SOUTHERN INYO HEALTHCARE DISTRICT

Notice of a Special Meeting of the Board of Directors

Date: Thursday, September 19, 2019
Time: 4:30 p.m.

Location: RCA Church
550 East Post St
Lone Pine, CA 93545

Secretary Carma Roper will be participating via phone
230 N. Webster, Independence, CA 93526

AGENDA

I. CALL TO ORDER

A. Pledge of Allegiance
B. Roll Call
C. Approval of Agenda

II. BUSINESS ITEMS

A. Appoint Board Member (Board of Directors)

B. Discussion regarding future of Southern Inyo Hospital facilities. (President/Attorney)

C. Consent Agenda: These items are considered routine and non-controversial and will be approved by one motion. If a member of the Board or public wishes to discuss an item, it will removed from Consent and considered separately at the end of Business Items.

1. Approval of Medical Staff Privileges

a. Jasiri Kennedy, MD, ER Physician, Two Year Medical Staff Privileges.

2. Approval of Contracts

a. ZOOM Meeting Subscription
b. Three Year ADP Payroll Renewal Agreement
c. Merchant McIntyre Associates Service Agreement
d. USAC Renewal Agreement

3. Approval of Board Minutes

a. Regular Board Meeting Minutes for July 9, 2019
b. Special Board Meeting Minutes for July 31, 2019
c. Special Board Meeting Minutes for August 8, 2019
d. Regular Board Meeting Minutes for August 13, 2019

4. Approval of Policies and Procedures
a. Charity Care, Deposit & Discount Payment
b. Emergency Management Program
c. Hazard Vulnerability Analysis
d. Nurse Practitioner Standardized Procedures

D. Laboratory Medical Directorship Agreement with Eva Wasef (CEO)
E. Kevin Flanigan, MD Clinic and ER Physician Agreement (CEO)
F. Jasiri Kennedy, MD, ER Physician Agreement (CEO)
G. Letter to OSHPD Acknowledgment of Seismic Compliance 2030 (CEO)
H. Volunteer Program (HR)
I. Approval of Resolution No. 19-7 for the Board of Directors to change the authorized signatory for the Southern Inyo Healthcare District Bank Accounts (Board of Directors)
J. Accounting Payable Clerk Job Description (Accounts Payable Rep)
K. American Medical Association Agreement
L. Amended ER Physician Agreement – Michael Dillon (CEO)

III. REPORTS

A. Financial Report
B. CEO Report
C. Quarterly Medical Staff Report (Dr. Ronald Ostrom and/or Dr. Todd Farrer)
D. Employee of the Month- September Employee of the Month will be announced at the October Regular Board Meeting.

IV. PUBLIC COMMENTS ON ITEMS NOT ON THE AGENDA

V. BOARD OF DIRECTORS COMMENTS ON ITEMS NOT ON THE AGENDA

VI. CLOSED SESSION

A. Existing Litigation (Govt Code 54956.9): Chapter 9 Bankruptcy
B. Potential Litigation: Medefis

VII. CLOSED SESSION REPORT

VIII. ADJOURNMENT

NOTICE TO THE PUBLIC

PUBLIC COMMENT PERIOD FOR REGULAR MEETINGS

Members of the public may comment on any item on the agenda before the Board takes action on it. The public may also comment on items of interest to the public that are within the subject matter jurisdiction of the Board; provided, however, the Board may not take action on any item not appearing on the agenda unless the action is otherwise authorized by law. Any person addressing the Board will be limited to a maximum of three (3) minutes so that all interested parties have an opportunity to speak.

COPIES OF PUBLIC RECORDS

All writings, materials, and information provided to the Board for their consideration relating to any open session agenda item of the meeting are available for public inspection and copying during regular business hours at the Administration Office of the District at 501 E. Locust Street, Lone Pine, California.

COMPLIANCE WITH ADA

This agenda shall be made available upon request in alternative formats to persons with a disability, as required by the Americans with Disabilities Act of 1990 (42 U.S.C. § 12132) and the Ralph M. Brown Act (Cal. Gov't Cod. § 54954.2). Persons requesting a disability related modification or accommodation in order to participate in the meeting should contact the Administrative Office during regular business hours by phone at (760) 876-5501, or in person at the District's Administrative Office at 501 E. Locust St., Lone Pine, California.

So. Inyo Hospital
PO Box 1009
Lone Pine, Ca. 93545

July 24, 2019

Dear Jackie:

Consider this letter my interest in being considered for a position on the Board of Southern Inyo Hospital when there is a vacancy. I have considerable qualifications having been a Nursing Home Administrator and quite familiar with hospital procedures. I do have a conflict of interest with providing television and the Doctor's House rental. My wife is also a private pay resident of the nursing home facility. I would appreciate your consideration for a position on the Board. Thank you for your attention.

Very truly yours,

Bruce Branson
bjbranson@lonepineisp.com
760-614-0004

Maritza Perkins

From: Pat Cecil <pcecil1952@gmail.com>
Sent: Tuesday, September 17, 2019 1:13 PM
To: Maritza Perkins
Subject: Board vacancy

Southern Inyo Health District
501 East Locust Street
Lone Pine, CA 93545

September 17, 2019

Attention: Maritza Perkins

Please accept this letter as an application for the Board vacancy. My address is 140 S. Hay Street, which is within the District 3 boundaries. I have lived at this address in Lone Pine for twelve years.

I have a BA in Social Science with a minor in Environmental Studies from San Jose State University, and 33 years of experience in City and County Planning (24 years in California). In the recent past, I have also been a member of the Inyo County Grand Jury. Over the years I have worked with numerous Boards and Commissions, am very familiar with the Brown Act, LAFCO regulations, Robert's Rules of Order and the Ethic Rules of the State of California.

I feel that with my experience and desire to maintain the quality of life in our community I would be a good addition to the Board.

If you require any additional information regarding my qualifications, please feel free to contact me.

Sincerely

James P. (Pat) Cecil
P.O. Box 1234 (140 S. Hay Street)
Lone Pine, CA 93545
760.876.5251
pcecil1952@gmail.com

SIHD
SOUTHERN INYO HEALTHCARE DISTRICT

Southern Inyo Hospital
501 E. LOCUST ST. • P.O. BOX 1009
LONE PINE, CALIFORNIA 93545

Telephone (760) 876-5501
Fax (760) 876-4388
Admin Fax (760) 876-2268

September 18, 2019

Board of Directors
Southern Inyo Hospital
P.O. Box 1009
Lone Pine, CA 93545

Active Medical Staff Privileges are extended to Jasiri Kennedy, MD, Emergency Department Physician for a period of two years, from September 18, 2019 to September 18, 2021 by the Board of Directors of Southern Inyo Healthcare District, in accordance with the Medical Staff Bylaws of Southern Inyo Healthcare District.

Respectfully,

Vickie Torix
Medical Staff Secretary

Ronald Ostrom, DO, Medical Director of ER	Date
Peter Spiers, CEO	Date
Jaque Hickman, Board President	Date

Zoom Meeting Plans for Your Business

A Month

Basic	Pro	Business	Enterprise
Personal Meeting	Great for Small Teams	Small & Med Businesses	Large Enterprise-Ready
Free	$14.99	$19.99	$19.99
Sign up, It's Free (https://www.zoom.us/signup)	/mo/host	/mo/host *Minimum of 10 hosts	/mo/host *Minimum of 50 hosts
Host up to 100 participants	Buy Now (https://www.zoom.us/buy?plan=pro&from=pro)	Buy Now (https://www.zoom.us/buy?plan=biz&from=biz)	Contact Sales (https://www.zoom.us/contacts:
Unlimited 1 to 1 meetings	All Basic features +	All Pro features +	All Business features +
40 mins limit on group meetings	Includes 100 participants Need more participants?	Includes 300 participants Need more participants?	Up to 1,000 participants Unlimited Cloud Storage
Unlimited number of meetings	Meeting duration limit is 24 hrs	Dedicated phone support	Dedicated Customer Success Manager
Online support	User management	Admin dashboard	Executive Business Reviews
Video Conferencing Features	Admin feature controls	Vanity URL	Bundle discounts on Webinars and Zoom Rooms
Web Conferencing Features	Reporting	Option for on-premise deployment	
Group Collaboration Features	Custom Personal Meeting ID	Managed domains	
Security	Assign scheduler	Single sign-on	
	1GB of MP4 or M4A cloud recording	Company branding	
	REST API (https://www.zoom.us/developer)	Custom emails	
	Skype for Business (Lync) interoperability	LTI integration	
	Optional Add-on Plans	Cloud Recording Transcripts	
		Optional Add-on Plans	

Software-Based Conference Room Solutions

Zoom Rooms	H.323 Room Connector
$49.00/mo/room	$49.00/mo/port *

ADP, LLC GUARANTEED PRICE AGREEMENT

Client Name:	**SOUTHERN INYO HOSPITAL**		
Effective Date:	10/01/2019		
Expiration Date:	10/01/2022		
Customer #(s):	456148	Reference ID #:	3-49445716380
Contact Name:	Maritza Perkins	Requested By:	Carly Fischer
Contact Email:	mperkins@sihd.org	Contact Phone:	760-876-2210

ADP, LLC ("ADP") is pleased to provide SOUTHERN INYO HOSPITAL ("Client") with a guaranteed price agreement (the "Price Agreement"), which shall govern any increases in fees to the Services (as defined in section 1 below) purchased by Client for the next 3 year(s), subject to the terms and conditions set forth in this Price Agreement. In consideration of the mutual agreements set forth below, ADP and Client agree as follows:

1) Price Increase: For the next 3 year(s) commencing with the Effective Date of this Price Agreement, ADP will increase prices per the schedule below for the processing services (the "Services") listed in section 1a that Client is receiving or shall receive as of the Effective Date.

1a) Included Services:

- Payroll
- HCM
- TLM

1b) Processing Services:

Year #	Guaranteed Price Period	Increase %	Increase Date
1	10/01/2019 to 09/30/2020	0.00%	10/01/2019
2	10/01/2020 to 09/30/2021	1.00%	10/01/2020
3	10/01/2021 to 09/30/2022	2.00%	10/01/2021

Items specifically excluded from this agreement are delivery, reverse wire fees, jurisdiction fees, year-end fees, and maintenance fees. In the month following the Expiration Date, Client's prices will be subject to the same price increases applied to its other clients of similar size and product utilization unless a renewal agreement is signed by both parties.

2) Guaranteed Term: As consideration for the Price Agreement, Client agrees to purchase the Services for a minimum guaranteed term of 3 year(s) commencing with the Effective Date of this Price Agreement and thereafter Client's agreement to purchase the Services shall remain in effect until terminated by Client or ADP in accordance with the terms of the ADP Major Accounts Agreement (or such equivalent ADP terms and conditions or agreement governing the provision and receipt of ADP Services including but not limited to any product specific terms set forth in such agreement) between ADP and Client (the "ADP Services Agreement").

3) Early Termination Fee: If Client terminates all Services without cause as provided in the ADP Services Agreement prior to the Expiration Date of this Price Agreement, Client agrees to pay ADP an early termination fee of 3 month(s) of average monthly processing fees for the Services (based on the average monthly fees during the twelve-month period immediately preceding the date of termination or a shorter period of time if monthly fees have been payable for less than 12 months at the termination date). If Client fails to pay the early termination fee, Client shall reimburse ADP for any expenses incurred, including interest and reasonable attorney fees, in collecting amounts due ADP hereunder. The early termination fee will be waived by ADP in the event there is a material breach by ADP of any material warranty, term, condition or covenant of the ADP Services Agreement and ADP fails to cure such breach within the timeframe provided in such ADP Services Agreement.

THE ADP SERVICES COVERED BY THIS AGREEMENT ARE PROVIDED IN ACCORDANCE WITH THE TERMS AND CONDITIONS SET FORTH IN THE AGREEMENT(S) BETWEEN CLIENT AND ADP COVERING THE SPECIFIC SERVICES. THIS AGREEMENT SUPPLEMENTS AND DOES NOT SUPERSEDE ANY OF THOSE TERMS AND CONDITIONS. THIS AGREEMENT IS NOT VALID UNLESS SIGNED BY BOTH PARTIES. IN THE EVENT CLIENT HAS AN EXISTING PRICE AGREEMENT IN PLACE, THIS AGREEMENT REPLACES ANY PRIOR PRICE AGREEMENT GOVERNING THE SAME SERVICES.

ADP, LLC		SOUTHERN INYO HOSPITAL	
Name:	_____	Name:	_____
Signature:	_____	Signature:	_____
Title:	_____	Title:	_____
Date:	_____	Date:	_____

NOTE: THIS PRICE AGREEMENT IS VALID ONLY IF SIGNED BY BOTH PARTIES WITHIN 30 DAYS OF THE DATE OF CREATION. THE AGREEMENT MUST BE SIGNED BY 09/27/2019 IN ORDER TO BE VALID. FINANCE OR RELATIONSHIP MANAGEMENT IS AUTHORIZED TO EXECUTE THIS AGREEMENT ON BEHALF OF ADP.

Reply all | Delete | Junk | Block | ...

FW: Federal Grant Funding Proposal

PS

Peter Spiers
Tue 9/17/2019 12:40 PM
Maritza Perkins

For the Board meeting...

From: Mark McIntyre [mailto:mmcintyre@merchantmcintyre.com]
Sent: Thursday, September 5, 2019 1:27 AM
To: Peter Spiers <pspiers@sihd.org>
Subject: Re: Federal Grant Funding Proposal

Here's how Merchant McIntyre rolls on the 90-day audition assessment: We will absolutely hold up our end of this process. If there are grants to be won in the immediate/near term, we'll show you. If SIHD isn't competitive for whatever reason, we'll explain why. If there's a major grant opportunity six months out, we may suggest you stop paying us for three months.

Our objective is to deliver the best possible ROI. We absolutely won't burn SIHD's money.

Thanks again for keeping us apprised in real time.

Mark D. McIntyre

MERCHANT MCINTYRE ASSOCIATES

Service Agreement

Southern Inyo Healthcare District ("SIHD") in Lone Pine, CA agrees to retain Merchant McIntyre & Associates, LLC in Washington, D.C. ("MM") (together, the "Parties") for government relations services commencing on September 15, 2019 and terminating on December 14, 2019 (the "Term").

Fee. SIHD agrees to pay MM a total professional fee of $7,500 per month, billed monthly in advance, plus expenses related to the program. Payment shall be made to MM on or before the first (1st) of each month at the address listed on the MM invoice(s). Federal funds may not be used to pay MM professional fees.

Deliverables. MM shall produce three (3) deliverables during the Term of this Agreement:

1. Conduct a Resource Inventory in Lone Pine to identify specific federal funding objectives and potential federal funding requests.

2. Prepare a comprehensive Federal Grants Strategy featuring a detailed Federal Grants Grid and a specific Action Plan for SIHD so SIHD's leadership can review and assess federal funding opportunities firsthand and evaluate MM's strategies to secure that funding.

3. Arrange substantive Congressional and Executive Branch meetings in D.C. between SIHD leaders and the federal decision makers who have jurisdiction over funding for SIHD.

Renewal. At the end of the initial Term, SIHD reserves the right to renew this Agreement, commencing on December 15, 2019 and terminating on December 14, 2020 (the "Renewal Term"). The Renewal Term shall incorporate all terms of the original Agreement.

