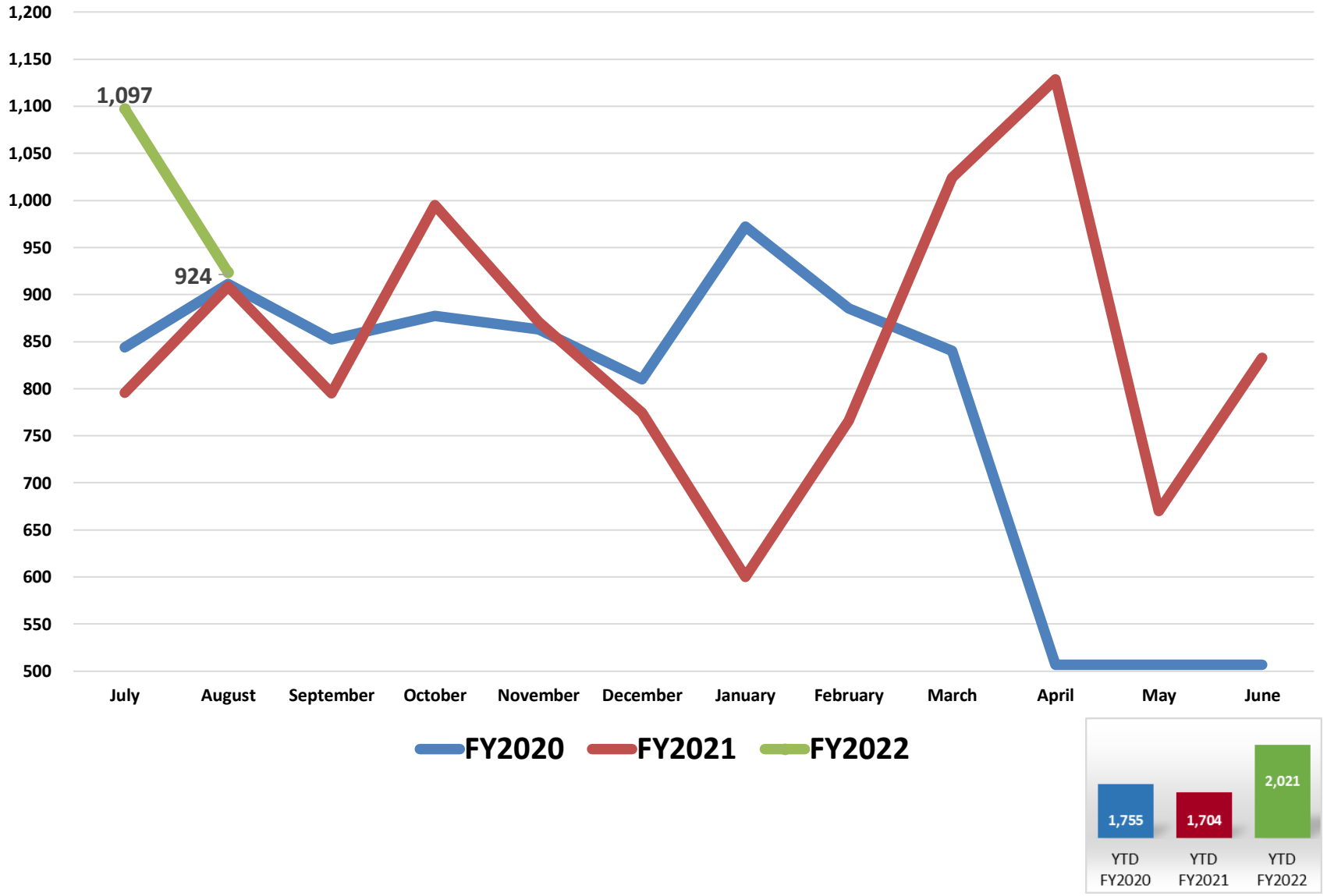
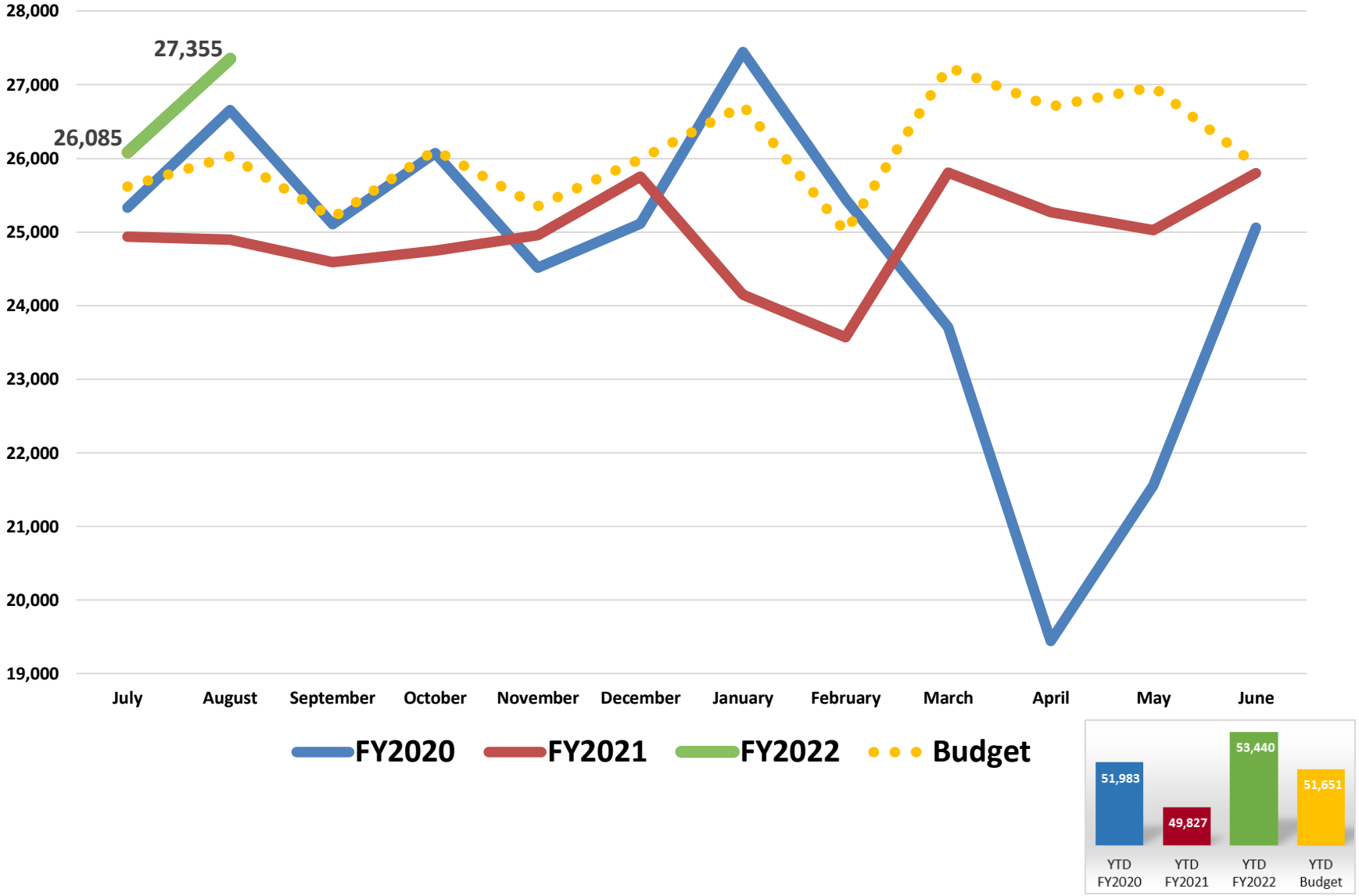
January
February
March
April
May
June
FY2020
FY2021
FY2022

5,329
4,841
4,850
YTD FY2020
YTD FY2021
YTD FY2022

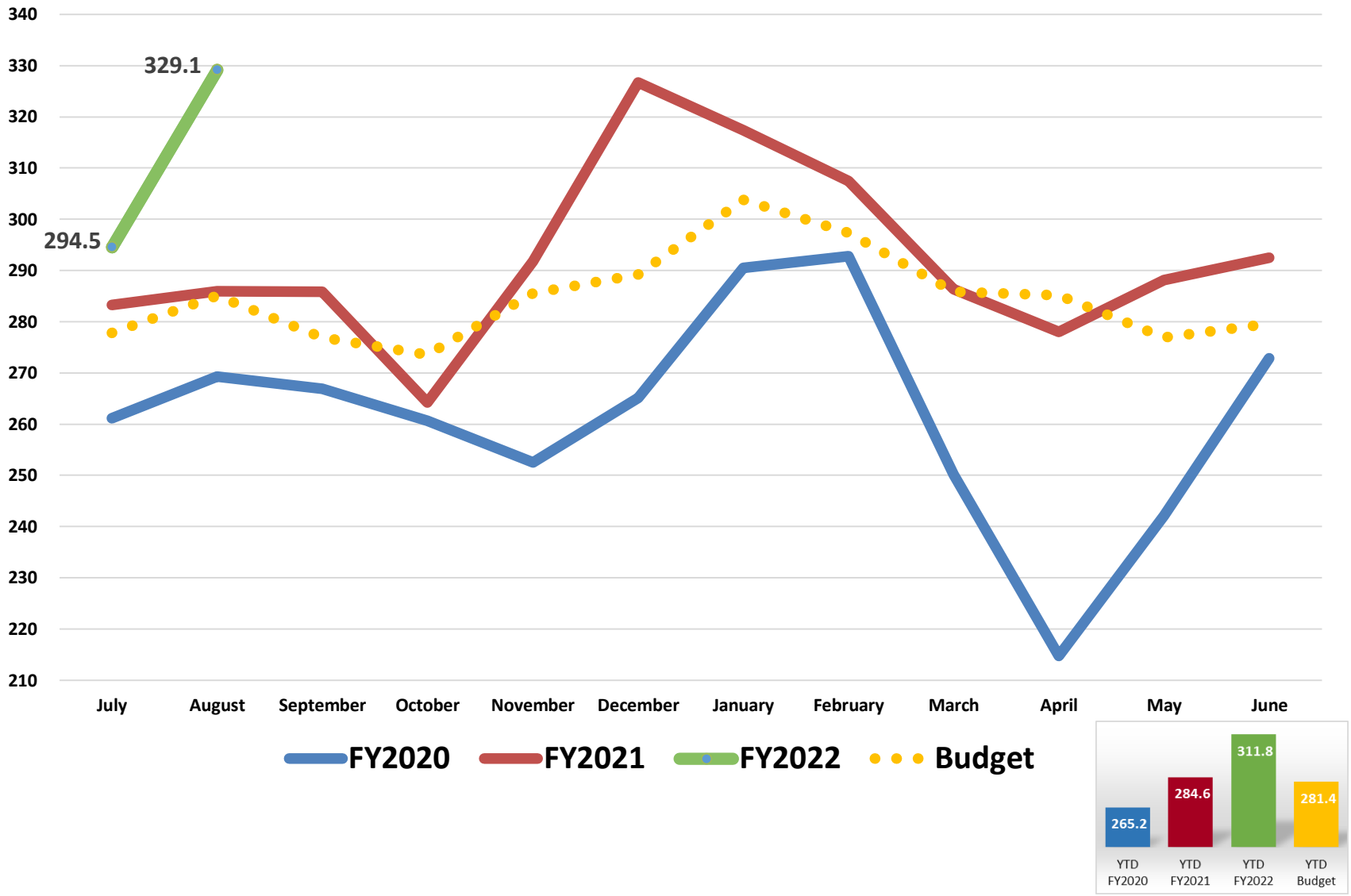
Observation Days



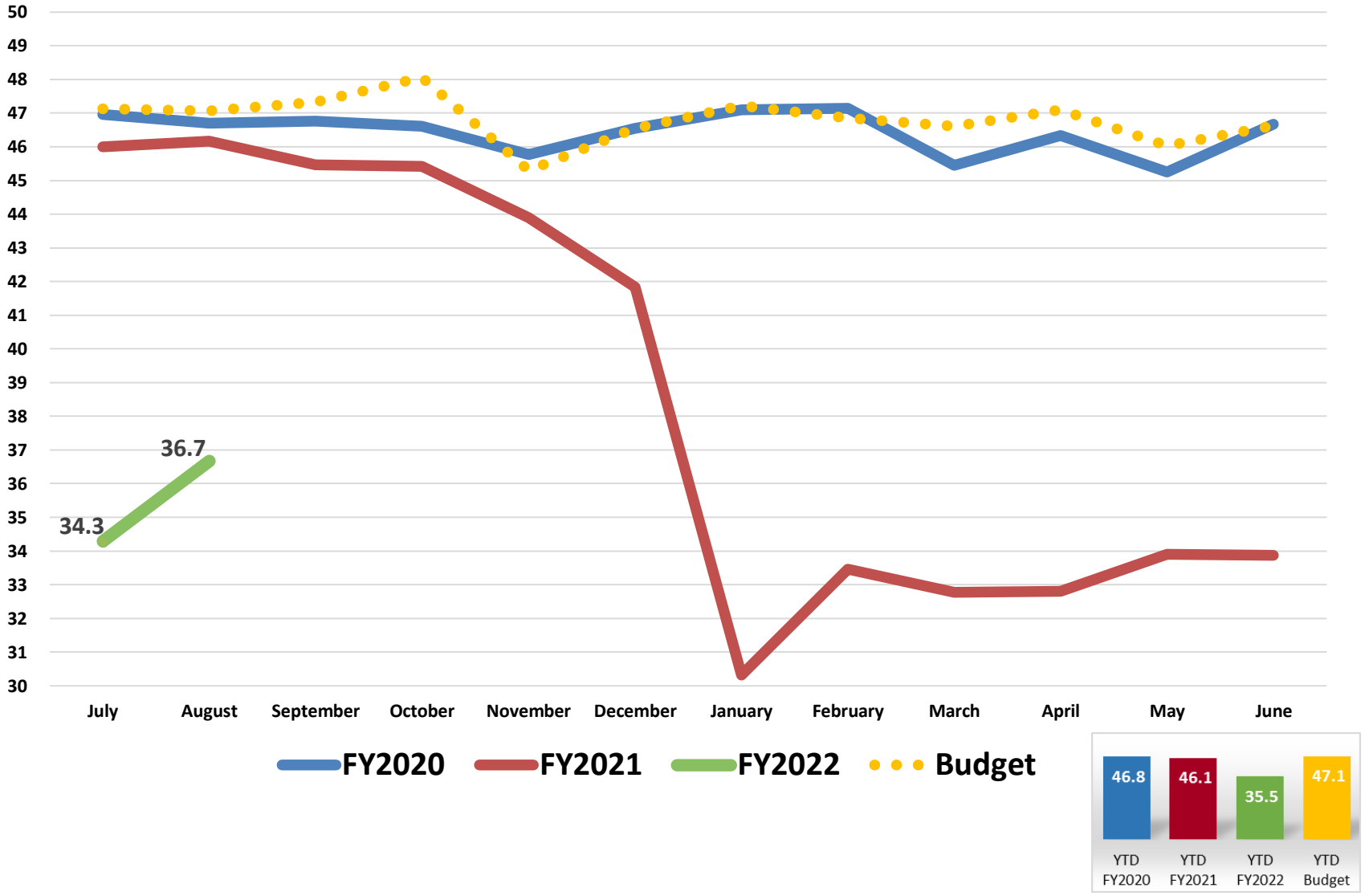
Adjusted Patient Days



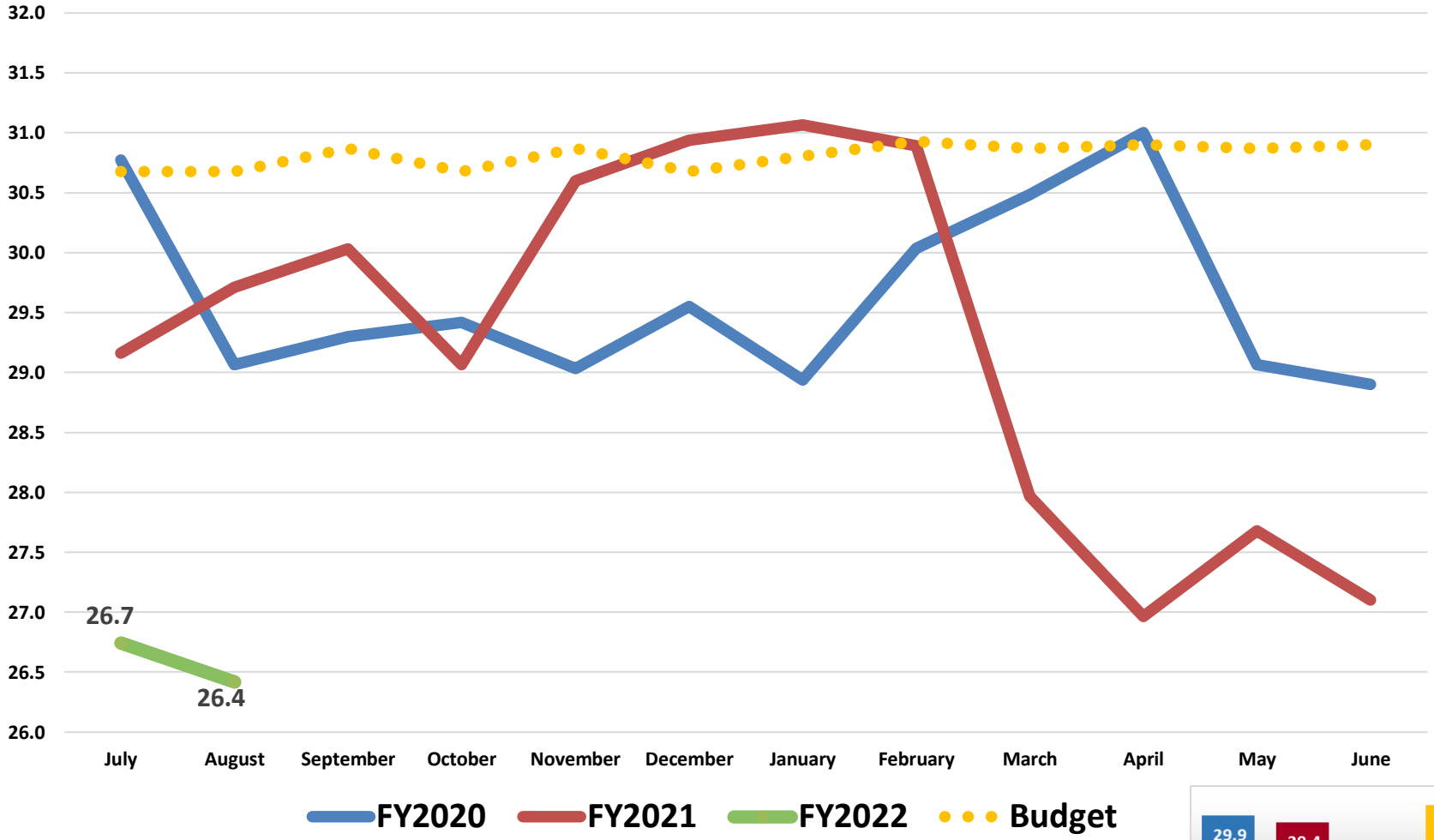
Medical Center – Avg. Patients Per Day

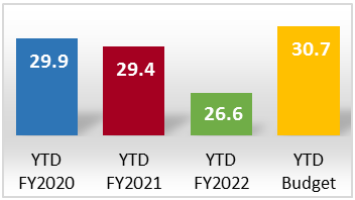


Acute I/P Psych - Avg. Patients Per Day

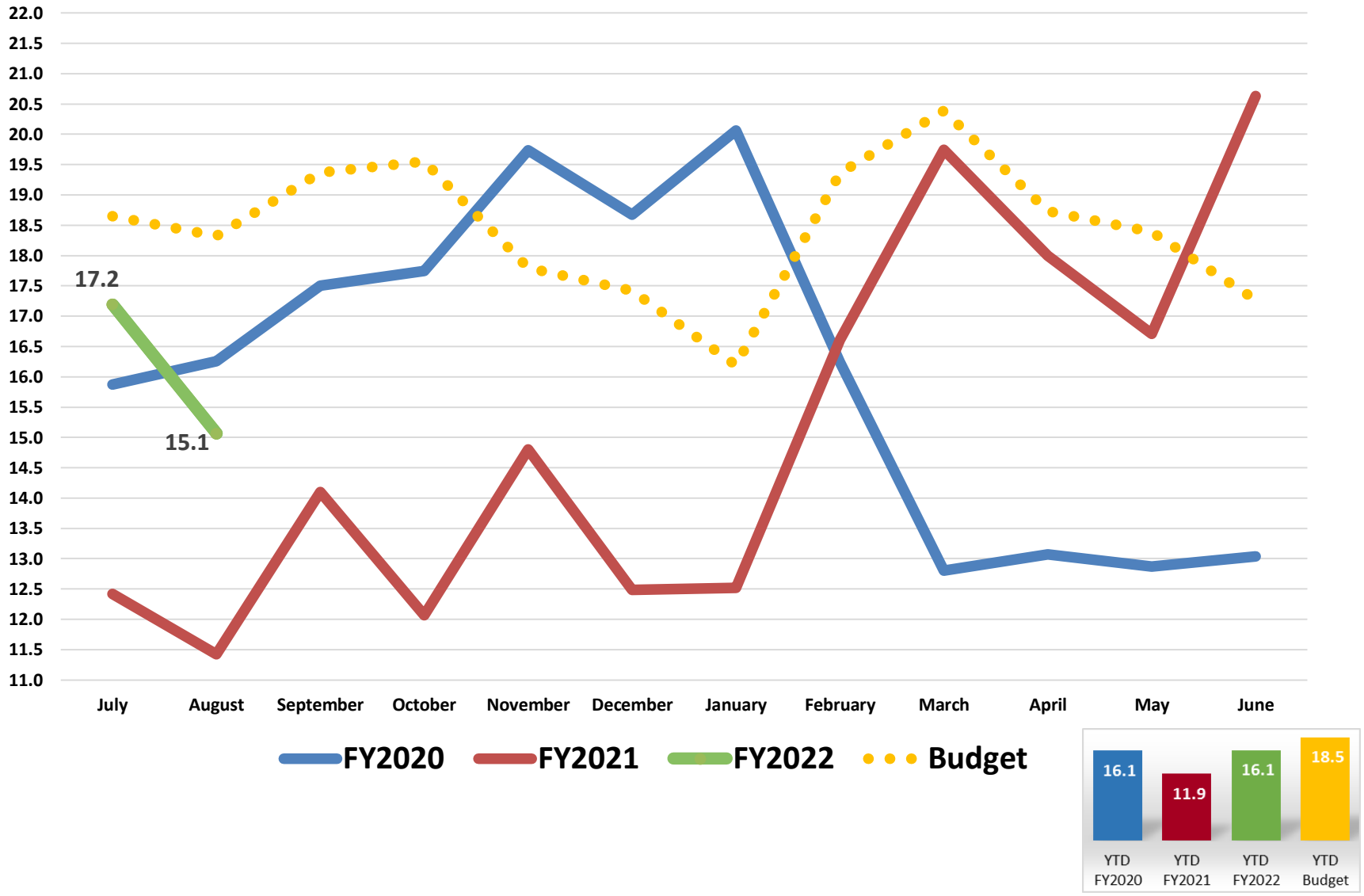


Sub-Acute - Avg. Patients Per Day

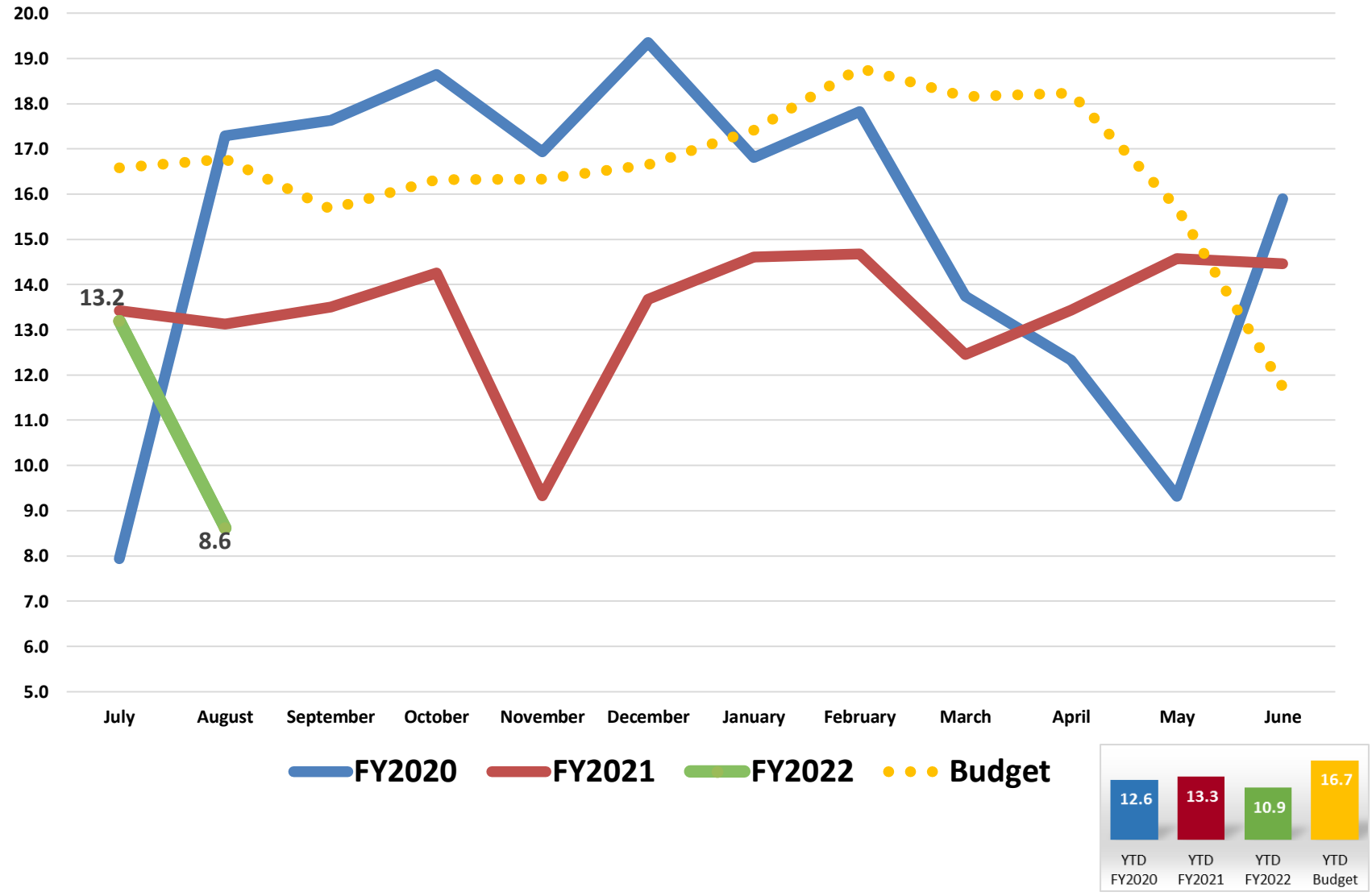




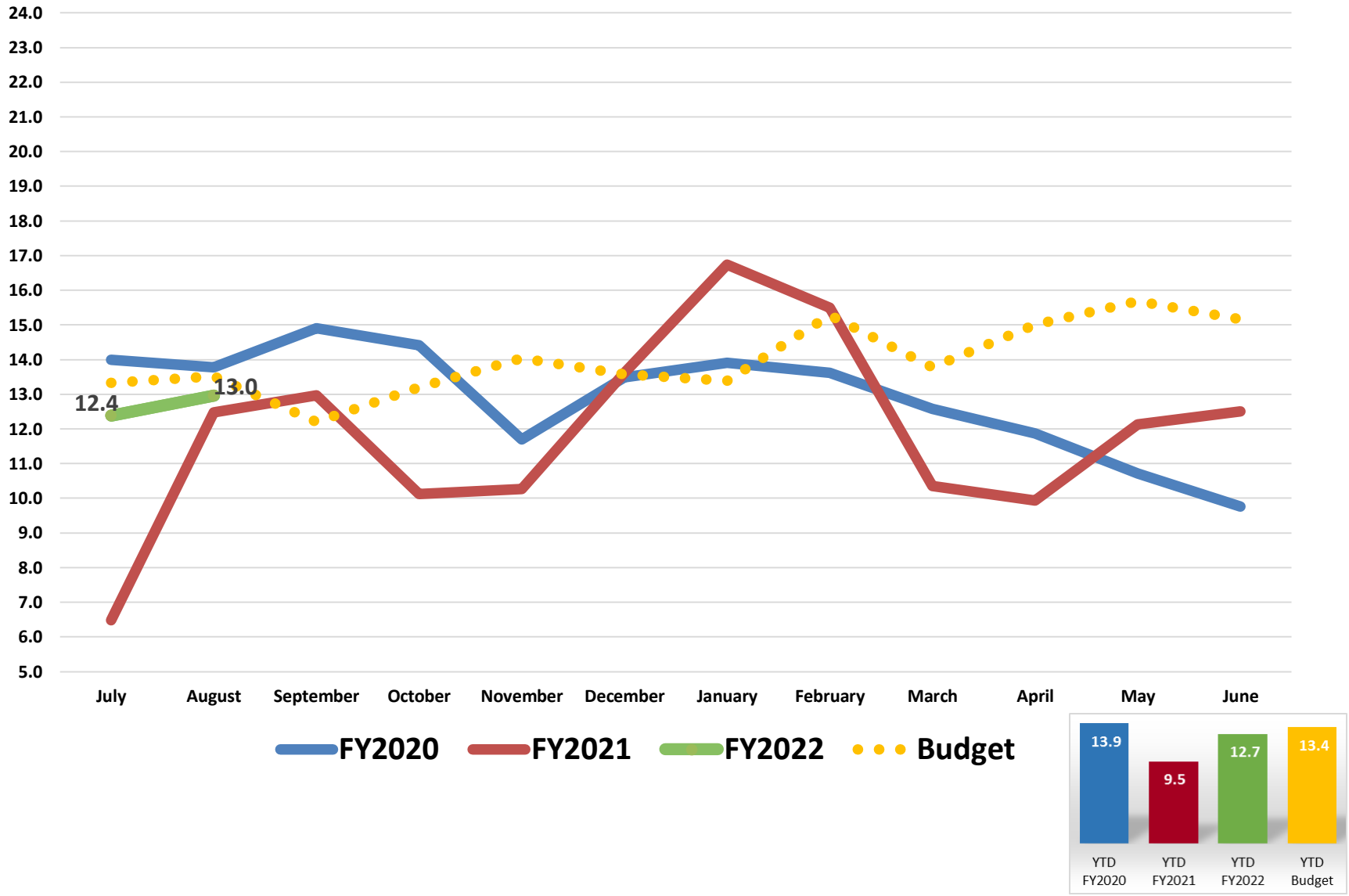
Rehabilitation Hospital - Avg. Patients Per Day



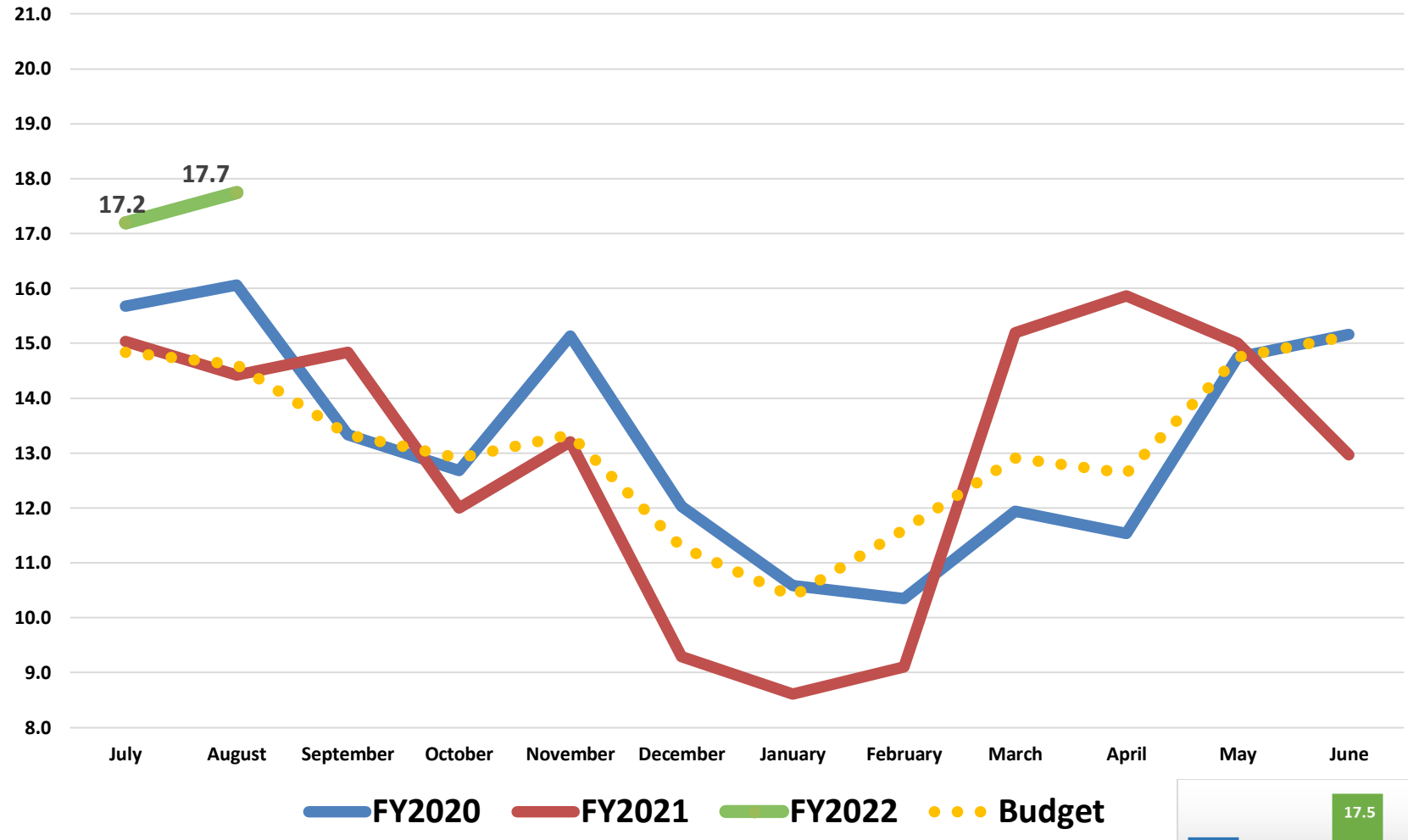
Transitional Care Services (TCS) - Avg. Patients Per Day