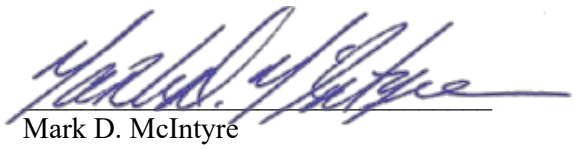
Scope of Work. In its capacity as a consultant, MM shall make its best effort to assist SIHD in pursuing its federal funding and government relations objectives. The nature of these objectives shall be determined by SIHD's leadership with the advice and assistance of MM. In this role, MM shall plan and implement all government relations strategies designed to accomplish SIHD's federal funding objectives; assist in the preparation of grant applications and supporting materials for the initiatives; develop meetings with Members of Congress, congressional staff, and federal agency decision-makers to advance the funding initiatives; and serve as liaison to federal agencies relevant to the funding initiatives. SIHD agrees to frequent communication with MM and to provide MM the necessary information in real time to help MM plan and implement strategies.

Indemnification. SIHD agrees to indemnify and hold MM harmless from and against all liability, including all actions, claims, damages, costs, and attorneys' fees, which MM may incur (or to which MM may be a party), arising out of actions taken or statements made by MM at SIHD's direction or based upon information provided by SIHD, except in the event of wrongful acts or omissions on MM's part.

Assignment. No other party shall assign any of its rights or delegate any of its duties or obligations under this Agreement without the express written consent of the other party.

—SIGNATURES ON NEXT PAGE—

IN WITNESS THEREOF, the parties hereto have executed or approved this Agreement on the dates below their signatures.



Mark D. McIntyre
Principal and Co-Founder
Merchant McIntyre & Associates, LLC

Date: 08/16/2019

Mr. Peter Spiers
Chief Executive Officer
Southern Inyo Healthcare District

Date: _____

# # # #

FILING AGENT RURAL HEALTHCARE AGREEMENT

THIS CONSULTING AGREEMENT (the "Agreement") is made and entered into this the ____ day of _____ 2019, between **Channelford Associates, Inc.**., (hereinafter, "Channelford"), a California Corporation, and **Southern Inyo Healthcare District** hereinafter, "Company"). Channelford and Company may be referred to in this Agreement collectively as the "Parties", or individually as a "Party".

WHEREAS, Channelford has expertise in the area of Rural Health Care Program (RHCP) including both the Telecommunications Program and the Health Care Connect Fund (HCF) and is willing to provide consulting services to Company and

WHEREAS, Company and Channelford desire to enter into an agreement defining their rights and obligations in regard to the performance of Channelford's services.

NOW THEREFORE, the Parties hereby mutually agree as follows:

AGREEMENT

1. **Services:** As of the date of this Agreement, Company contracts with Channelford for Rural Health Care Program subsidy services. Channelford agrees to: (1) provide professional services to collect the information needed from Company for subsidy under applicable state or federal programs; (2) complete any required Rural Health Care applicable forms; (3) act as Company's agent in dealings with Company's telecommunications service providers and the applicable state or federal government agency and; (4) work to obtain the maximum subsidy from available state and federal programs. Channelford makes no guarantee of subsidy from any applicable Rural Health Care Program, and will solely determine which services to submit. In the event that legislative or regulatory changes substantially modify any applicable Rural Health Care Program, the Parties agree to renegotiate the rights and obligations set forth in this Agreement. Upon request Channelford will provide the Company with copies of any and all documents submitted on Company's behalf upon full payment of professional fees due Channelford.

2. **Compensation:** Compensation will be billed as defined below over the term of the Agreement. Each year is billable based on the monies that are associated with that year. That is, compensation for year 1 will be based on the subsidies approved and received for year 1. Compensation for year 2 will be based on the subsidies approved and received for year 2. Compensation for year 3 will be based on the subsidies approved and received for year 3. Compensation for year 4 will be based on the subsidies approved and received for year 4. Compensation for year 5 will be based on the subsidies approved and received for year 5. So long as Channelford shall be performing its duties in compliance with all the terms hereof, Company shall pay to Channelford, and Channelford shall accept from Company, for all of the services to be rendered by Channelford hereunder compensation as follows:

   a) **Professional Fees:** Company agrees to pay Channelford ten percent (10%) of actual subsidy credits/receipts received by company as set forth on the applicable program's Funding Approval Schedule. Each funded circuit(s) will generate a separate funding approval from USAC RHCP with a unique FRN (Funding Request Number), and invoiced fees will be described in this manner.

The professional fees will be due and payable upon receipt of the applicable funding from the applicable government agency and are due and payable within thirty (30) days of when the particular funding is received by the company

b) If Company fails to make payments on a timely basis, Channelford shall have the right to charge a late fee of 1 ½ % per month on any undisputed balances 90 days in arrears.

3. **Term:** Subject to the provisions for termination set forth below, the term of this Agreement shall begin on the effective date set forth above and shall continue through the remainder of the funding years associated with that year and the following three (3) funding years (hereinafter "Initial Term"): That is the current full or partial year, and the following complete three (3) fund years since funding cycles overlap unless terminated earlier pursuant to any of its express provisions.

The original term of this agreement will end with the completion of all funding and invoicing for the 2022-2023 funding year.

For the avoidance of doubt, the application process or ("Start Date") for the services and benefits contemplated by this agreement for a particular USAC funding year begins six (6) months (or January 1st) prior to each USAC funding year (or July 1st – June 30th) and progresses for a year past the end of any given USAC funding year. USAC may change the rules, timeline, and filing windows based on the overall utilization of the funding monies and/or governmental changes to the program. Channelford will keep Company appraised of ongoing changes to the program as they occur.

4. **Relationship of the Parties:** The relationship between the Parties shall be one of independent contractor. Channelford shall not be deemed an employee of Company or any related entity or facility, nor shall this Agreement constitute or be construed as a joint venture, partnership, agency or other type of relationship.

5. **Termination:** This Agreement may be terminated under one or more of the following conditions:

a) When a Party is in breach of this Agreement by failing to perform any of its obligations as provided for in this Agreement, and has failed to cure such breach within 30 days of the receipt of written notice of breach from the non-breaching Party

b) The Parties mutually agree in writing to such termination.

c) The applicable Rural Health Care program ceases to exist or the applicable program is terminated.

d) The intent not to renew this contract must be communicated in writing to the other Party at least ninety (90) days prior to the next "Start Date" associated with the expiration of the "initial term" *or* subsequent renewal term. See section above "**3. Term:**"

e) Such provisions of this Agreement that, by their nature, would be expected to survive termination of this Agreement, including, without limitation, Sections 2, 6, and 7, of this Agreement shall survive any termination of this Agreement. If this Agreement is terminated pursuant to this Section 5, after the filing of form 466/466A or 462, the termination fee will be the above agreed upon ten percent (10%) of the funding

commitment unless already paid. All other rights to receive consulting fees shall terminate on the date of termination.

6. **Proprietary Rights:** Channelford and Company shall retain all rights to methodology, knowledge, and data belonging to each of them prior to this Agreement and used to perform herein. Company agrees that its proprietary rights do not extend to any ownership, copyright, patent, trade secrecy, or other rights in all works, inventions, improvements, discoveries, processes or other properties made or conceived by Channelford prior to the term of this Agreement, which result from work performed by Channelford for itself or others, or which are derived from works, processes or properties resulting from work performed for Company. Company further agrees that Channelford's confidential and proprietary information that may be used by Channelford in performing work under this Agreement shall remain property of Channelford

7. **Notices:** All notices and other communications under this Agreement must be in writing and will be deemed given: (a) when delivered personally; (b) on the fifth business day after being mailed by certified mail, return receipt requested; (c) the next business day after delivery to a recognized overnight courier; or (d) upon transmission and confirmation of receipt by a facsimile operator if sent by facsimile, to the Parties at the following addresses or facsimile numbers (or to such other address or facsimile number as such Party may have specified by notice given to the other Party pursuant to this provision):

If to Company:	If to Channelford:
Jaque Hickman, President of Board	**Steve Rau, CEO**
Name/Title	**Name/Title**
Southern Inyo Healthcare District	**Channelford Associates, Inc.**
Hospital	**Company**
509 East Locust St	**2006 Channelford Road**
Physical Address	**Physical Address**
Lone Pine, CA 93545	**Westlake Village, CA 91361**
City/State/Zip	**City/State/Zip**

8. **General Provisions:**

a. **Attorneys' Fees and Costs**. In the event that attorneys' fees or other costs are incurred to secure performance of any of the obligations set forth in this Agreement, to establish damages for the breach hereof including collection costs or to obtain any other appropriate relief, whether by way of prosecution or defense, the prevailing Party shall be entitled to recover such reasonable fees and costs incurred therein.

b. Counterparts. This Agreement may be executed in one or more counterparts (including by facsimile or portable document format (PDF) for the convenience of the Parties hereto, each of which will be deemed an original, but all of which together will constitute one and the same instrument. No signature page to this Agreement evidencing a Party's execution hereof will be

deemed to be delivered by such Party to any other Party hereto until such delivering Party has received signature pages from all Parties signatory to this Agreement.

c. Assignment. Either Party may assign this Agreement at any time, by giving the other Party 30 days prior written notice.

d. Entire Agreement; Amendment. This Agreement, and the attached Letter of Agency Agreement (LOA), which is hereby made a part of and is incorporated into this Agreement, contains the entire understanding of the Parties relating to the subject matter hereof and supersede all prior written or oral and all contemporaneous oral agreements and understandings relating to the subject matter hereof. This Agreement may be amended, supplemented or modified, and any provision hereof may be waived, only by written instrument making specific reference to this Agreement signed by the Party against whom enforcement is sought. This Agreement shall be binding on, and inure to the benefit of, the Parties hereto and their respective permitted successors and permitted assigns.

e. Waiver. No delay or omission by either Party to exercise any right hereunder shall impair such right or be construed as a waiver thereof. All remedies provided for in this Agreement shall be cumulative and in addition to, and not in lieu of, any other remedies available to either Party at law, in equity or otherwise.

f. Severability. If any provision of this Agreement is declared or found to be illegal, unenforceable or void, then each Party shall be relieved of its obligations arising under such provision to the extent such provision is declared or found to be illegal, unenforceable or void. Each provision not so affected shall be enforced to the fullest extent permitted by law.

g. Governing Law. Jurisdiction in California. This Agreement shall not be effective until signed by Channelford at its offices in Westlake Village, CA or by any of its authorized representatives. This Agreement shall be considered to have been made in the State of California and shall be interpreted in accordance with the laws and regulations of California, with venue in Inyo County, CA.

h. Other Documents. Each Party hereto agrees to execute any and all such additional documents and to perform such other acts as may be necessary or expedient to further the purposes of this Agreement.

i. Construction. No provision or this Agreement shall be construed in favor of or against any Party on the ground that such Party or its counsel drafted the provision. Any remedies provided for herein are not exclusive of any other lawful remedies, which may be available to either Party. This Agreement shall at all times be construed so as to carry out the purposes stated herein.

j. Federal Law, Medicare, & Medicaid. Any provision of this Agreement to the contrary notwithstanding, if, during the Term, Company determines that any of the terms of this Agreement materially violate any provisions of state or federal law which, if enforced, would jeopardize the ability of Company to continue to participate in the Medicare and the Medicaid healthcare programs, or in any other federal or state healthcare programs, or would jeopardize the continued federal tax-exempt status of Company, or any entities which are affiliated with Company, or would result in the imposition of any excise taxes under federal income tax laws or would potentially subject Company to any civil monetary penalties or criminal prosecution, then the Parties agree to immediately endeavor to renegotiate terms which would result in Company being in appropriate

legal compliance, in Company's opinion. If the Parties are unable to timely agree on such terms, however, Company may terminate this Agreement by delivering at least a thirty (30) day notice to Channelford.

[SIGNATURE PAGE TO FOLLOW]

IN WITNESS WHEREOF, the Parties hereto have executed and delivered this Agreement as of the date first above written.

SIGNED, this _____ day of_____, 2019

Southern Inyo Healthcare District	**Channelford Associates, Inc.**
Authorized Signature	**Authorized Signature**
Jaque Hickman	Steve Rau
Type or Print Name	**Type or Print Name**
President of Board of Directors	CEO

Title	Title
Date	**Date**
95-6005450	
Federal Tax ID (EIN)	

This agreement allows for the use of an Electronic Signature (E-Signature) by either Party, when executing this agreement.

Channelford Associates, Inc.
LETTER OF AGENCY (LOA)
For Processing Of Rural Health Care Applications

Channelford Associates, Inc., 2006 Channelford Road, Westlake Village, CA 91361
Ph: 888-625-1050 Fax: 888-288-2119 email: steve@channelford.com

Southern Inyo Healthcare District
Health Care Provider (HCP) Name

509 East Locust St
Address

Lone Pine, CA 93545
City, State & Zip

HCP authorizes Channelford Associates, Inc. (Channelford), to represent the HCP as a consultant, and to submit forms for the Rural Health Care Fund's Rural Health Care program (administered by USAC), and to act as the mailing contact person, on HCP's behalf.

HCP will assist Channelford in obtaining copies of all necessary documents necessary to process subsidies for HCP. Pursuant to this end HCP agrees to the following as it concerns common carriers and equipment providers to Company:

> ATTENTION: ("Service Providers") i.e. AT&T, CenturyLink, Comcast, Frontier, Local Operating Companies, Spectrum, Verizon, Windstream and other common carriers cable providers and equipment vendors.
>
> HCP hereby authorizes Channelford, its agents, access to our account information (e.g., customer service records, inventory itemization, rates, charges, and copies of billing) in connection with the sales and/or marketing of network services, customer premises equipment (CPE) and enhanced services.
>
> HCP hereby requests and authorizes Service Providers to provide to Channelford any information requested by them pertaining to telecommunications services used by our Company, for properties owned, managed, or operated by our company (see Addendum).
>
> Under the terms of this letter, HCP hereby authorizes Channelford to access the information above for the sole purpose of analysis and presentation of findings to HCP. This LOA is solely for information gathering; no modifications, additions, or service terminations are authorized by HCP without our expressed written consent.
>
> HCP hereby requests that this authorization to be applied to all of our existing accounts and any new accounts. This authorization does not preclude HCP from acting on its own behalf if it is deemed necessary. I understand that this authorization will remain effective until modified and/or revoked, in writing, by me or another authorized representative of HCP.

HCP will forward copies of any bid requests for information, or actual bids, to Channelford, as soon as received. (Unless an email request clearly shows Channelford was copied on it).

HCP will immediately notify Channelford of any network changes affecting services submitted to USAC, for credits. This applies for the entire funding year HCP is receiving credits. Fund years run from July 1st, to June 30th.This LOA will remain in place until June 30, 2023.

This LOA will continue until rescinded in writing by HCP.

HCP signing representative certifies that they are authorized to sign this document on behalf of the above-named entity or entities.

Company: Southern Inyo Healthcare District
Authorized Signature: Jaque Hickman
President of Board of Directors
Title:
Date:

This agreement allows for the use of an Electronic Signature (E-Signature) by either Party, when executing this agreement.

Version: 07.26.18

RURAL HEALTH CARE PROGRAM CONSULTING AGREEMENT

THIS CONSULTING AGREEMENT (the "Agreement") is made and entered into this the ____ day of _____ 2019, between **SpectraCorp Technologies Group Inc**., (hereinafter, "SpectraCorp"), a Texas Corporation, and, **_Southern Inyo Healthcare District_ (**hereinafter, "Company"). SpectraCorp and Company may be referred to in this Agreement collectively as the "Parties" or individually as a "Party".