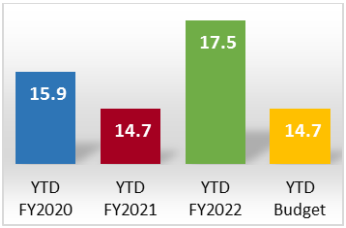


TCS Ortho - Avg. Patients Per Day

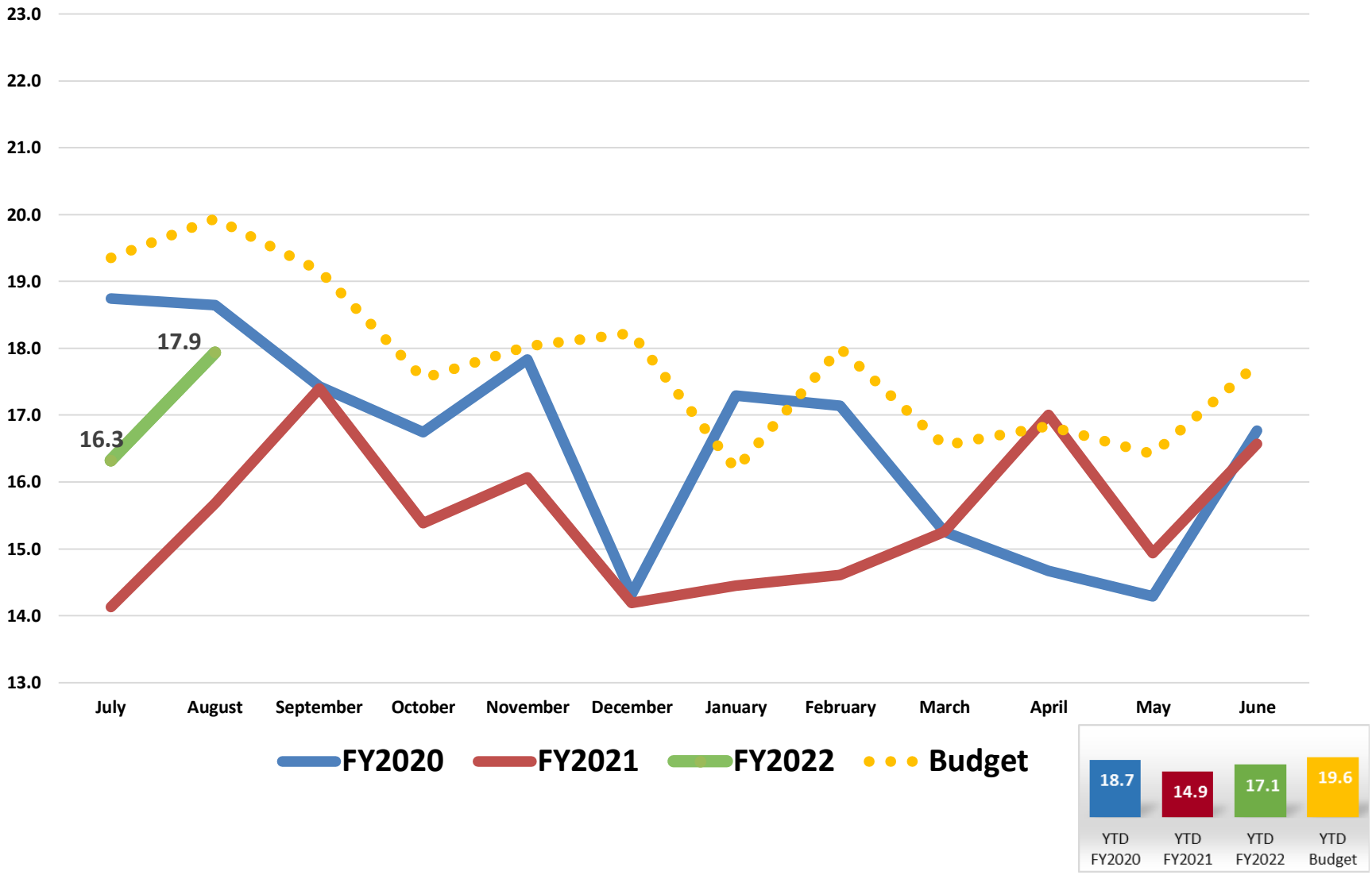


NICU - Avg. Patients Per Day

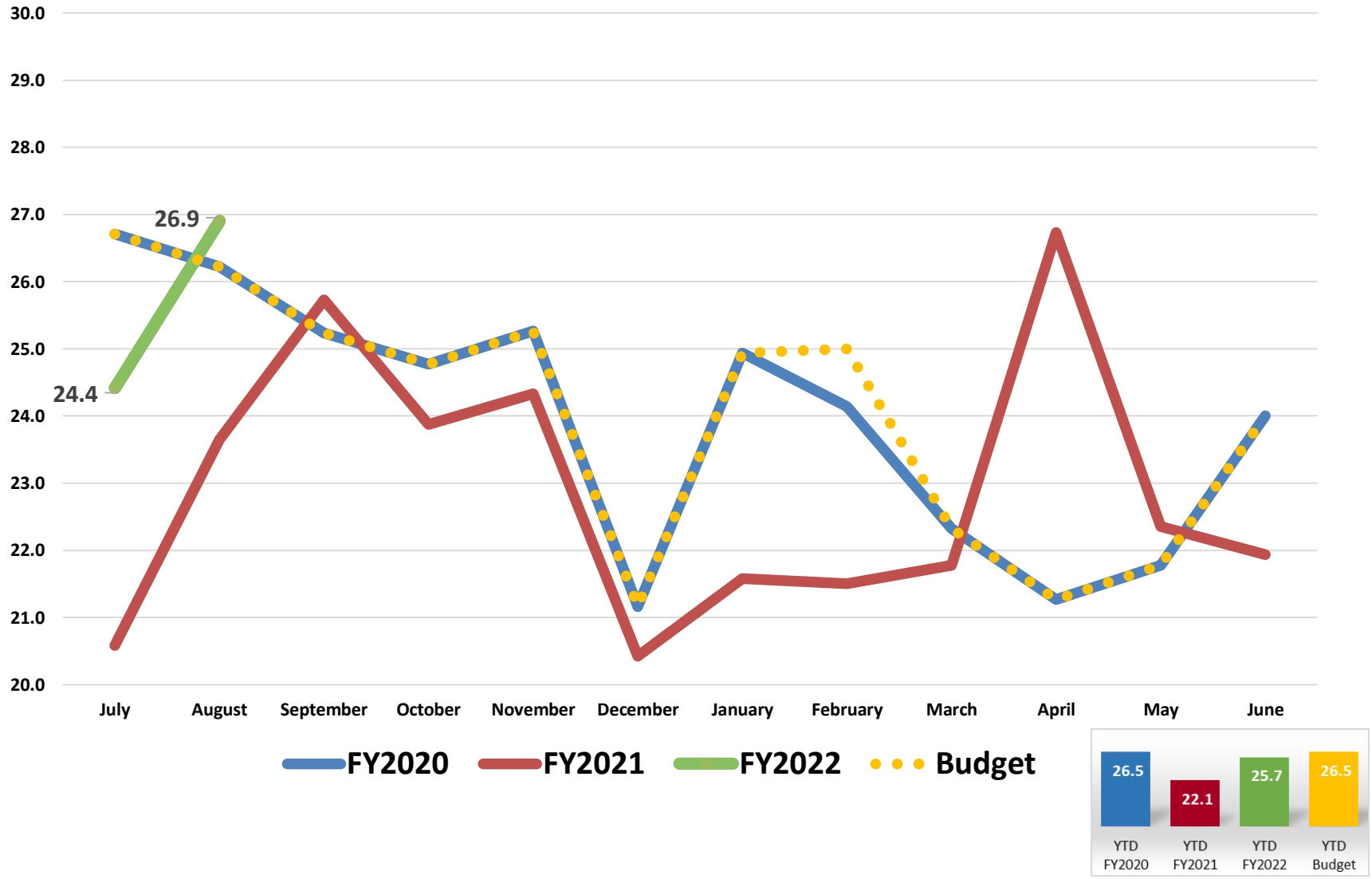




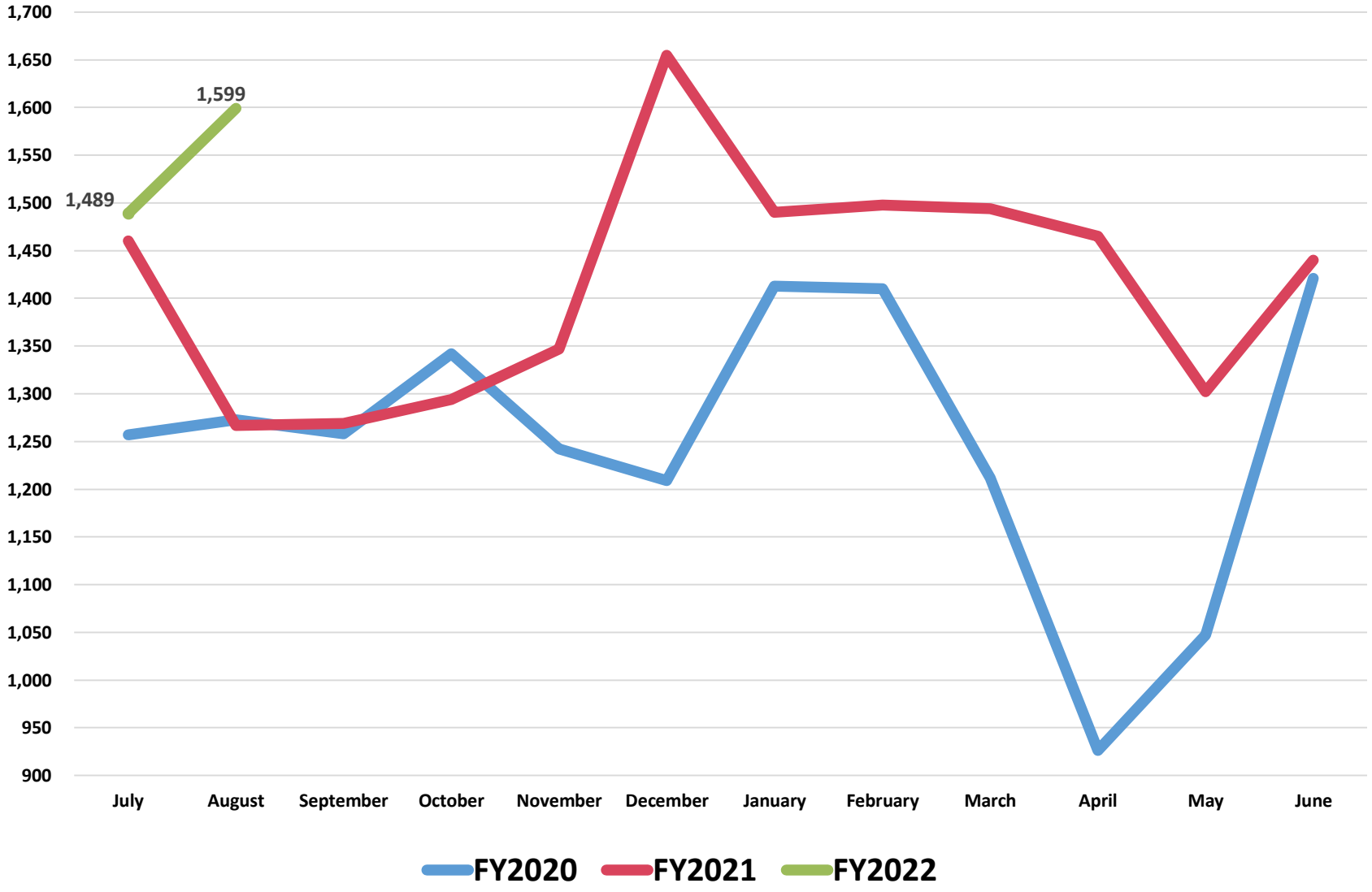
Nursery - Avg. Patients Per Day



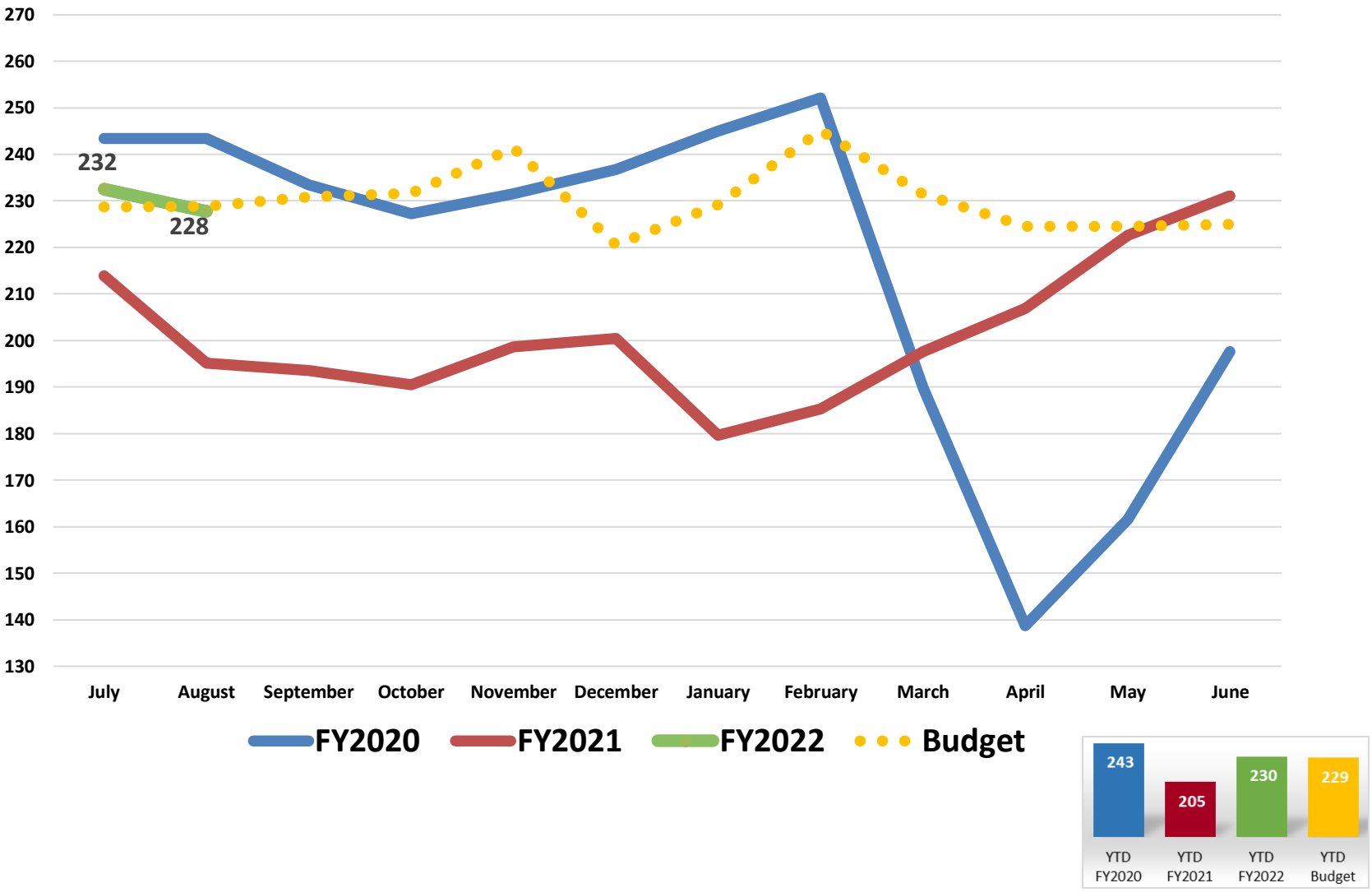
Obstetrics - Avg. Patients Per Day



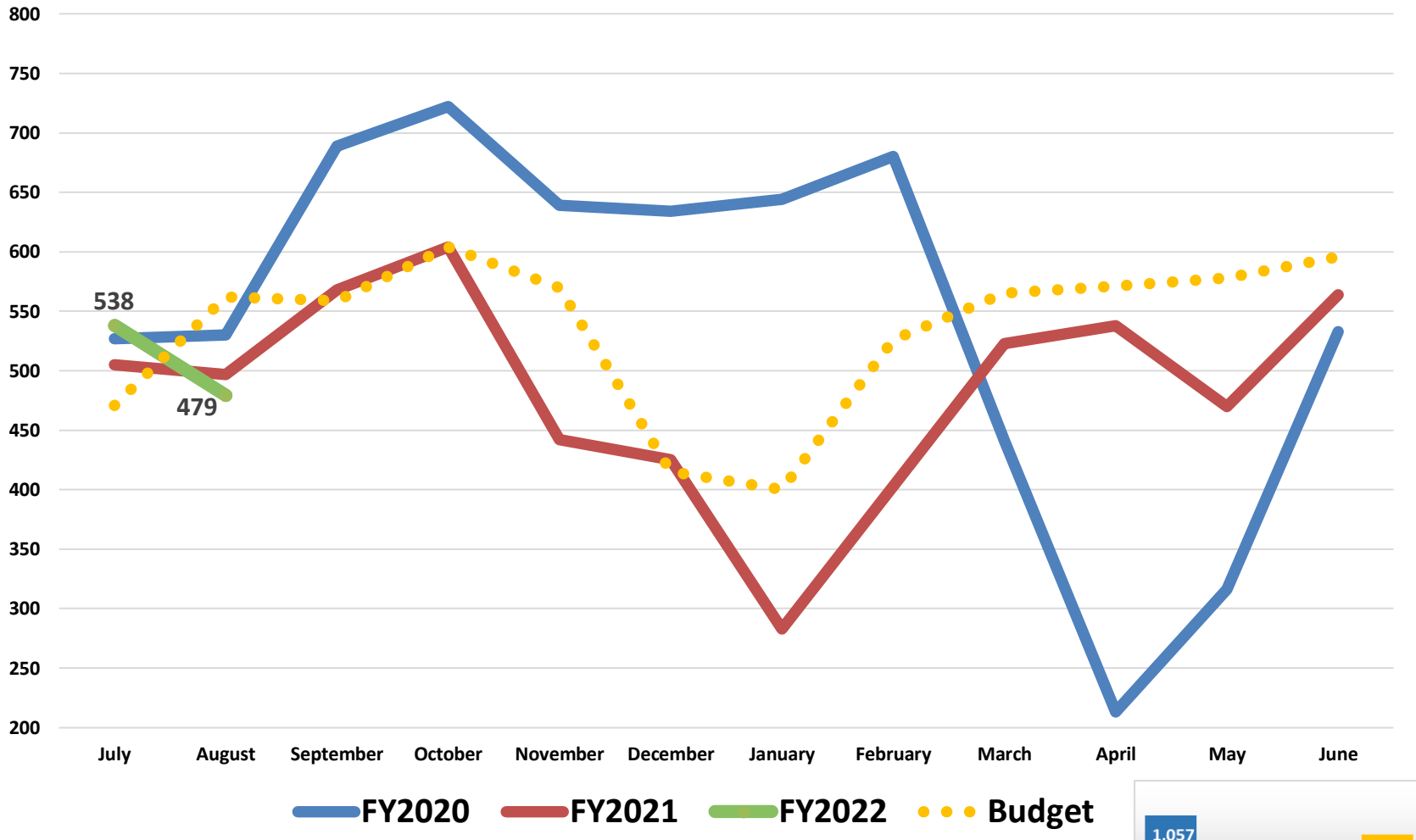
Outpatient Registrations per Day

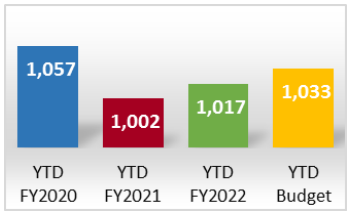


Emergency Dept – Avg Treated Per Day

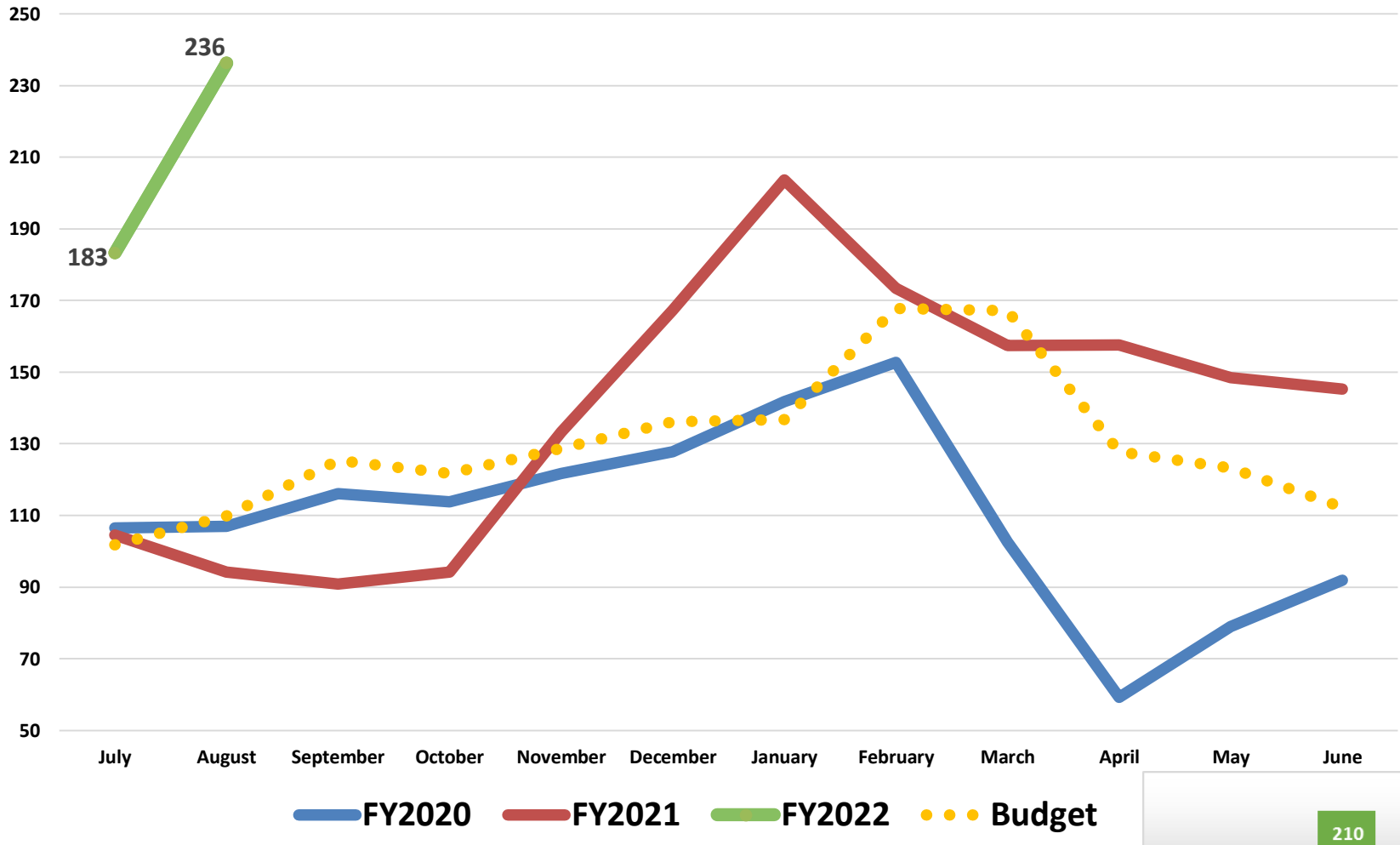


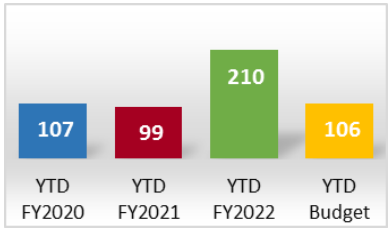
Endoscopy Procedures



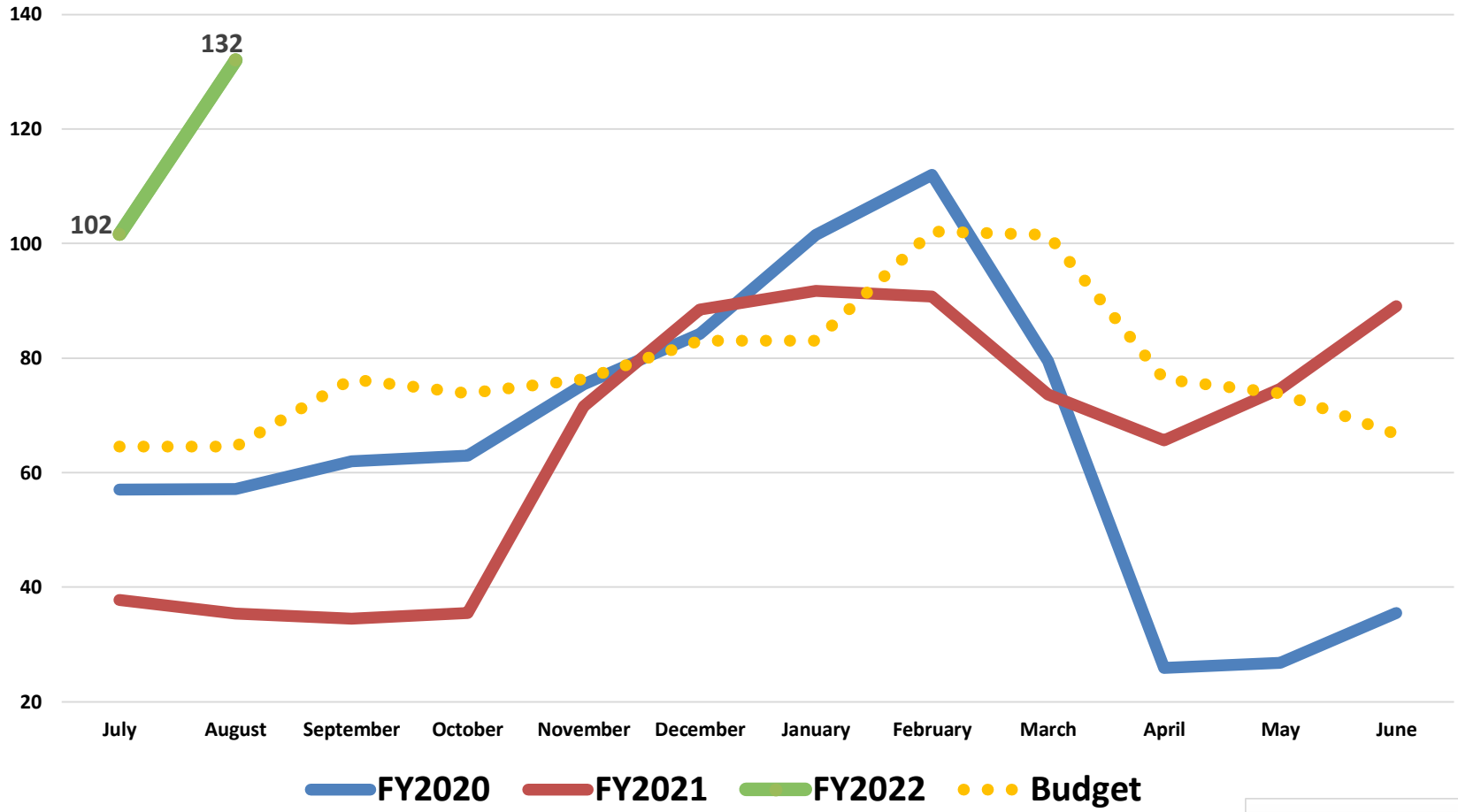


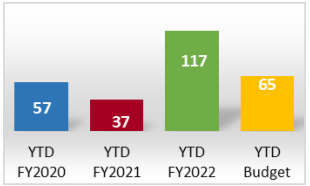
Urgent Care – Court Average Visits Per Day



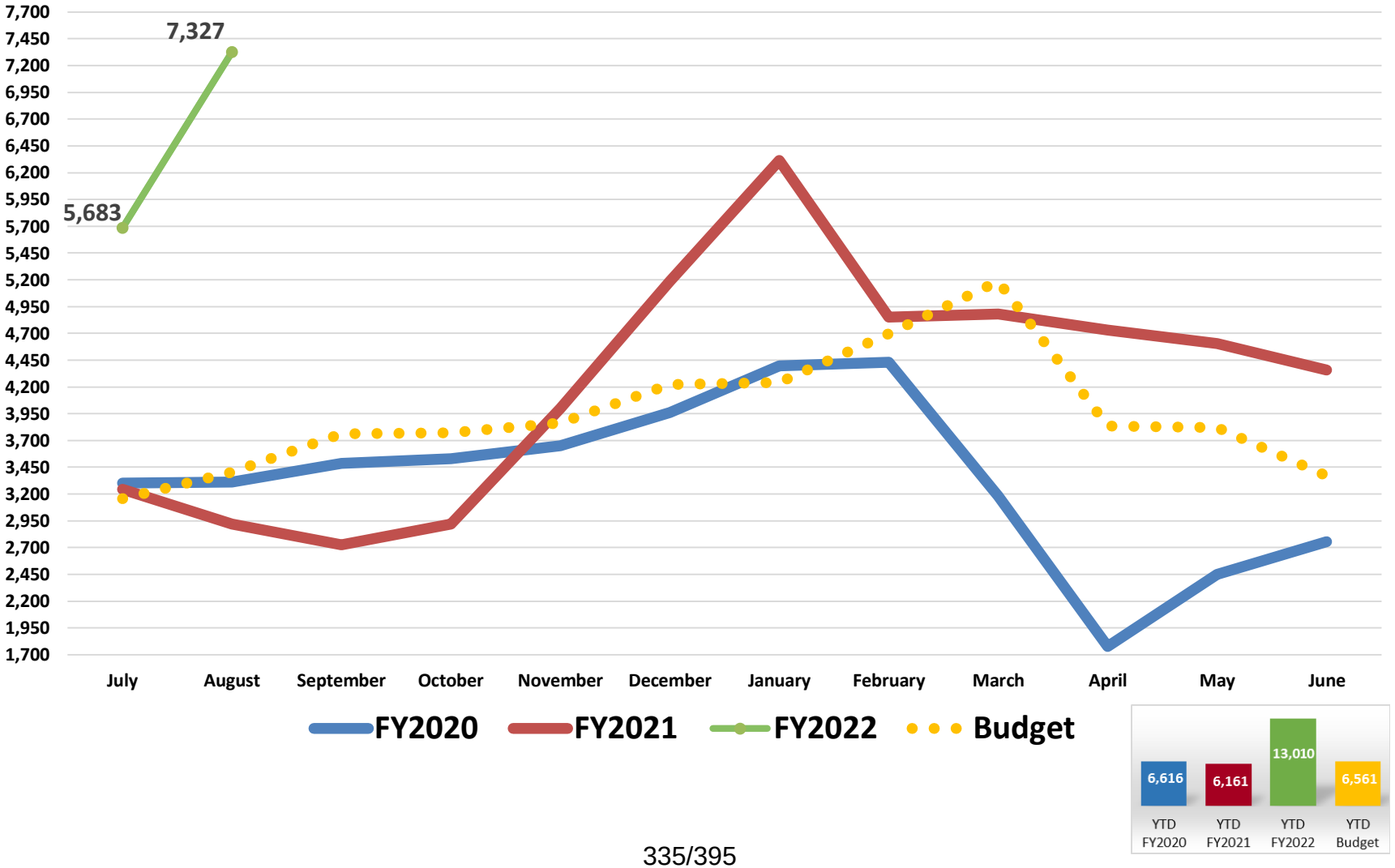


Urgent Care – Demaree Average Visits Per Day

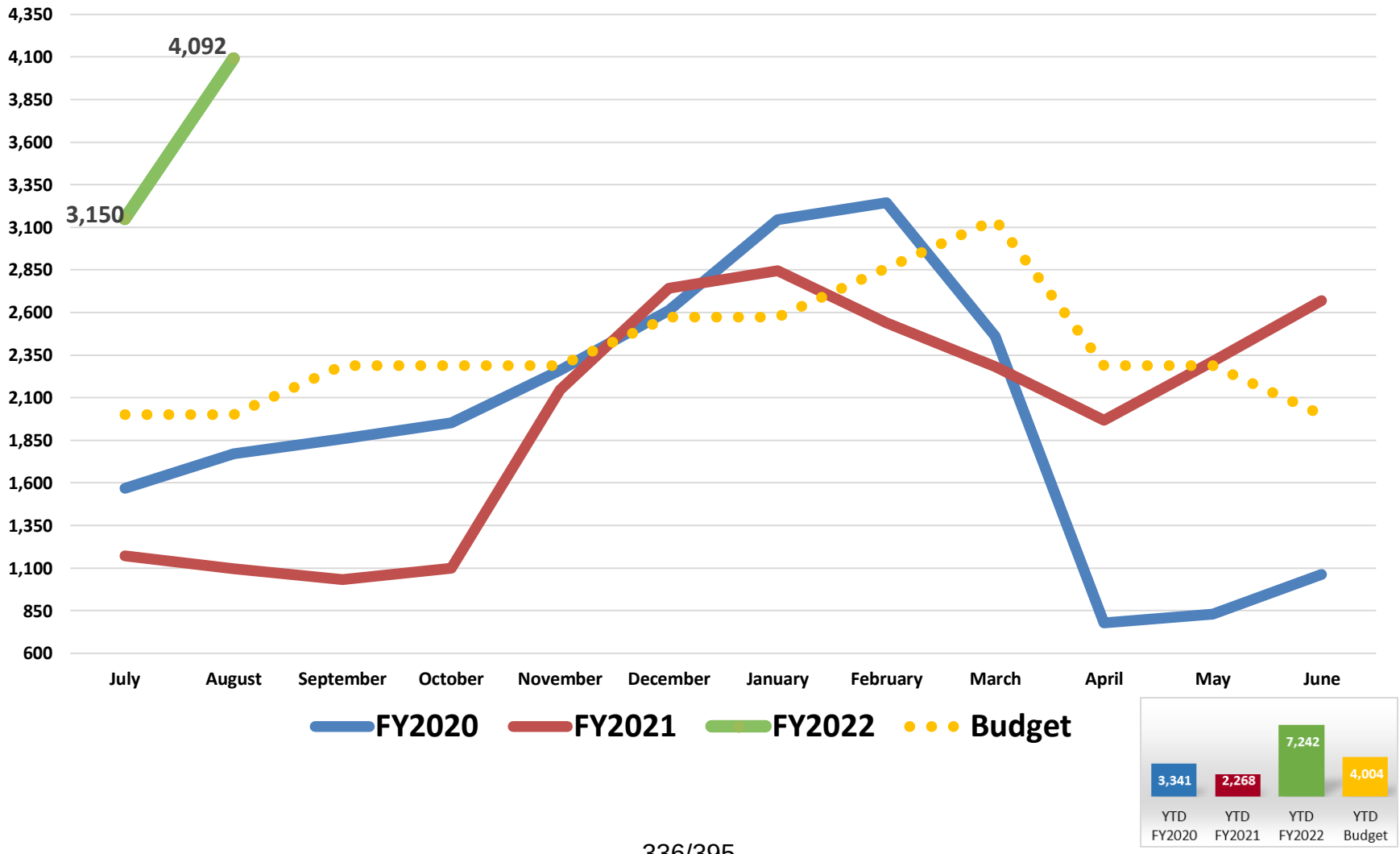




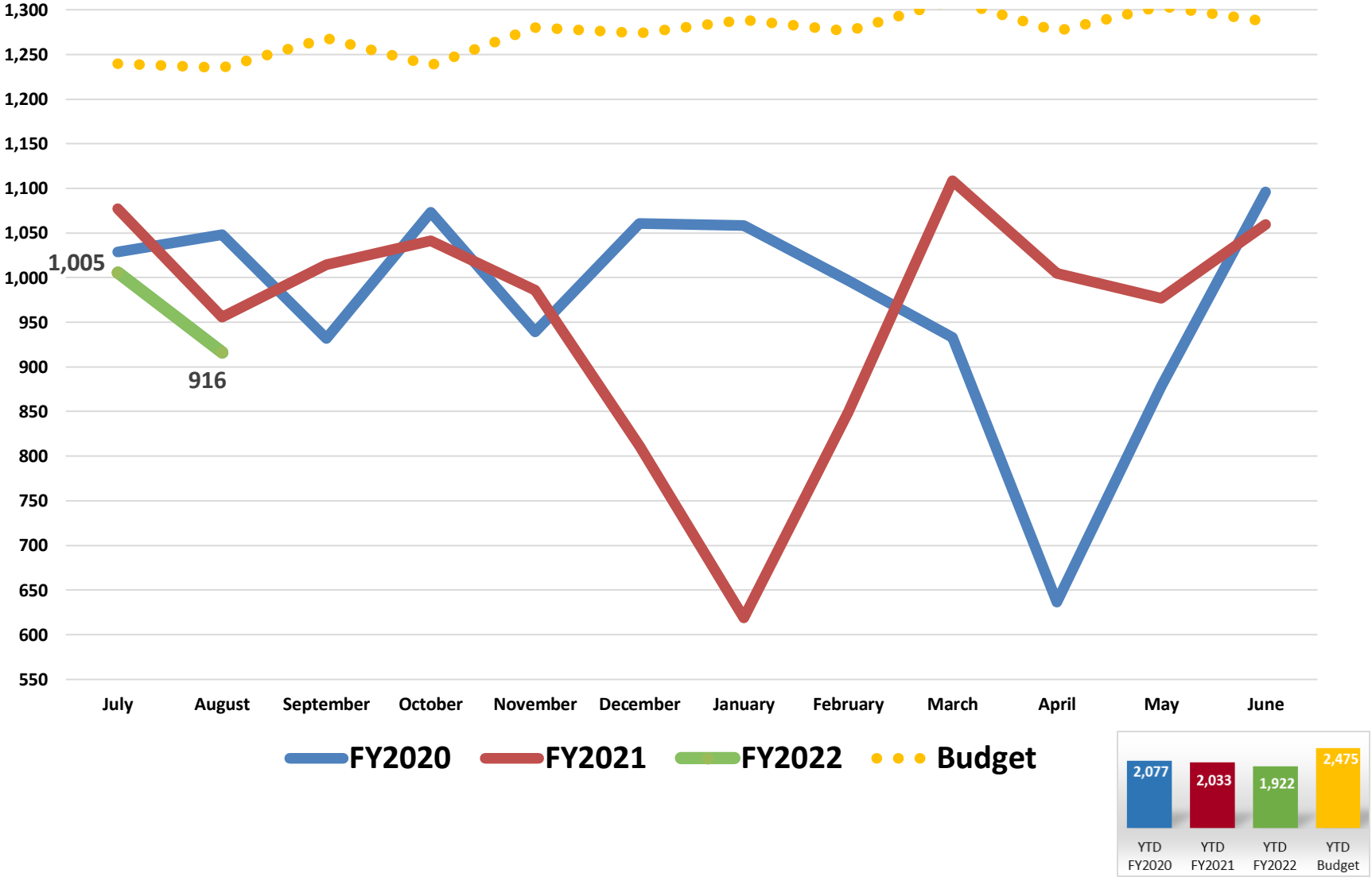
Urgent Care – Court Total Visits



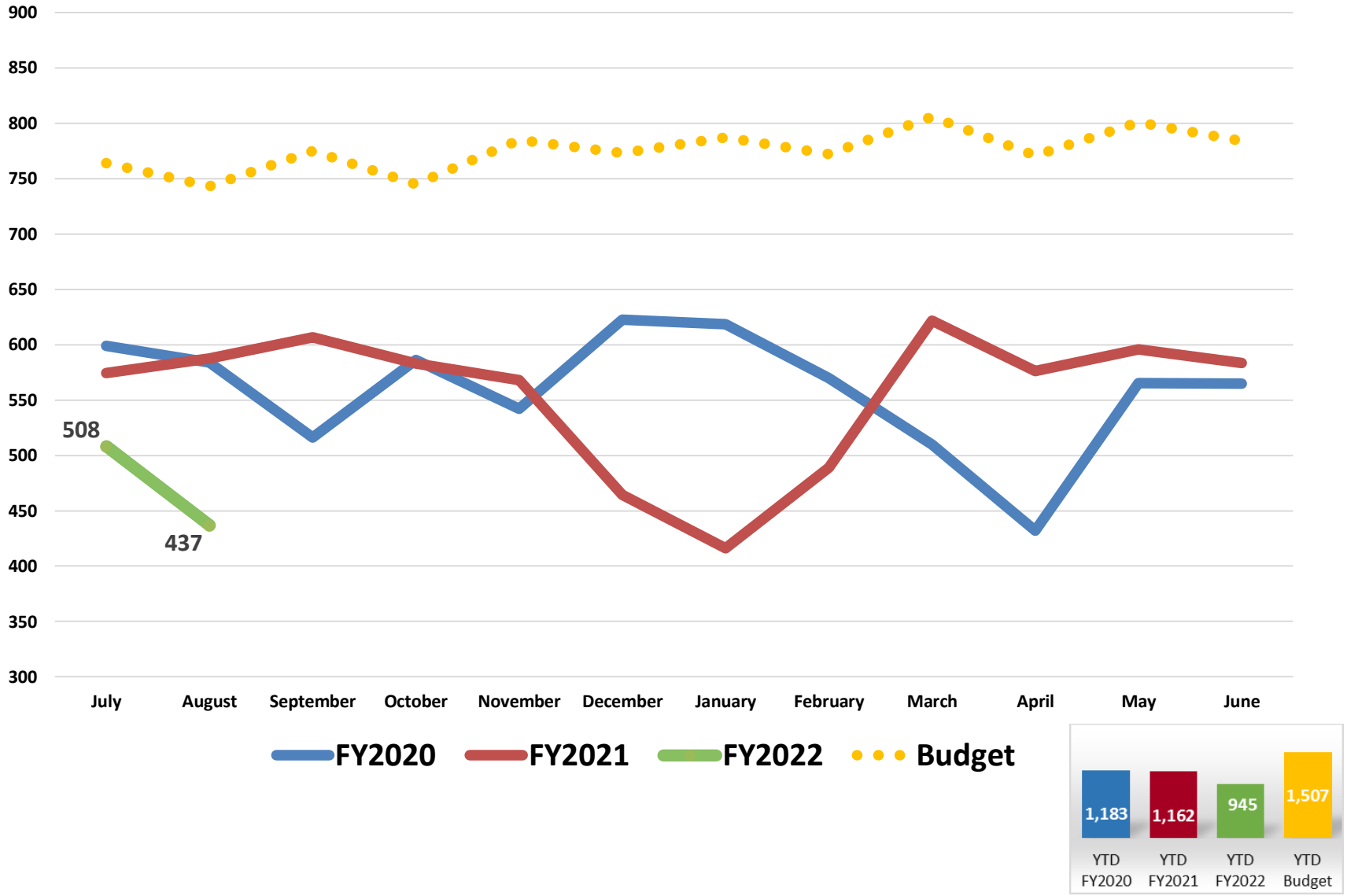
Urgent Care – Demaree Total Visits



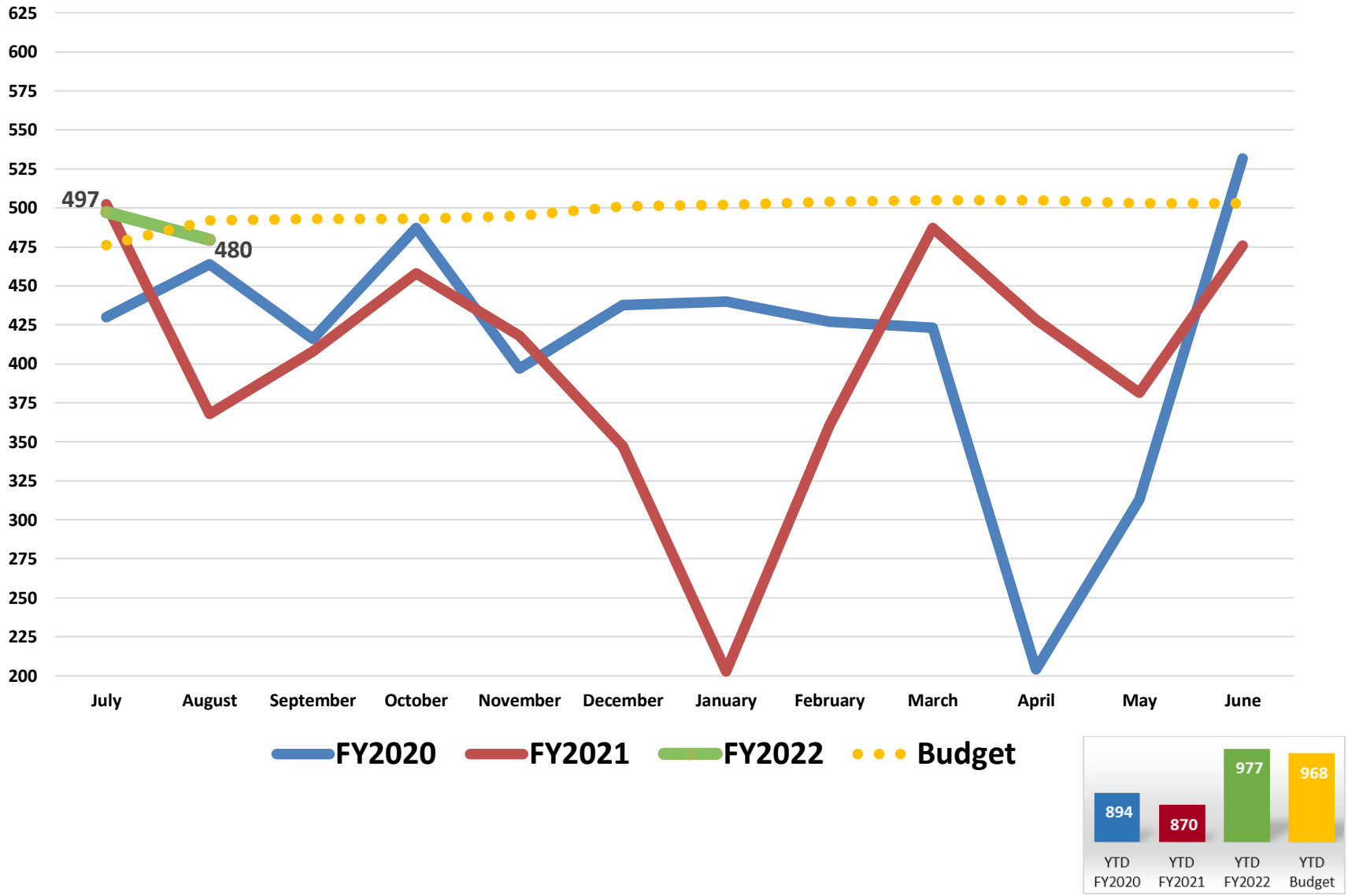
Surgery (IP & OP) – 100 Min Units



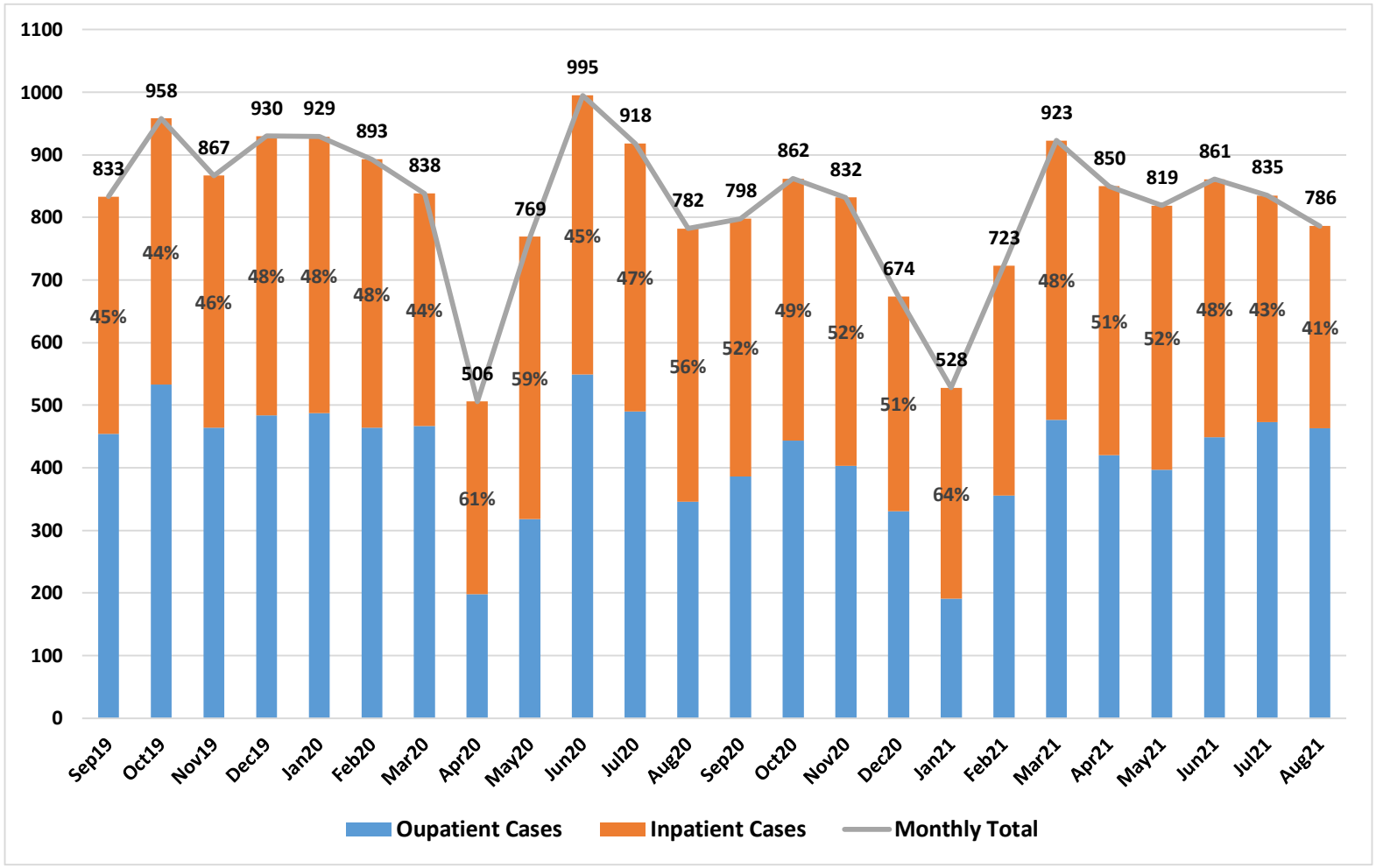
Surgery (IP Only) – 100 Min Units



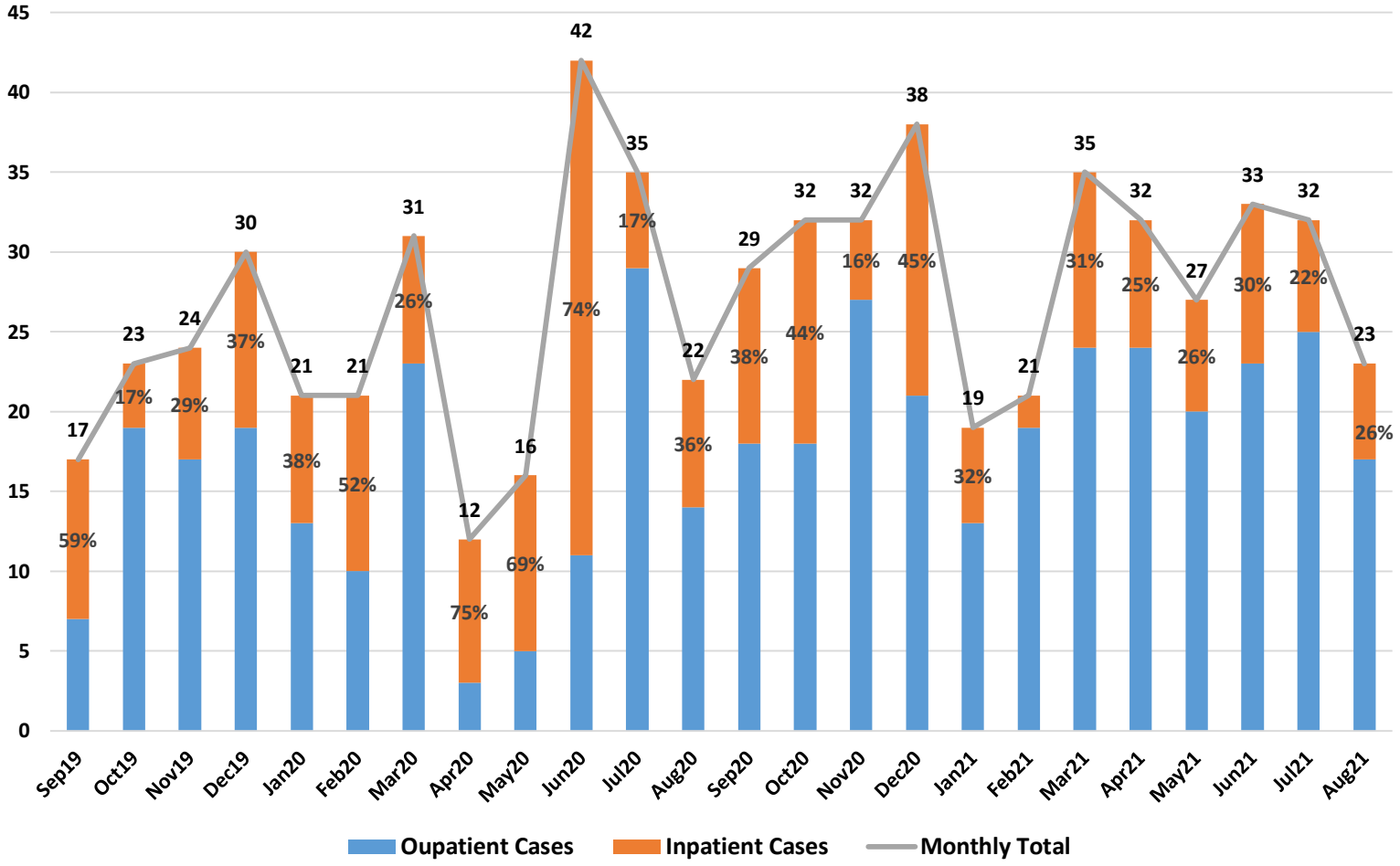
Surgery (OP Only) – 100 Min Units



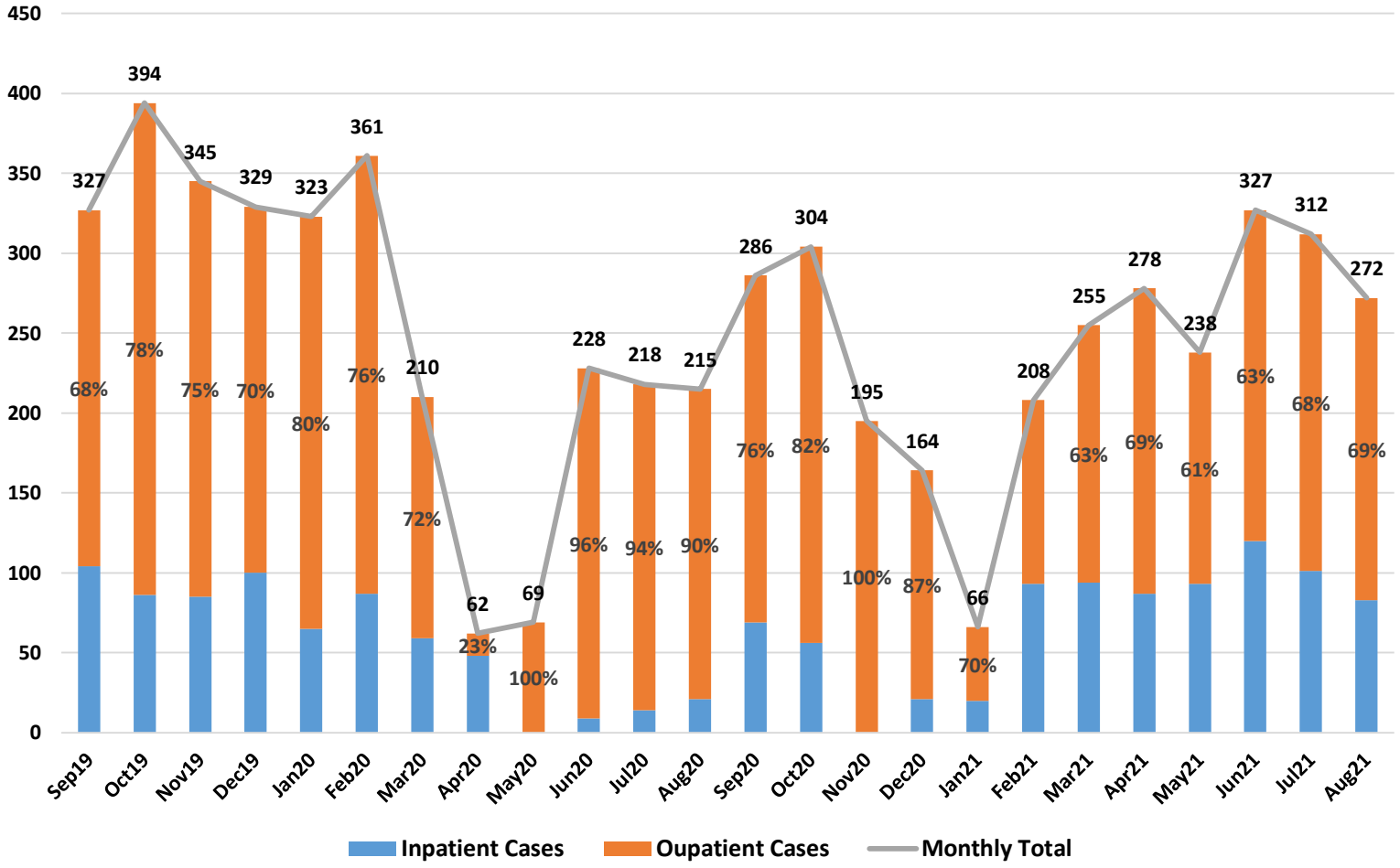
Surgery Cases



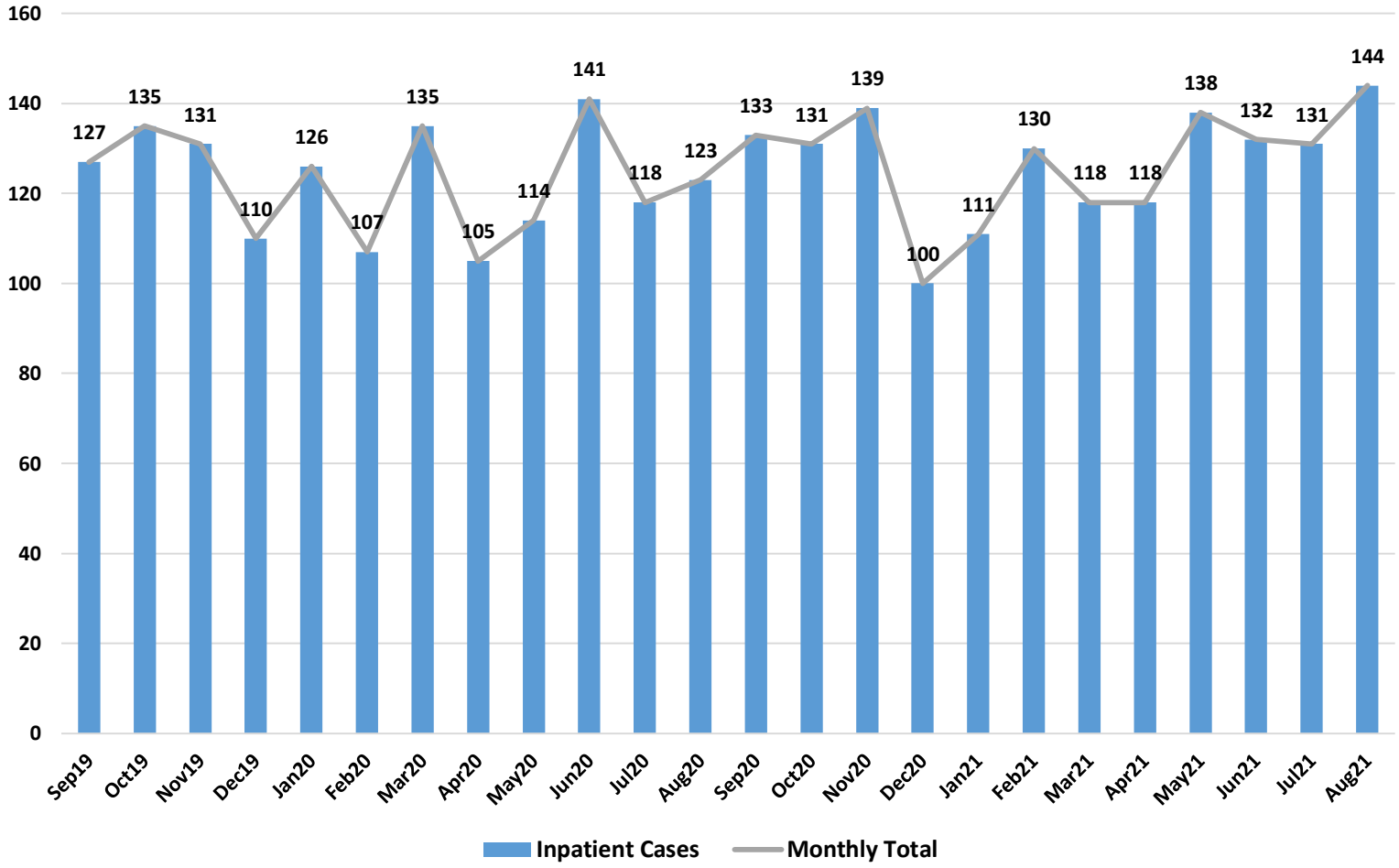
Robotic Cases



Endo Cases (Endo Suites)



OB Cases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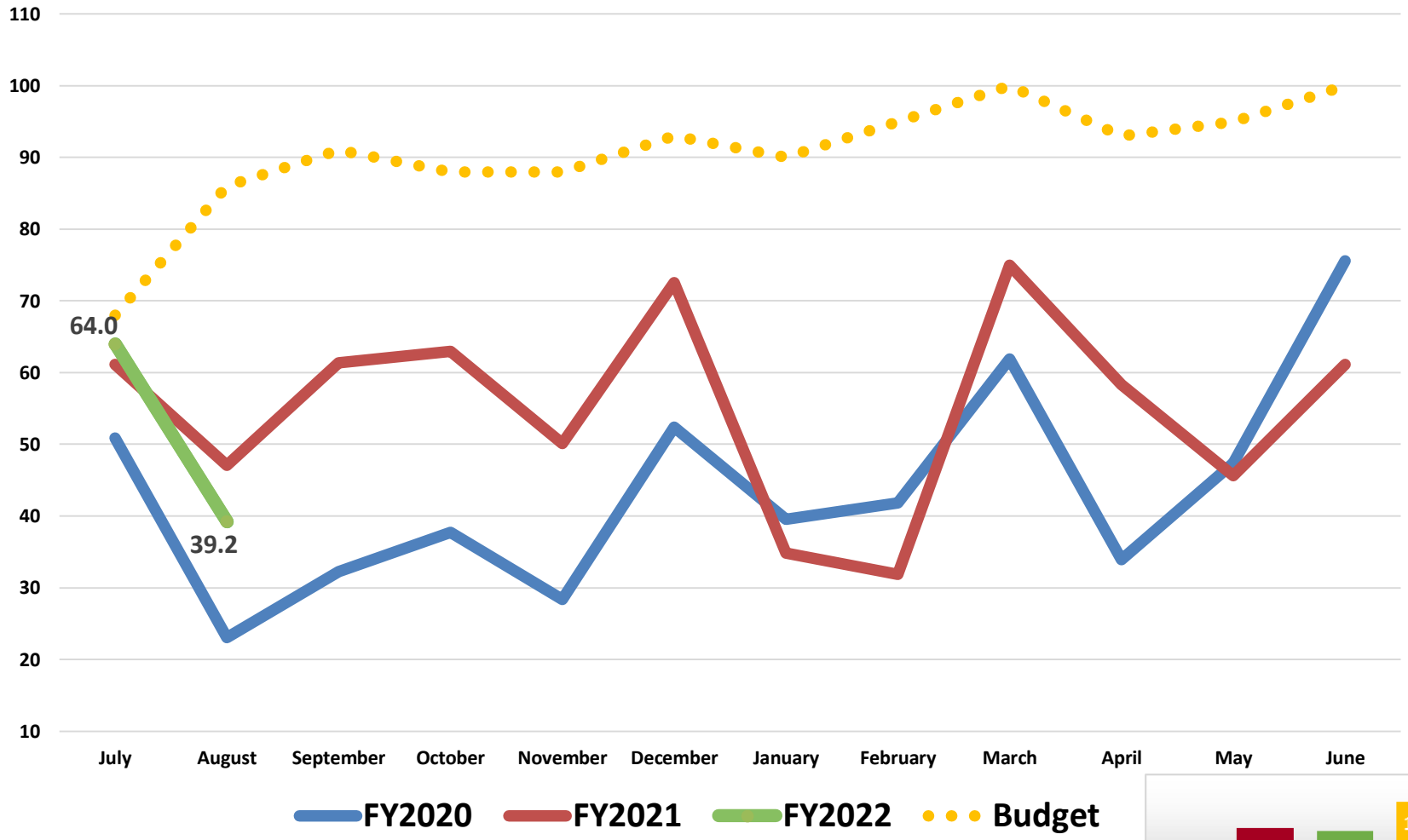
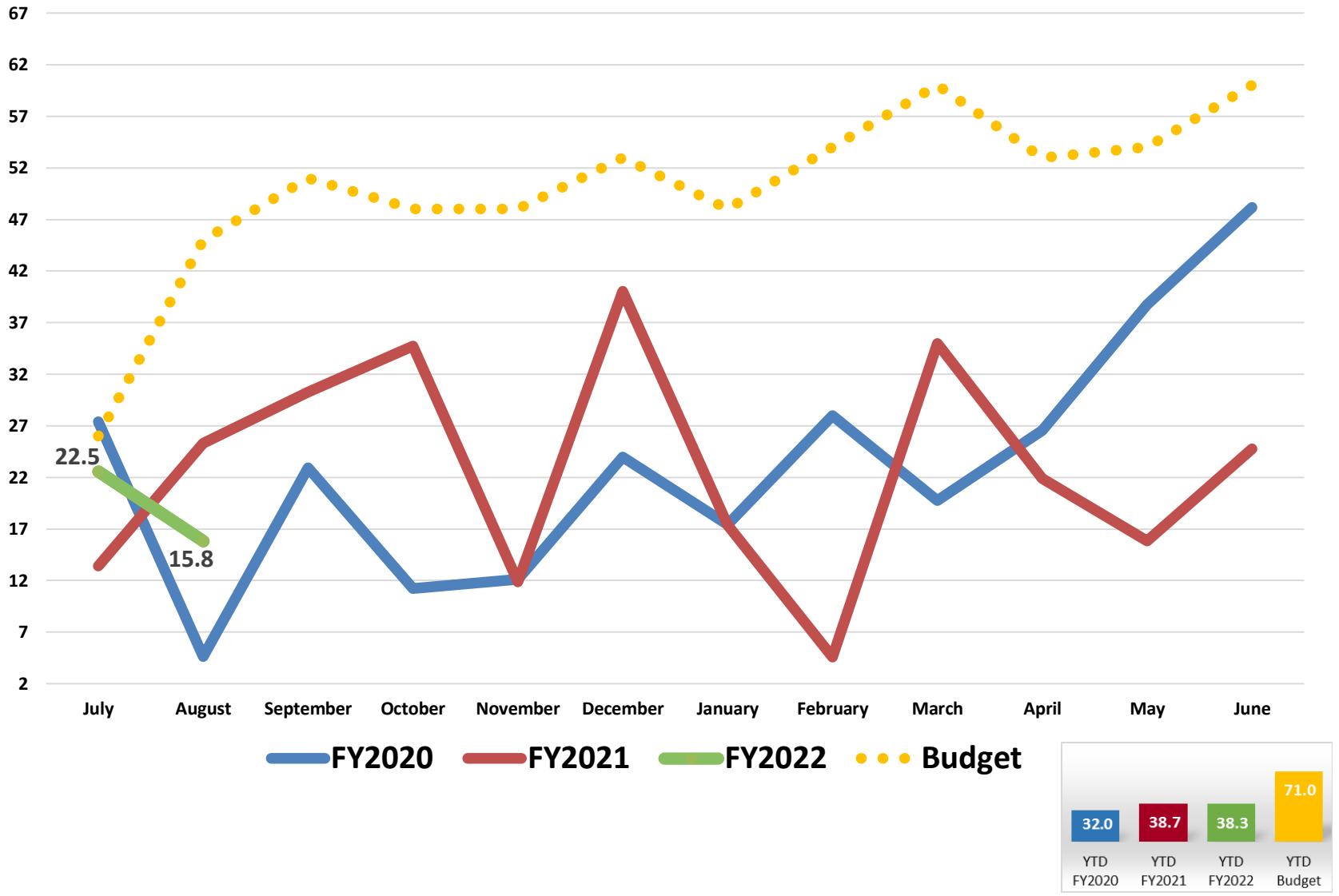
May21
Jun21
Jul21
Aug21
Inpatient Cases
Monthly Total

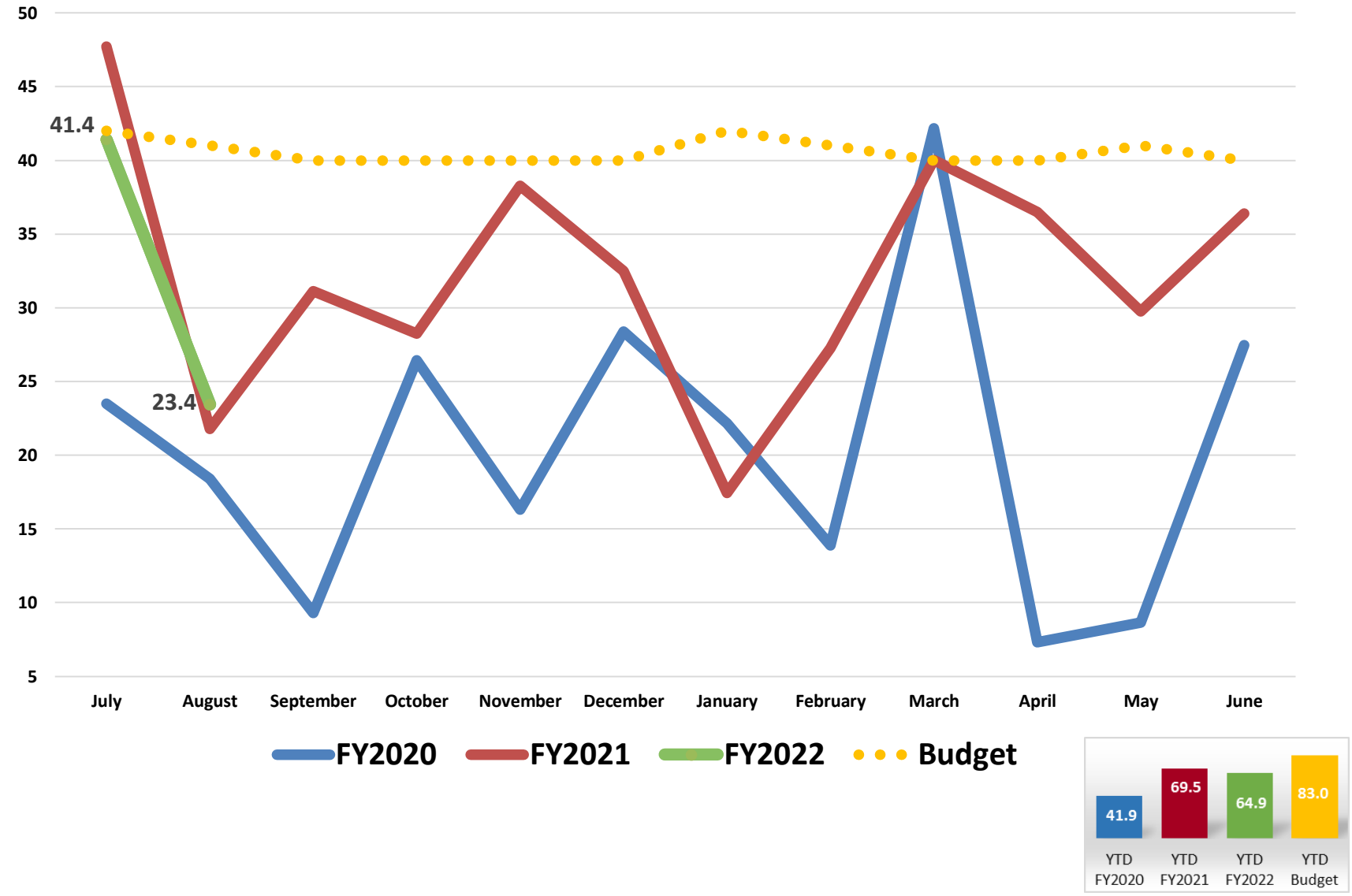
Robotic Surgery (IP & OP) – 100 Min Units



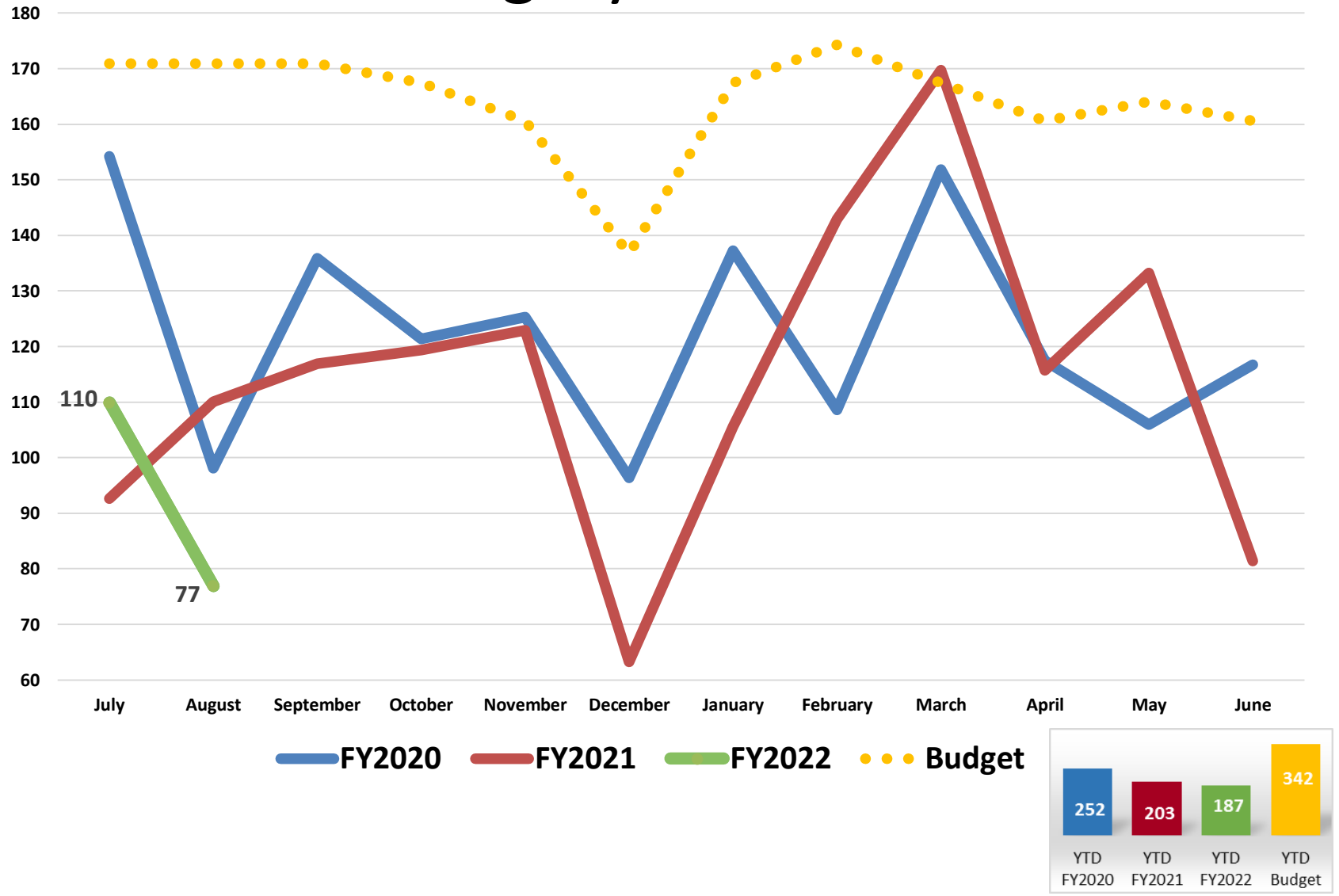
Robotic Surgery (IP Only) – 100 Min Units