WHEREAS, SpectraCorp has expertise in consulting on various telecommunication matters and is willing to provide consulting services to Company toward those ends; and

WHEREAS, Company and SpectraCorp desire to enter into an agreement defining their rights and obligations in regard to the performance of SpectraCorp's services.

NOW THEREFORE, the Parties hereby mutually agree as follows:

AGREEMENT

1. **Services:** In order to initiate and provide the various services outlined in this Agreement, Company agrees to sign a Letter of Agency (LOA) authorizing SpectraCorp to review and look at the background documents to be used in the various reviews. The LOA, which is attached to this Agreement, must be signed concurrently with this Agreement in order for SpectraCorp to start any actionable work product. The Company also agrees to provide as needed copies of various telecom bills in a timely manner to allow SpectraCorp to do a complete analysis of those bills to complete the analysis for the services outlined below.

   As of the date of this Agreement, Company contracts SpectraCorp to assist Company in preparing the documentation required for the filing of subsides for the Rural Health Care Program's (RHCP) Telecom Program and/or the Health Care Connect Fund (HCF). Both programs in which are administered by the Universal Service Administrative Company (USAC) on behalf of the Federal Communications Commission (FCC).

2. **Compensation:** Compensation will be billed as defined below over the term of the Agreement. Each year is billable based on the monies that are associated with that year. That is, compensation for year 1 will be based on the subsidies approved and received for year 1. Compensation for year 2 will be based on the subsidies approved and received for year 2. Compensation for year 3 will be based on the subsidies approved and received for year 3. Compensation for year 4 will be based on the subsidies approved and received for year 4. Compensation for year 5 will be based on the subsidies approved and received for year 5. As long as SpectraCorp shall perform its duties in compliance with all the terms hereof, Company shall pay to SpectraCorp, and SpectraCorp shall accept from Company, for all of the services to be rendered by SpectraCorp hereunder compensation as follows:

   a) For Services rendered concerning RHCP Funding, SpectraCorp will receive twenty percent (20%) of all monies actually received by Company. This money will be due and payable within thirty (30) days of when the particular funding is received by the Company.

   b) Should the issuing government entity change the amount of the funding from the amount calculated by SpectraCorp during the filing process, SpectraCorp will adjust its fee accordingly.

c) If Company fails to *make payments on a timely basis,* SpectraCorp shall have the right to charge a late fee of 1 ½ % per month on any balances 90 days in arrears.

3. Term: Subject to the provisions for termination set forth below, the term of this Agreement shall begin on the effective date set forth above and shall continue through the remainder of the funding years associated with that year and the following three (3) funding years (hereinafter "Initial Term"): That is the current full or partial year, and the following complete three (3) fund years since funding cycles overlap unless terminated earlier pursuant to any of its express provisions.

The original term of this agreement will end with the completion of all funding and invoicing for the 2022-2023 funding year.

For the avoidance of doubt, the application process or ("Start Date") for the services and benefits contemplated by this agreement for a particular USAC funding year *begins* six (6) months (or January 1st) prior to each USAC funding year (or July 1st – June 30th) and *progresses* for a year past the end of any given USAC funding year. USAC may change the rules, timeline, and filing windows based on the overall utilization of the funding monies and/or governmental changes to the program. SpectraCorp will keep Company appraised of ongoing changes to the program as they occur.

4. Relationship of the Parties: The relationship between the Parties shall be one of independent contractor. SpectraCorp shall not be deemed an employee of Company or any related entity or facility, nor shall this Agreement constitute or be construed as a joint venture, partnership, agency or other type of relationship.

5. Termination: This Agreement may be terminated under one or more of the following conditions:

a) When a Party is in breach of this Agreement by failing to perform any of its obligations as provided for in this Agreement, and has failed to cure such breach within 30 days of the receipt of written notice of breach from the non-breaching Party.

b) The Parties mutually agree in writing to such termination to the address and Party defined in Section 8 - Notices.

c) The applicable program ceases to exist or the applicable program is terminated.

d) The intent not to renew this contract must be communicated in writing to the other Party at least ninety (90) days prior to the next "Start Date" associated with the expiration of the Initial Term *or* subsequent renewal term. See section above "**3. Term:"**.

e) Such provisions of this Agreement that, by their nature, would be expected to survive termination of this Agreement, including, without limitation, Sections 2, 6, and 7, of this Agreement. After the filing has been initiated, the termination fee will be the above agreed upon percentage specified in paragraph 2 (a) of the funding commitment unless already paid and shall include all fees outlined therein, whether filed, refiled and any subsequent filings during the Initial term of this Agreement. All other rights to receive consulting fees shall terminate on the date of termination. IT IS AGREED AND ACCEPTED THAT ALL MONIES DUE TO SPECTRACORP HEREUNDER WILL SURVIVE ANY TERMINATION AS PROVIDED HEREIN.

6. **Proprietary Rights**. SpectraCorp and Company shall retain all rights to methodology, knowledge, and data belonging to each of them prior to this Agreement and used to perform herein. Company agrees that its proprietary rights do not extend to any ownership, copyright, patent, trade secrecy, or other rights in all works, inventions, improvements, discoveries, processes or other properties made or conceived by SpectraCorp prior to the term of this Agreement, which result from work performed by SpectraCorp for itself or others, or which are derived from works, processes or properties resulting from work performed for Company. Company further agrees that SpectraCorp's confidential and proprietary information that may be used by SpectraCorp in performing work under this Agreement shall remain property of SpectraCorp.

7. **Notices**. All notices and other communications under this Agreement must be in writing and will be deemed given: (a) when delivered personally; (b) on the fifth business day after being mailed by certified mail, return receipt requested; (c) the next business day after delivery to a recognized overnight courier; or (d) upon transmission and confirmation of receipt by a facsimile operator if sent by facsimile, to the Parties at the following addresses or facsimile numbers (or to such other address or facsimile number as such Party may have specified by notice given to the other Party pursuant to this provision):

If to Company:	If to SpectraCorp:
Jaque Hickman, President of Board	**Paul Hale, CEO**
Name/Title	**Name/Title**
Southern Inyo Healthcare District	**SpectraCorp Technologies Group, Inc.**
Hospital	**Company**
509 East Locust St	**8131 LBJ Freeway, Suite 360**
Physical Address	**Physical Address**
Lone Pine, CA 93545	**Dallas, TX 75251**
City/State/Zip	**City/State/Zip**

8. **General Provisions:**

   a) **Attorneys' Fees and Costs.** In the event that attorneys' fees or other costs are incurred to secure performance of any of the obligations set forth in this Agreement, to establish damages for the breach hereof including collection costs or to obtain any other appropriate relief, whether by way of prosecution or defense, the prevailing Party shall be entitled to recover such reasonable fees and costs incurred therein.

   b) **Counterparts**. This Agreement may be executed in one or more counterparts (including by facsimile or portable document format (PDF) for the convenience of the Parties hereto, each of which will be deemed an original, but all of which together will constitute one and the same instrument. No signature page to this Agreement evidencing a Party's execution hereof will be deemed to be delivered by such Party to any other Party hereto until such delivering Party has received signature pages from all Parties signatory to this Agreement.

c) **Assignment**. Either Party may assign this Agreement at any time, by giving the other Party 30 day's prior written notice.

d) **Entire Agreement; Amendment**. This Agreement, the attached Letter of Agency (LOA), which is hereby made a part of and is incorporated into this Agreement, contains the entire understanding of the Parties relating to the subject matter hereof and supersede all prior written or oral and all contemporaneous oral agreements and understandings relating to the subject matter hereof. This Agreement may be amended, supplemented or modified, and any provision hereof may be waived, only by written instrument making specific reference to this Agreement signed by the Party against whom enforcement is sought. This Agreement shall be binding on, and inure to the benefit of, the Parties hereto and their respective permitted successors and permitted assigns.

e) **Waiver**. No delay or omission by either Party to exercise any right hereunder shall impair such right or be construed as a waiver thereof. All remedies provided for in this Agreement shall be cumulative and in addition to, and not in lieu of, any other remedies available to either Party at law, in equity or otherwise.

f) **Severability**. If any provision of this Agreement is declared or found to be illegal, unenforceable or void, then each Party shall be relieved of its obligations arising under such provision to the extent such provision is declared or found to be illegal, unenforceable or void. Each provision not so affected shall be enforced to the fullest extent permitted by law.

g) **Governing Law**. Jurisdiction in Texas**.** This Agreement shall not be effective until signed by SpectraCorp at its offices in Dallas, TX or by any of its authorized representatives. This Agreement shall be considered to have been made in the State of Texas and shall be interpreted in accordance with the laws and regulations of Texas, with venue in Dallas County, TX.

h) **Other Documents**. Each Party hereto agrees to execute any and all such additional documents and to perform such other acts as may be necessary or expedient to further the purposes of this Agreement.

i) **Construction**. No provision or this Agreement shall be construed in favor of or against any Party on the ground that such Party or its counsel drafted the provision. Any remedies provided for herein are not exclusive of any other lawful remedies, which may be available to either Party. This Agreement shall at all times be construed so as to carry out the purposes stated herein.

j) **Federal Law, Medicare, & Medicaid** Any provisions of this Agreement to the contrary notwithstanding, if, during the Term, Company determines that any of the terms of this Agreement materially violate any provisions of state or federal law which, if enforced, would jeopardize the ability of Company to continue to participate in the Medicare and the Medicaid healthcare programs, or in any other federal or state healthcare programs, or would jeopardize the continued federal tax-exempt status of Company, or any entities which are affiliated with Company, or would result in the imposition of any excise taxes under federal income tax laws or would potentially

subject Company to any civil monetary penalties or criminal prosecution, then the Parties agree to immediately endeavor to renegotiate terms which would result in Company being in appropriate legal compliance, in Company's opinion. If the Parties are unable to timely agree on such terms, however, Company may terminate this Agreement by delivering at least a thirty (30) day notice to SpectraCorp.

[SIGNATURE PAGE TO FOLLOW]

IN WITNESS WHEREOF, the Parties hereto have executed and delivered this Agreement as of the date first above written.

SIGNED, this _____ day of_____, 2019

Southern Inyo Healthcare District	**SpectraCorp Technologies, Inc.**
Authorized Signature	**Authorized Signature**
Jaque Hickman	Paul Hale
Type or Print Name	**Type or Print Name**
President of Board of Directors	CEO
Title	**Title**
Date	**Date**
95-6005450	

Federal Tax ID (EIN)	

This agreement allows for the use of an Electronic Signature (E-Signature) by either Party, when executing this agreement.

SpectraCorp Technologies Group, Inc., 8131 LBJ Freeway, Suite 360, Dallas TX 75251
Ph: 972-671-1700 Fax: 972-671-1701 email: pdwyer@spectracorp.com

Southern Inyo Healthcare District
Company Name

509 East Locust St
Address

Lone Pine, CA 93545
City, State & Zip

Agent and Consulting Declaration

Southern Inyo Healthcare District ("Company") authorizes SpectraCorp Technologies Group, Inc. ("SpectraCorp"), to represent the Company's location(s) (see Addendum) as its agent and consultant, to obtain all necessary information and documents regarding the supported equipment, facility(ies), and/or service(s) that are necessary to submit all required forms necessary to process funding requests and/or respond to FCC or USAC inquires through the Rural Health Care Program ("RHCP").

Authorization for Document Review, Analysis and Submission
Company will assist SpectraCorp in obtaining copies of all information and documents as necessary and agrees to the following as it concerns to common carriers and equipment providers of Company:

Service Providers
ATTENTION: AT&T, CenturyLink, Comcast, Frontier, Local Operating Companies, Spectrum, Verizon, Windstream and all other common carriers, cable providers and equipment vendors:

- Company hereby authorizes SpectraCorp, to access to our account information (i.e., customer service records, inventory itemization, rates, charges, copies of billing, etc.) in connection with the sales and/or marketing of network services, customer premises equipment (CPE) and enhanced services.
- Company hereby requests and authorizes Service Providers to provide to SpectraCorp any information requested pertaining to telecommunications services used by our Company, for properties owned, managed and/or operated by Company (see Addendum).
- This LOA is solely for information gathering; no modifications, additions, or service terminations are authorized by our Company without our expressed written consent.
- Company hereby requests that this authorization is applicable to all of our existing and any new accounts. This authorization does not preclude Company from acting on its own behalf if it is deemed necessary. I understand that this authorization will remain effective until modified and/or revoked, in writing, by me or another authorized representative of the Company.

Company signing representative certifies that they are authorized to sign this document on behalf of the above-named entity or entities.

Company: Southern Inyo Healthcare District
Signature: Jaque Hickman
President of Board of Directors
Title:
Date:

SOUTHERN INYO HEALTHCARE DISTRICT

Regular Meeting of the Board of Directors Minutes

Date: Tuesday, July 9, 2019
Time: 4:30 p.m.

Location: RCA Church
550 East Post St
Lone Pine, CA 93545

AGENDA

PRESENT
Jaque Hickman, President
Richard Fedchenko, Treasurer
Charles Carson, Vice President

ABSENT
Carma Roper, Secretary
Mark Lacey, Director

OTHERS
Chet Beedle, Financial Consultant
Shannon Jimerson, CNO
Scott Nave, Attorney
Chris Mark, IT

I. CALL TO ORDER

The Meeting was called to order at 4:30pm.

Treasurer Fedchenko moved to approve the 07/09/2019 Regular Board Meeting Agenda. Vice President Carson seconded. All Approved.

II. BUSINESS ITEMS

A. Discussion regarding future of Southern Inyo Hospital facilities. (President/Attorney)

Attorney Scott Nave reported that the next hearing is on July 24th. The filing is due July 10, 2019. He is working with the bankruptcy attorney. SIHD is hoping that the judge allows us to continue with the case. Still working on the HCCA portion.
There is no decision on the Optum case which is a big part of our organization plan.

B. Consent Agenda: These items are considered routine and non-controversial and will be approved by one motion. If a member of the Board or public wishes to discuss an item, it will removed from Consent and considered separately at the end of Business Items.

1. Approval of Minutes

    a. Regular Board Meeting Minutes of 06/11/2019.
    b. Special Board Meeting Minutes of 06/18/2019.
    c. Special Board Meeting Minutes of 07/02/2019.

President Hickman stated that one of the reasons for a special meeting was regarding the revolving loan with the Inyo County Treasury. When IGT's are due, SIHD can request the money from Inyo County without having to have a board meeting. Once SIHD receives the funds, we turn around and pay the county back. We are in good standing with Inyo Co. Treasury and they recommended we go with a revolving loan. The other reason was to give clinic medical staff privileges for Dr. Tracy Levens.

2. Approval of Medical Staff Privileges

    a. Jasiri Kennedy, MD, ER Physician, Extended Temporary Medical Staff Privileges

3. Approval of Contracts

    a. MModal Renewal Quote-

Chris Marks, IT requested that the MModal Renewal Quote be removed from Consent Agenda and moved to Business Item for discussion.

MModal Renewal Quote was pulled from consent agenda and put as an Individual Business Item for further discussion.

Action: Vice President Carson approved the Consent agenda with the removal of MModal Renewal Quote. Treasurer Fedchenko seconded. All Approved.