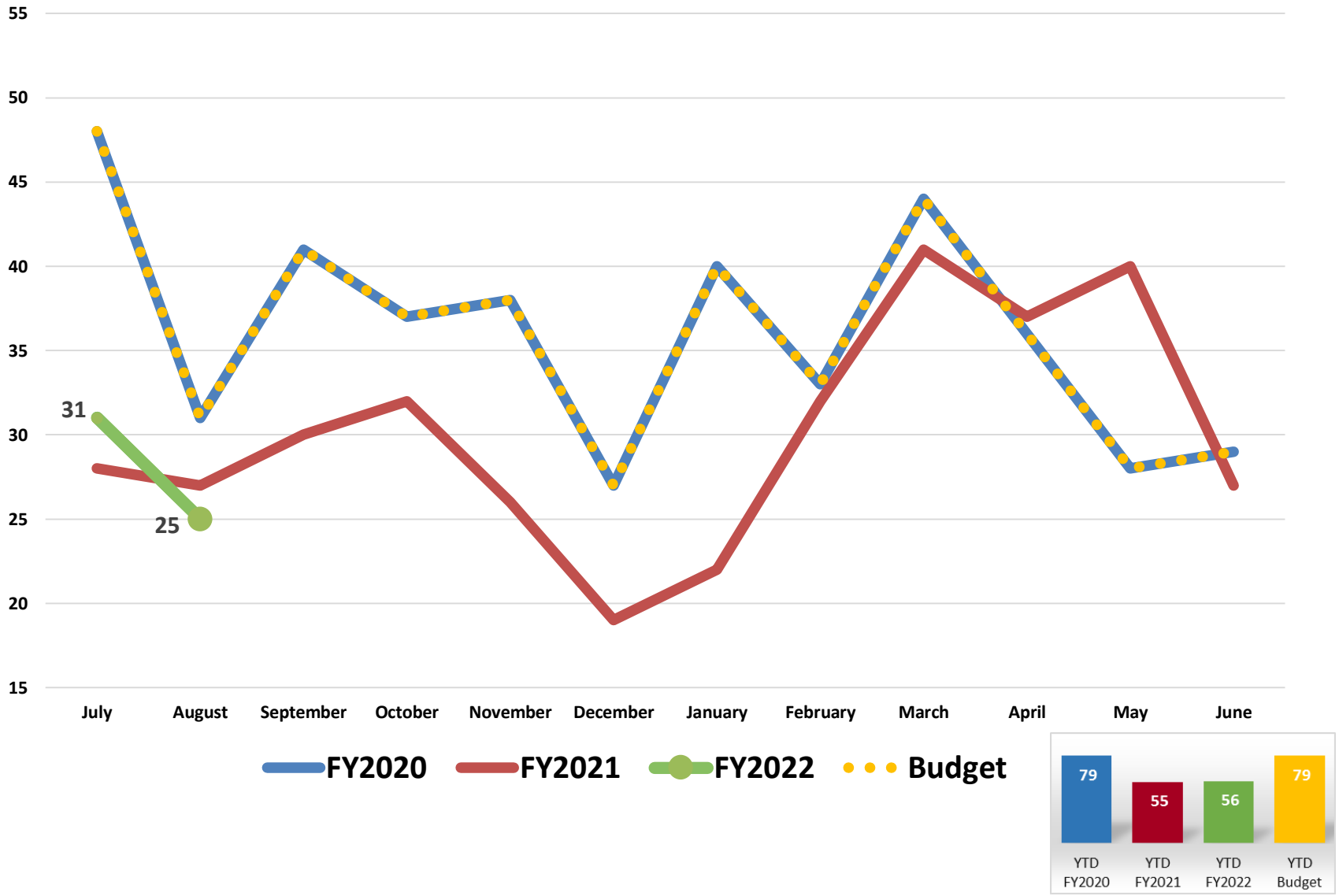
Robotic Surgery (OP Only) – 100 Min Units



Cardiac Surgery – 100 Min Units

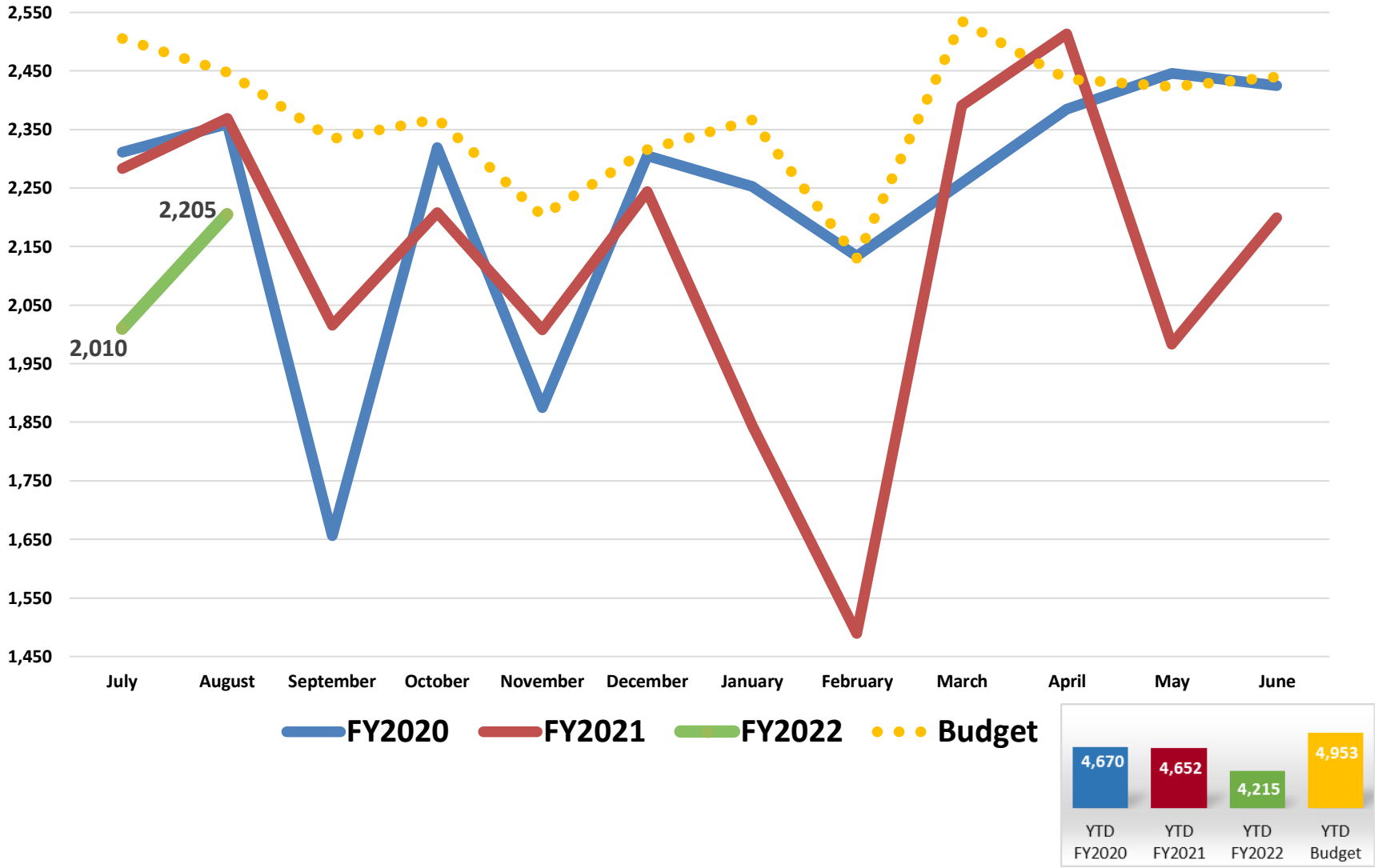


Cardiac Surgery – Cases

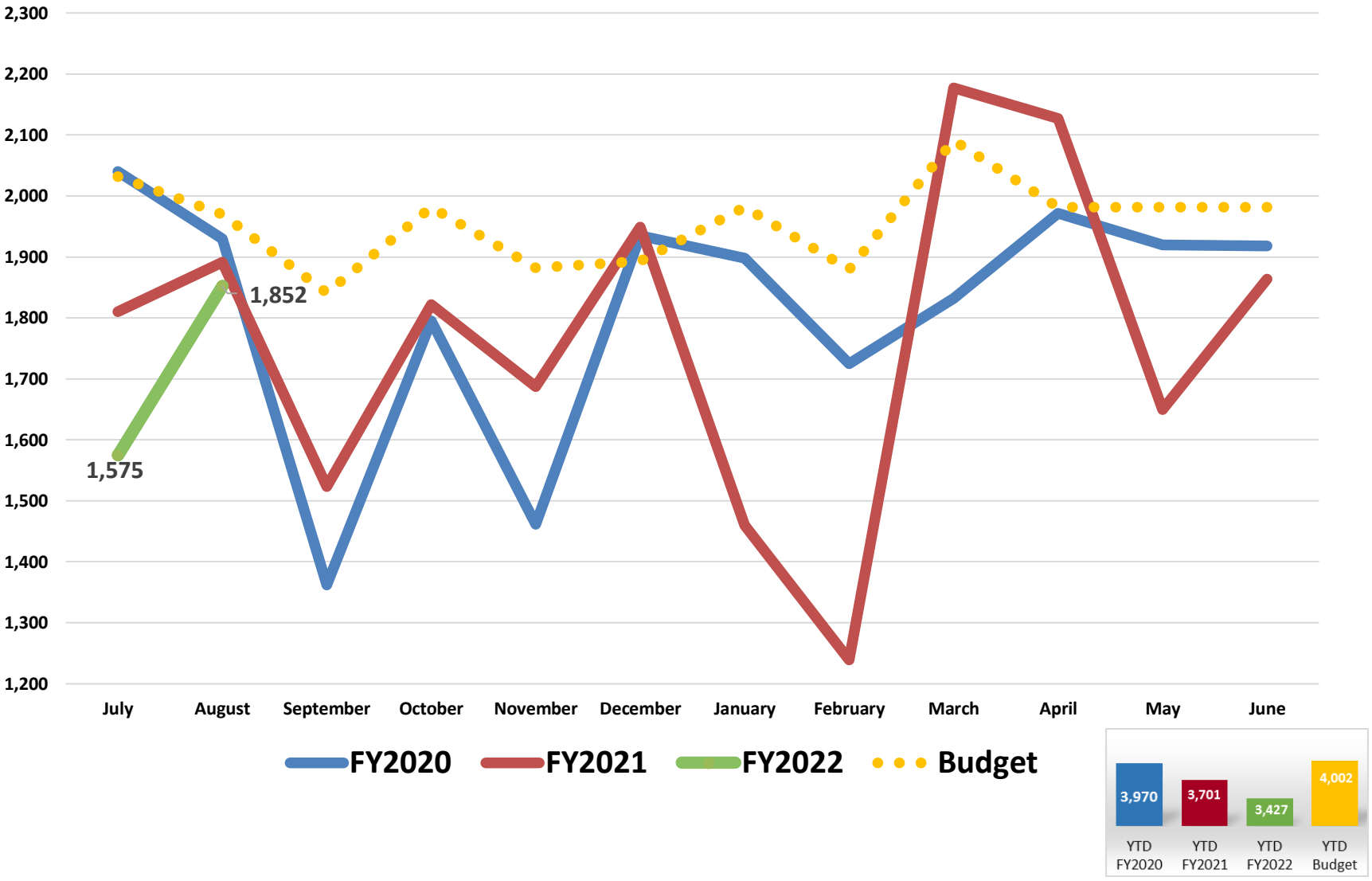


Radiation Oncology Treatments

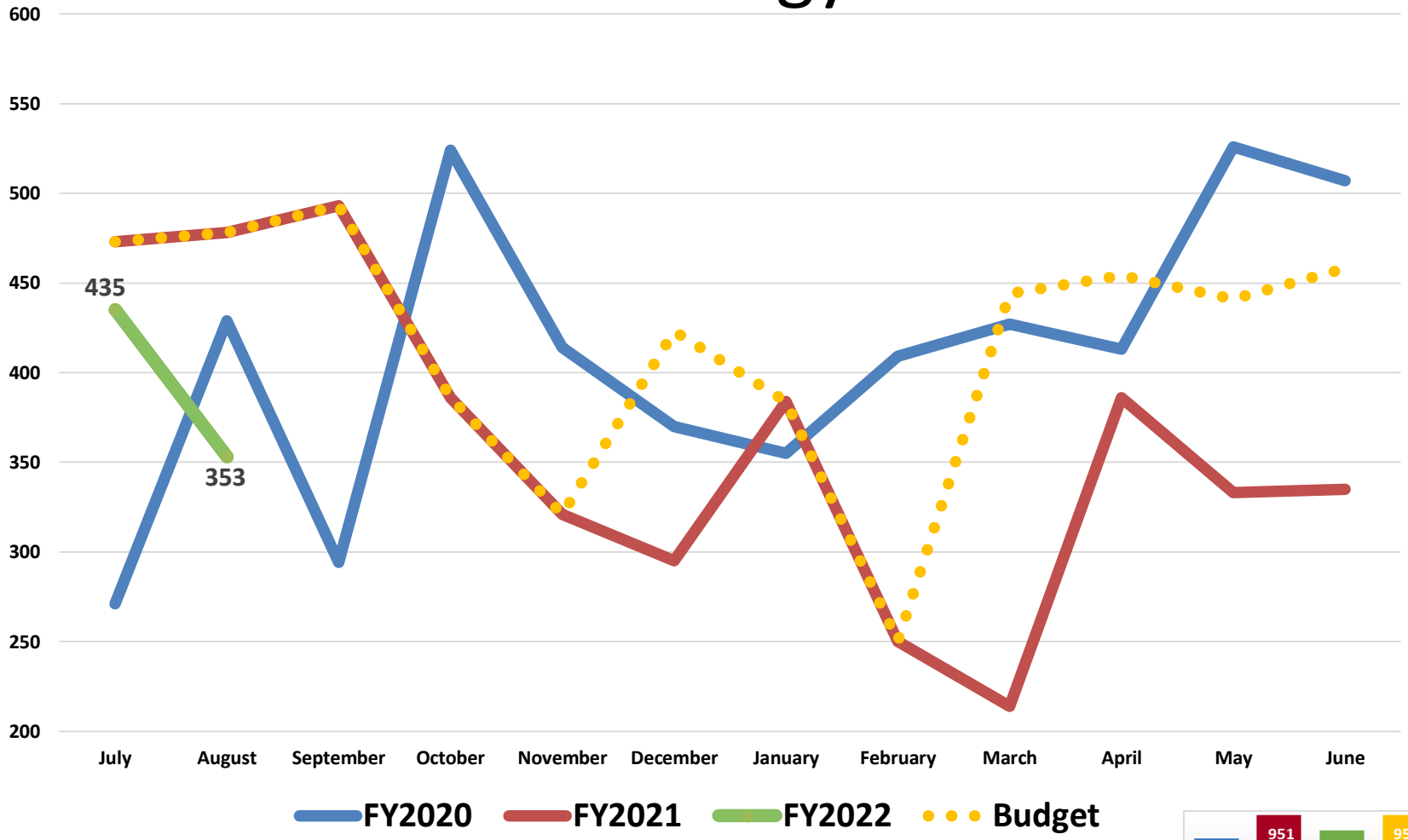
Hanford and Visalia

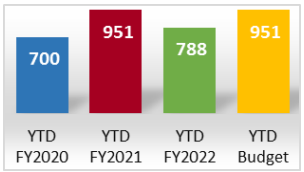


Radiation Oncology - Visalia

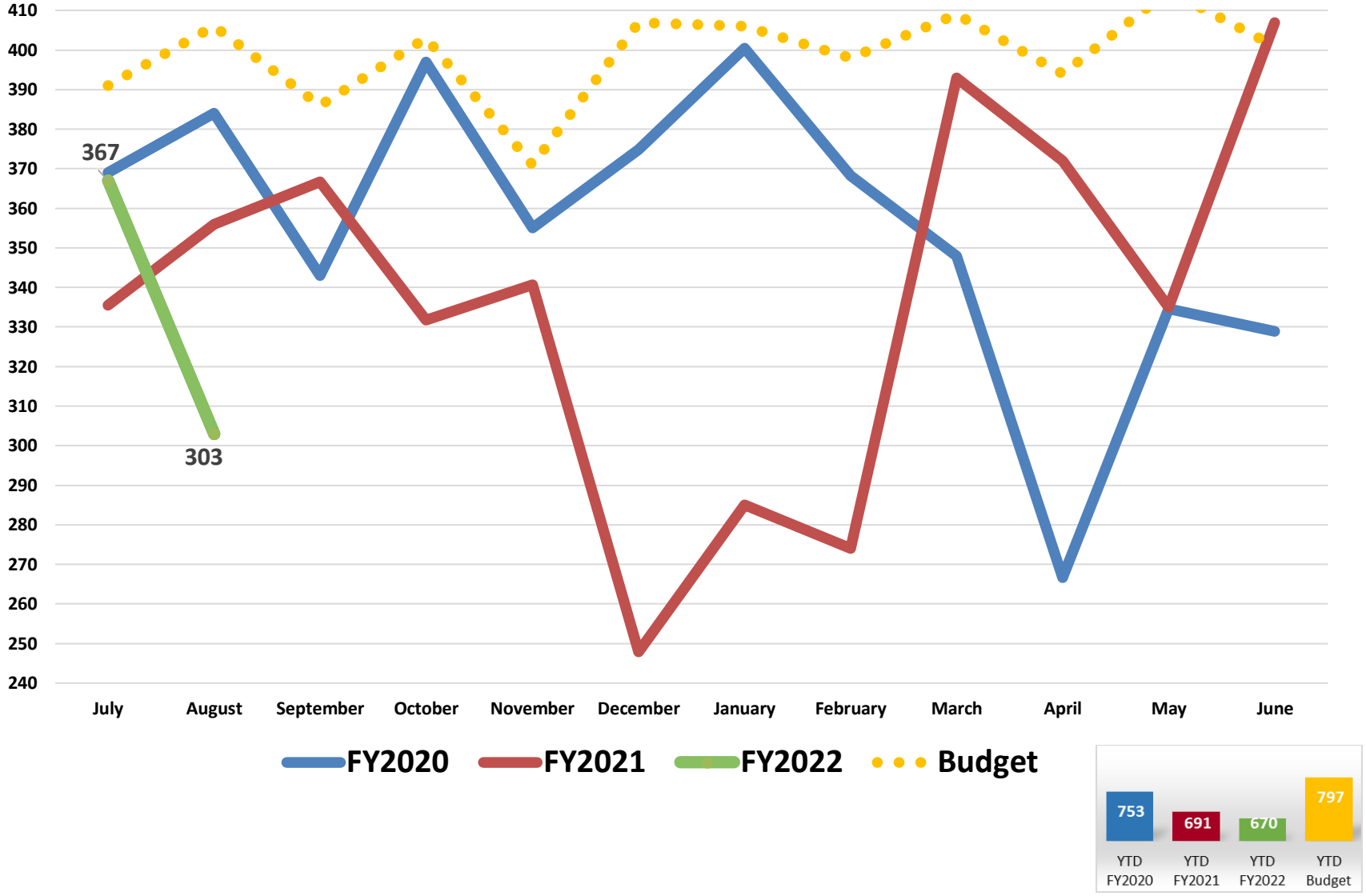


Radiation Oncology - Hanford

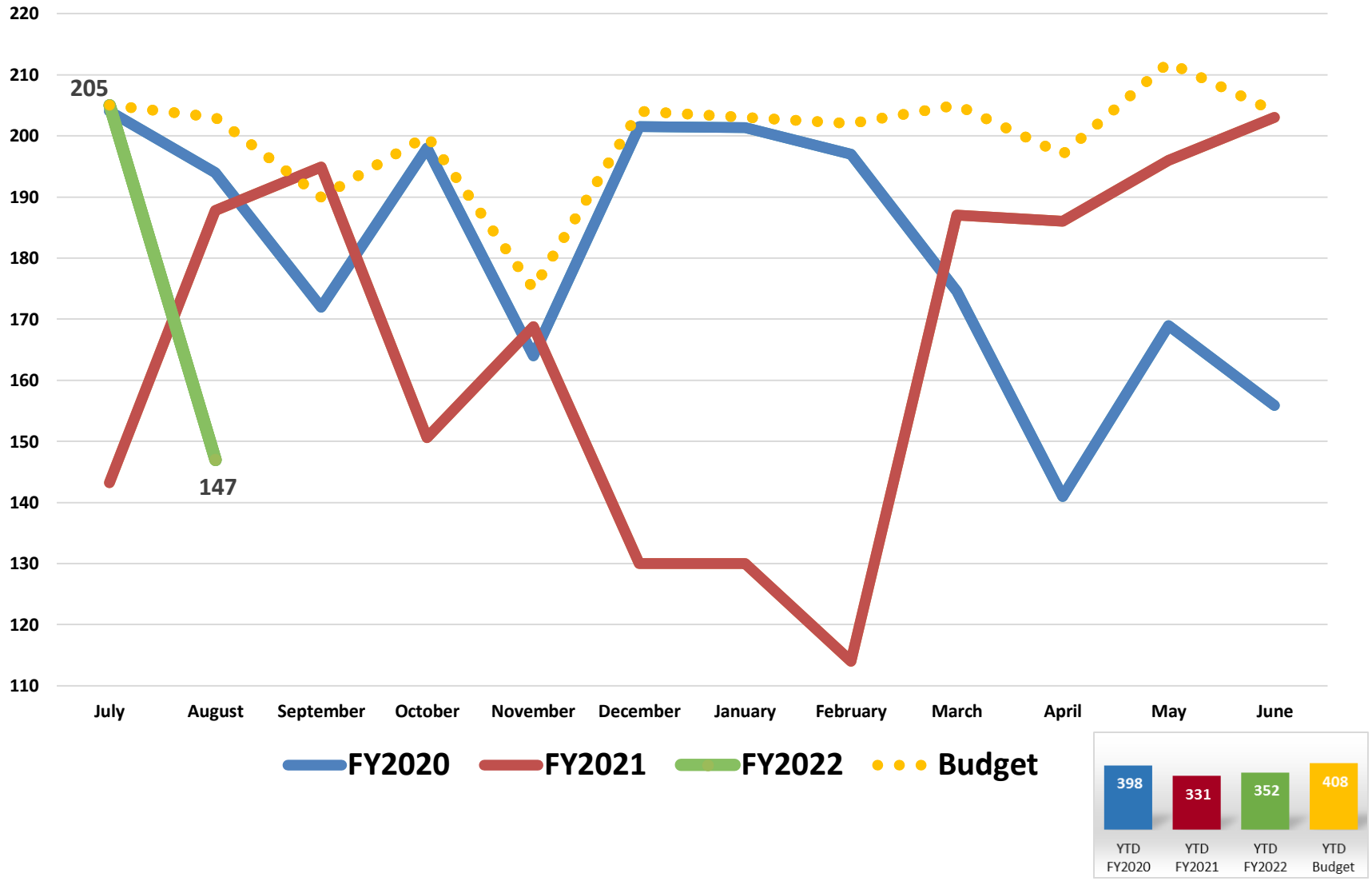




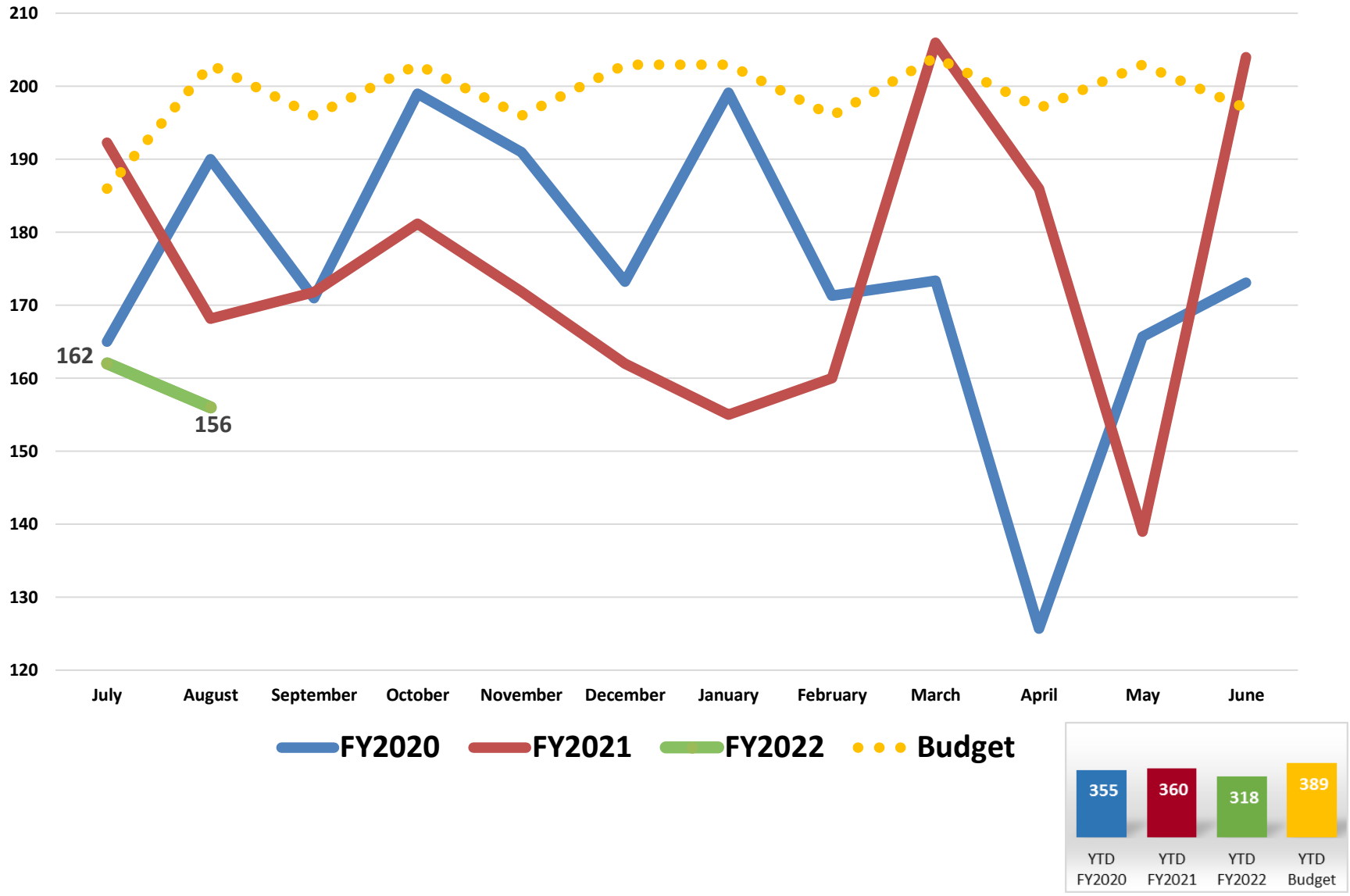
Cath Lab (IP & OP) – 100 Min Units



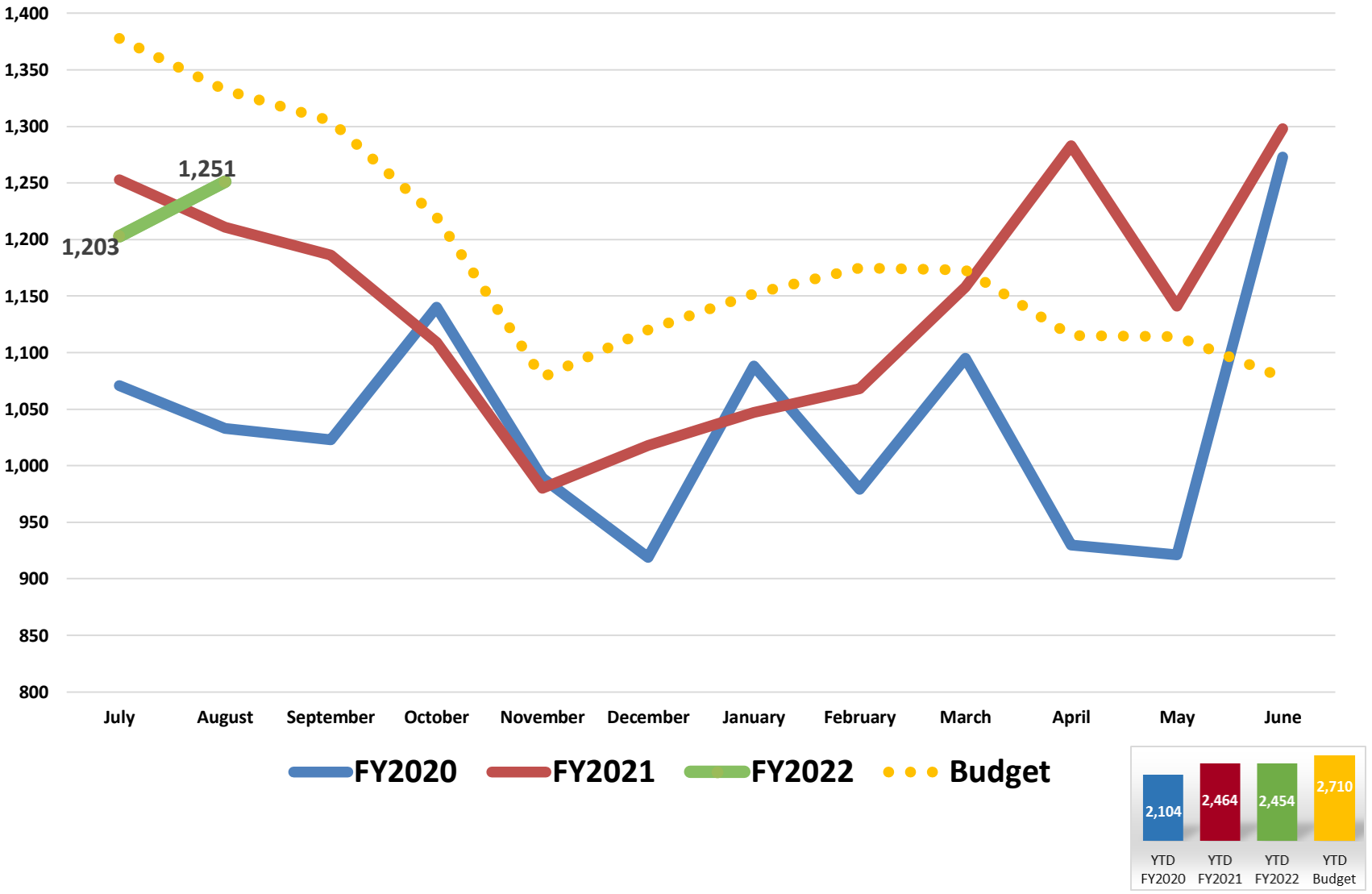
Cath Lab (IP Only) – 100 Min Units



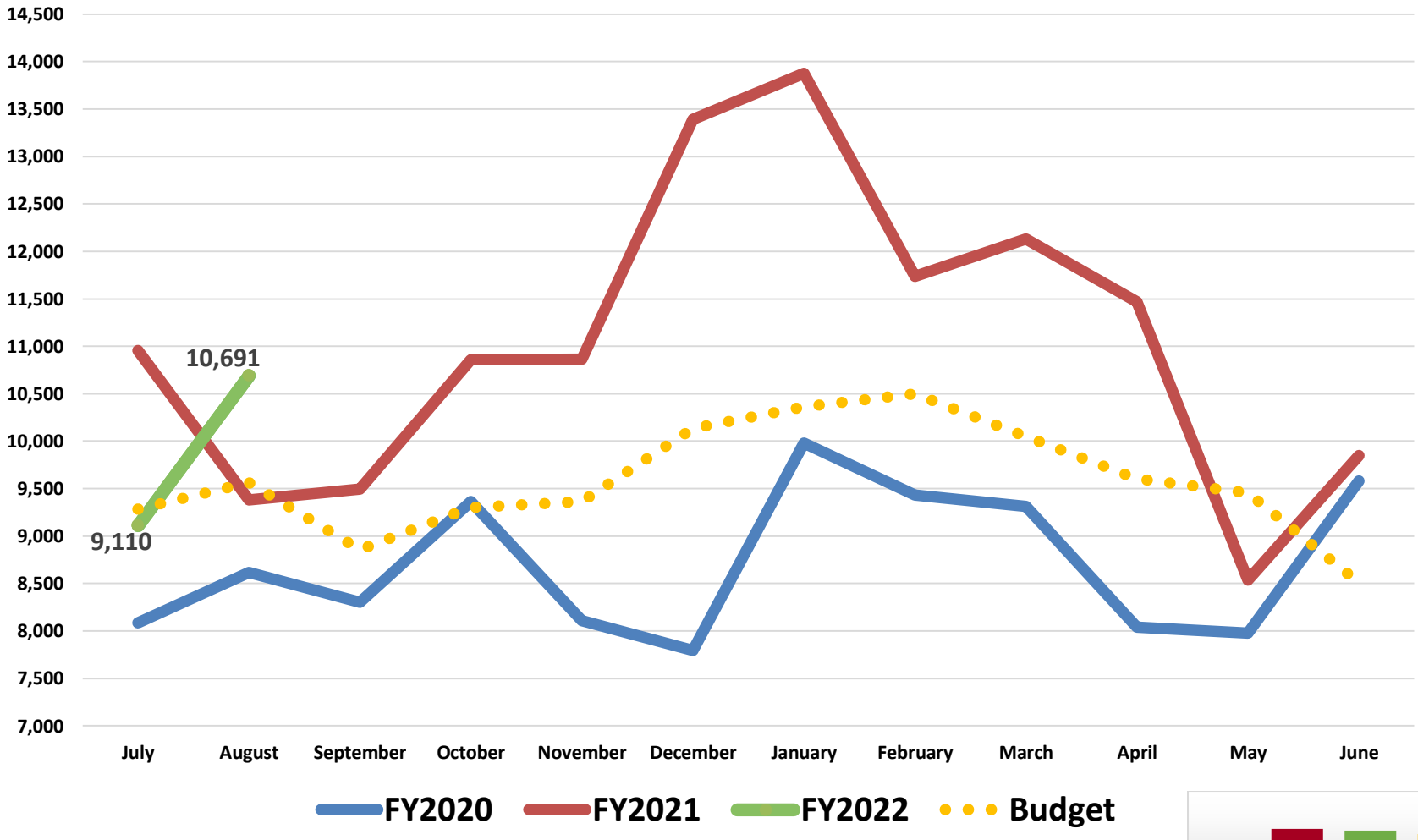
Cath Lab (OP Only) – 100 Min Units

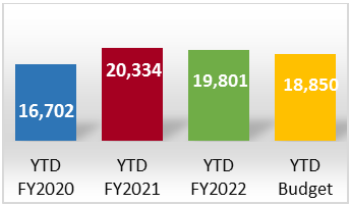


GME Family Medicine Clinic Visits

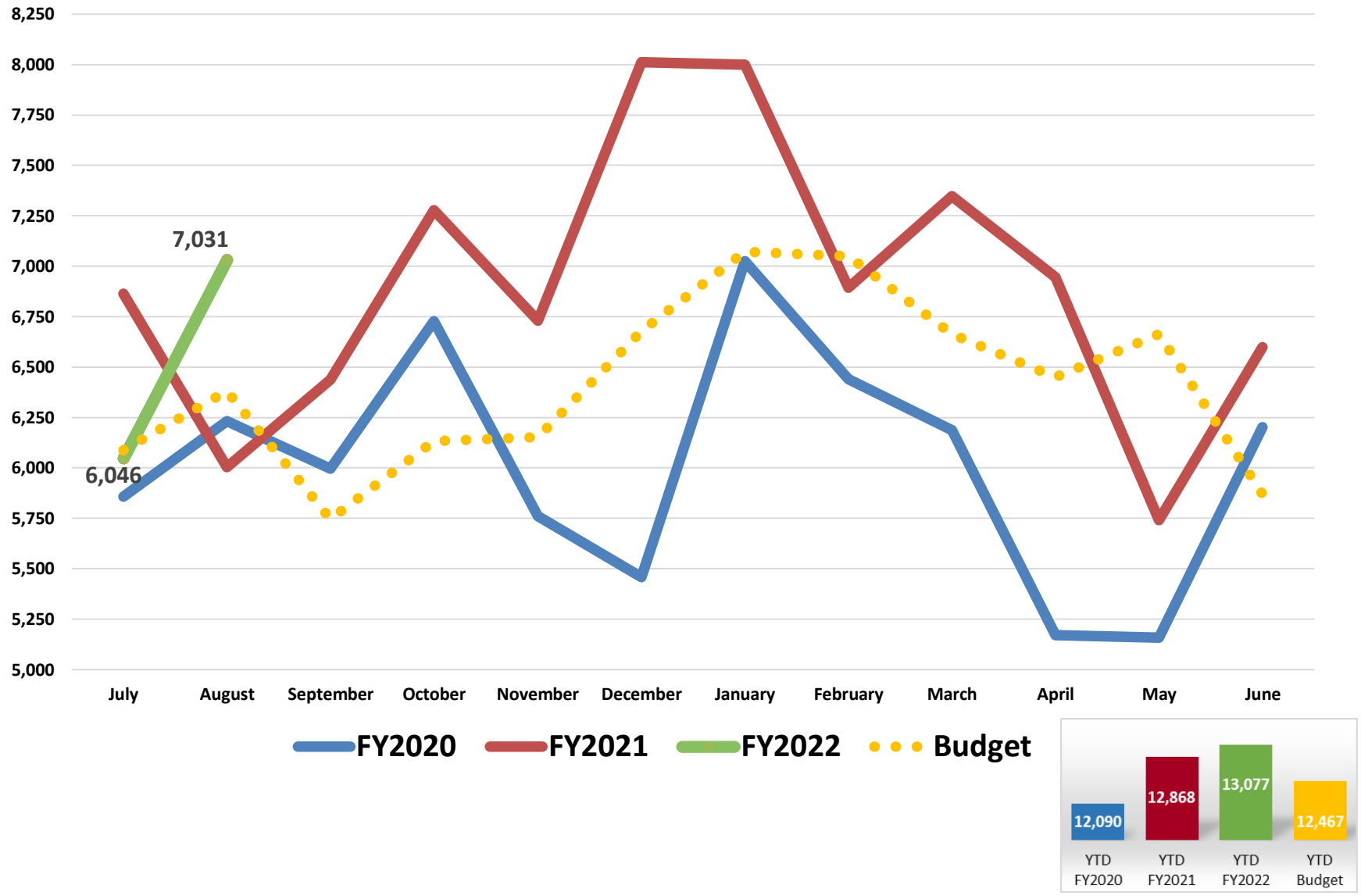


Rural Health Clinic Registrations

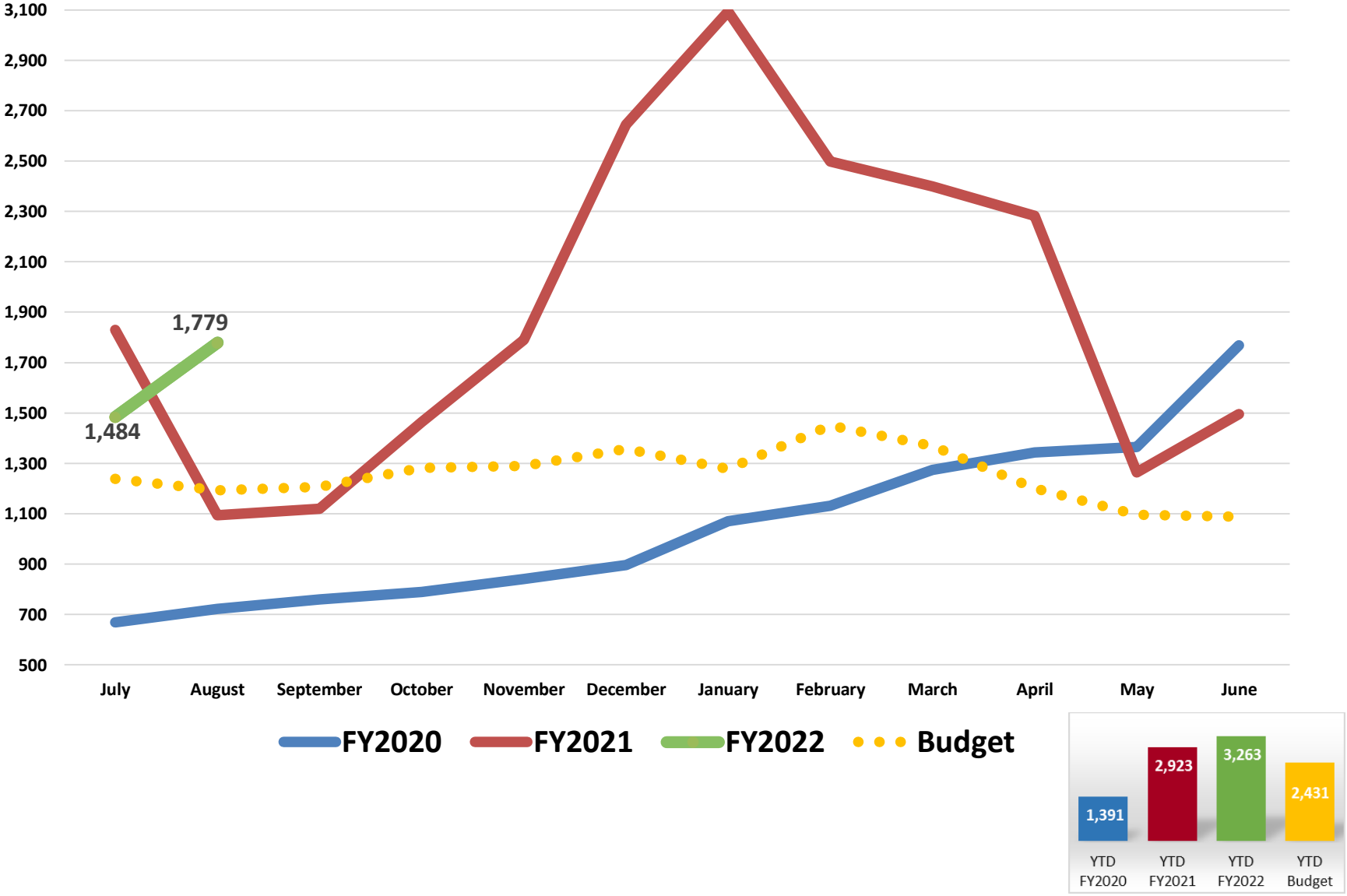




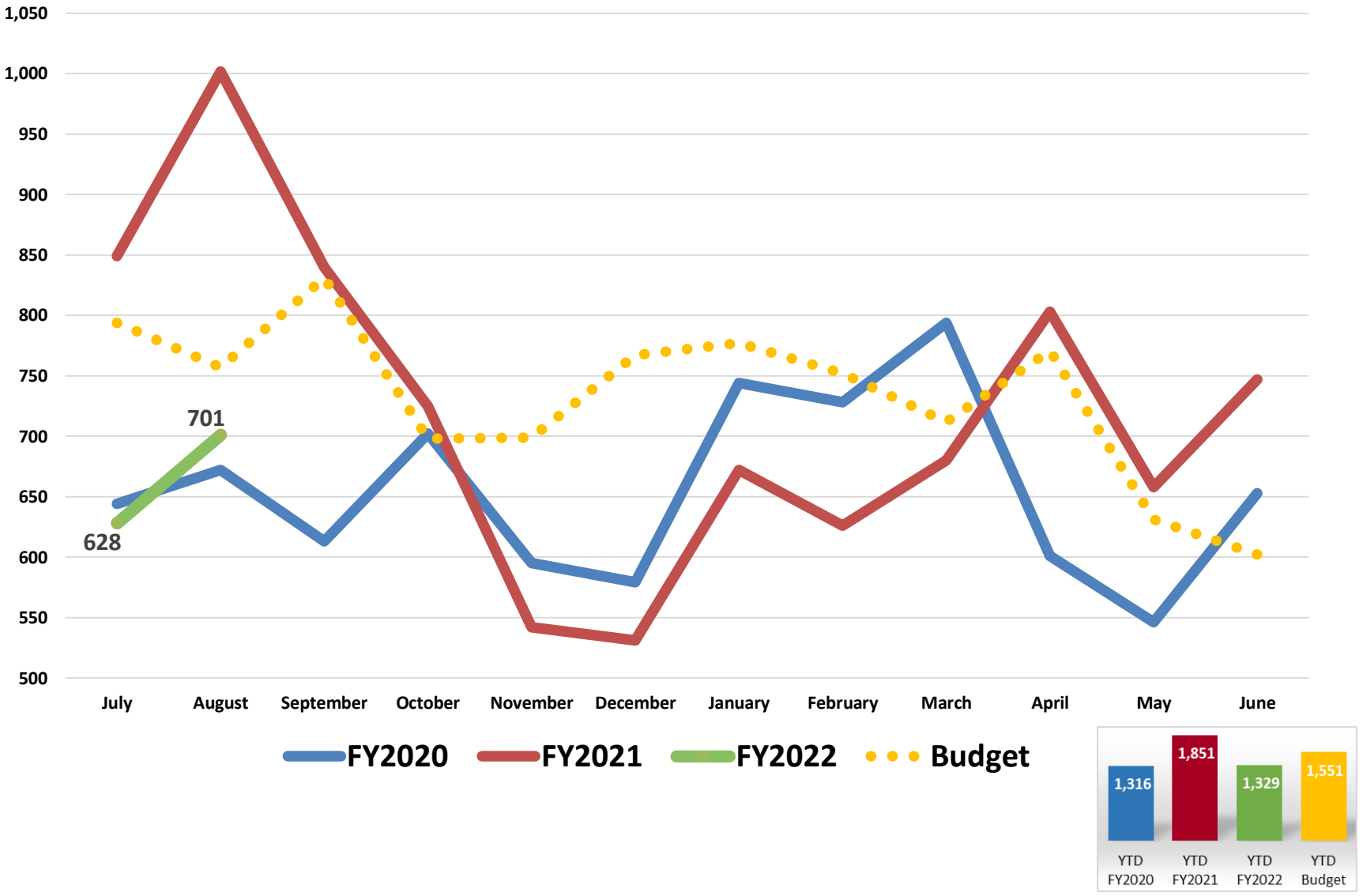
Exeter RHC - Registrations



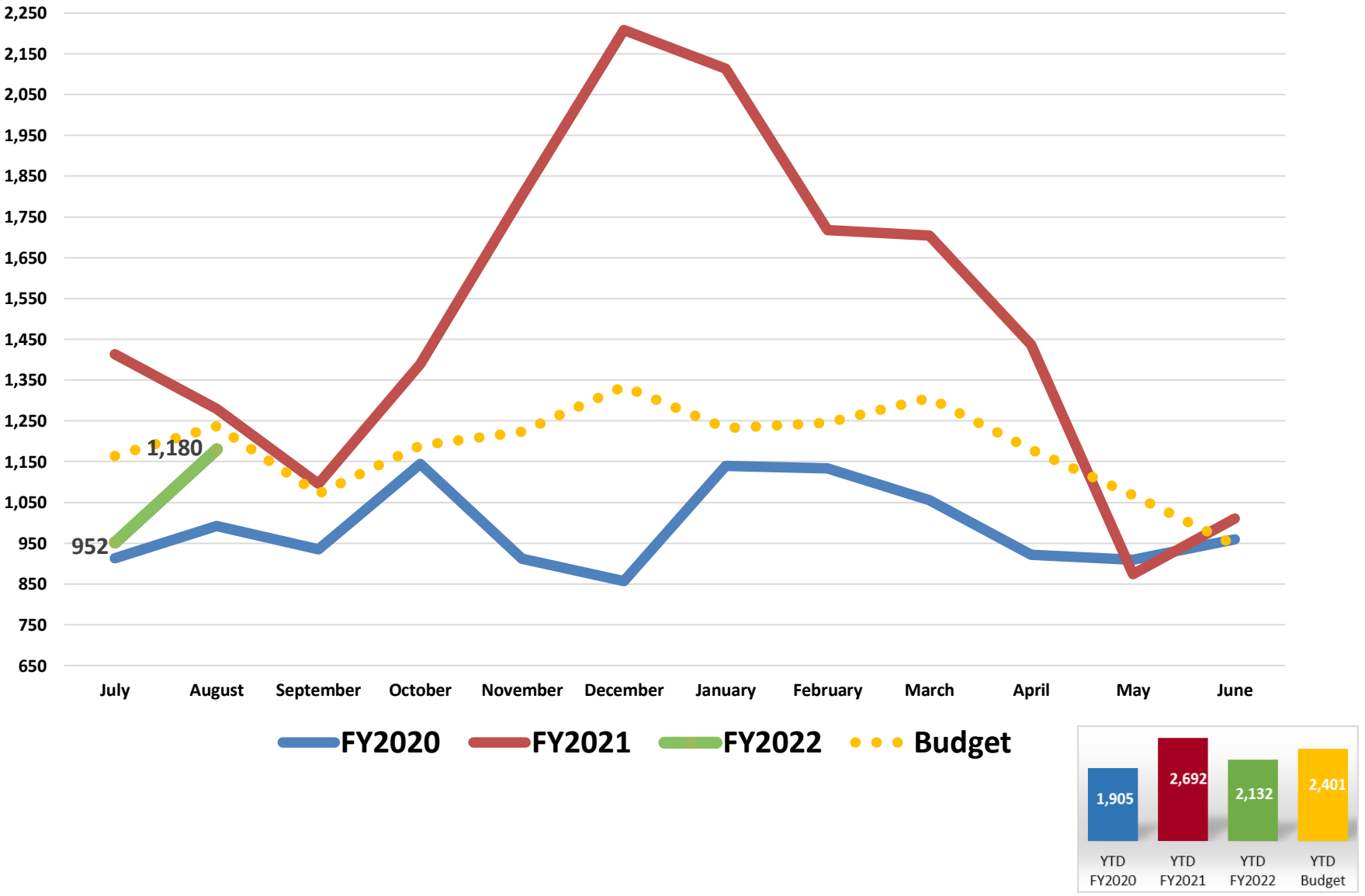
Lindsay RHC - Registrations



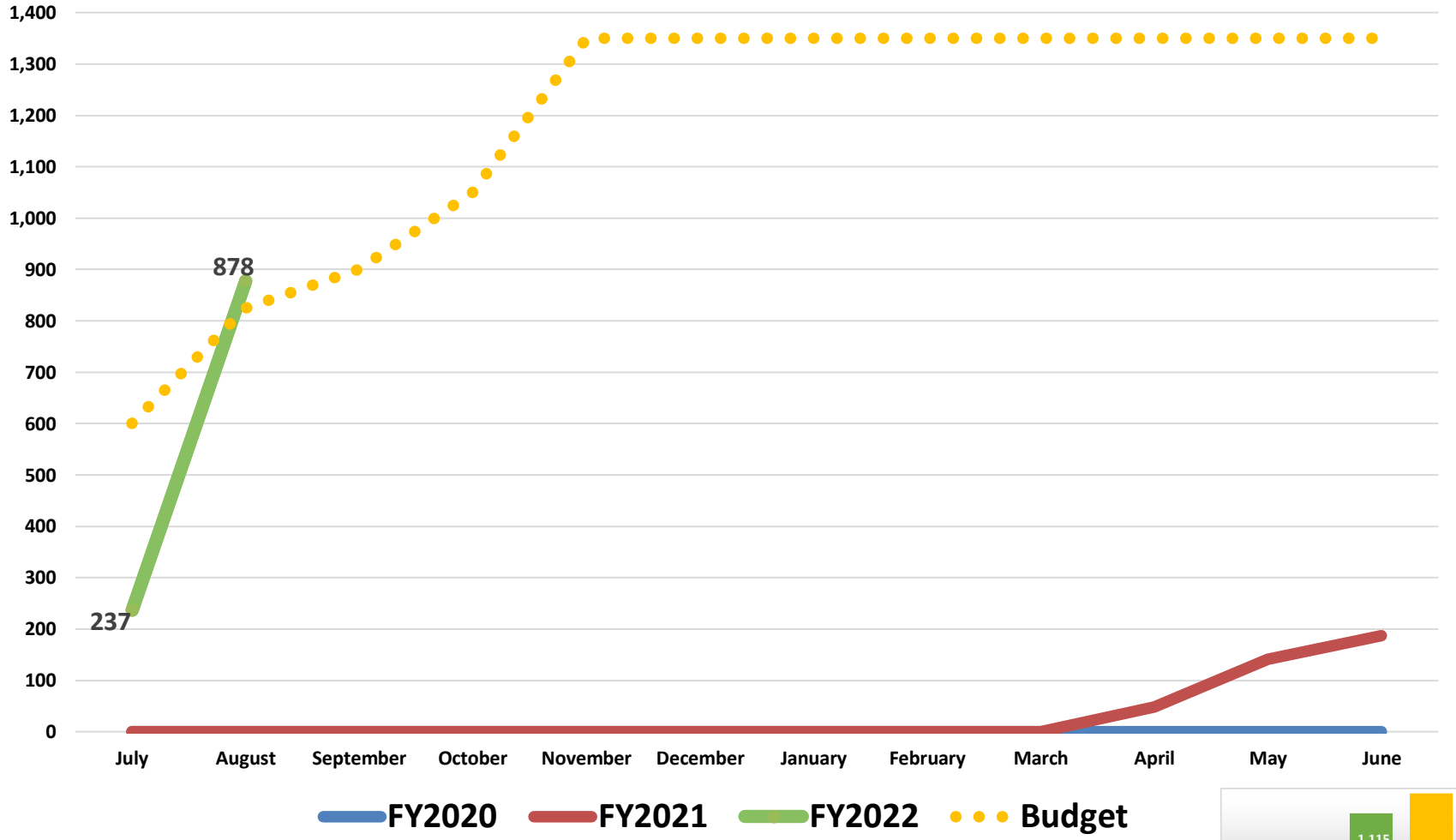
Woodlake RHC - Registrations

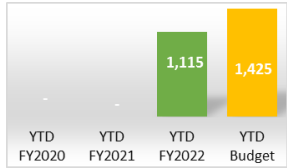


Dinuba RHC - Registrations

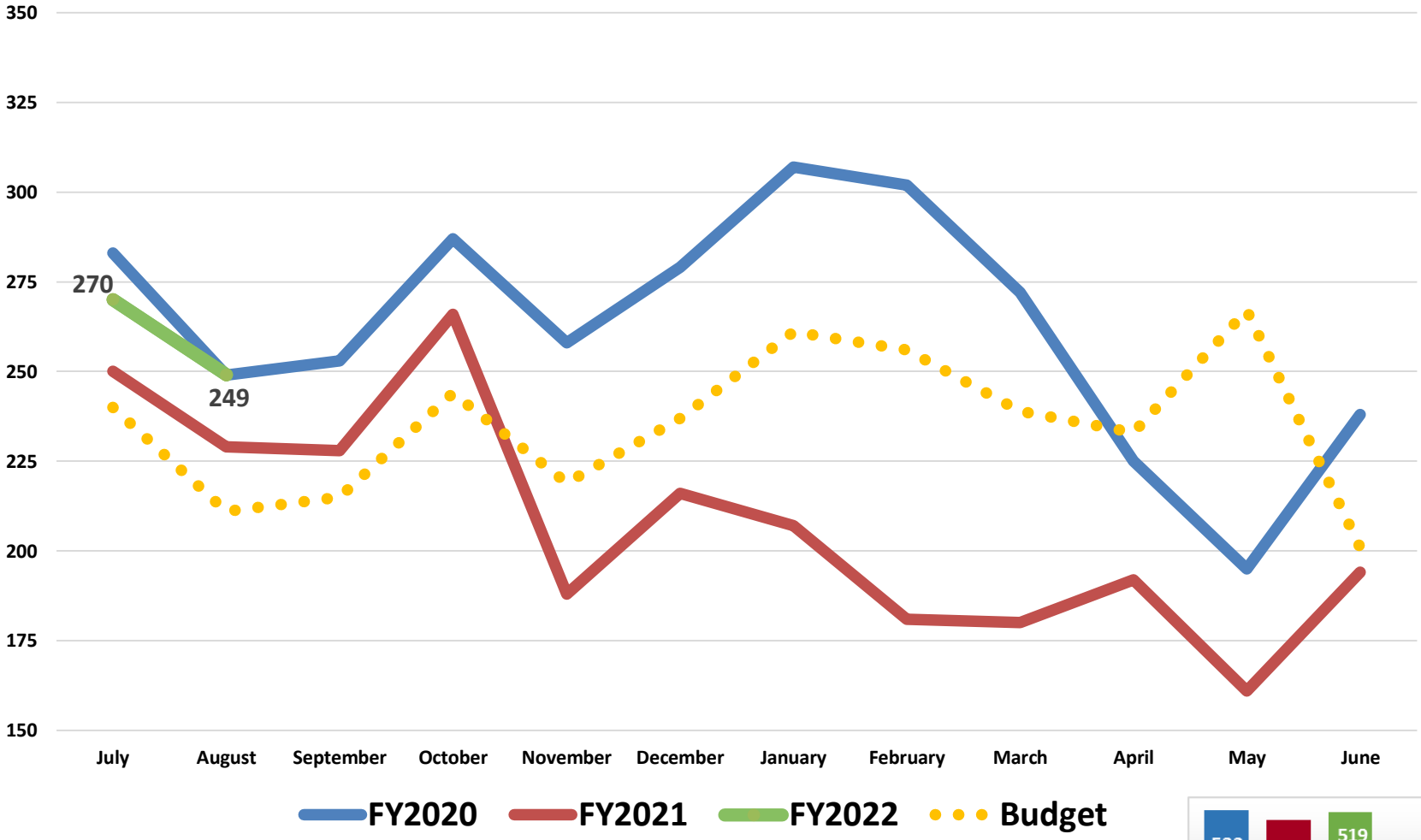