MModal Renewal Quote- Chris Marks stated that he was on vacation and unfortunately the original quote was added to the packet. Chris spoke with MModal they said we can upgrade and move server offsite to hosted solution for the same price. SIHD will not have to worry about the back up or operating system. We have been having a couple issues when Chris updates the work stations which will be eliminated once we get the upgrade.

President Hickman asked that Chris Marks confirm if we can return the old server or reuse if needed.

Earl (Public) asked where the info will be stored. Per Chris, currently the data is stored onsite. If the board approves the quote the data will be stored on MModal's server. We will have a BAA-Business Associate Agreement which protects the district.
Earl was looking for the specific location (what state). Chris Marks will find out where the data center is located.

Action: Vice President Carson moved to approve the renewal quote (cloud) with MModal (provided at Board Meeting). President Hickman seconded. Treasurer Fedchenko abstains.

C. ATI Medical Waste Service Agreement (Facility Director)

Jeff Sheffield resigned with ATI for 24 months (SIHD's previous medical waste vendor before Medasend). The monthly cost will be $595.00 a month, anything above 44 gallon container will be additional $49.00. This will be a cost savings compared to Medasend.

Attorney Nave has concerns on the termination portion on contract. It states 24 months with automatic renewal. SIHD should not have contracts with automatic renewal. Attorney Nave recommends changing that prevision and have it state only to be renewed with agreement of both parties. There are good business reasons why you do not want automatic renewal. In addition, CMS does not like its Healthcare facilities to have contracts with automatic renewal.

Action: **Treasurer Fedchenko approved the ATI Medical Waste Service agreement with the modification of one time renewal with subject to mutual agreement change. Vice President Carson seconded. All approved.**

D. Transfer Agreement-Southern Inyo Healthcare District and Kern Valley Healthcare District. (Interim Administrator)

SIHD had a life safety survey which included Disaster Transfer agreements surrounding SIHD. A lot of the transfer agreements were out dated. CNO Shannon Jimerson reached out to Kern Valley Healthcare District. Will need to update with Ridgecrest Hospital and Northern Inyo Hospital. Shannon will be handing the update with other surrounding hospitals.

Treasurer Fedchenko asked what are the important aspects of a Transfer Agreement.
The reason is so that we have mutual agreement between hospitals. For example, if either Kern Valley or SIHD needed to evacuate, either hospital is willing to accept patients.

SIHD needs to have the transfer agreements renewed annually. Will need to revise the contract. SIHD will need to update all other transfer agreements to have annually renewal.

Action: President Hickman moved to approve the Transfer Agreement between Southern Inyo Healthcare District and Kern Valley Healthcare District for a three year agreement. Vice President Carson seconded.

E. ER Physician Agreement- Michael Dillon, MD

Action: **Vice President Carson moved to approve the ER Physician Agreement with Michael Dillon, MD. Treasurer Fedchenko seconded. All Approved.**

III. REPORTS

A. Financial Report

1. Financial Statement for April 2019
2. Cash flow Projections-2020 Budget

Financial Consultant Chet Beedle reviewed the financials and cash flow projections that were presented at the Finance Committee Meeting. Also reviewed was the cash flow projections for 2020.

Chet Beedle stated that SIHD is on a Medicare Withhold.

B. Interim Administrator Report

CNO Shannon Jimerson reviewed the monthly numbers.
SIHD needs a telemetry unit.
Jimerson stated that SIHD is still waiting on the Swing Bed License.

C. Medical Staff Report (Quarterly Report)
Nothing reported at this time.

IV. PUBLIC COMMENTS ON ITEMS NOT ON THE AGENDA

Dallas Bumpus stated he was a patient at SIHD recently. He wanted to thank everyone at SIHD. He had a great experience.

President Hickman acknowledged Dallas Bumpus. Dallas Bumpus was SIHD's Activities Director for almost 27 years. He is officially retiring. He would like to come back for volunteer work.

V. BOARD OF DIRECTORS COMMENTS ON ITEMS NOT ON THE AGENDA

President Hickman stated that it has been challenging for the staff. Working through Payroll. Chet and Shannon trying to work through payroll to see what we can do to maximize our revenue. There was a recent Life and Safety survey. Jeff is dealing with an old generator. Due to generator being old, there are tags and corrections needed. The only solution is a new generator.
SIHD needs a new sign and paint. Will talk to the public about that. Stay tuned. Things are looking up.

VI. CLOSED SESSION

A. Existing Litigation (Govt Code 54956.9): Chapter 9 Bankruptcy
B. Personnel Appointment-CEO

VII. CLOSED SESSION REPORT

In closed session, the Board of Directors discussed the status of the Chapter 9 bankruptcy and appointment of a CEO. No other items were discussed.

VIII. ADJOURNMENT

The open session adjourned at 5:54 pm.

_____ _____
President or Secretary of the Board of Directors Date

Regular Board Meeting Minutes for July 9, 2019

SOUTHERN INYO HEALTHCARE DISTRICT

Special Meeting of the Board of Directors Minutes

Date: Wednesday, July 31, 2019
Time: 3:30 p.m.

Location: Southern Inyo Hospital-Conference Room
501 East Locust St
Lone Pine, CA 93545

Secretary Carma Roper will be participating via phone
230 N. Webster, Independence, CA 93526

AGENDA

PRESENT
Jaque Hickman, President
Richard Fedchenko, Treasurer
Carma Roper, Secretary (via phone in the district)

ABSENT
Charles Carson, Vice President
Mark Lacey, Director

OTHERS
Peter Spiers, CEO
Anita Sonke, AP
Scott Nave, Attorney (via phone)
Chet Beedle, Financial Consultant

I. CALL TO ORDER

The meeting was called to order at 3:30 pm.

Treasurer Fedchenko moved to approve the 07/31/2019 Special Board Meeting agenda. Secretary Roper seconded. All Approved.

Roll Call-

Richard Fedchenko	"AYE"
Carma Roper	"AYE"
Jaque Hickman	"AYE"

II. BUSINESS ITEMS

A. Attis Management Response Letter

Owner of Lee's Frontier is submitting an application for a dispensary of marijuana. He will also be putting in a Jersey Mike's Sub in town.

The background on this item-Owner of Lee's Frontier owns Attis Management and they have marijuana dispensaries in many places.

Attis Management had a public meeting at Lone Pine Chamber of Commerce. The school board was quite concerned. The business partner from Attis Management provided information and calmed the fears.

There will be an application approved in Southern Inyo and points to Lone Pine. There will be a proposal put together. Attis spoke with the county and they would like to give a percentage of net to SIHD as a revenue source.

Attis Management is asking for SIHD to give a response to their application. They already have one from the School, Lions Club and the Chamber of Commerce. This letter does not need to state that SIHD is in favor but can say we don't object.

Treasurer Fedchenko wanted to know what happen with the discussion of the hospital to include a dispensary. President Hickman stated it's not an impossibility but with the timing and energy to put together has not come about. One of the things we need to consider is that we don't have a local pharmacy anymore. SIHD needs to look into getting a pharmacy here. Attorney Nave stated SIHD would also need to make sure that Medicare and Feds would allow us to dispense marijuana.

This could be put on the bankruptcy plan as a revenue source. SIHD could also set a minimum of our expectation. For example, a minimum of 15k given to the district a year.
The terms are negotiable.

Action: President Hickman moved to respond to Attis with a response letter stating SIHD doesn't have any objections to their application for marijuana business in South County-Lone pine. SIHD will work with Attis Management to negotiate a benefit for SIHD's revenue cycle. Treasurer Fedchenko seconded.

Roll Call-

Richard Fedchenko	"AYE"
Carma Roper	"AYE"
Jaque Hickman	"AYE"

B. Resignation of Director Richard Fedchenko

As of August 1, 2019, Richard Fedchenko resigns as Treasurer of SIHD's Board of Directors.

Attorney Nave stated that SIHD needs to post a notice stating the vacancy for 15 days. If the Board of Directors does not elect within 60 days, the County will need to elect in 30 days.

A replacement is needed ASAP.

To be included on the vacancy notice- Letter of interest and qualifications. A resume can be included.

The Board of Directors will need to have the nomination at Open Session. The Directors will announce in September Regular Board Meeting or at a Special Meeting.

C. High Desert Medical Contract

High Desert Medical is SIHD's Lab Medical Director.
Attorney Nave stated that High Desert Medical wants to include clinical services. Even though it does not include clinical services on the Medical Directorship contract. If the Board is fine with this, we can do a physician services agreement for High Desert to provide laboratory services. Also, High Desert Medical requested for SIHD to sign permission for them to bill Medi-cal and insurance companies. Attorney Nave stated that usually the district is responsible for billing and collecting patient charges. Peter Spiers, CEO and Chet Beedle, Financial Consultant will have to weigh in on this.

Chet Beedle stated that there are various pathologist that are starting to request to be able to bill patients for the professional component. The thing with that is the pathologist will bill the patient for the professional fees. The patient will receive an invoice from hospital and then another invoice from pathologist. The other hospitals that Chet deals with stated they do not like that approach and do not allow this. President Hickman agrees and stated that she doesn't want that to happen. This will create negativity to our community.

What happens if High Desert Medical does not want to continue with services if we do not allow the billing for professional fees?
Chet Beedle suggested to contact surrounding hospitals and see if the pathologist is willing to take on another hospital.

The Board request that George to look at different sources. SIHD is to get the facts together and include item at the next board meeting.

Business Item "C" is to be tabled to the next Board meeting.

III. CLOSED SESSION

A. Personnel Appointment: Interim CEO
B. Potential Litigation: Medefis
C. Existing Litigation: Chapter 9 Bankruptcy

V. CLOSED SESSION REPORT

In closed session the Board discussed one case of potential litigation involving Medefis, the Chapter 9 bankruptcy existing litigation, and upon motion by Director Fedchenko, seconded by Director Roper, voted unanimously to appoint Peter Spiers as Interim Chief Executive Officer for a six month period. No other items discussed. Closed session adjourned at 5:16 p.m.

VI. ADJOURNED

The open session meeting adjourned at 4:19pm.

_____ _____

President or Secretary of Board of Directors Date

SOUTHERN INYO HEALTHCARE DISTRICT

Second Amended Special Meeting of the Board of Directors Minutes

Date: Thursday August 8, 2019
Time: 4:00 p.m.

Location: Southern Inyo Hospital-Conference Room
501 East Locust St
Lone Pine, CA 93545

Secretary Carma Roper will be participating via phone
230 N. Webster, Independence, CA 93526

AGENDA

PRESENT
Jaque Hickman, President
Charles Carson, Vice President
Carma Roper, Secretary (via phone in district)

ABSENT
Mark Lacey, Director

I. CALL TO ORDER
The meeting was called to order at 4:00 pm.

Vice President Carson moved to approve the Second Amended Special Meeting on August 8, 2019 with the change of no resolution needed for LAIF account just update form. President Hickman seconded.

Roll Call-
Charles Carson "AYE"
Jaque Hickman "AYE"
Carma Roper "AYE"

II. BUSINESS ITEMS

A. Wincare Quotes

Michael Floyd, DON and Tambria Kalenowski, ADON discussed in detail the importance of Business Item A. SIHD's current provider is closing its doors as of October 1, 2019 due to CMS's new regulations. SIHD needs a system to replace STAT. Wincare did the MDS for Skilled Nursing which is how we generate our revenue in Skilled Nursing. With having to switch services, SIHD is also looking to improve our overall system so there are not multiple systems needed.

Three quotes were provided from PointClick Care, Matrix Care and American Health Tech.

As a group, Point Click Care would be the best fit for SIHD. Point Click Care would generate more revenue and reduce the cost. The one time set up fee is $14,105.00 and the monthly would be $1,283.63.

Matrix Care would be 14,850.00 one-time payment and 587.00 monthly.
American Health Tech would be 17,290.00 one-time payment and 412.98 monthly.

Even though Point Click Care cost more per month, the revenue and decrease would pay for the monthly subscription. Per Michael Floyd, this will guarantee 50 hours of less of overtime from the Skilled Nursing department.

Medsphere doesn't provide these services.
Point Click Care populates and sends bills.
Dr. Farrar has used the other systems and highly recommends Point Click Care.

Peter Spiers mentioned that 20-30% of skilled nursing is not being captured.

Michael Floyd stated that hand held devices can be used.

TARS are a huge part of billing. Point Click Care is connected to State-Medical which means TARS will be completed in a timely manner.

Wincare notified SIHD on July 31st. Michael Floyd, CNO started the research and setting up demos.

Action: Vice President Carson moved to approve Point Click Care quote as the replacement program for Wincare. Secretary Roper seconded.

Roll Call-
Carma Roper "AYE"
Charles Carson "AYE"
Jaque Hickman "AYE"

B. Update LAIF Change of Authorization for Transfer Funds

This update is to remove anyone who no longer provides services for SIHD and add the new CEO, Peter Spiers as an authorized signer.

C. Update LAIF Change of Bank Account Authorization

SIHD attempted to transfer funds to our General Account but was notified by LAIF that they had our old General Account number. SIHD had Bank of America in the past which had 12 digits. When El Dorado took over they eliminated two digits (zeros). This update will provide LAIF with the correct bank account number.

Action: Secretary Roper moved to approve Business Item B. Update LAIF Change of Authorization for Transfer Funds and Business Item C. Update LAIF Change of Bank Account Autorization with the note that no resolutions are needed. Vice President Carson seconded.

Roll Call-
Carma Roper "AYE"
Charles Carson "AYE"
Jaque Roper "AYE"

III. ADJOURNED
The meeting was adjourned at 4:32 pm.

_____ _____
President or Secretary of Board of Directors Date

Second Amended Special Board meeting for 08/08/2019

SOUTHERN INYO HEALTHCARE DISTRICT

Regular Meeting of the Board of Directors Minutes

Date: Tuesday, August 13, 2019
Time: 4:30 p.m.

Location: RCA Church
550 East Post St
Lone Pine, CA 93545

AGENDA

PRESENT
Jaque Hickman, President
Charles Carson, Vice President
Carma Roper, Secretary

ABSENT
Mark Lacey, Director

OTHERS
Peter Spiers, CEO
Chet Beedle, Financial Consultant
Scott Nave, Attorney
Jeff Golden, Attorney

I. CALL TO ORDER

The meeting was called to order at 4:30 p.m.

Secretary Roper moved to approve the August 13, 2019 Regular Board Meeting Agenda. Vice President Carson seconded. All approved.

II. BUSINESS ITEMS

A. Discussion regarding future of Southern Inyo Hospital facilities. (President/Attorney)

Attorney Nave introduced Jeff Golden, SIHD's Bankruptcy Attorney. Attorney Golden. Foley & Lardner was disqualified to represent SIHD and we needed to find a new bankruptcy counsel.

Attorney Jeff Golden provided overview and the next steps with the bankruptcy. There was a status conference about a month ago. There will be another status conference in October. The Judge is expecting SIHD to explain to him where we are in terms of the process of getting a plan on file.

Attorney Nave added that the HCCA Mediation was scheduled for August 15th but it was rescheduled to Sept 11, 2019. Mediation is to see if they can resolve all of the claims between HCCA and the District.

B. Consent Agenda: These items are considered routine and non-controversial and will be approved by one motion. If a member of the Board or public wishes to discuss an item, it will removed from Consent and considered separately at the end of Business Items.

1. Approval of Medical Staff Privileges

a. Kevin Flanigan, MD, Clinic Physician and Hospitalist, Temporary 90 days Medical Staff Privileges
b. Ronald Smith, MD, ER Physician, Extended Medical Staff Privileges
c. Michael Dillon, MD, ER Physician, Two Years Medical Staff Privileges
d. Eric Bradfield, SNF NP, Two Years Medical Staff Privileges
e. Jasiri Kennedy, MD, ER Physician, Temporary 90 days Medical Staff Privileges.

2. Approval of Contracts

a. Relias
b. Ronald Smith, MD, ER Physician Agreement

Action: Secretary Roper moved to approve the Medical Staff Privileges and the Contracts from the Consent agenda. Vice President seconded. All approved.

C. 2020 Annual Financial Budget and Staff Memo

Chet reviewed the 2020 Annual Financial Budget which included the Payroll Parity Increase for employees and memo.

Payroll Two Part Plan- Take half of the increase approved for salaries which is 4% and make it a parity adjustment. Chet Beedle asked for a list of all the active employees with hire date, job class and salaries. Chet made a recommendation for an increase to all employees that qualify. Also figured into this, all managers qualifying under the existing IRS criteria of exempt from federal overtime statutes and the 2020 minimum wage requirement of $13.00 an hour.

President Hickman stated to keep in mind that the idea is to periodically have Chet Beedle review. So that the payroll does not end up having big jumps and gaps. The parity is part of the process that we continue with and entertain and can keep bringing people forward at our best of our financial ability. SIHD will review the employee's length of time, job description and rate.

SOUTHERN INYO HEATLCARE DISTRICT
INCOME STATEMENT
BUDGET FY 2020

ALL PATIENT DAYS	13,681	12,437	7,963
ED VISITS	1,291	1,173	992

	OUTPT & CLINIC VISITS	6,949	6,317	6,627
	ADJUSTED PT DAYS	29,369	26,699	16,591
		2020	2019(MAR) ANNUALIZED	2019
	Patient Revenue/Expense	BUDGET		BUDGET
	In Patient Revenue	915,919	832,653	339,036
	Long Term Care Revenue	4,723,202	4,293,820	3,906,623
	Out Patient Revenue	967,166	903,893	992,493
	ED Revenue	4,810,900	4,373,545	3,184,420
	Clinic Revenue	661,272	601,156	423,721
	Total Patient Revenue	12,078,458	11,005,068	8,846,293
	Deductions From Revenue			
	Contractual	-3,467,491	(3,052,504)	(2,252,267)
	Bad Debts	-332,233	(292,472)	(176,925)
	Charity	-56,797	(50,000)	(8,847)
	Total Deductions From Revenue	-3,856,522	-3,394,976	-2,438,039
	% Of Total Deductions to Revenue	-31.93%	-30.85%	-27.56%
	Net Patient Revenue	8,221,936	7,610,092	6,408,254
	Other Operating Revenue	353,257	341,311	193,574
	Net Revenue	8,575,192	7,951,403	6,601,828
	Operating Expenses			
1	Salaries & Wages	4,384,926	4,216,275	4,220,675
3	Benefits	1,439,571	1,054,068	1,055,168
4	Contracted Labor	580,531	558,203	287,653
5	Professional Fees	1,151,549	1,107,259	739,285
6	Purchase Service	139,360	134,000	24,941
7	Supplies	393,505	382,044	349,428
10	Utilities	186,808	177,912	114,221
11	Repairs and Maintenance	69,343	66,676	75,688
12	Insurance / Taxes	211,672	203,531	138,049
13	Other Expenses	996,720	965,748	387,344
15	Rents / Leases	114,314	109,917	78,081
16	Depreciation	80,461	77,367	144,352
	Short Term Interest	0	0	-
	Total Expense	9,748,760	9,052,999	7,614,887

	Net Income / Loss From Operations	(1,173,568)	(1,101,596)	(1,013,058)
18	Interest Income/Donations	0	0	0
9160	Taxes	617,881	594,116	252,531
	Deferred Income From GO Bond Taxes	0	0	0
17	Interest	-230,659	(230,659)	-146,109
9290/9550	Donations/Foundation	0	0	0
	Other	100,372	96,512	62,285
	Total Non Operating	487,594	459,969	168,707
	Net Profit / Loss	(685,973)	(641,627)	(844,352)
	Other Expense Detail			
	Legal Fees	84,460	82,000	34,287
	Consulting	302,165	293,364	131,000
	Other Pofessional Fees	173,040	168,000	113,787
	Minor Equipment	11,605	11,267	13,057
	Freight	3,297	3,201	-28
	Licenses & Taxes	100,906	97,967	22,028
	Dues/Subscriptions	12,039	11,688	9,039
	Outside Training	17,853	17,333	8,499
	Travel	15,729	15,271	9,953
	Recruiting	19,227	18,667	3,903
	Other Direct Expenses	5,886	5,715	491
	IT Licenses & Software	219,846	211,500	2,804
	Advertising /Marketing	1,880	1,825	495
	Software Purchase	9,593	9,313	32,779
	Security	2,699	2,620	1,415
	Postage	16,498	16,017	3,837
	Total Other Expenses	996,721	965,748	387,344

Action: Vice President Carson moved to approve Chet Beedle's 2020 Annual Financial Budget. Secretary Roper seconded. All approved.

Action: Secretary Roper moved to approve the Parity Staff Memo. Vice President Carson seconded. All approved.

D. UpToDate Renewal Agreement

UpToDate is an electronic reference for physicians. For example, drug interactions. It allows the physicians to instruct themselves electronically. It can answer a physician's questions if they may have on treatment on a patient.

Michael Floyd stated that he knows that a couple ER physicians use the service. This service should be used for patient teaching on discharge (DischargeTeaching) which is mandatory.

Most places have that on their electronic health record. It actually should be provided by our Electronic Medical Records contract.

Chet Beedle stated that this is an independent source that small hospitals use.

President Hickman requested that we ask the physicians to confirm if they use the services or are there any other options SIHD can explore. Also to notify UpToDate that SIHD's CNO is out of town and SIHD would like to request a grace period/ extension.

Action: President Hickman moved to give Peter Spiers, CEO to make final decision on renewing with UpToDate after discussing with staff. Secretary Roper seconded. All approved.

E. Altaware- Firewall Quote

Chris Marks stated that it is uncertain as to when the firewall will fail. The current firewall is old. If the firewall crashed SIHD will lose internet and phones. There will be no communication. If the old firewall is replaced with a new one, the old firewall can be used a backup.

Secretary Roper asked if this was budgeted. In the future, she would like to know. Please include staff memos.

Action: Vice President Carson moved to approve that Peter Spiers, Chet Beedle and IT purchase a firewall when needed without having to present to the Board of Directors with a not to exceed of 12k. Secretary Roper seconded. All approved.

F. High Desert Pathology Contract

Attorney Nave stated that this came to us when Dr. Tadros requested that he be allowed to bill for professional services that he provides. Attorney Nave reviewed the current contract and it is not for professional services, just Medical Directorship for the Laboratory. Typically we can combine the services into one agreement but in this particular contract, professional services is not included.

In general with physicians, we don't not have them bill for services provided. SIHD handles all billing ourselves at the facility. This generated a lot of discussion internally.

Attorney Nave believes that request has been superseded by other information that has become available. Management would like the Board to make decision regarding those services in general.

Peter Speirs, CEO stated that we have reached out to Northern Inyo Hospital and their pathologist, Dr. Wasef. Dr. Wasef has some history with SIHD. Dr. Wasef is interested in coming onboard to provide Medical Directorship services and it would not impact SIHD at all financially. It can create a stronger bond with NIH on a number of levels. Peter Spiers will be meeting with Dr. Wasef. There is also utilization that she can help us with, on how to do laboratory services that will beneficial. We will get some value.

Per Attorney Nave, SIHD will need to send notice of 30 day termination of agreement to High Desert Medical. Will need to make sure the Board approves the new contract with the new pathologist so there is not down time.

Action: Secretary Roper moved the NON-renewal of the Laboratory Medical Directorship contract with High Desert Medical. Also to allow Peter Spiers, CEO to give the 30 day notice of termination and explore other services. Vice President Carson seconded. All approved.

G. Walden University Affiliation Agreement

The presented Affiliation agreement is for a nursing program. The agreement was revised by Attorney Nave and approved by Walden University. There is no cost. This is a 5 year contract.

President Hickman stated that this is for a Registered Nurse who works with SIHD and is taking online courses while working at SIHD.

Action: Secretary Roper moved to approve the affiliation agreement with Walden University. Vice President Carson seconded. All approved.

III. REPORTS

A. Financial Report

Chet Beedle reviewed the financials that were presented at the Finance Committee Meeting.

B. CEO Report

Introduction of Peter Spiers, CEO.
Peter Spiers has been working with hospitals for over 40 years. Peter Spiers stated he was happy to be at SIHD.

Peter Spiers provided his hospital wide operational assessment and restructure.

Current Status-
Reviewed all 18 current departments
Every area reviewed had structural/operational gaps
Silos/communication/ IT gaps across the organization
Operating culture fragmented/morale low

Initial Areas of focus-
Organizational Integration/Culture
Growth
Revenue/Expense Performance
Capital Acquisition

Priority Focus-
Financial Services.
Rural Health Clinic
Physical Therapy
Capital Acquisition

Operational restructure/Teams-

Administrative Leadership Team (A-Team)
SIHD Management Team
Pharmacy Services Development Team
RHC Development Team - PT Growth Team
Salvation Foundation Campaign Planning Team
Financial Services Re-structure Team
Capital Acquisition Task Force
Physical Plant Upgrade Team
Public Relations/Marketing Team
HR Station Control Team
Employee Activity Planning Team

SIHD will be working on staff metrics. Need to staff on patient census.
Capital acquisition, we can't depend just on revenue cycle. We need Grants, foundation drives and federal grants. The last federal grant was 10 years ago. Currently working on an agreement with Merchant McIntyre (federal grant).
Monthly numbers were reviewed.
Financial Services Team met this week and the new moto is Mo money, Mo faster.

C. Medical Staff Report (Quarterly Report)

CNA Class has completed and the students are ready to take test. They are scheduled for August 20-30th. If they all pass there will be 6 new CNA's. Currently we are using LVN's to cover and its quite expensive (overtime).
President Hickman stated that she doesn't agree with the long wait to take test after completion of course.

Michael Floyd is the new Director of Nursing for Skilled Nursing.
Tambria Kalenowski is the ADON.
Jeff Sheffield redid a room in Skilled Nursing. There are new drapes throughout the facility.
There are six room that have new air conditioners. 14 to go.

SIHD is working to meet with Great Basin (air pollution control district) in regards to a grant. SIHD is hoping they can put together their grant program which will allow us to make capital improvements for things that effect air quality. That would include new van, generator, boiler and roofing. SIHD has a number of things that we need, that they can provide and they have the funding to provide it. Facilities spend a great deal of their time with things that are needing consent repair, work and parts due to being old. We are trying to assist by trying to find these other sources to help fund those needs.

Medical Staff, Peter Spiers, Shannon Jimerson and Karen Sheffield will be working with the physicians on medical records. SIHD have tools to help (dragon service that dictate). We need to work through this because it is hurting our coding. We are currently down on coding.

IV. PUBLIC COMMENTS ON ITEMS NOT ON THE AGENDA

Member of the public (Skip K.) asked about creating an optometry program.
Peter Spiers agrees that this would bring in some money. This is something to look into.

V. BOARD OF DIRECTORS COMMENTS ON ITEMS NOT ON THE AGENDA

Richard Fedchenko stepped down as a SIHD Board Member as of August 1, 2019.
SIHD is looking for a replacement. Must be 18 years or older and lives in the district. Must not be a convicted felon. SIHD has posted a vacancy notice on August 1, 2019 that will need to be posted for 15days. The Board of Directors will then have 60 days to fill the spot and will be announced at a Board Meeting. If the Board of Directors does not make a decision, Inyo County will have 30 days to elect.

Thank you to RCA Church. Healthy Communities had their Back to School event. CHP was there giving a bike safety course. SIHD-Clinic was there giving away school supplies and Clinic info. Health and Human Services, FFA, Buster Club form High School was there.

SIHD hospice closed but had $3,600. Hospice chose Healthy Communities to give the money to. Healthy Communities held on to the monies to save for the hospital. The check was presented to the hospital.

SIH Salvation donated a cardiac monitor with printer.
SIHD held a BBQ for Employee Appreciation Day.

There is a yearly update on parcel taxes. SIHD completed and submitted the 2019-2020 assessment. Last year, SIHD's parcel taxes were at approx. 350k. Updated 2019-2020 is at 383k. Thank you to Richard White and Annette Wood for working on assessment.
Inyo County determined that Air BnB's are considered businesses.

Dr. Flanigan with NIH received permission to practice medicine at SIHD.

President Hickman introduced ISHD's new Human Resources Manager, Barbara Southey and Accountant, Patricia Kemp.

VI. CLOSED SESSION

A. Existing Litigation (Govt Code 54956.9): Chapter 9 Bankruptcy
B. Potential Litigation: Medefis

VII. CLOSED SESSION REPORT

The Board of Director and legal counsel discussed the existing litigation and potential litigation with Medefis. No other items discussed.

VIII. ADJOURNMENT

The open session meeting adjourned at 6:47pm.

_____ _____

President or Secretary of the Board of Directors Date

TITLE: Charity Care, Deposit and Discount Payment

DEPARTMENT: Business Office **PAGE 1 OF 3**

SCOPE: **FINANCIAL PERSONNEL**

POLICY: The Business Office will maintain an understandable, written financial assistance policy for low-income uninsured and underinsured patients, addressing the hospital's charity care, deposit and discount payment policy.

The written charity care, deposit and discount payment policy will be in compliance with AB 774.

Uninsured patients, as well as insured patients with high medical costs, are eligible to apply under the policy if their family income is at or below 250 percent of the federal poverty level.

The charity care, deposit and discount payment policy will state the process used to determine whether a patient is eligible for charity care or a discounted payment.

Underinsured patients, such as those with high-deductible consumer-driven health plans, are eligible to apply under the District's policy. To be eligible, patients must incur out-of-pocket costs that exceed 10 percent of their family income in the prior 12 months.

A patient applying must make every reasonable effort to provide the hospital with documentation of income and health benefits coverage. If the patient fails to provide information that is reasonable and necessary for the hospital to make a determination, the hospital may consider that grounds for disqualification.

PROCEDURE:

If a patient or hospital staff member considers that the patient may be eligible for charity care or discounted payment, they will provide the patient with a Financial Statement form and request that it be returned to the Financial Counselor for eligibility determination.

The Financial Counselor will review all Financial Statements submitted for eligibility determination for either charity care or discount payment as soon as reasonably possible, but in all cases prior to instituting any collection practices other than the initial deposit requirements as specified in the deposit schedule. (attached)

In determining eligibility for charity care, the financial counselor will require all relevant income information from the patient to verify possible eligibility. (This includes, but is not limited to Income Tax Returns, W-2's, recent pay stubs and bank statements) This information may not be used for collection activities.

Notice

Business services staff will provide patients with a written notice about the availability of the discount payment and charity care policy. This notice will be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to, the emergency department, billing office, admitting office, rural health clinic, retail pharmacy and other outpatient locations. This notice will be in English and other languages as required by Insurance Code 12693.30.