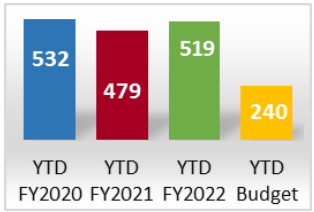
Tulare RHC - Registrations



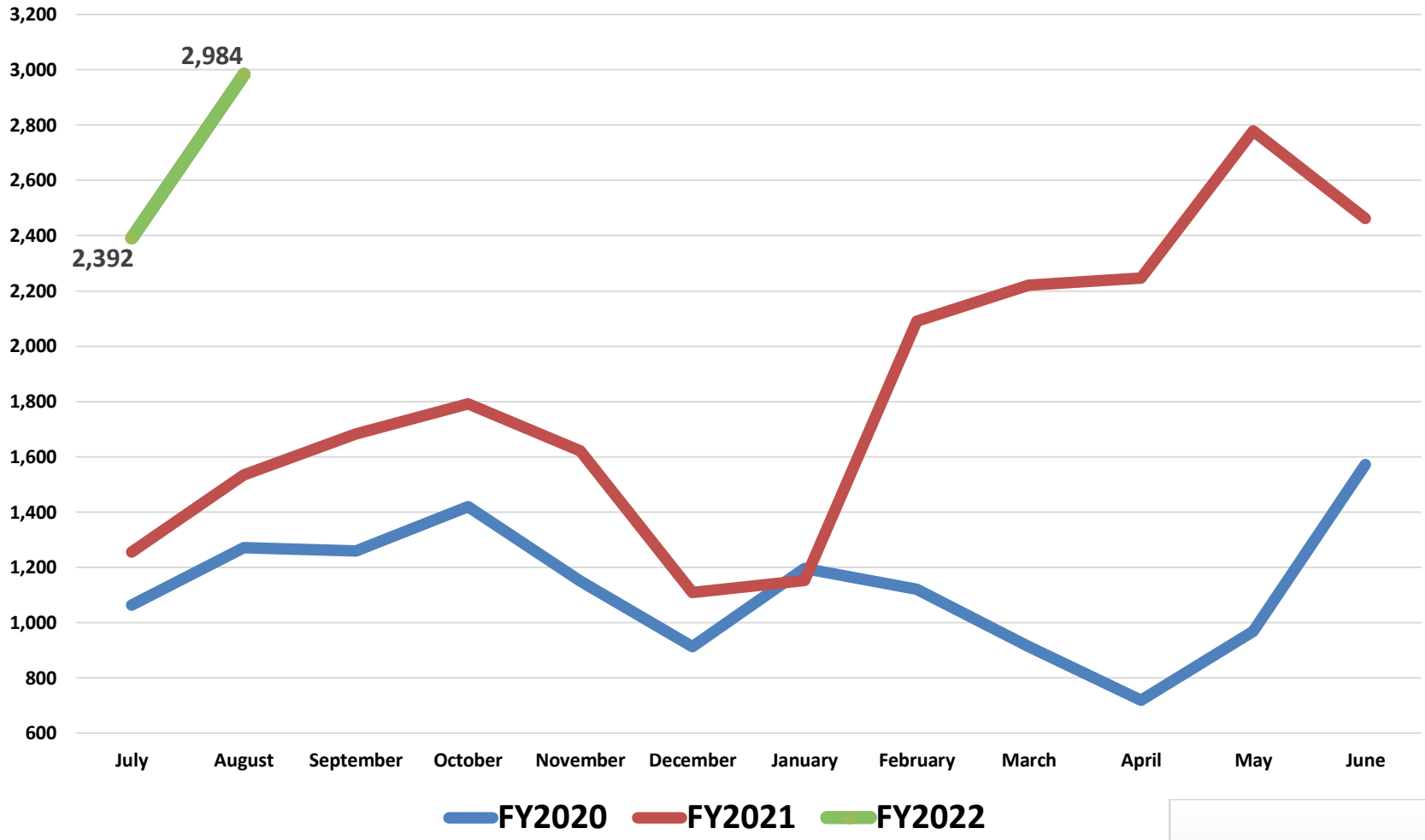


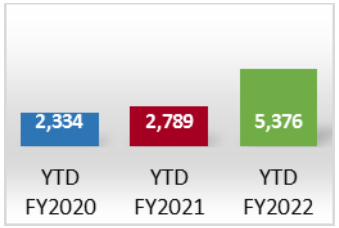
Neurosurgery Clinic - Registrations



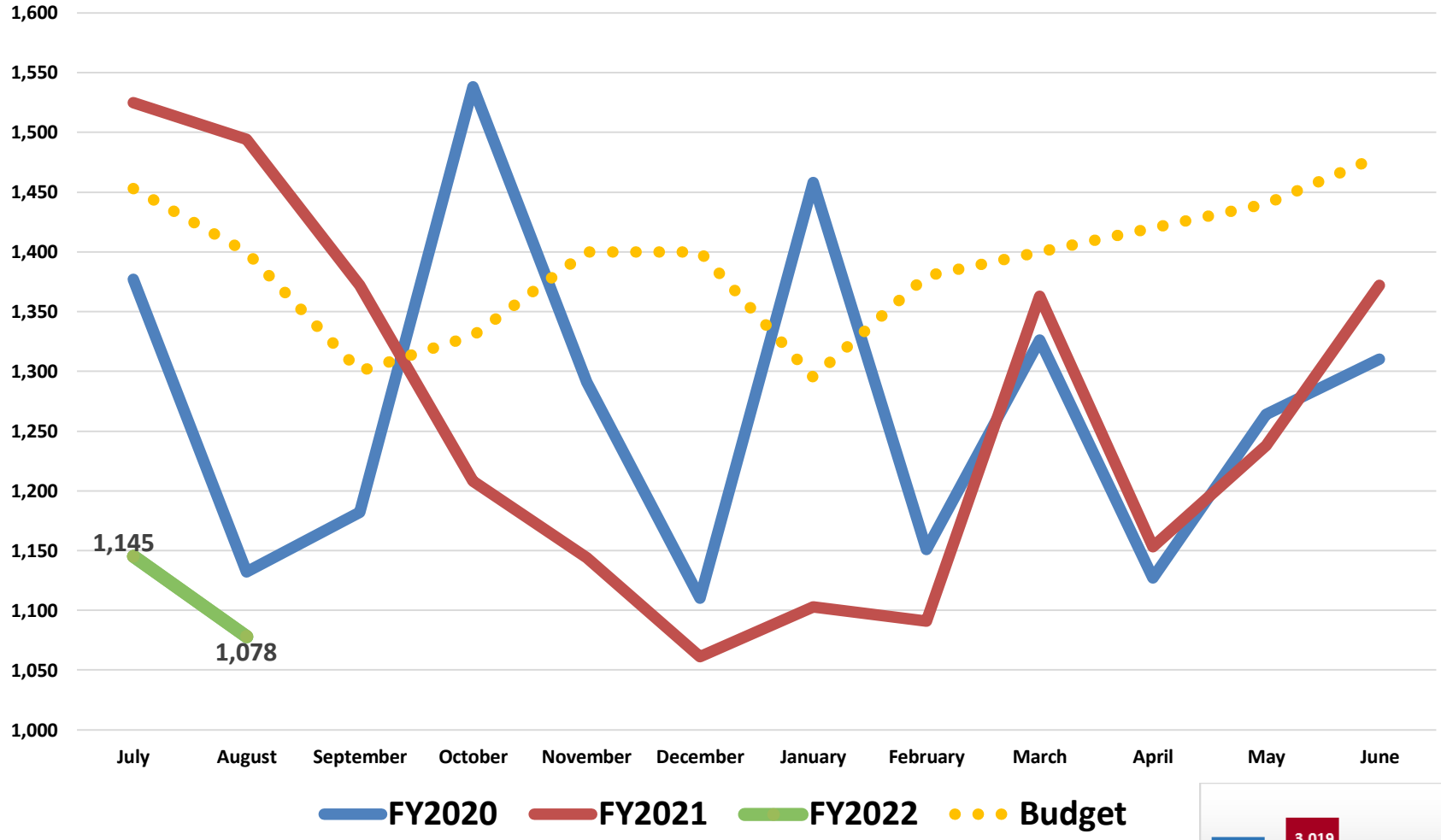


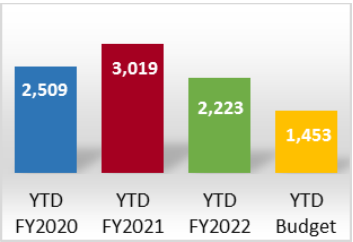
Neurosurgery Clinic - wRVU's



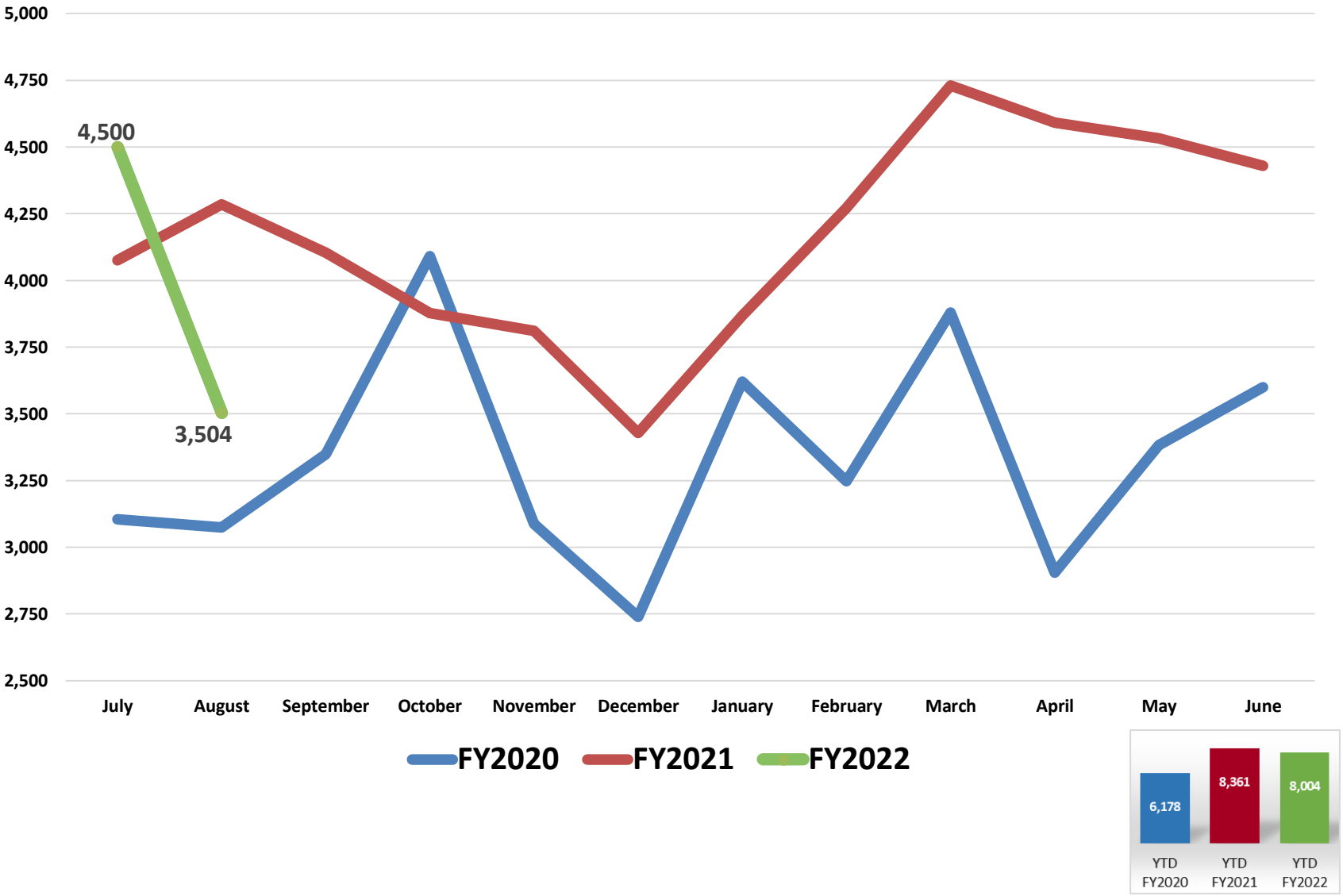


Sequoia Cardiology - Registrations

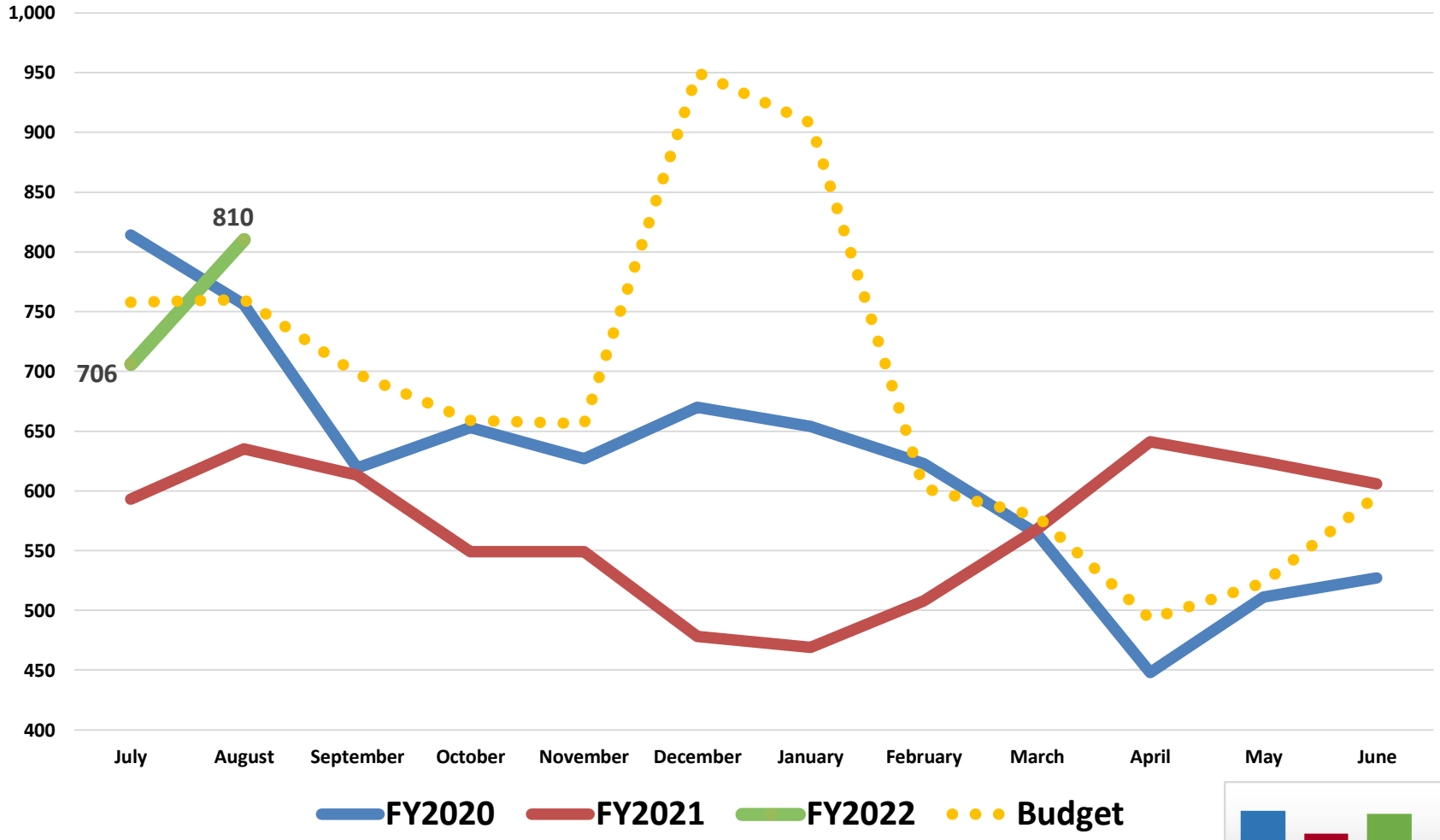


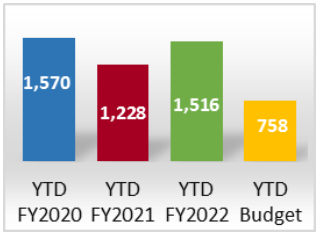


Sequoia Cardiology – wRVU's

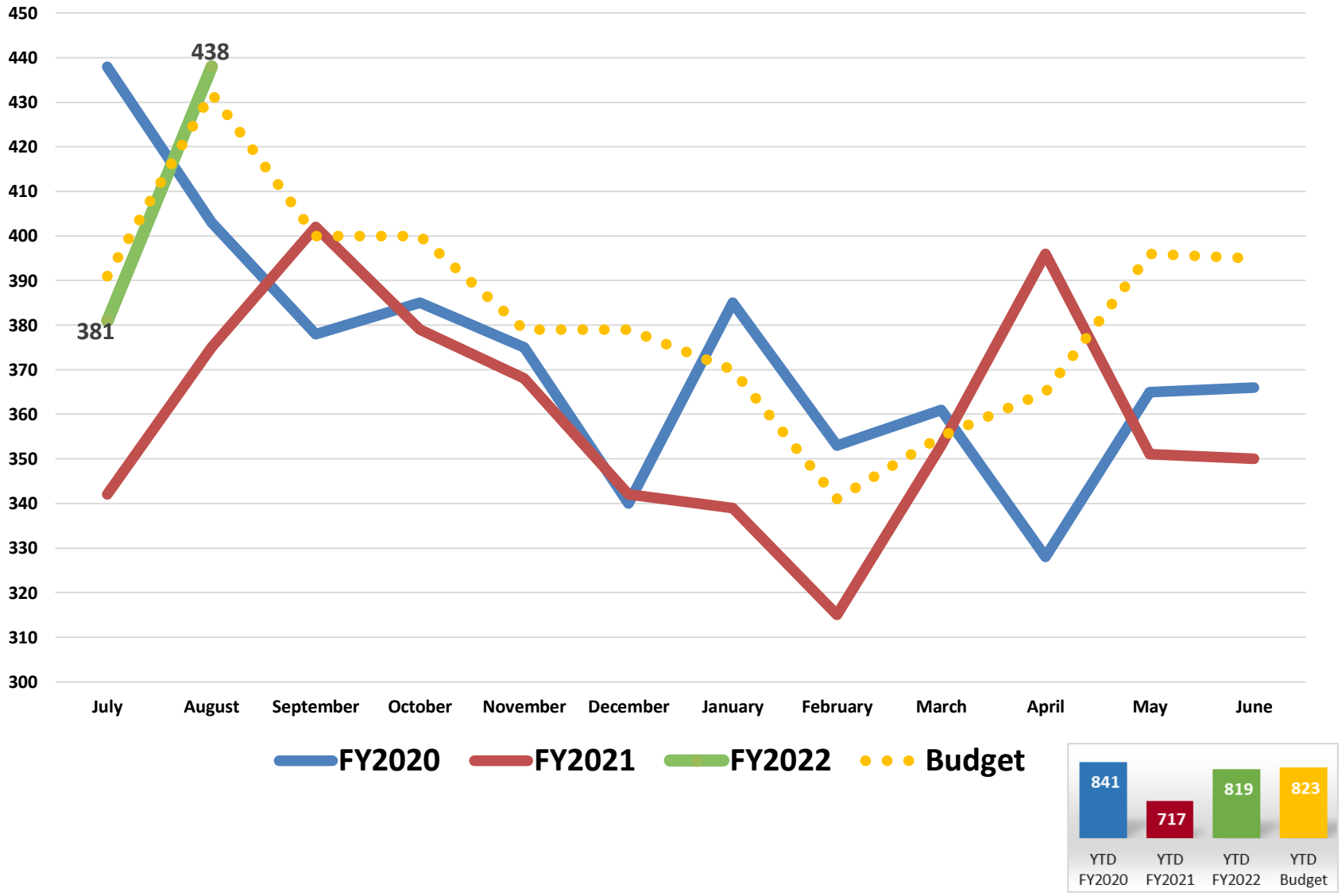


Labor Triage Registrations

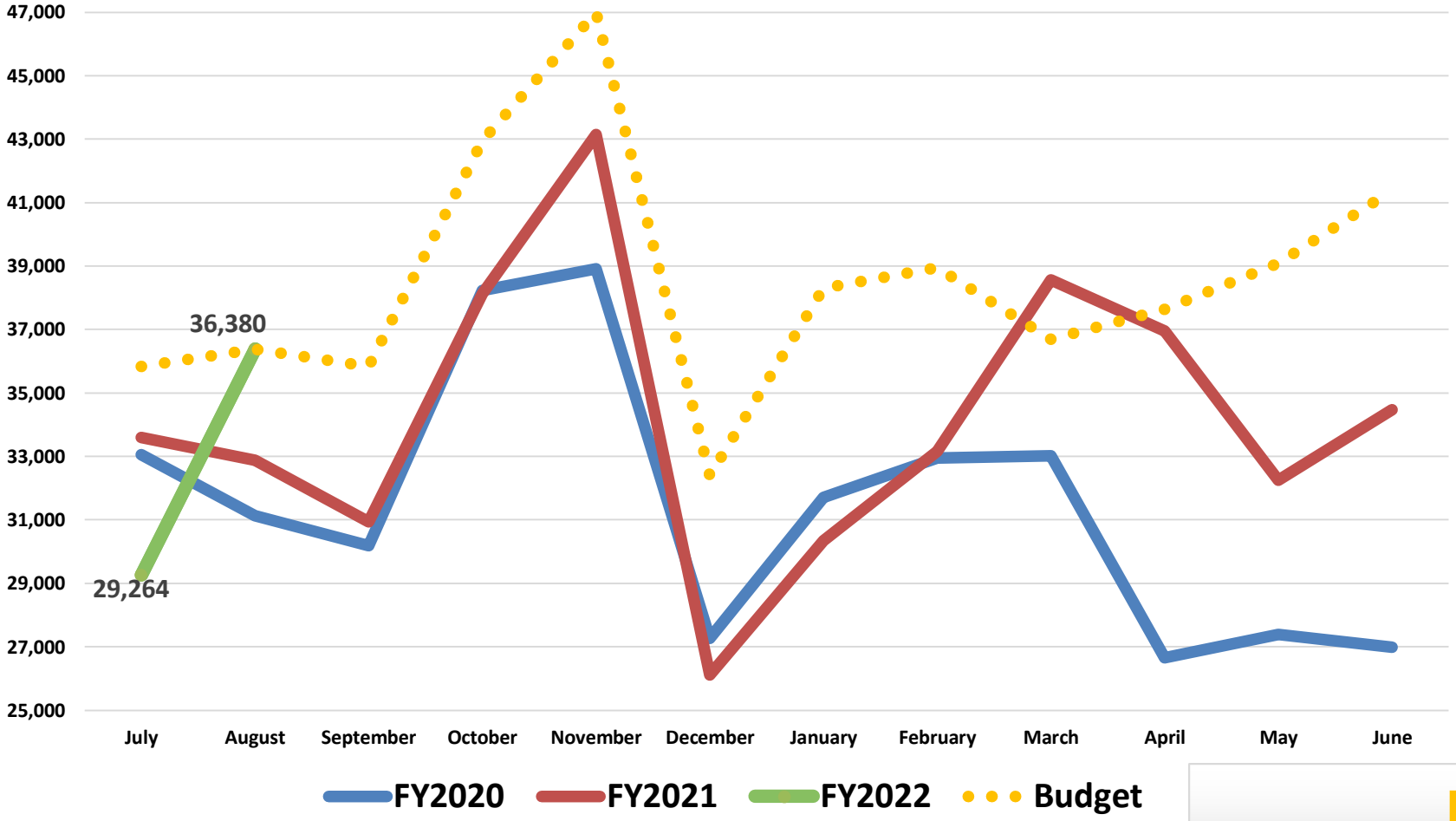


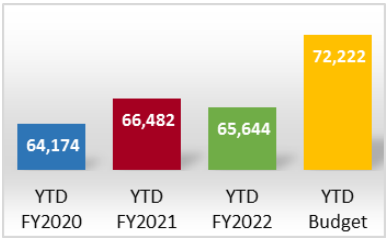


Deliveries

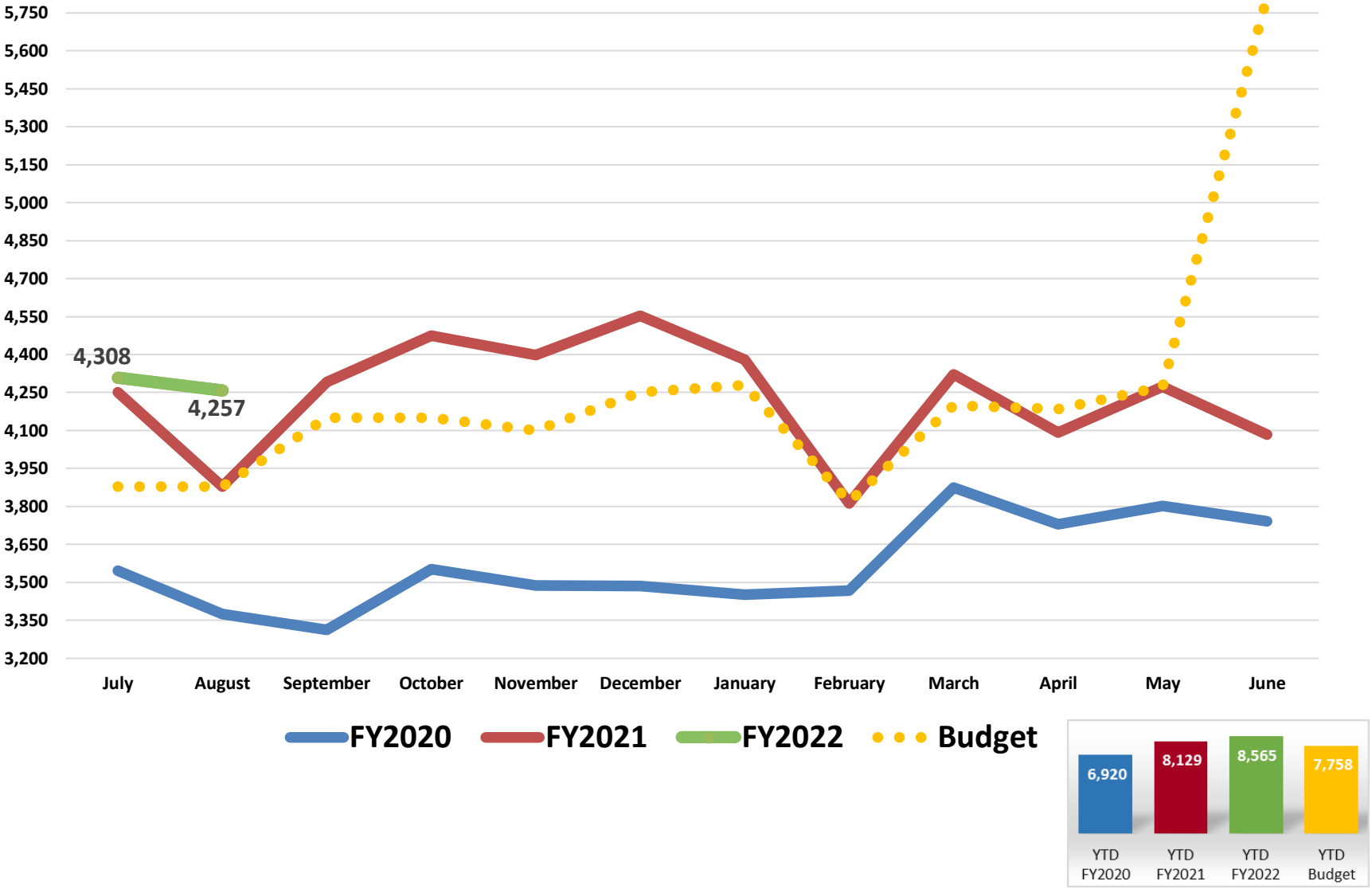

450
440
430
420
410
400
390
380
370
360
350
340
330
320
310
300
438
381
July
August
September
October
November
December
January
February
March
April
May
June
FY2020
FY2021
FY2022
Budget
841
717
819
823
YTD FY2020
YTD FY2021
YTD FY2022
YTD Budget

KDMF RVU's

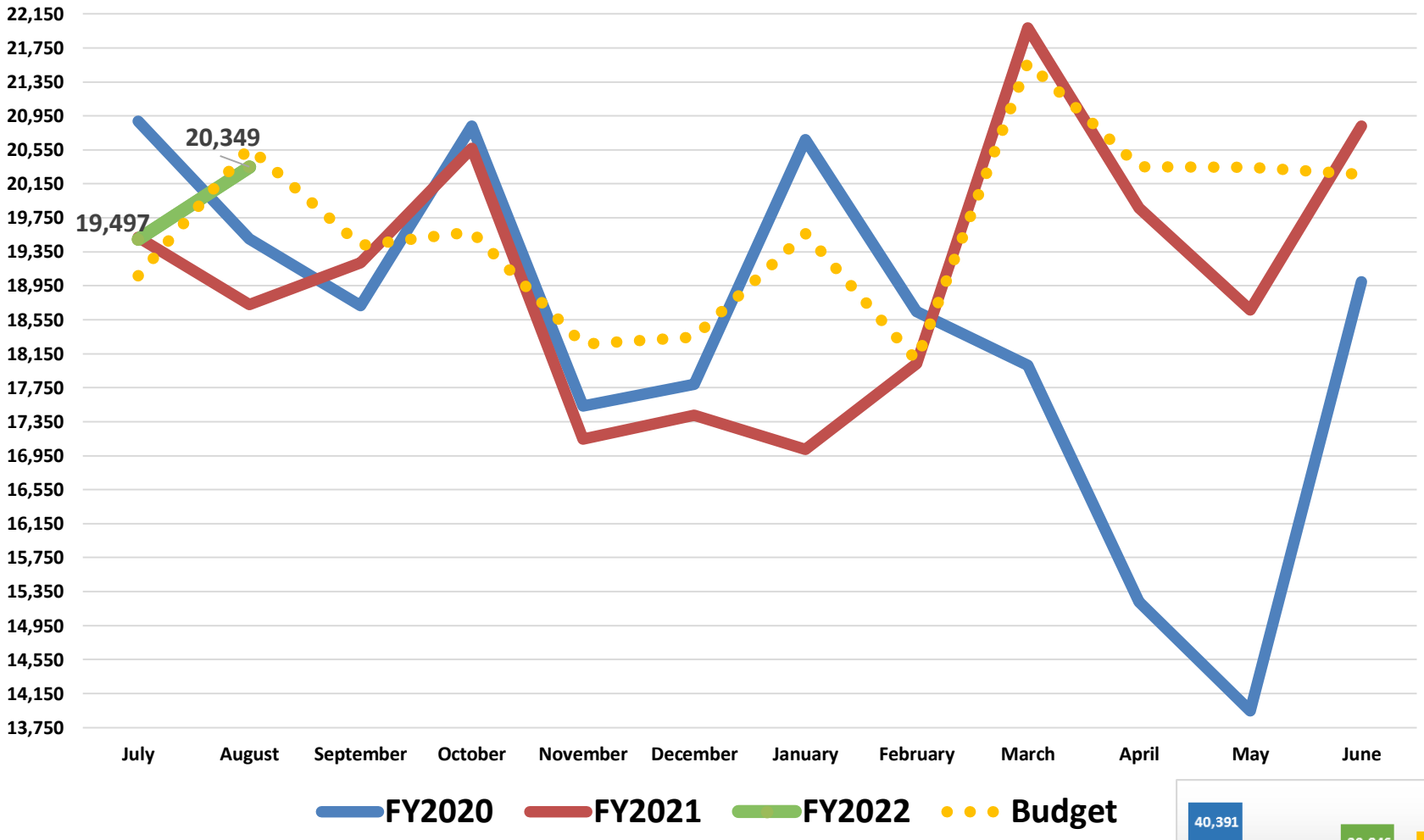

47,000
45,000
43,000
41,000
39,000
37,000
35,000
33,000
31,000
29,000
27,000
25,000
36,380
29,264
July
August
September
October
November
December
January
February
March
April
May
June
FY2020
FY2021
FY2022
Budget