Eligibility

In determining eligibility for charity care, business services staff will consider the income and monetary assets of the patient. However, they will not include any of the various retirement or deferred-compensation plans that an applicant may have, the first $10,000 of an applicant's monetary assets, and 50 percent of any amount over the first $10,000 in determining eligibility.

Billing Requirements

Business services staff will make all reasonable efforts to obtain information from the patient about whether private or public health insurance might fully or partially cover the charges for care, including private health insurance, Medicare, Medi-Cal, Healthy Families, or other state or federally funded programs.

When a patient is billed who has not provided proof of coverage by a third party at the time the care was rendered or upon discharge, the business services staff will include as part of that billing process a "clear and conspicuous" notice of the following:

- A statement of charges for services rendered;
- A statement that, if the consumer does not have health insurance coverage, the consumer may be eligible for Medicare, Healthy Families Medi-Cal or charity care;
- A statement indicating how patients may obtain applications for the Medi-Cal and the Healthy Families Program and that the Hospital will assist in obtaining these applications;
- Information regarding the financially qualified patient and charity care application process, including the following:
  A. A statement that indicates that, if the patient lacks or has inadequate insurance and meets certain low and moderate-income requirements, the patient may qualify for a discounted payment or charity care.

B. The name and number of the then current patient financial counselor and the business office for further information about the hospital's discount payment and charity care policy, and how to apply for assistance.

Payment Plan

If a patient tries to qualify for the SIHD charity care or discount payment and attempts in good faith to settle an outstanding bill by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, SIHD will not send the bill to a collection agency unless that agency agrees to comply with the requirements of AB 774.

SIHD will not use wage garnishments or liens on primary residences as a means of collecting debt from eligible patients. However, an unaffiliated collection agency may obtain a court order authorizing wage garnishment.

Any extended payment plan offered by SIHD to assist patients eligible under the charity care and deposit and discount payment policy, or any other policy adopted by SIHD for assisting low-income patients will be interest free.

Before commencing collection activities, SIHD will provide the patient with a clear and conspicuous written notice regarding the patient's rights under state and federal fair debt collection rules. The notice must include a statement that the Federal Trade Commission enforces these requirements.

Attachments: Charity Criteria
Sliding Scale
Deposit Schedule

Reference: AB 774

APPROVAL	DATE	APPROVAL	DATE
Department/Division Manager		Interdisciplinary Team	N/A
Unit Medical Director (if applicable)	N/A	Governing Board	
Medical Staff Committee (if applicable)	N/A	Administration	
Reviewed By:		Reviewed By:	
Reviewed By:		Reviewed By:	

SOUTHERN INYO HEALTHCARE DISTRICT

HOSPITAL AND CLINIC CHARITY CRITERIA

FAMILY UNIT	MONTHLY INCOME A
1	2,602
2	3,523
3	4,444
4	5,365
5	6,285
6	7,206
7	8,127
8	9,048
9	9,969
10	10,890

Patient Owes:

RHC	$20.00	
Lab	$10.00	
Xray	$15.00	
U.S	$15.00	
CT	$30.00	
OP Serv	$25.00	
Rehab(PT,OT)	$20.00	per visit
Surg/Proc	$50.00	
CRNA	$50.00	
Phy-Surg	$400.00	
E/R	$50.00	
Phy-ER	$50.00	
Acute Care	$50.00	daily
Swing	$50.00	daily

EFFECTIVE: 1/1/2019

SOUTHERN INYO HEALTHCARE DISTRICT

DEPOSIT SCHEDULE:

Hospital Admission		$ 3,000.00	Or the verifiable Co-pay requirement from the primary insurer.
Skilled Nursing		$ 8,000.00	Or the verifiable Co-pay requirement from the primary insurer.
Outpatients / Clinics		$ 100.00	Or the verifiable Co-pay requirement from the primary insurer.
Emergency Room		$ 200.00	Or the verifiable Co-pay requirement from the primary insurer.

AVAILABLE DISCOUNTS: **MULTIPLE DISCOUNT TYPES WILL NOT BE COMBINED**

Cash / Uninsured Hospital Services			30%	Based on all charges. Pay arrangements may be made based on amount due.
Cash / Uninsured Rural Health Clinic Services			50%	Based on all charges. Pay arrangements may be made based on amount due
Sliding Scale				Sliding scale discount based on 250% of the currently posted "Poverty Guidelines" (see sliding scale schedule)
Employee & Board			50%	Applicable to the patient's personal liability portion of the hospital's charges; not to include patient deductible and or co-pay's.
Administrative Allowance				From time -to-time the CEO may grant a special discount when warranted by special circumstances. Such discounts or allowances will only be granted upon written authorization from the CEO/CFO to the Business Office Manager or Controller.

Acceptable payment arrangements may be made by seeing the Financial Counselor.

Revised: 9/1/2019

Southern Inyo Healthcare District
Financial Assistance
Notification of Eligibility Determination

Southern Inyo Healthcare District has conducted an eligibility determination for financial assistance for:

_____	_____	_____
Patient's Name	account number	date(s) of service

The request for financial assistance was made by the patient or on behalf of the patient on _____.

Based on the information provided by the patient or on behalf of the patient, the following determination has been made:

___ Your request for financial assistance has been approved for all outpatient services provided at Southern Inyo Healthcare District.

You are approved for _____% financial assistance for the current calendar year, expiring on December 31, 20__. It is your responsibility to fill out a new application including documentation of family size and income before the December 31 expiration date.

___ You are approved for _____% catastrophic event financial assistance for the account number(s) and date(s) of service listed above only.

___ Your request for financial assistance is pending approval. However, the following information is required before any adjustment can be applied to your account:

_____
_____
_____
_____
_____

___ Your request for financial assistance has been denied because:

Reason: _____
_____
_____
_____

If you have any questions on this decision, please contact:

_____
Patient Financial Assistance
Southern Inyo Healthcare District
(760) 876-5501 Ext. 2271

Poverty Guidelines, all states (except Alaska and Hawaii) — 2019 Annual

Household /Family Size	50%	*100%*	125%	130%	133%	135%	138%	150%	175%	185%	200%	250%	300%	400%
1	6,245	$12,490	15,613	16,237	16,612	16,862	17,236	18,735	21,858	23,107	24,980	31,225	37,470	49,960
2	8,455	$16,910	21,138	21,983	22,490	22,829	23,336	25,365	29,593	31,284	33,820	42,275	50,730	67,640
3	10,665	$21,330	26,663	27,729	28,369	28,796	29,435	31,995	37,328	39,461	42,660	53,325	63,990	85,320
4	12,875	$25,750	32,188	33,475	34,248	34,763	35,535	38,625	45,063	47,638	51,500	64,375	77,250	103,000
5	15,085	$30,170	37,713	39,221	40,126	40,730	41,635	45,255	52,798	55,815	60,340	75,425	90,510	120,680
6	17,295	$34,590	43,238	44,967	46,005	46,697	47,734	51,885	60,533	63,992	69,180	86,475	103,770	138,360
7	19,505	$39,010	48,763	50,713	51,883	52,664	53,834	58,515	68,268	72,169	78,020	97,525	117,030	156,040
8	21,715	$43,430	54,288	56,459	57,762	58,631	59,933	65,145	76,003	80,346	86,860	108,575	130,290	173,720
9	23,925	$47,850	59,813	62,205	63,641	64,598	66,033	71,775	83,738	88,523	95,700	119,625	143,550	191,400
10	26,135	$52,270	65,338	67,951	69,519	70,565	72,133	78,405	91,473	96,700	104,540	130,675	156,810	209,080

Poverty Guidelines, all states (except Alaska and Hawaii) — 2019 Monthly

Household /Family Size	50%	*100%*	125%	130%	133%	135%	138%	150%	175%	185%	200%	250%	300%	400%
1	520	$1,041	1,301	1,353	1,384	1,405	1,436	1,561	1,821	1,926	2,082	2,602	3,123	4,163
2	705	$1,409	1,761	1,832	1,874	1,902	1,945	2,114	2,466	2,607	2,818	3,523	4,228	5,637
3	889	$1,778	2,222	2,311	2,364	2,400	2,453	2,666	3,111	3,288	3,555	4,444	5,333	7,110
4	1,073	$2,146	2,682	2,790	2,854	2,897	2,961	3,219	3,755	3,970	4,292	5,365	6,438	8,583
5	1,257	$2,514	3,143	3,268	3,344	3,394	3,470	3,771	4,400	4,651	5,028	6,285	7,543	10,057
6	1,441	$2,883	3,603	3,747	3,834	3,891	3,978	4,324	5,044	5,333	5,765	7,206	8,648	11,530
7	1,625	$3,251	4,064	4,226	4,324	4,389	4,486	4,876	5,689	6,014	6,502	8,127	9,753	13,003
8	1,810	$3,619	4,524	4,705	4,813	4,886	4,994	5,429	6,334	6,695	7,238	9,048	10,858	14,477
9	1,994	$3,988	4,984	5,184	5,303	5,383	5,503	5,981	6,978	7,377	7,975	9,969	11,963	15,950
10	2,178	$4,356	5,445	5,663	5,793	5,880	6,011	6,534	7,623	8,058	8,712	10,890	13,068	17,423

SLIDING FEE SCALE PROGRAM

Southern Inyo Healthcare District (SIHD) offers our uninsured patients a Sliding Fee Scale Program upon qualification. The application process is simple. One must apply for Medi-Cal before applying for our Sliding Scale Program. Once this is done, a Financial Statement must be filled out showing the monthly income of all members of the patient's household, along with other relevant financial information. Documentation that supports the Financial Statement must also be provided - see the attached requirements.

Eligibility will be based on 250% of the Federal Poverty Guideline. Once eligibility is established, it remains in effect for a maximum of one year or earlier, at the discretion of SIHD. Any changes in a patient's financial information must be reported to SIHD immediately so eligibility can be re-evaluated.

You have been given this information because we believe you may qualify for consideration under this program. Please complete our Financial Statement (attached) and return it to the reception staff immediately. Provide us with your supporting documentation as soon as possible by bringing it to our facility or by mailing it to: P.O. Box 1009 Lone Pine, CA 93545 ATTN: Business Office

You will be notified in writing of our decision as soon as possible after we review your Financial Statement and supporting documentation. Prompt payment for the services you receive is required, whether or not they qualify for a reduction under our Sliding Scale Program.

Contact our Business Office by calling (760) 876-5501, Extension 2231 or 2233, if you have any questions or need assistance concerning this program.

SOUTHERN INYO HEALTHCARE DISTRICT

HOW TO COMPLETE THE FINANCIAL STATEMENT AND PROVIDE SUPPORTING DOCUMENTATION

It is important to complete the Financial Statement in its entirety. Please read and answer every question asked. If the question does not apply to you, write "N/A" for not applicable. If your answer is none, please write "none" so we know you have considered the question. The information requested on this form is to be provided for all members of your household.

If you are working, provide copies of your most recent pay stubs.

If you receive unemployment income, disability income, social security income, retirement and/or pension income, provide copies of the statements showing the amounts you receive. If you receive child support or alimony, provide copies of documentation showing the amounts you receive.

If you are self-employed, provide copies of your most recent income tax return including relevant schedules.

If you receive monies in the form of gifts, assistance, loans or any other unreported compensation, provide a written statement of explanation.

If you have bank accounts, investment or retirement accounts, treasury bills, certificates of deposit, money market funds, stocks, bonds, or other certificates, please provide copies of your most recent monthly or quarterly statements. If you receive income from notes of indebtedness or under a rental contract, provide a copy of the document or contract that details the arrangement.

SOUTHERN INYO HEALTHCARE DISTRICT

Dear Patient,

We need financial information in order to complete your application for our Sliding Scale Program. We need this information within **30 days** from the date that you applied for our program. You will continue to be billed and responsible for **all** Clinic/Hospital charges until this information is received. ***The information must be provided for all members of the household.***

Listed below are some of the most common items that we can use in determining eligibility (Please provide as many as possible).

Financial Statement ***(required)***
Paycheck Stubs (2 months)
Income Tax Returns
Unemployment Income
Any Other Income (CD's, Market Funds, Stocks, etc.)
State Disability Income
Social Security Income (SSI)/Social Security Disability (SSD)
Child Support
General Assistance
Bank Statements (2 months)
Letter of Support (From the person who is helping you)
Golden State Advantage Card (Food Stamp Card)
Medi-Cal Denial Letter ***(**Must have this in order to qualify**)***

If I can be or any assistance or you have any questions, please do not hesitate to contact me.

Thank you for your assistance,

(760) 876-5501 ext. 2231 or 2233

Financial Statement

Patient Name	Med Rec Number	Account Number

Address	City	State	Zip	How Long?

Telephone Number	If less than one year, Previous Address

Circle Reason Patient Is Applying

Clinic Appointment	Pre-Admission Arrangements	Hospital Services
Payment Arrangements	Delinquent Account	Collection Letter

Members of Household (including patient): List additional members of household on separate sheet.

	Last Name	First Name	MI	Birthdate	M / S	Social Security Number	Gross Monthly Income
1							
2							
3							
4							
5							
6							

Personal Property. Do you or members of your household have any of the following?:

X	Item	$ Value	X	Item	$ Value
	Checks/Cash (on hand, home, elsewhere)			Certificates of Deposit	
	Treasury Bills			Money Market Funds	
	Notes: Mortgages, Deeds of Trust, etc.			Stocks, Bonds, Certificates	
	Checking Account(s): Bank, Address				
	Savings Account(s): Bank, Address				
	Resources which can be converted to cash (specify):				
	Other:				

Motor Vehicles (include autos, trucks, motorcycles, jet skis, motor homes, boats, trailers):

X	Year	Make	Model	Used for Work?	Owner	$ Value

Other Income:

X	Source	Monthly Amt.	X	Source	Monthly Amt.
	Social Security/ Disability/Unemployment			Dividends/ Interest/ Royalties	
	Pension/Retirement			Child Support / Alimony	
	Rental Income			Self-employment or Business Income	
	Other (specify)				

Living Arrangements: Circle the one that applies

Renting	Own/Buying	Room with another person	Other (explain)

Real Property:

x	***Description***	**$ Value**

Accident:

Was patient's problem caused by an accident? Yes No	If yes, date of accident: / /
Where did accident occur?	How?
Is patient seeking compensation through an insurance settlement or lawsuit Yes No Comment:	

Circle any of the following that apply to the patient:

Have or Will apply for Medi-cal	65 or Over	Blind	Pregnant

Other Information:

Provide Address & Phone of any Employer

I declare or affirm that the statements above are true and correct to the best of my knowledge and belief. I understand that withholding information or giving false information will make the patient and/or responsible party liable for payment of all charges for services rendered.

Signature of Patient or Provider of Information:	Date:
Signature of Witness:	Date:

Do Not Write Below this Area for Office Use Only:

Financial Counselors Notes:

SOUTHERN INYO HOSPITAL POLICY AND PROCEDURE
Lone Pine, California

Subject: Emergency Management Program (EMP)	Reference Number: 1001
Department: Hospital-wide	Date Written: 11/08/2011 Date Reviewed/Revised: 04/2015
APPROVED BY: Lee Barron	
Signature:	
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SCOPE OF SERVICES:

Southern Inyo Hospitals Emergency Management Program's (EMP) scope is to provide for a program that ensures effective mitigation, preparation, response and recovery to disasters or emergencies affecting the environment of care. This hospital has developed an “all hazards” approach that supports a level of preparedness sufficient to address a wide range of emergencies/disasters regardless of the cause.

DEFINITIONS:

- Emergency:
  - An unexpected or sudden event that significantly disrupts the organizations ability to provide care, or the environment of care itself, or something that results in a sudden, significantly changed or increased demand for the organizations services. (Definition from The Joint Commission)
  - Emergencies can be either human-made or natural, or a combination of both, and they exist on a continuum of severity.
- Disaster:
  - A type of emergency that, due to its complexity, scope or duration, threatens the organization’s capabilities and requires outside assistance to sustain patient care, safety or security functions.
- Four (4) Phases of Emergency Management:
  - Mitigation Activities: Those activities that are developed to reduce the risk of and potential damage from an emergency/disaster. Occurs before an emergency/ disaster.
  - Preparedness: Occurs before an emergency/disaster.
  - Response: During and after an emergency/disaster.
  - Recovery: During and after an emergency/disaster.

SOUTHERN INYO HOSPITAL POLICY AND PROCEDURE
Lone Pine, California

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- Emergency Operations Plan (EOP): Describes the response procedures to follow when an emergency/disaster occurs.

OBJECTIVE:

- The objective of the Emergency Management Program is to effectively prepare for, manage an emergency/disaster and restore the facility to the same operational capabilities as pre-emergency levels.

- Six (6) critical areas of emergency response shall be managed in order to assess the hospital's needs and prepare staff to respond to incidents. The six critical areas are:

  - Communication
  - Resources and assets
  - Security and safety
  - Management of staff
  - Utilities management
  - Management of patients

GOALS:

- The goals of the Emergency Management Program include the following:

  - Identifying mitigation activities
  - Identifying procedures to prepare and respond to potential disasters or emergencies
  - Providing education to staff on the elements of the Emergency Operations Plan
  - Establishing and implementing procedures in response to an assortment of disasters and emergencies

- Identifying alternate sources for supplies and services in the event of a disaster or emergency through establishing mutual-aid agreements with neighboring hospitals and/or healthcare systems; public health departments; hazardous materials response teams; local fire department; local police departments; area pharmacies; medical supply vendors

- Identifying recovery strategies and actions to be activated in the event of a disaster or emergency

RESPONSIBILITY:

- The Emergency Management Committee, is responsible for developing, implementing and monitoring all aspects of the Emergency Management Program at this hospital, including hazard vulnerability analysis, mitigation, preparedness, response and recovery (Emergency Operations Plan).

  - It is understood that the Emergency Management Committee has a working knowledge of emergency management, hospital operations (daily operations and emergency operations) and the Hospital Command Center operations.

  - The Emergency Management Committee shall stay abreast of changes in regulations and standards as they pertain to emergency management.

  - The Emergency Management Committee shall track NIMS implementation and compliance.

  - The Emergency Management Committee shall be knowledgeable of local, state and federal emergency management agencies and their principle staff.

- Hospital leaders, as well as medical staff, shall actively participate in the organization's Emergency Management Program.

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- The Emergency Operations Plan shall be developed in coordination with community partners. Community partners include Law Enforcement, Fire Departments, Public Transportation System, Public Health Department, Utilities, Public Safety and Security Agencies, HazMat Response, Telecommunications, Mental Health, other healthcare facilities, other government agencies.

- In instances when the community partners are unable or unwilling to participate in the emergency planning efforts, the following shall be documented:

    - Evidence of communication with the community, including meeting(s) with city officials where administrators explain the importance of partnership between the hospital and the community during emergencies.

    - Evidence of response(s) from the community in the form of letters, community meeting minutes, e-mail correspondence.

- State and local regulations shall be addressed in the hospitals EOP.

- When reviewing the current EOP and accompanying annexes or developing new annexes, the Incident Planning Guides and Incident Response Guides (HICS) shall be used.

- See Emergency Management Program Manager - Responsibilities Policy (1003), Emergency Management Committee Policy (1004), Incident Planning Guides (IPGs) Policy (1007), Emergency Operations Plan (1012).

HAZARD VULNERABILITY ANALYSIS (HVA):

- This hospital has developed specific procedures in response to potential disasters and emergencies that may occur. The hospital will utilize the hazard vulnerability analysis (HVA) of Inyo County to identify areas of vulnerability and undertake provisions to lessen the severity and/or impact of a disaster or emergency that could affect the services provided by the hospital. The hospital shall develop and/or revise specific policies and procedures in response to potential emergencies/disasters identified by the HVA.

- The HVA is evaluated on an annual basis and as needed.

SOUTHERN INYO HOSPITAL POLICY AND PROCEDURE
Lone Pine, California

Subject: Emergency Management Program (EMP)	Reference Number: 1001
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- In coordination with community Emergency Management Planning, the hospital will prioritize potential emergencies/disasters identified in the hazard vulnerability analysis which will then need to have mitigation, preparation, response and recovery activities undertaken and procedures developed and implemented.
    - The hospital shall communicate its needs and vulnerabilities to community emergency response agencies, and identify the capabilities of the community in meeting the needs of the hospital.
    - This communication shall take place at the time of the hospital's annual evaluation of the Emergency Management Program and also when the needs or vulnerabilities of the hospital change.
- For each emergency/disaster identified in the hospitals HVA, the following shall be defined:
    - Mitigation activities that are designed to reduce the risk of and potential damage due to an emergency/disaster
    - Preparedness activities that organize and mobilize essential resources
    - Response strategies and actions to be activated during the emergency/disaster
    - Recovery strategies/actions that will help to restore the systems that are critical to resuming normal operations of the hospital
- List the potential disasters and emergencies that are specific to your location.
- See Hazard Vulnerability Analysis (HVA) Policy.

INVENTORY OF ASSETS AND RESOURCES:

- A documented inventory of assets and resources on-site that are needed during the emergency/disaster. At a minimum, this inventory should include:
    - PPE
    - Water

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- Fuel
- Staffing
- Medical and surgical resources
- Pharmaceutical resources

- The inventory of assets and resources shall be evaluated on an annual basis and as needed
- Methods shall be in place for the monitoring of the inventory of assets and resources during an emergency/disaster

COOPERATIVE PLANNING:

- Southern Inyo Hospital shall regularly participate in community preparedness meetings, training and activities. The following shall be discussed:
  - Mutual understanding of roles and responsibilities
  - Incident management principles
  - Resource allocations
  - Effective communication, the use of common language, information sharing practices
- Southern Inyo Hospital participates in cooperative planning for emergencies/ disasters with the following healthcare organizations in our geographic area.
- The Emergency Management Committee designee shall meet with other healthcare organizations in the community at the quarterly ICEMA meetings.
- During the cooperative planning sessions with these organizations, the following issues are discussed and identified:

- Elements of each organization's incident command structures and Hospital Command Centers
- List of names, responsibilities and phone numbers of individuals in each organization's command structure
- List of resources that can be pooled/shared for response to emergency situations
- Mutual aid agreement or Memorandum of Understanding shall be developed and maintained. The agreement shall address the following (not all inclusive):
  - How the hospital shall request assistance
  - Sharing of resources
  - Credentialing
  - Patient transfers
- Mechanism to send information on patients and deceased individuals to cooperating organizations to help facilitate identification and location of victims of the emergency/disaster

- The Emergency Management Committee shall meet with the Public Health Department to define role and responsibilities, discuss response needs, and develop plans and procedures to keep the healthcare system operating.
- The Public Health Department may provide oversight of the Medical Reserve Corp (MRC) which encompasses volunteer healthcare providers who can give medical assistance during an emergency/disaster.
  - These volunteers may be used in shelters, alternative care sites, medication distribution sites, hospitals, other healthcare organizations.
- See Cooperative Healthcare Organizations - Command Structure Phone List, List of Pooled/Shared Resources.

EMERGENCY OPERATIONS PLAN ACTIVATION:

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- The Emergency Operations Plan and Hospital Command Center will be activated when it has been determined that a disaster or emergency has occurred or has the potential for occurring.

- When the facility is notified of an emergency/disaster, the individual receiving notification will immediately notify the Chief Executive Officer, or his/her designee, of the situation whether it be an internal or external emergency/disaster.

- The Director of Nursing will respond to the site of an internal emergency and report back to the Chief Executive Officer or his/her designee, the status of the situation. The Chief Executive Officer or his/her designee will evaluate the emergency to determine whether the Emergency Operations Plan shall be activated.

- If the plan is to be activated, the Chief Executive Officer or his/her designee will notify the Switchboard Operator to call “Code Triage, Internal or External”.

INCIDENT COMMAND SYSTEM:

- The command structure utilized by this facility in coordination with the communitywide command structure is the Incident Command System as described in the Hospital Incident Command System Guidebook.

- The hospital’s Emergency Operations Plan identifies the incident command system, who is in charge of specific activities and when they are to assume oversight responsibilities.

- Southern Inyo Hospital shall be integrated into the community response, including the overall incident command structure.

- The Incident Commander will assume responsibility of the Hospital Command Center and activate the appropriate positions noted on the Incident Management Team Chart.

    - Until the Incident Command System is in place, the Chief Executive Officer or his/her designee will determine if the Labor Pool will be opened depending on the size of the emergency/disaster. If the Labor Pool is not opened, the Director of Nursing may assign additional help to the Emergency Area as needed. Additional staff will be called in as needed via the callback system.

- The House Supervisor will notify the Switchboard Operator of additional outside agencies that may need to assist the hospital in the event of an internal emergency, i.e., fire department with a flood or gas leak.

- The recovery phase will be initiated after the Building/Grounds Damage Unit has evaluated the facility once the emergency/disaster is over. The recovery phase of the plan will be initiated by the Incident Commander or his/her designee.

COMMUNICATION:

- Notification of External Authorities:

  - This hospital shall have two-way radio equipment and operators who are familiar with the equipment. In the event the hospital does not have a two-way radio unit, arrangements shall be made with community Emergency Management Director for the assignment of a two-way radio unit to the hospital.

  - The hospital will provide for alternate communication methods in the event of a failure. Two-way radio equipment and cell phones shall be available in the event of an emergency/disaster. In the event that cell phones are not working, satellite phones, ham radios or portable 800 MHz radios may be used.

- The Security Branch Director will approve media access to the facility, with only the appointed Public Information Officer interacting with the media.

- A medical record system must be chosen or designed to meet the minimum requirements of emergency management operations.

- See Communication Processes Policy and Telephone System - Failure Policy.
  See additional policies in the Communications subsection.

STAFF RESPONSIBILITIES:

- Notification of Staff When Emergency Operations Plan is Initiated:

  - In an emergency/disaster, all hospital staff, regardless of position, are expected to report to the hospital for duty as soon as it is feasible to travel. Each department

manager maintains a current callback list of all staff. Once the Emergency Operations Plan has been activated, the department manager will assign staff to initiate the callback list.

- In the event there is excess staff, the Hospital Command Center will communicate with department managers regarding rescheduling of staff for future needs. Medical staff will report to the Medical Care Branch Director for assignments.

- See Job Action Sheets (JASs) Policy and List of HICS Available Job Action Sheets.

- Alternate Roles and Responsibilities of Staff During Emergencies:

  - Staff may not be assigned to their regular duties. Staff will be asked to perform various jobs, which will be considered vital to the effective operation of the hospital. Staff will be assigned duties based on the needs of the hospital. If staff is not needed in their usual units/departments, they will be sent to the Labor Pool for assignment.

  - See Job Action Sheets (JASs) Policy, List of HICS Available Job Action Sheets and Labor Pool Policy.

- Identification of Staff in Emergencies:

  - Staff on duty during activation of the Emergency Operations Plan will be identified by employee photo identification badge, which is to be worn at all times by all staff while on duty. To further illicit clear identification of staff in the event of an emergency/disaster, all staff will be given a color-coded “staff identification” tag by their department manager.

  - Identification of staff reporting to the hospital in the event of an emergency/disaster will be given color-coded “staff identification” tags at the time of “signing-in” at the Labor Pool.

- Staff Activities and Support:

  - The hospital will provide for staff support activities in the event of an emergency/ disaster, which include, but may not be limited to:

    - Housing/lodging needs

- Transportation needs
- Family support needs, as necessary
- Incident stress debriefing and counseling

- See Staff Support Programs Policy.

- Orientation and Inservices:
  - Staff will attend orientation upon hire and annually thereafter, reviewing their specific roles and responsibilities during an emergency/disaster.
  - Inservice education will be given on the backup communication system and obtaining supplies/equipment in the event of an emergency/disaster.
  - The Emergency Management Committee is responsible for inservicing staff to the hospital-wide Emergency Operations Plan.
  - The department manager is responsible for inservicing department staff on the department specific responsibilities during an emergency/disaster.
  - See General Staff Training Policy and Staff Support Programs Policy.
    See additional policies in the Management of Staff subsection.

RESOURCES AND ASSETS:

- The hospital keeps a documented inventory of assets it has on-site that would be needed in the event of an emergency or disaster. At a minimum the inventory should include:
  - Personal protective equipment
  - Water
  - Food
  - Fuel

- Staffing
- Medical resources and assets
- Surgical resources and assets
- Pharmaceutical resources and assets

- Methods are established to monitor quantities of assets and resources during and emergency or disaster.

- Arrange for emergency/disaster supporting services to be performed by local businesses, utility companies, government agencies and individuals. Emergency/disaster supporting services would include:
  - Transportation
  - Communications
  - Traffic control
  - Food supplies
  - Utility maintenance
  - Medical supplies

- These arrangements must be coordinated with the assistance of the Emergency Services Director and the local Emergency Management Director, whenever possible. The hospital shall estimate its emergency needs for each kind of support and, when feasible, arrange to have supporting supplies, equipment and manpower pre-designated for hospital use.

- Arrange with the local and state Emergency Management Directors for the training of hospital staff who would perform the radiological monitoring of casualties and hospital areas and the acquisition of necessary radiological monitoring equipment. This equipment shall be stored in the hospital as a part of its essential emergency material.

- Essential supplies, pharmaceuticals, medical supplies, equipment, food, water, linen and utilities shall be provided to meet shelter requirements for up 96 hours when the hospital

cannot be supported by the community. Procedures are in place for the procurement of additional supplies in an emergency/disaster.

- In the event that the hospital cannot be supported by the local community for at least 96 hours, the Incident Commander, Incident Command staff and in consultation with community leaders, will evaluate the following options and implement those options that best serve the hospital and community:
  - Conservation of resources
  - Curtailment of services
  - Supplementing of resources from outside of the local community
  - Staged evacuation
  - Total evacuation

- See Emergency Management Committee Policy, Equipment and Supplies Policy, Utilities - Emergency Management Policy, Emergency Water Supply Policy, and Emergency Management - Bed Space Availability Form.

SECURITY AND SAFETY:

- Signs must be posted throughout the hospital showing shelter locations, including instructions for taking shelter.

- Efficient traffic flow must be established:
  - Prepare floor plans which designate areas for specific patient care functions and ensure that staff are familiar with these plans
  - Prepare and have available traffic control signs to show external and internal routing of casualties and other traffic
  - Assign and train volunteers to perform traffic control and security functions

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- In the event of an emergency/disaster, the Security Department and appointed Security Branch Team shall maintain control of entry and egress from the facility. The Security Branch Team will also maintain crowd and traffic control.

- Radioactive or Chemical Isolation and Decontamination:

    - There is a designated decontamination room with a separate ventilation system or ventilation shutoff available for radioactive or chemical isolation and decontamination. Staff are trained in the response to radiation or hazardous material contamination.