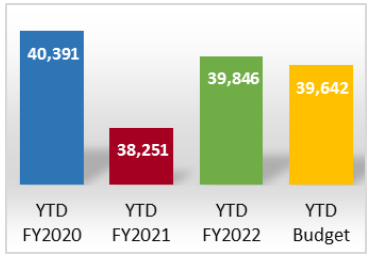

64,174
66,482
65,644
72,222
YTD FY2020
YTD FY2021
YTD FY2022
YTD Budget

Hospice Days

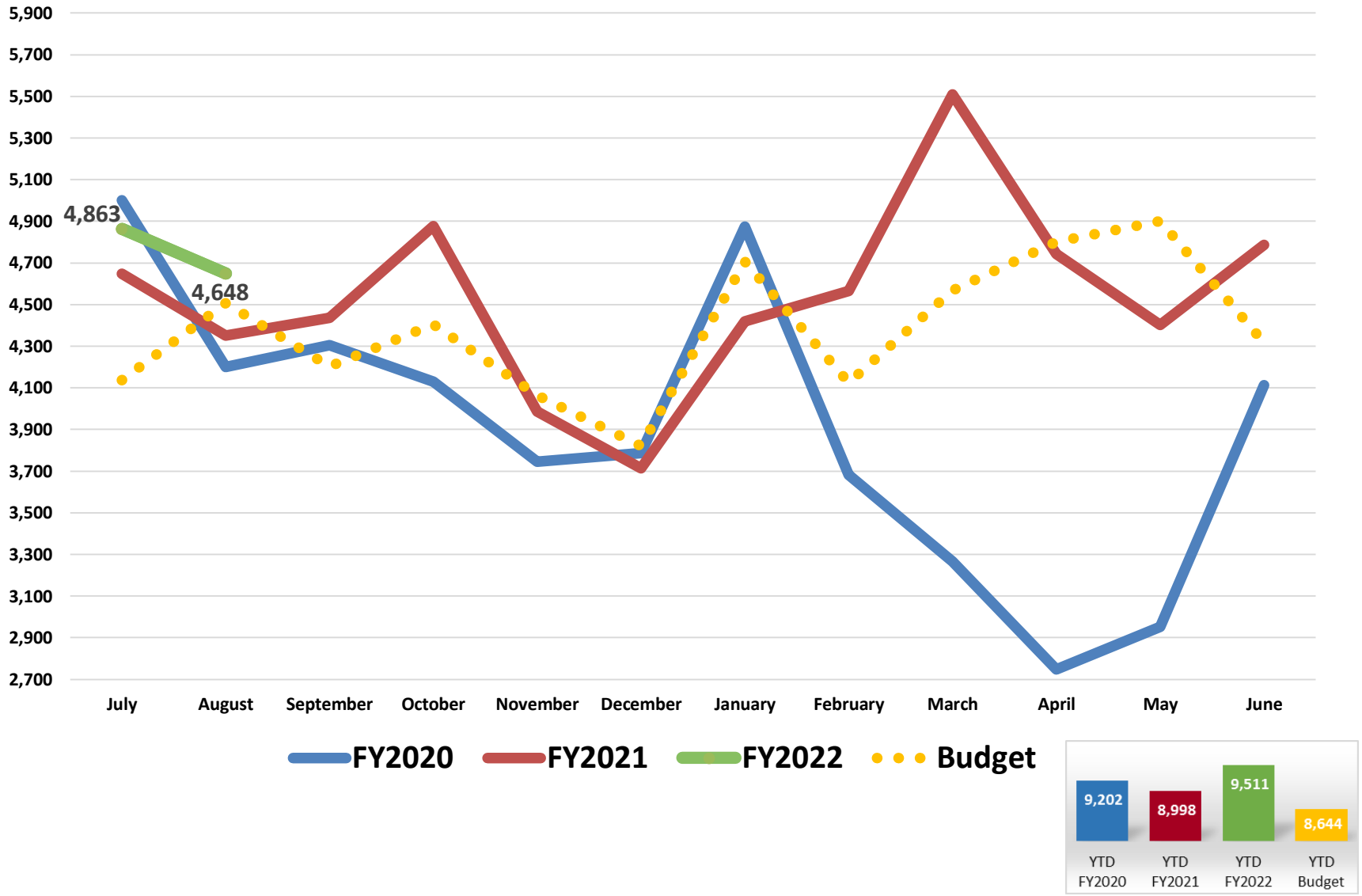


All O/P Rehab Services Across District

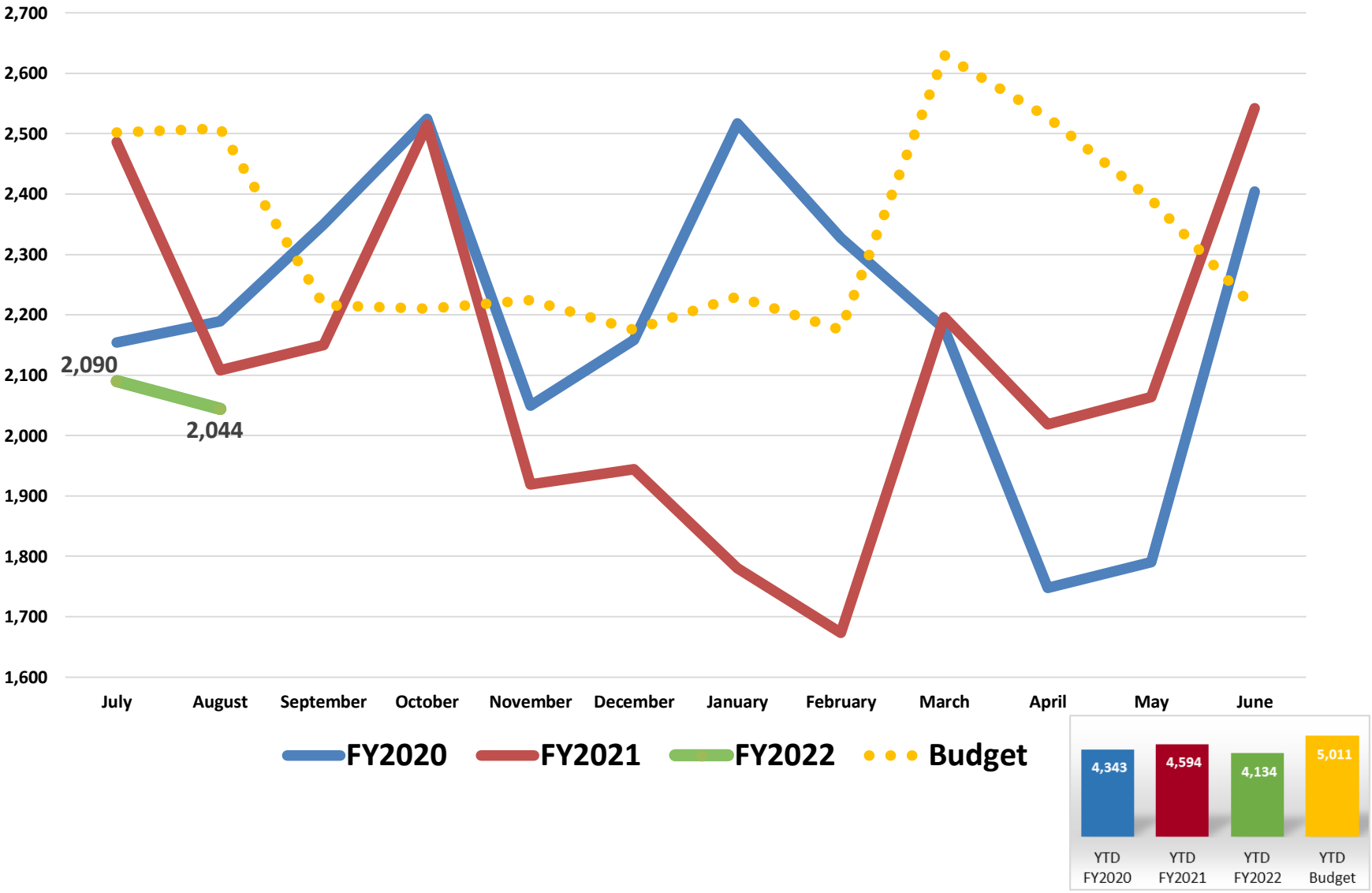




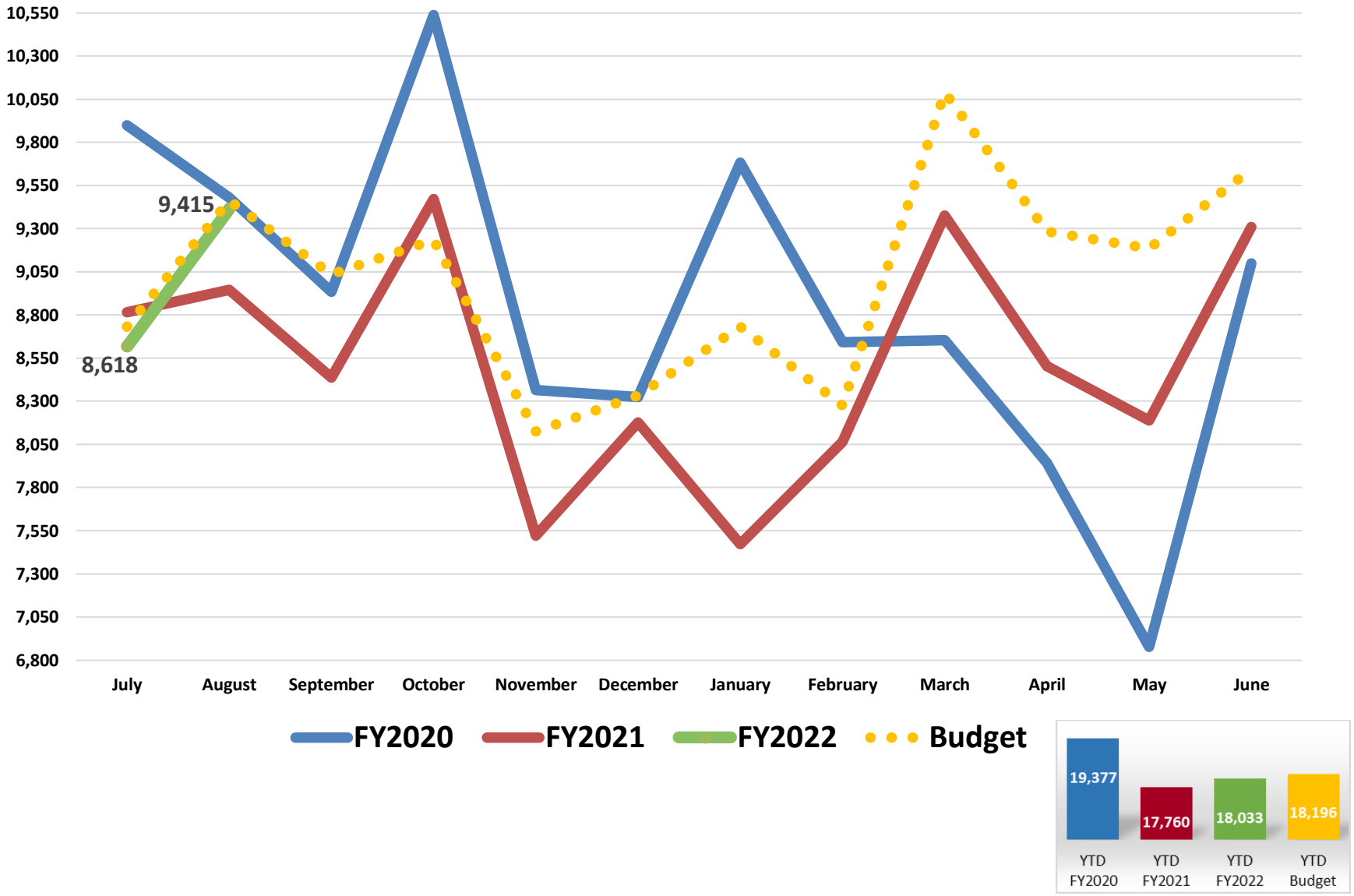
O/P Rehab Services



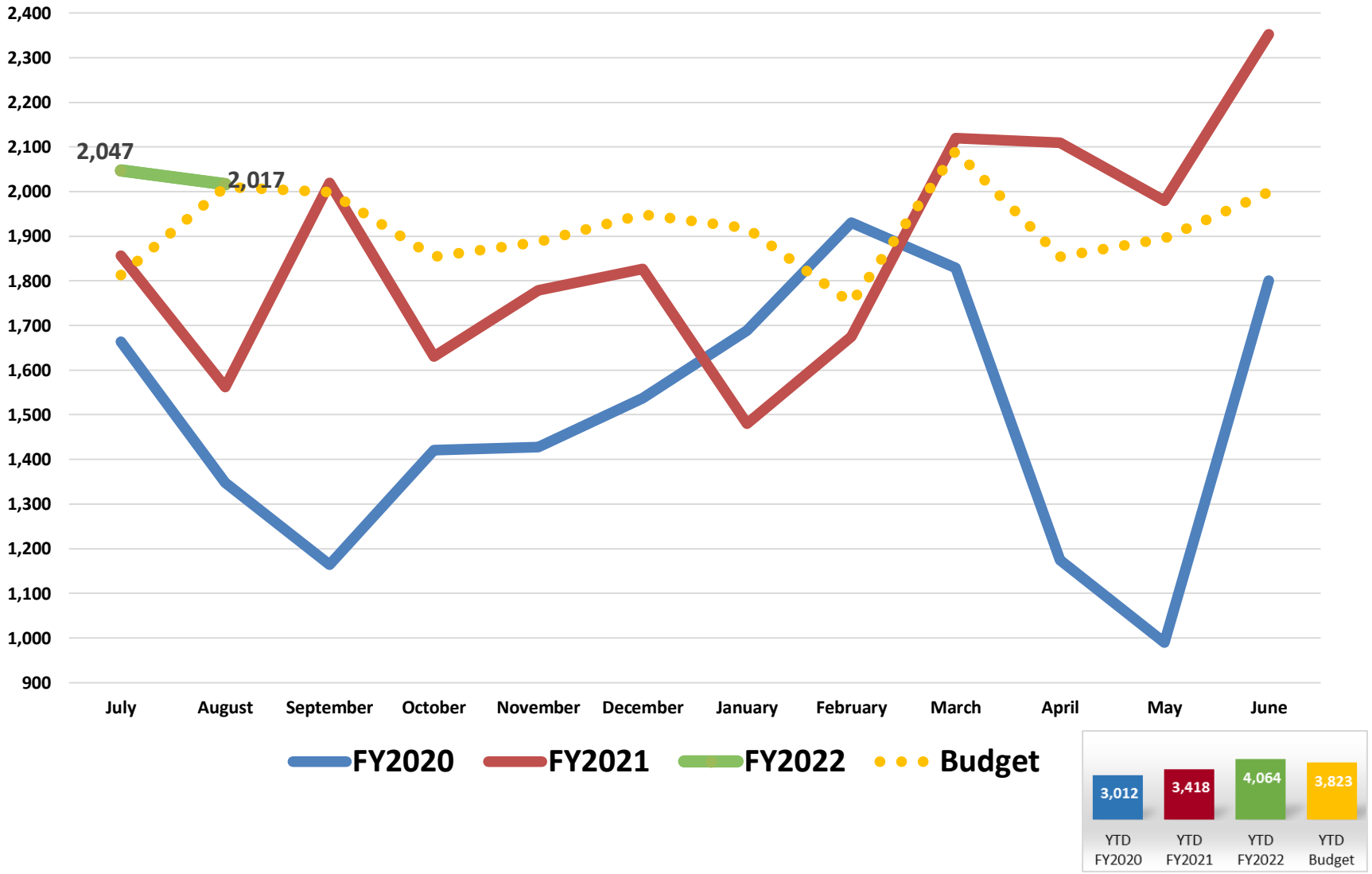
O/P Rehab - Exeter



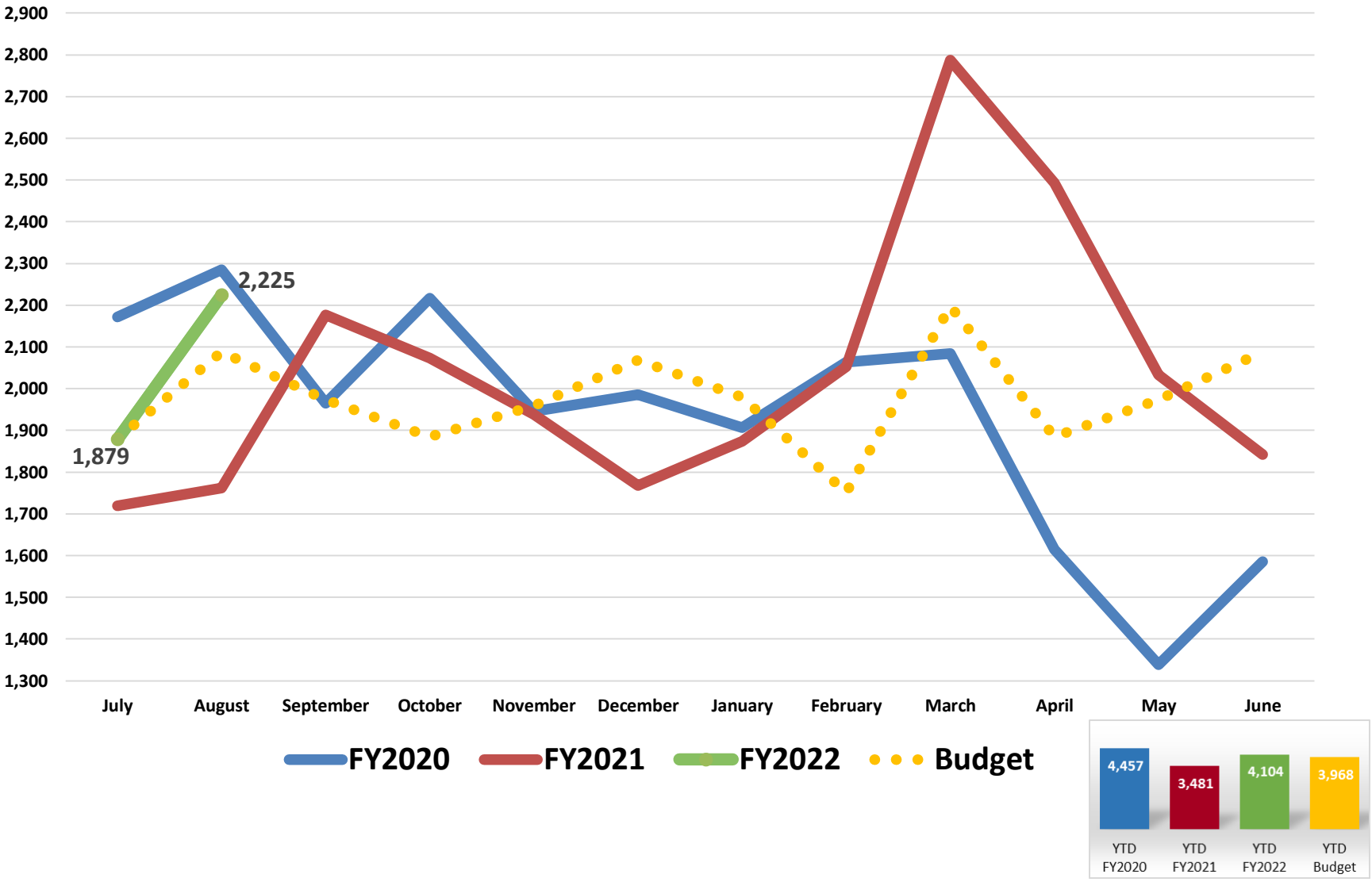
O/P Rehab - Akers



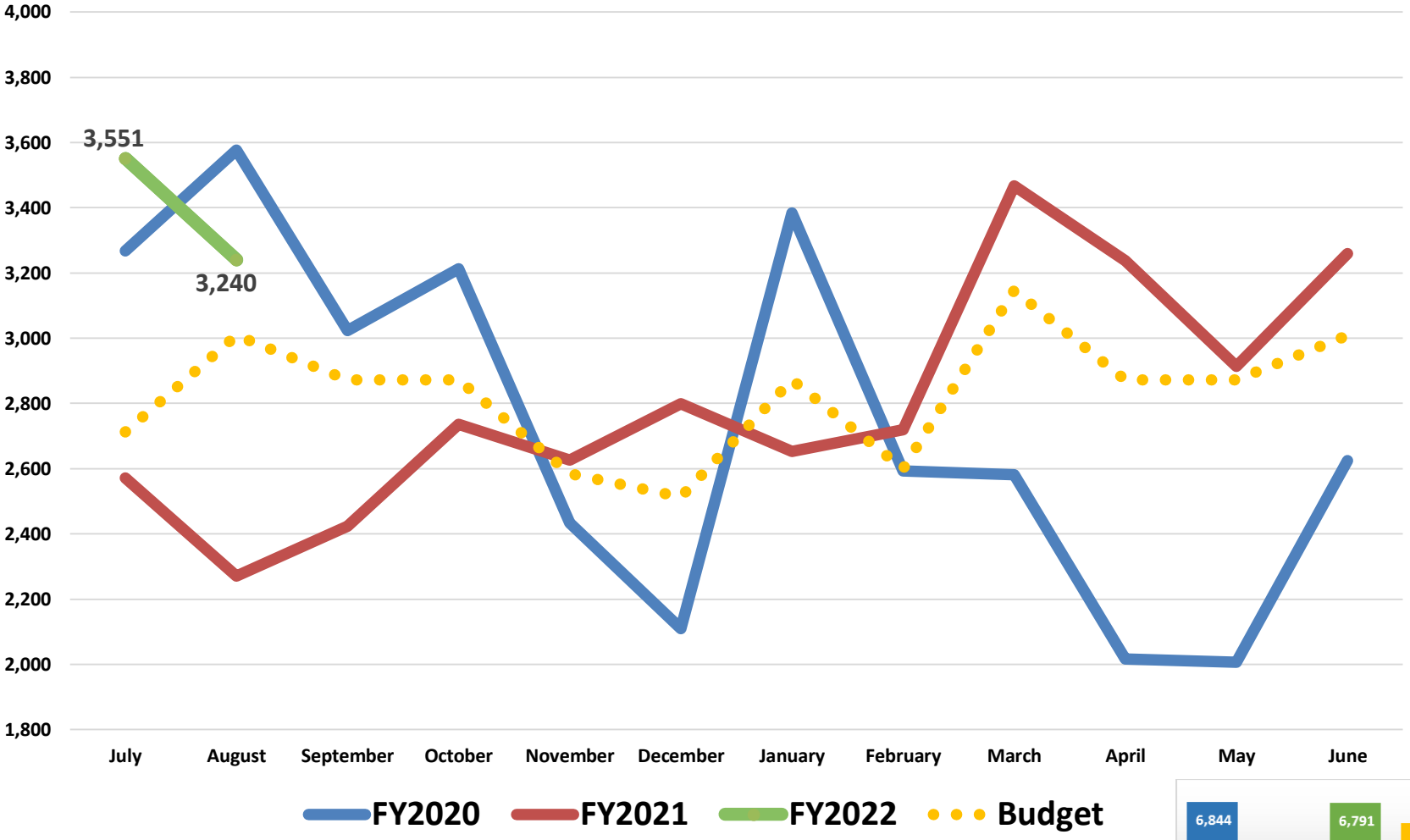
O/P Rehab - LLOPT

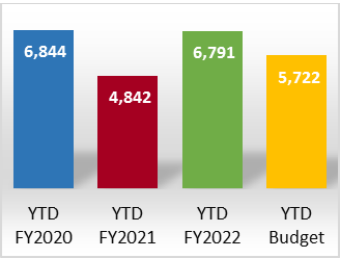


O/P Rehab - Dinuba

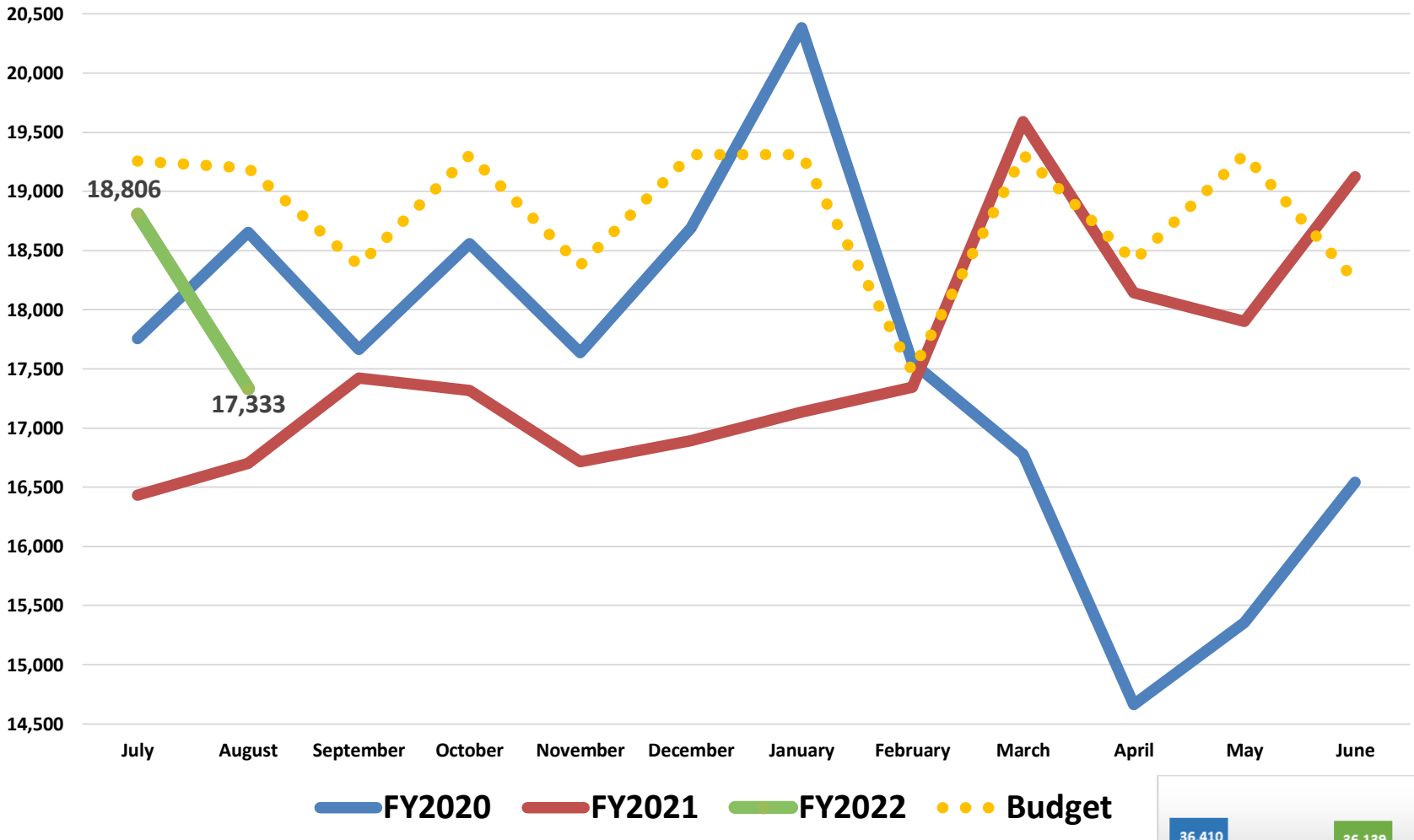


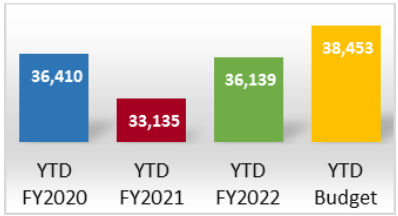
Therapy - Cypress Hand Center



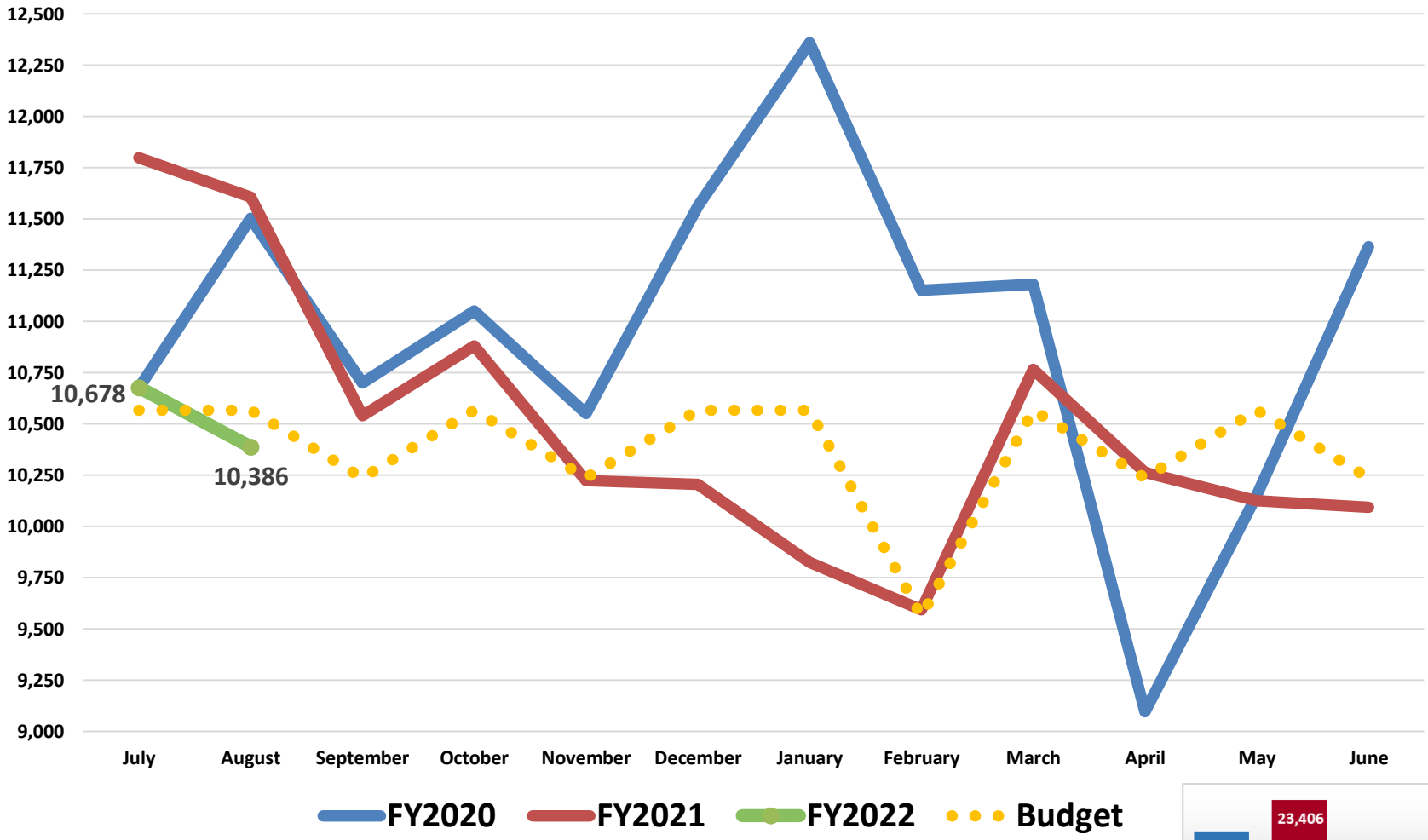


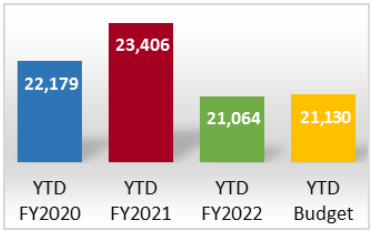
Physical & Other Therapy Units (I/P & O/P)



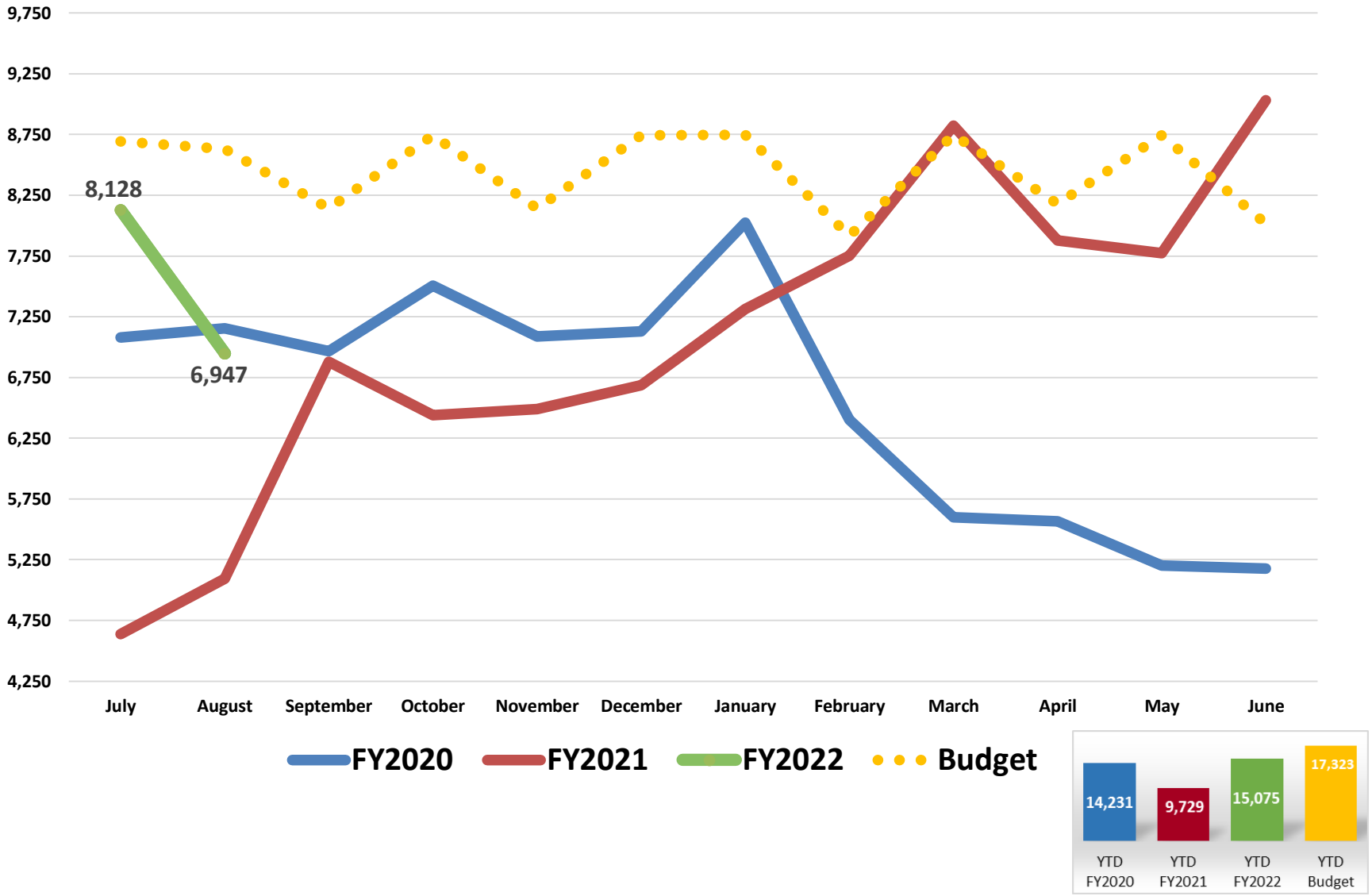


Physical & Other Therapy Units (I/P & O/P)-Main Campus

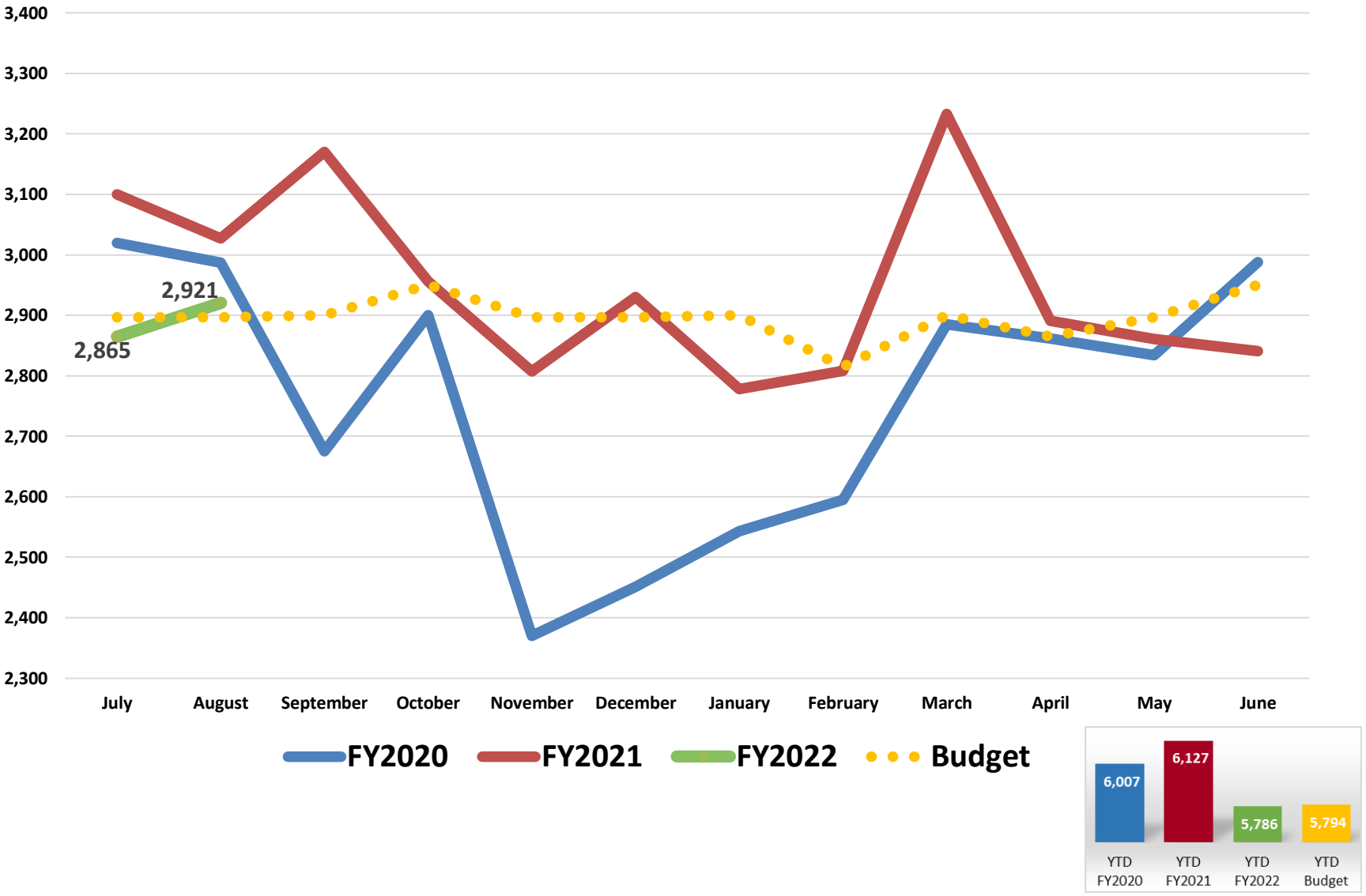




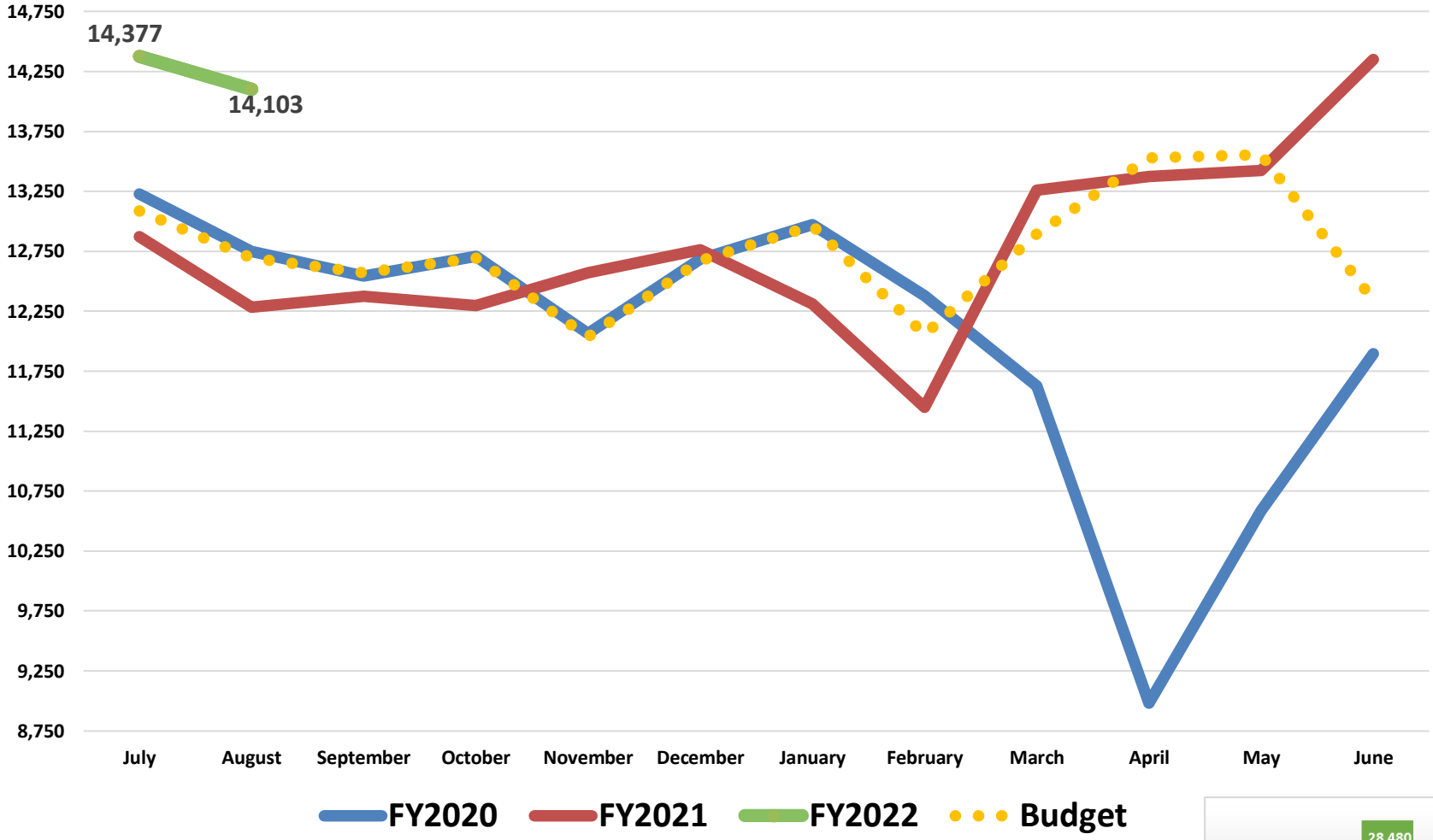
Physical & Other Therapy Units (I/P & O/P)-KDRH & South Campus

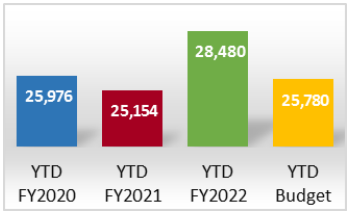


Home Health Visits

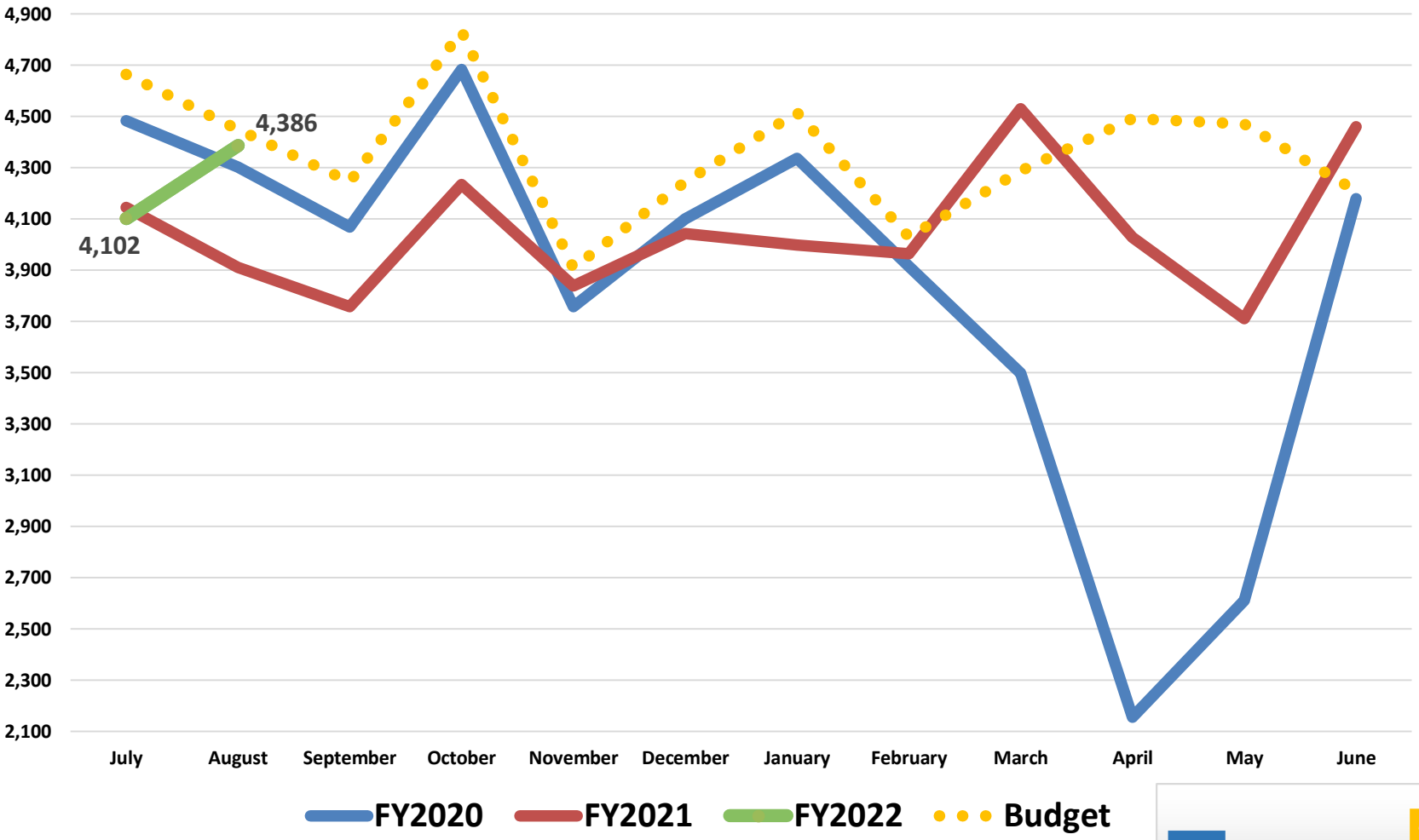


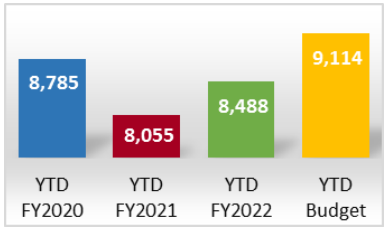
Radiology – Main Campus



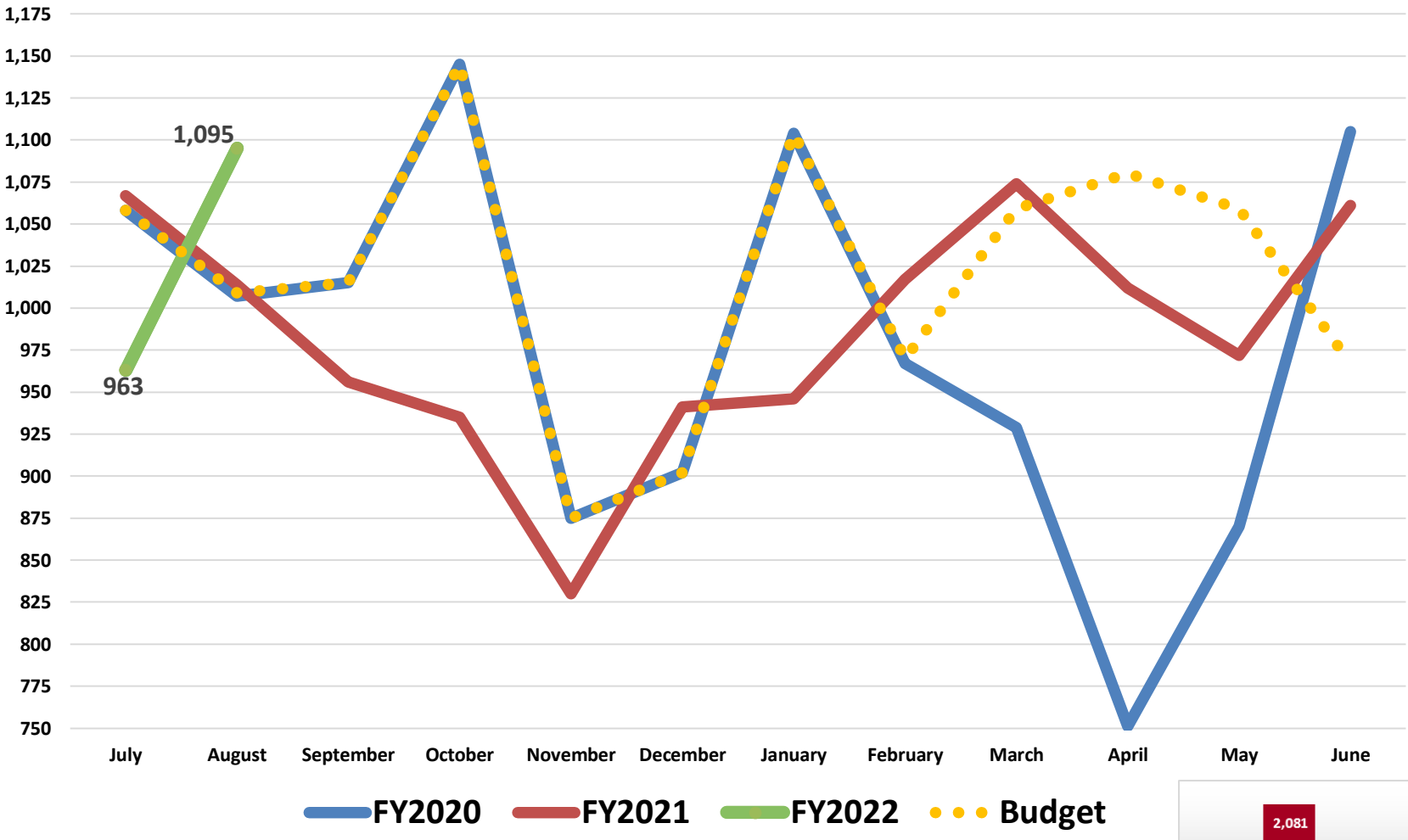


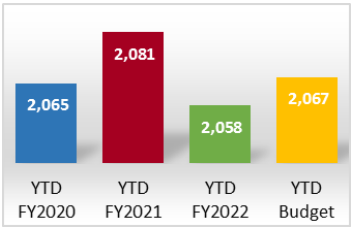
Radiology – West Campus Imaging



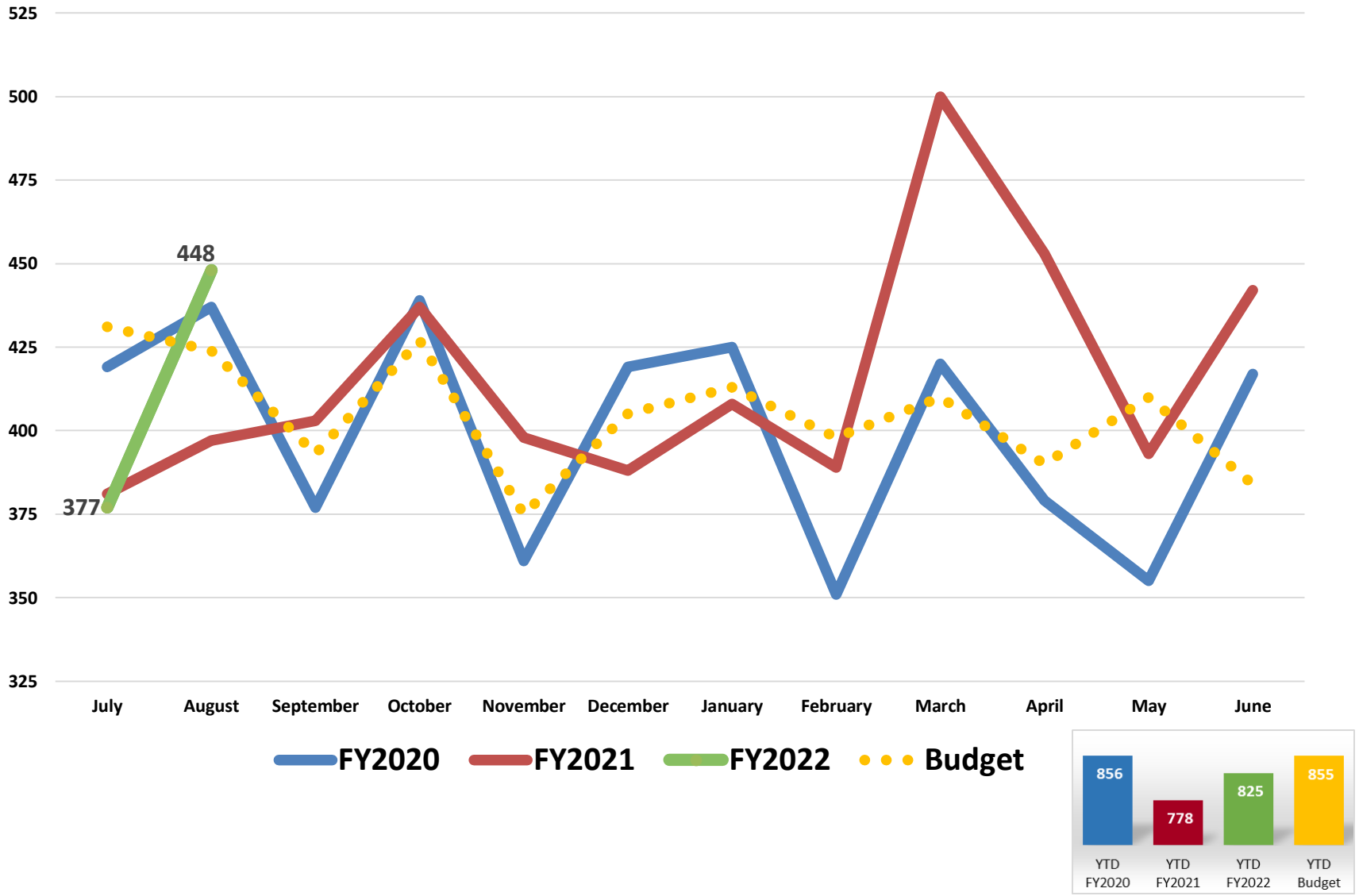


West Campus – Diagnostic Radiology

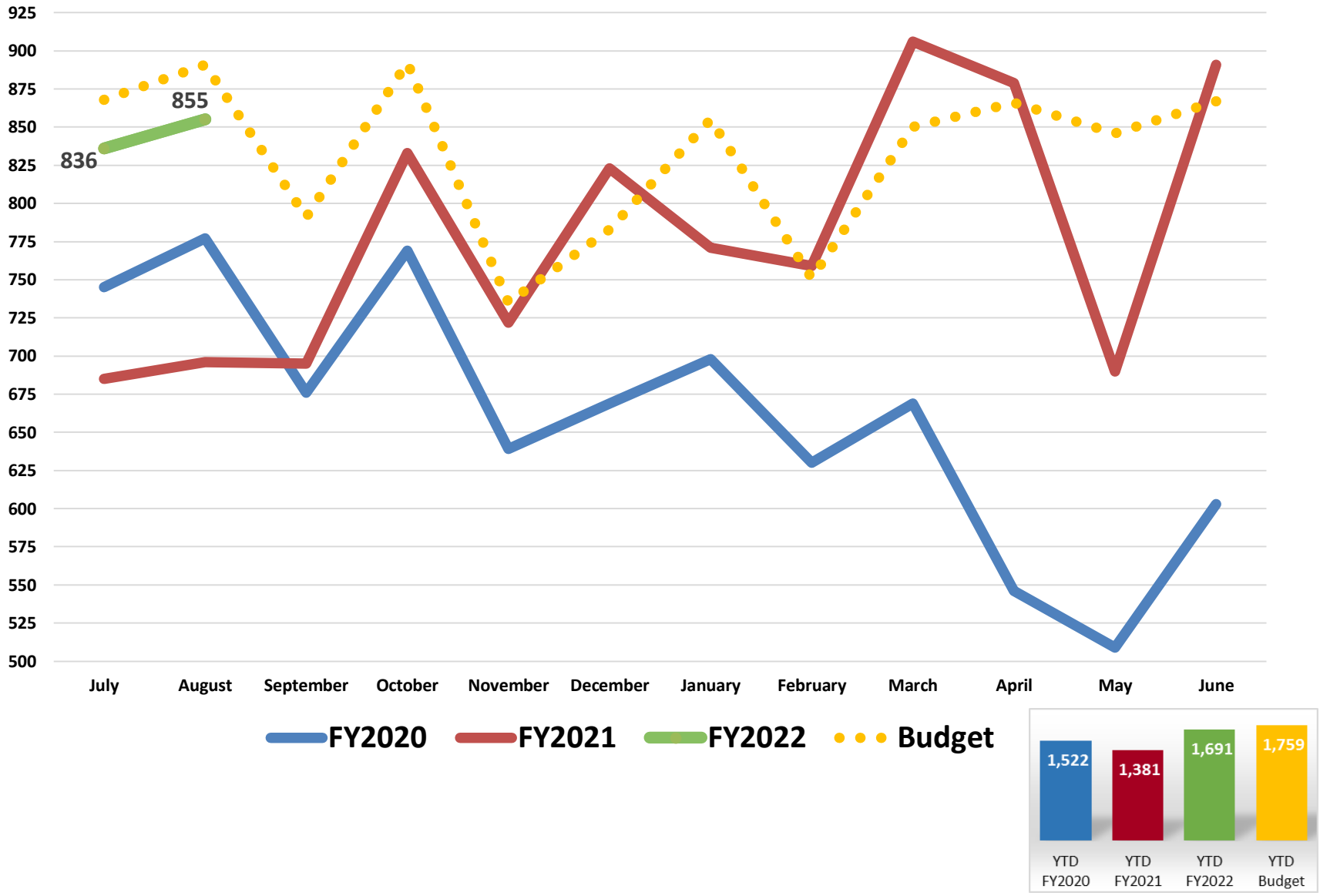




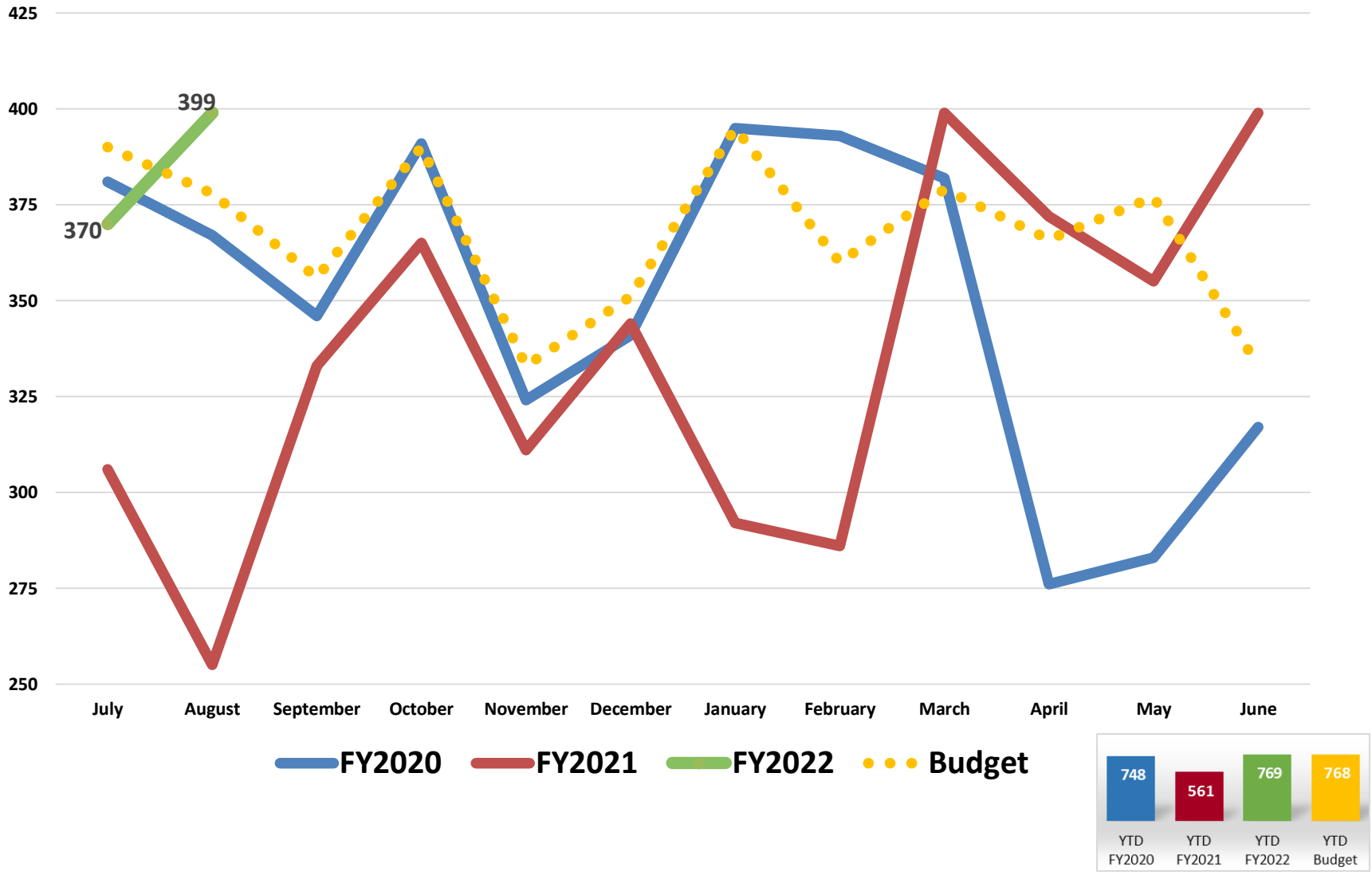
West Campus – CT Scan



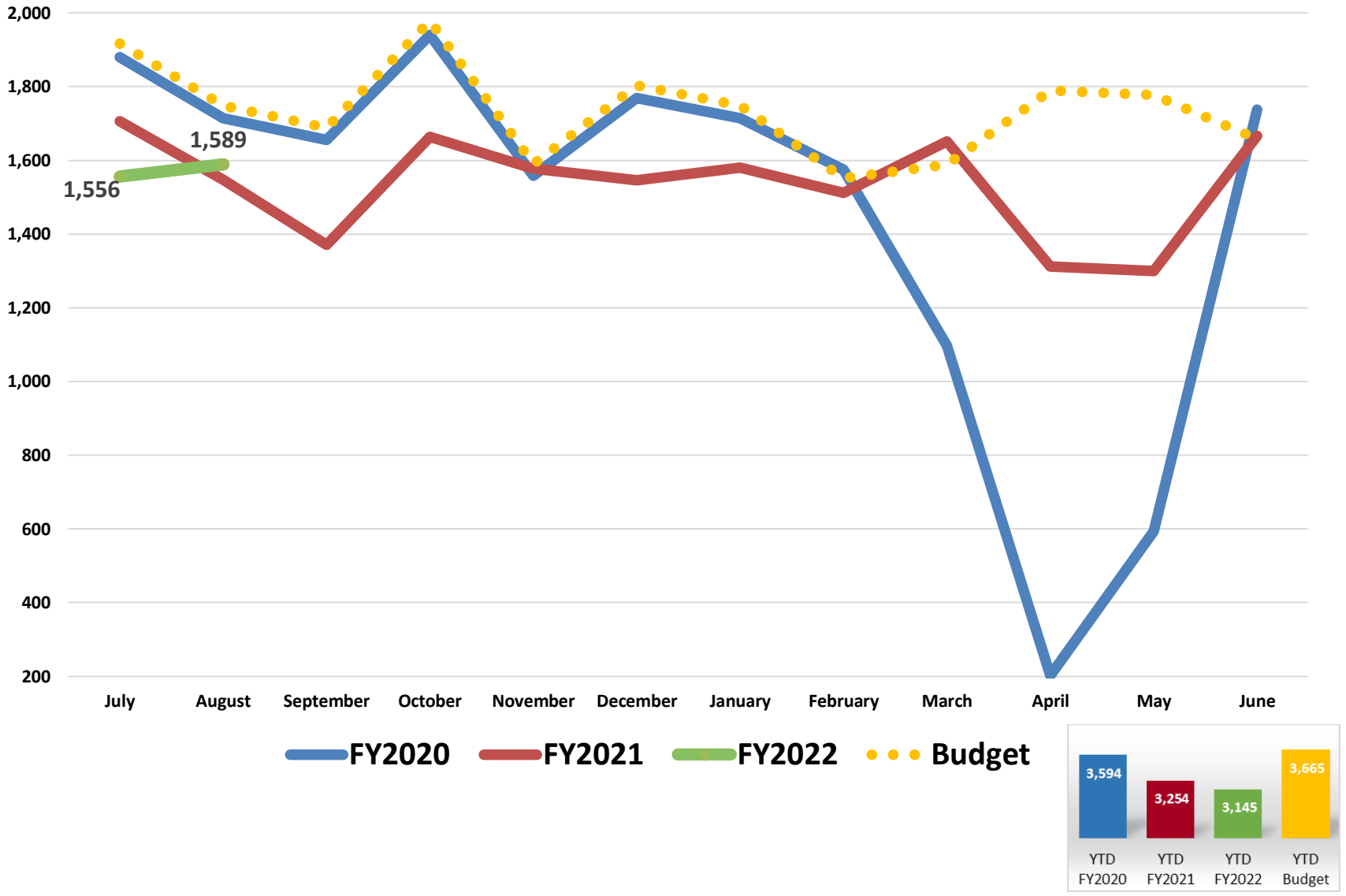
West Campus - Ultrasound



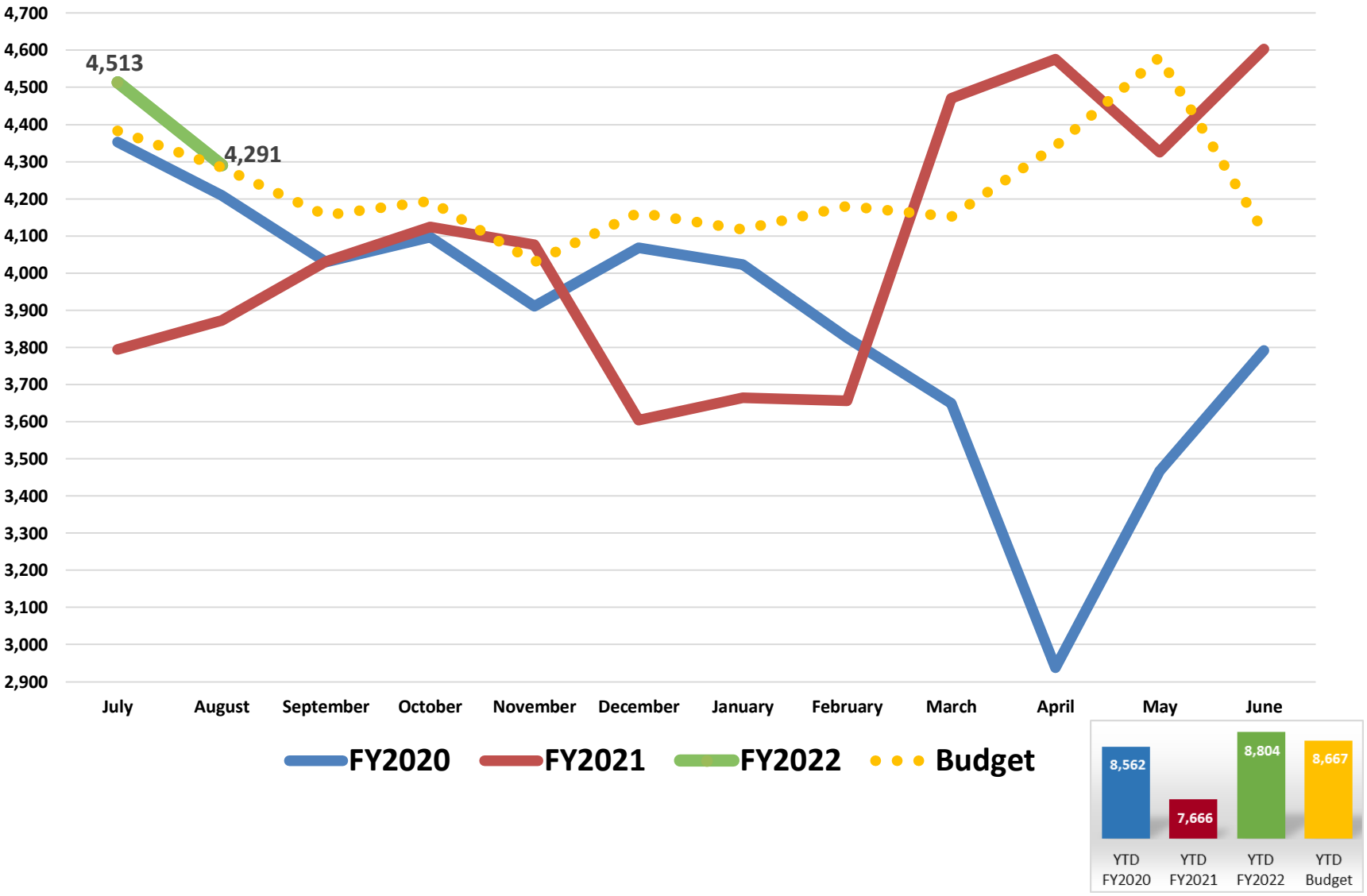
West Campus - MRI



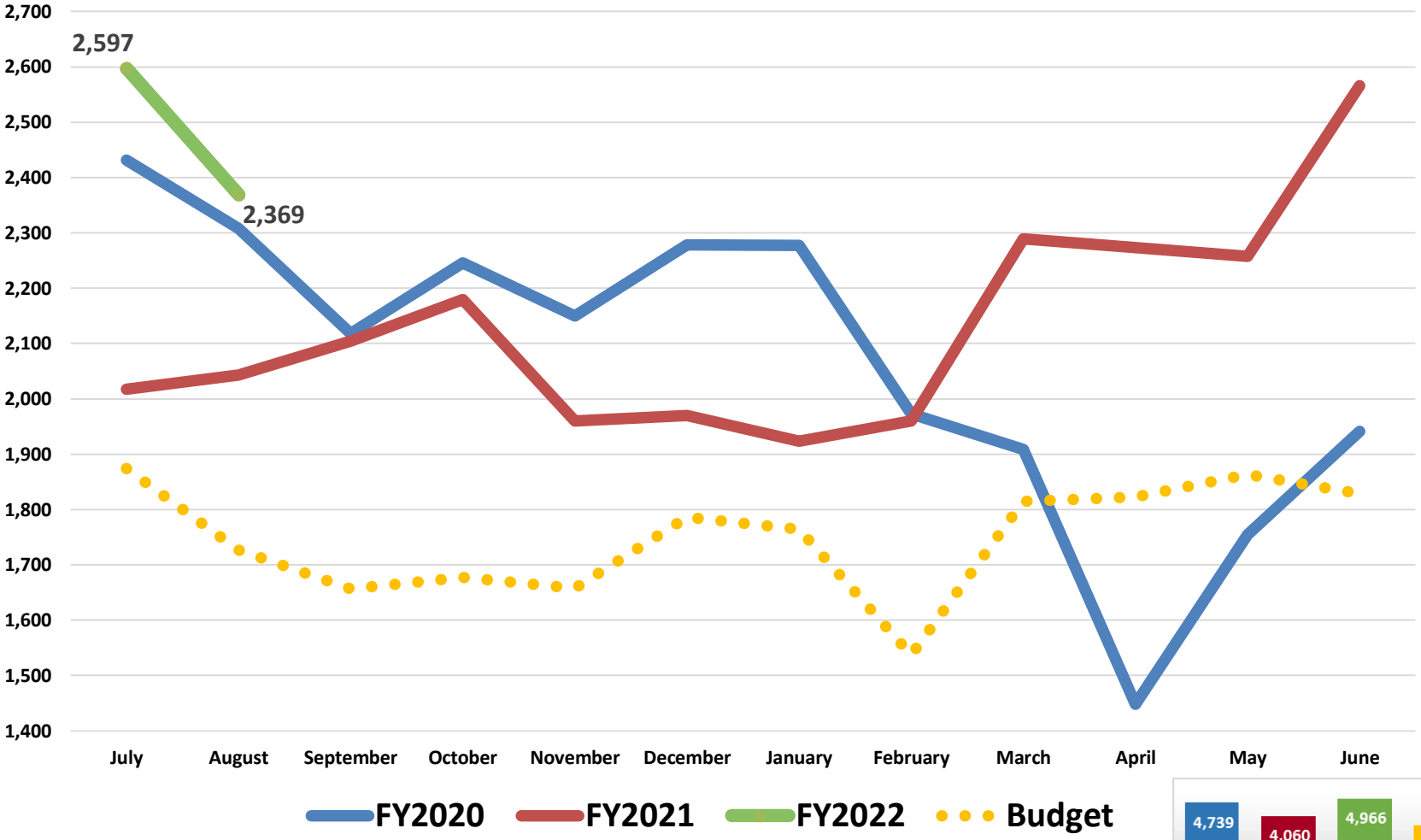
West Campus – Breast Center

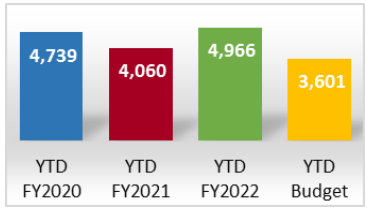


Radiology all areas – CT

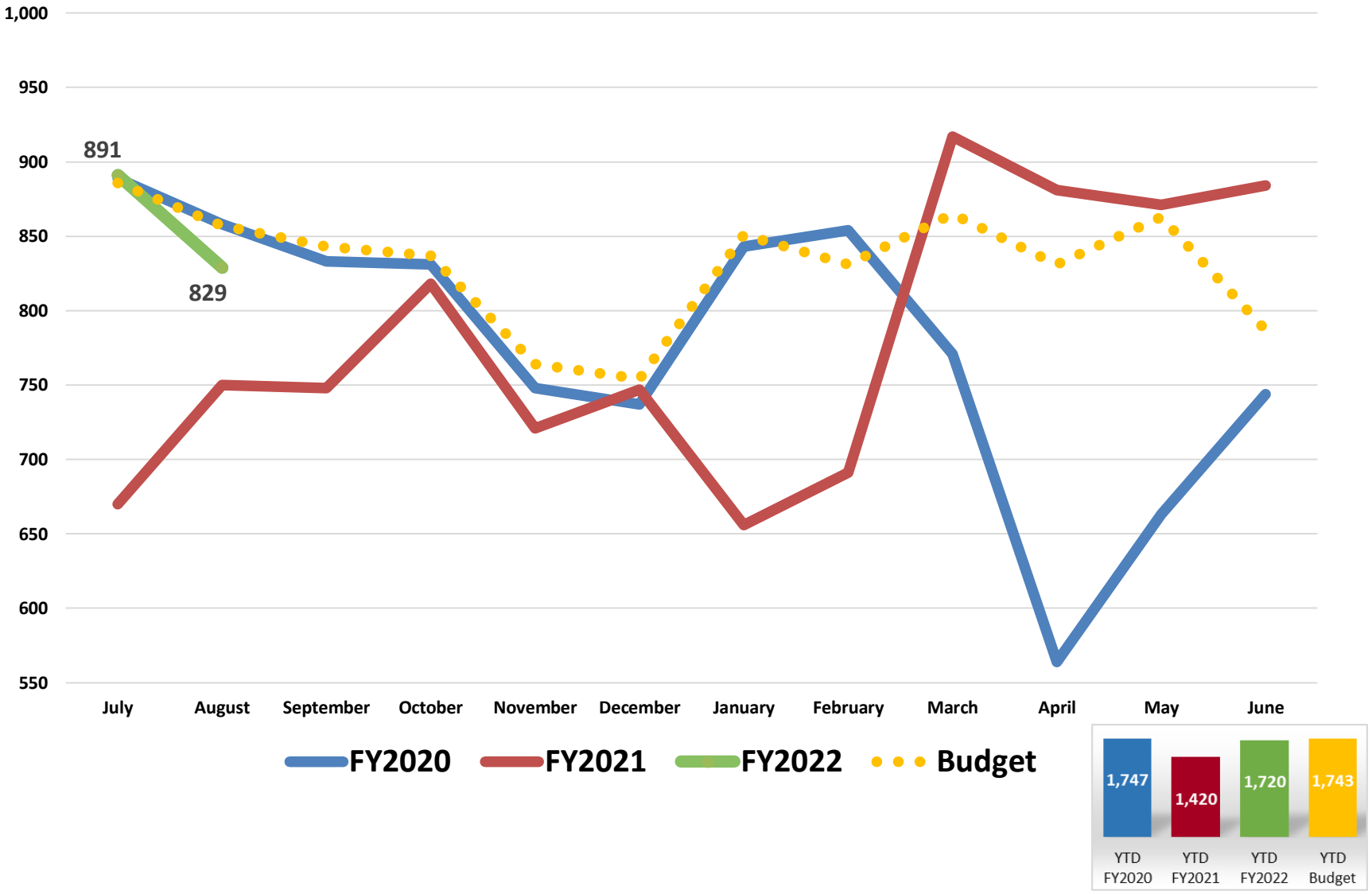


Radiology all areas – Ultrasound

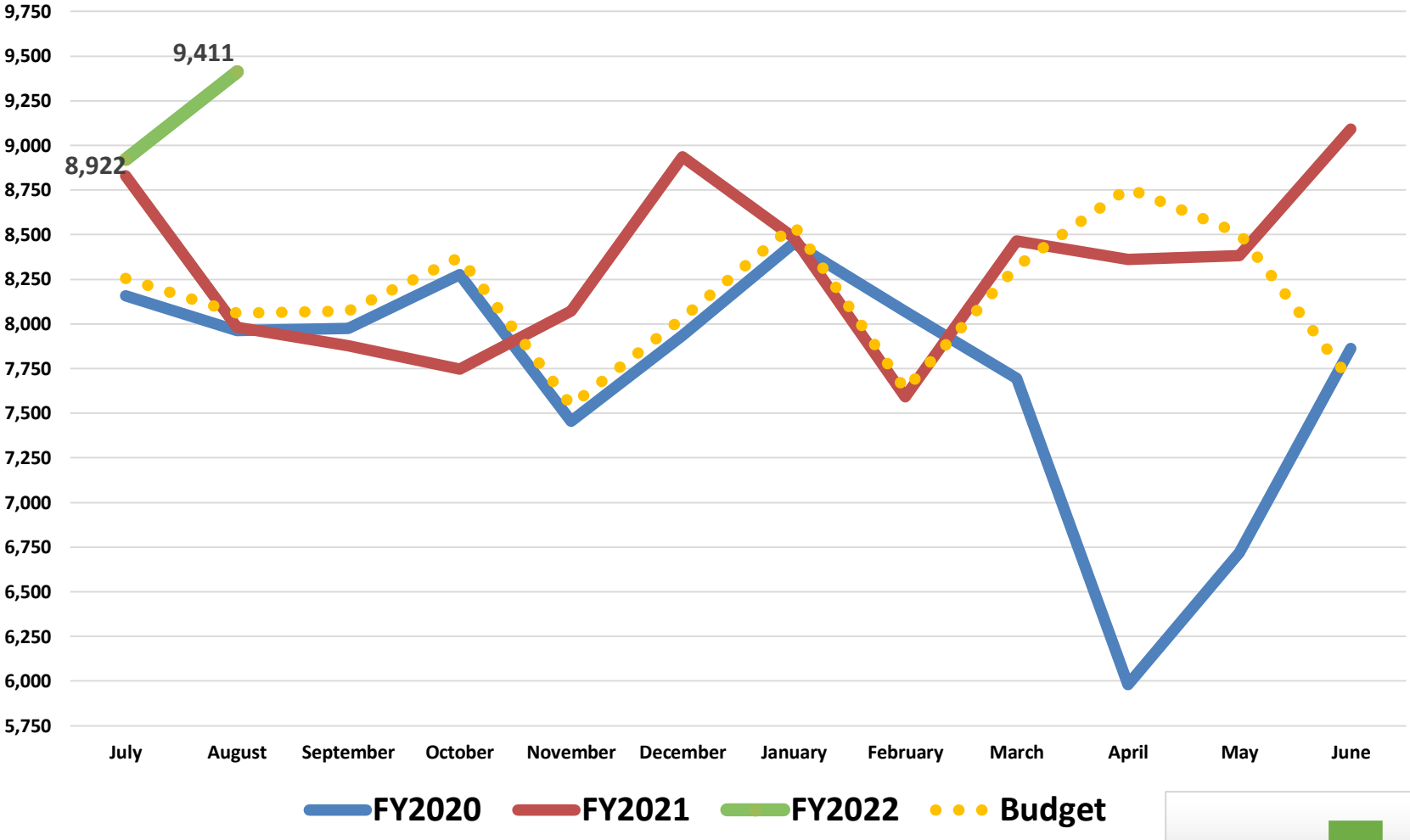


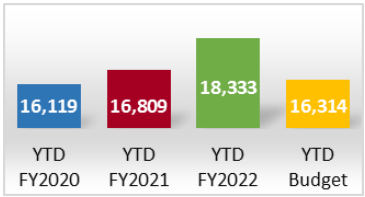


Radiology all areas – MRI

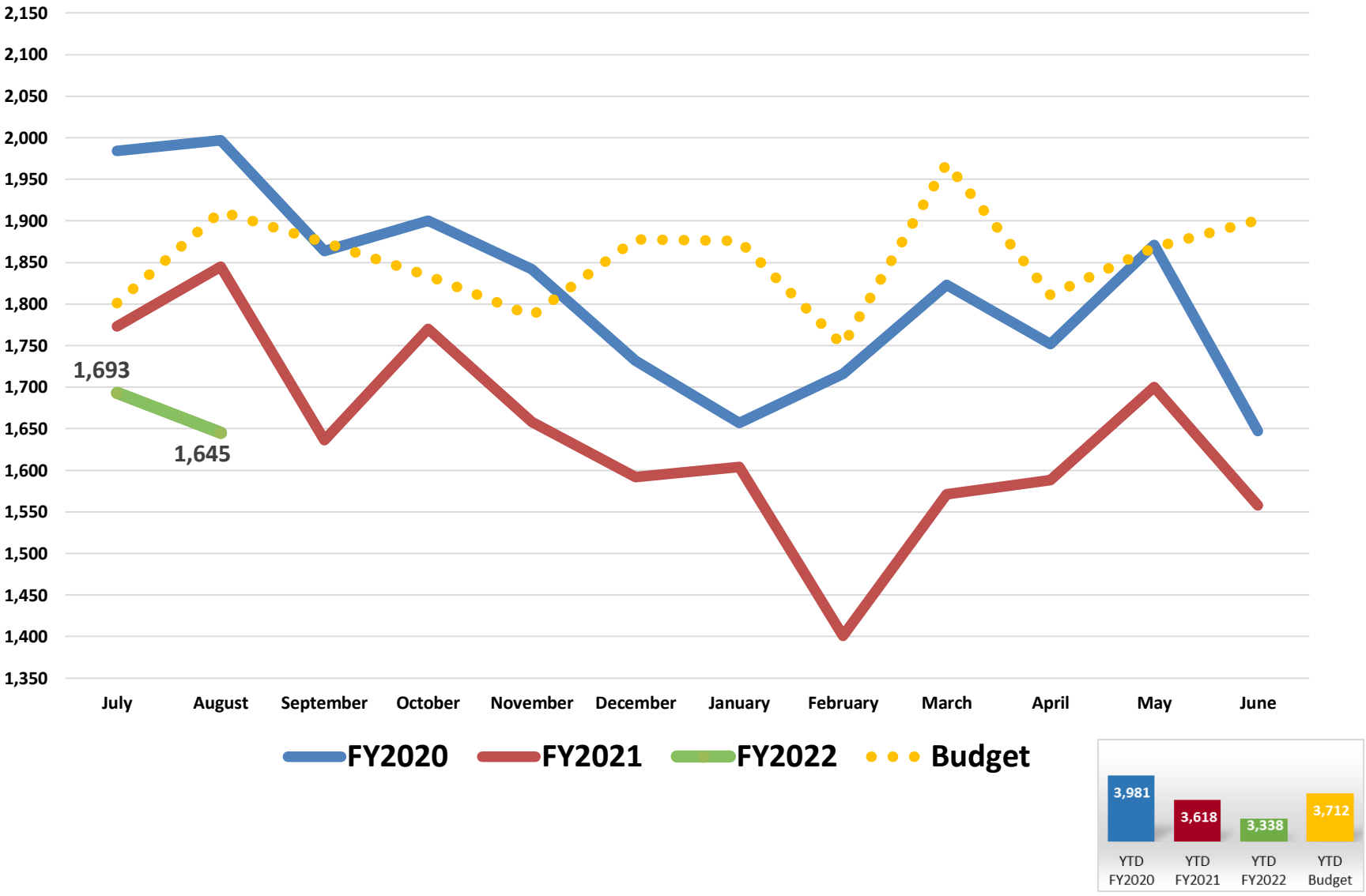


Radiology Modality – Diagnostic Radiology



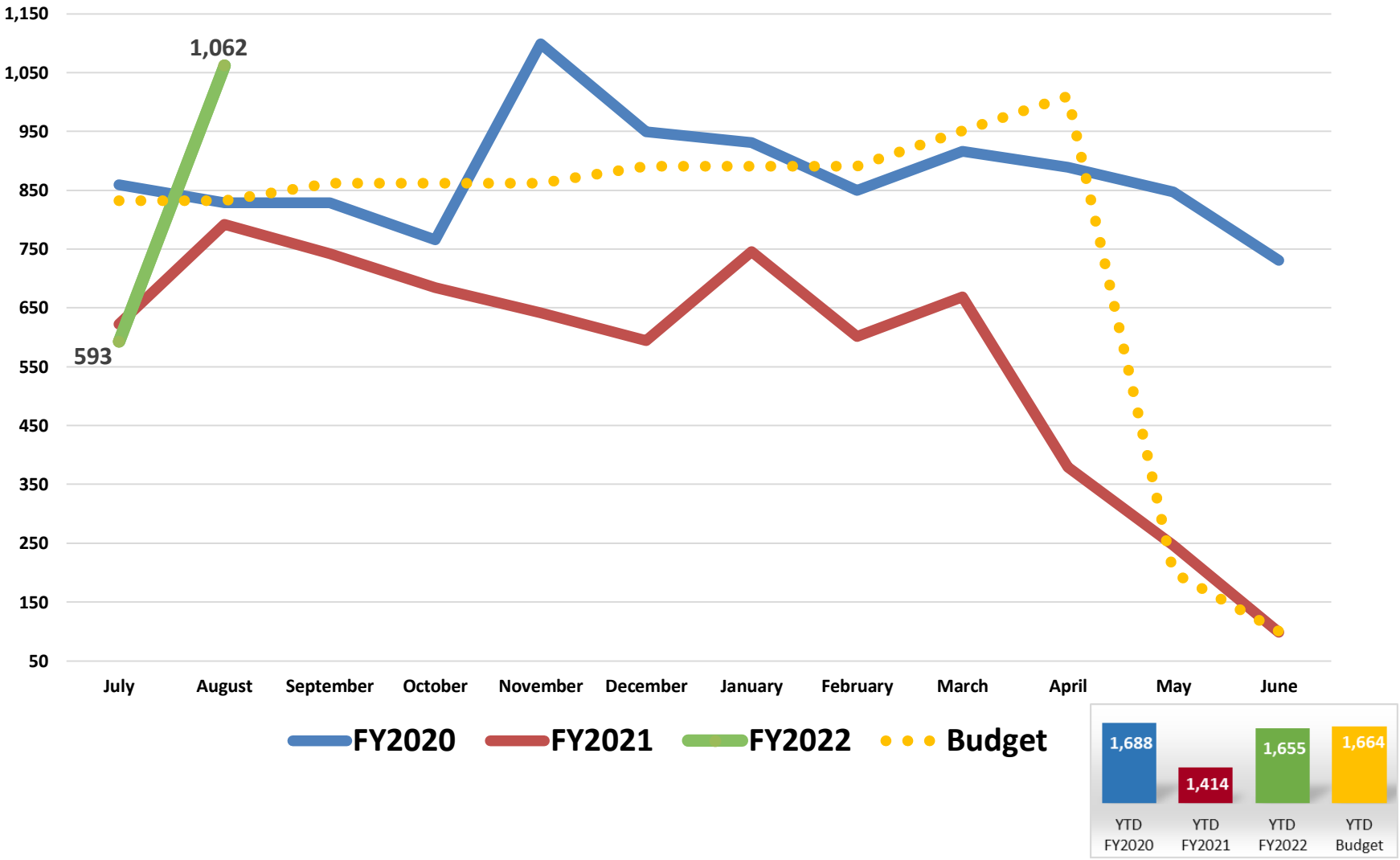


Chronic Dialysis - Visalia



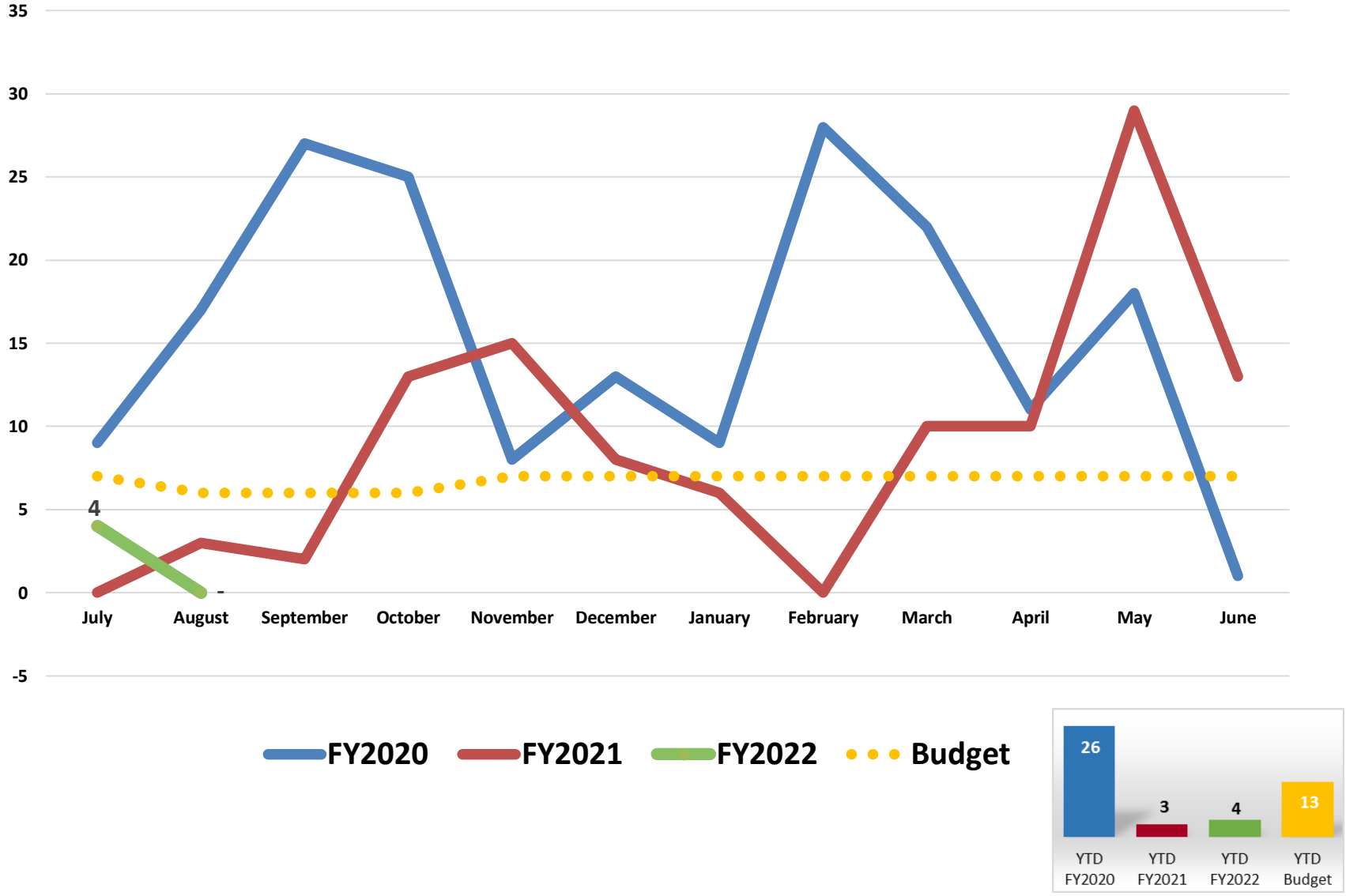
CAPD/CCPD – Maintenance Sessions

(Continuous peritoneal dialysis)



CAPD/CCPD – Training Sessions

(Continuous peritoneal dialysis)



Infusion Center – Outpatient Visits