    - See Radiation Emergencies Policy (3201).

- At the time the Emergency Operations Plan is activated, the Security Department staff on duty will be responsible for locking all exits and entrances with the exception of the ambulance entrance. All staff of the hospital are required to wear employee photo identification badges or carry cards identifying them as staff. Only persons with proper identification shall be admitted to the hospital during an emergency/disaster.

- See Security Policy. See additional policies in the Security and Safety subsection.

UTILITIES MANAGEMENT:

- The hospital will provide for alternative sources of essential utilities, including:

    - An emergency source of electrical power capable of operating all essential electrical equipment and a plan for failure of back-up generators

    - An alternate source of safe water

    - An alternate source for safe medical gas and vacuum delivery

    - An alternate means of waste disposal in the event of sewage system failure

    - Sufficient fuel to last for at least two (2) weeks of expanded operation

        - Fuel oil, coal or tank-stored gas, are most adaptable for emergency purposes.

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- See Emergency Procedures for Utility System Failure/Disruption Policy (2502), Disruption of Hospital Services Notification Policy (2503), Disruption of Services - Water Policy (2504), Disruption of Services - Electrical Policy (2506), Disruption of Services - Medical Gas Policy (25010), Disruption of Services - Propane Policy (2511), and Disruption of Services - Sewage Policy (2512). See additional policies in the Utilities Management subsection.

MANAGEMENT OF PATIENTS:

- Management of Patients During Emergencies (i.e., Scheduling, Modification or Discontinuation of Services, Control of Patient Information and Patient Transportation):

    - Upon activation of the Emergency Operations Plan, normal admission requirements will be abolished. Initially, admissions to the hospital will be limited to those whose survival depends upon services obtainable only through hospital bed care.

    - Outpatient care will be restricted to those whose lives may ultimately depend upon the present expenditure of medical supplies and health manpower time.

    - All elective admissions and procedures will be canceled, including elective surgery, non-emergent outpatient procedures and transferring patients who are stable to be discharged.

    - Patients may be transferred to other facilities so those emergency victims may be accommodated.

    - An EMTALA waiver may be activated and individuals may be redirected or relocated for a Medical Screening Exam in the event that the hospital's Emergency Operations plan is activated. (Section 1135(b) of the Social Security Act §489.24(a)(2)). The state Health Department shall be notified when utilizing an EMTALA Emergency Waiver.

    - In the event that the hospital's Emergency Operations Plan is activated, persons may be transferred prior to being stabilized if, based upon the circumstances of the emergency, the hospital is unable to provide proper care, treatment or services. (Section 1135(b) of the Social Security Act §489.24(a)(2)).

    - Additions or changes in the hospital's bylaws may be required to give official sanction to certain provisions of the Emergency Management Program, such as:

- The provisions for special handling of patients.
- Modification of the language of the release statement signed at the time of admission, adding words to the effect that the patient agrees that, in case of an emergency/disaster, his/her physician may surrender the authority for control and treatment of the patient to others, in accordance with the hospital's emergency operating procedure.

- See Admission Policy and Registration - Emergency Management Policy and Patient Medical Record and Victim/Patient Tracking Policy. See additional policies in the Patient Management and Support Activities subsection.

- Evacuation of the Facility:
  - When a situation arises requiring evacuation of patients from threatened or affected areas, safety of lives is Southern Inyo Hospitals primary concern. Authority to order an evacuation is vested only in the Chief Executive Officer/Incident Commander. Patients shall be evacuated to an area of safety by whatever means are available. Formal agreements are in place with ambulance services and neighboring facilities to transfer patients as necessary. All staff must be trained in evacuation procedures. Evacuation routes are posted throughout the hospital.
  - Relocation to alternate health facility or place of safety (i.e., churches, schools):
    - Prepare maps of routes to the relocation site
    - Confirm periodically the availability of the relocation site
    - Establish lists of supplies and equipment, by priority, to be relocated
    - Arrange adequate transportation for evacuation and relocation
  - See Evacuation Policy (2613).
- Establishing an Alternate Care Site When the Environment Cannot Support Adequate Patient Care:
  - Formal agreements are in place so that patients may be transferred to a facility that can provide adequate patient care.

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- The Liaison Officer will be responsible for interfacility communication between the hospital and the designated alternative care site, and for retaining records of which patients were transferred to and/or from an alternative care site.
- The patient care unit transferring the patient is responsible for obtaining copies of the patient's medical records, gathering personal belongings and ensuring the patient's medications are continued throughout the transfer.
- If any hospital equipment is transferred with the patient, the patient care unit is responsible for documenting what equipment was transferred with the patient so that the equipment may be retrieved during the recovery phase post emergency.
- The following agreements are in place:
  - Ambulance contract agreements for transfer of patient between facilities, other alternate care sites
  - Transfer agreements will be made between neighboring facilities
  - Vendors will be contracted for emergency acquisitions of medical supplies, pharmaceuticals, food, equipment, water, linen, emergency repair services, etc.
- Alternate care sites must be able to provide the necessary resources to care for patients, i.e., emergency power, site access and security, access to or the ability to obtain utility resources, such as medical gases, vacuum, etc., communications, staff.
- Alternate care sites may include hotels, high school gyms, libraries, places of worship, or other structures.
- Contact Inyo County Health and Human Services for ACF sites. Refer to Inyo County Disaster Plan.
- AHRQ has developed Alternate Care Facilities and Patient Transfer Tools that may be used (http://www.ahrq.gov/prep/acfselection/):
  - Disaster Alternate Care Facilities Selection Tool:

- ♦ An interactive worksheet that assists users in selecting sites and identifying what they need to do to prepare these sites for use. It evaluates the characteristics of several potential facilities and calculates the results into weighted scores, which planners can use to select appropriate sites for care and plan for operations during a disaster.

- Disaster Alternate Care Facility Patient Selection Tool:

  - ♦ A decision support tool that matches a hospitalized patient's clinical needs with the capabilities of an alternate care facility. This information may help clinicians determine which patients might be eligible for discharge or transfer to an alternate care facility to increase a hospital's capacity for incoming patients.

- See Evacuation Policy (2613).

- Mass Fatalities:

  - During an emergency/disaster involving deaths, local and/or state mass fatality plan shall be followed.

    - The mass fatality plan is developed by the medical examiner/coroner, public safety, public health, and hospital representatives.

  - The Mass Fatality Plan shall address:

    - Family notification
    - Family support center
    - Mortuary services
    - Security of decedents and decedents' belongings
    - Chain of custody
    - Documentation

- Integration with medical examiner/coroner/law enforcement

- See Decedent Identification and Tracking Policy (2617), Signing of a Death Certificate (2615), Patient/Decedent Belongings Management Policy (, Mortuary Services Policy, Legal Evidence - Chain of Custody Policy

CONTINUING AND/OR RE-ESTABLISHING OPERATIONS FOLLOWING AN EMERGENCY:

- The hospital has mechanisms in place to restore the operational capabilities of the facility to pre-emergency levels. Once the emergency/disaster is over, the Building and Grounds Damage Unit, including the Engineering Department Director, Emergency Management Program Manager, Risk Manager and administration representative, will begin assessing the damage to the facility and the environmental concerns to determine whether the facility can safety provide medical care to the community and provide a safe environment for patients, staff and visitors.

  - Pictures and/or videos will be taken of all damages to the facility's buildings, grounds, equipment, etc., including all off-campus structures.

  - Architects, building inspectors and structural engineers may be called in to determine if the buildings are safe for occupancy.

  - All potential environmental concerns will be evaluated for proper function, i.e., hazardous waste, fuel tanks, to ensure there is not leakage into the local sewer or water system or any other impact on other environmental concerns.

  - Ensure staff support programs have been instituted, i.e., crisis counseling, flexible work hours, cash advances, day care, particularly if your staff and the hospital have been directly impacted by the emergency/disaster.

  - Clear debris and secure unsafe buildings as necessary.

  - Restore internal and external communication devices.

  - Inventory equipment and supplies for damage and determine if additional supplies need to be obtained from suppliers. Pictures/videos will be taken of all damaged supplies and equipment for insurance purposes. Damaged supplies and equipment will be retained until approval is received from the insurance agent for disposal.

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- Notify the community through local media services what services the hospital will be providing and where they will be provided in the event services are moved off the hospital campus.

- Notify the hospital's insurance agent and contact a third-party expert to prepare the claim.

- Ensure records and data have been protected and restore information as necessary from backup tapes. (See Information Management Disaster Recovery Plan.)

- Keep detailed records.

NIMS PREPAREDNESS FUNDING:

- This hospital shall establish a working relationship with the state Department of Health and state hospital association to identify activities to obtain and appropriately allocate preparedness funding.

- A proactive process shall be developed and implemented to seek other federal funding to support preparedness that takes advantage of developing interoperability training with local and regional multi-disciplinary partners.

- The hospital's Emergency Management Program documentation includes information on local, state and federal preparedness grants that have been received and deliverables to be achieved. Documentation demonstrates that preparedness grants received by the hospital meet any regional, state of local funding commitments.

EVALUATION OF THE EMERGENCY OPERATIONS PLAN:

- The Emergency Operations Plan (EOP) defines and integrates the facility's role with the communitywide emergency management efforts to promote inter-operability between the facility and the community.

- The Emergency Operations Plan shall be tested twice a year at each site included in the EOP, either in response to an actual emergency/disaster or in a planned exercise.

- Exercises shall be developed based on the hospital's hazard vulnerability analysis (HVA) testing the most threatening hazard(s) and shall evaluate the hospital's ability to handle

communications, resources and assets, security, staff, utilities and patients. Exercises should validate the effectiveness of the Emergency Operations Plan and identify opportunities to improve.

- Two (2) exercise per year shall include an influx of volunteer or simulated patients for organizations that offer emergency services or are community-designated disaster receiving stations. (TJC - tabletop sessions are not acceptable.)

- At least one (1) exercise per year shall be escalated to evaluate how effectively the hospital performs when the hospital cannot be supported by the local community. (Tabletop sessions are acceptable to meet the community portion of this exercise.)

- If applicable, the hospital will participate in at least one (1) communitywide exercise annually that is relevant to the priority of emergencies identified in the hazard vulnerability analysis. Surge capacity, integration of Incident Command and intra-operability of communications shall be evaluated. (TJC - tabletop sessions are acceptable to meet the community portion of this exercise.)

- The hospital shall designate an individual(s) to monitor the performance of the emergency response exercises and document opportunities for improvement.

- The Emergency Management Committee shall modify the hospitals Emergency Operations Plan based on the evaluations of the emergency response exercises and responses to actual emergencies/disasters (After Action Report). These improvements shall be communicated to staff as appropriate.

- This hospital cooperates with all local, county and state emergency management drills. The Emergency Management Program Manager is a member of the countywide emergency management system and coordinates with other agencies any large scale drills. (Describe the level of cooperation that exists between the hospital and other disaster response agencies, i.e., fire department, police department, county disaster agencies in a specified geographic area.)

- See Emergency Operations Plan - Exercises and Improvement Plans Policy, Job Action Sheets (JASs) Policy, List of HICS Available Job Action Sheets, and Hospital Command Center (HCC) Policy.

PERFORMANCE STANDARDS:

SOUTHERN INYO HOSPITAL POLICY AND PROCEDURE
Lone Pine, California

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- The Emergency Management Program shall be evaluated based on information gathered from priorities set from the HVA, emergency response exercises, actual emergency/disaster, changes in the mission or capability of the hospital, changes within the community, the plans objectives and goals and performance.

- There is a planned, systematic, interdisciplinary approach to process design and performance measurement, analysis and improvement related to organization-wide safety.

- The Emergency Management Committee will develop and establish performance measures and related outcomes, in a collaborative fashion, based on those priority issues known to be associated with the healthcare environment.

- Performance measures and outcomes will be prioritized based upon high risk; high volume, problem prone situations and potential or actual sentinel event related occurrences.

- Criteria for performance improvement measurement and outcome indicator selection will be based on the following:

    - The measure can identify the events it was intended to identify

    - The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable

    - The measure has defined data elements and allowable values

    - The measure can detect changes in performance over time

    - The measure allows for comparison over time within the organization or between the organization and other entities

    - The data intended for collection are available

    - Results can be reported in a way that is useful to the organization and other interested stakeholders

- The Emergency Management Committee, on an ongoing basis, shall monitor performance regarding actual or potential risks related to one or more of the following:

- Staff knowledge and skills
- Level of staff participation
- Monitoring and inspection activities
- Emergency and incident reporting
- Inspection, preventive maintenance and testing of safety equipment
- Other performance measures and outcomes will be established by the Emergency Management Committee, based on the criterion listed above. Data sources, frequency of data collection, individual(s) responsible for data collection, aggregation and reporting will be determined by the Emergency Management Committee.

- To identify opportunities for improvement/corrective action, the Emergency Management Committee will follow the organizations improvement methodology, the HICS model. The basic steps to this model will consistently be followed, and include planning, designing, measuring, analyzing/assessing, improving and evaluating effectiveness.

- Should the Emergency Management Committee feel a team approach (other than the Emergency Management Committee) is necessary for performance and process improvement to occur, the Emergency Management Committee will follow the organization's performance improvement guidelines for improvement team member selection.
  - Determination of team necessity will be based on those priority issues listed (high-risk, volume and problem prone situations and sentinel event occurrence).
  - The Emergency Management Committee will review the necessity of team development, requesting team participation only in those instances where it is felt the Emergency Management Committee's contributions toward improvement would be limited (due to specialty, limited scope and/or knowledge of the subject matter).
  - Should team development be deemed necessary, primarily, team members will be selected on the basis of their knowledge of the subject identified for improvement, and those individuals who are "closest" to the subject identified. The team will be interdisciplinary, as appropriate to the subject to be improved.

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- Performance improvement monitoring and outcome activities will be presented to the Emergency Management Committee by the Emergency Management Program Manager at least on a quarterly basis, with a report of performance outcome forwarded to the Organizational Performance Improvement Committee, MEC and Governing Body quarterly.

- The following performance measures are recommended:

    - Percent of staff able to demonstrate knowledge and skill of their role and expected participation in the Emergency Management Program

    - Percent of staff able to demonstrate knowledge of their responsibilities during an exercise

    - Number of emergency management exercises conducted within specified time span

- See PI Monitoring and Evaluation Plan Form - Emergency Management Program.

ANNUAL EVALUATION OF THE EMERGENCY MANAGEMENT PROGRAM'S OBJECTIVES, SCOPE, PERFORMANCE AND EFFECTIVENESS:

- The annual evaluation of the Emergency Management Program will include a review of the scope and objectives according to the current accrediting organization standards, HICS guidelines and NIMS requirements to evaluate the degree in which the program meets accreditation standards, NIMS requirements and the current risk assessment of the hospital.

    - A comparison of the expectations and actual results of the program will be evaluated to determine if the goals and objectives of the program were met.

    - The overall performance of the program will be reviewed by evaluating the results of performance improvement outcomes. The overall effectiveness of the program will be evaluated by determining the degree that expectations where met.

    - The Emergency Operations Plan shall be revised and updated based on the annual evaluation of the Emergency Management Program, including the Hazard Vulnerability Analysis.

SOUTHERN INYO HOSPITAL POLICY AND PROCEDURE
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- The performance and effectiveness of the Emergency Management Program shall be reviewed by the Emergency Management Committee, the Performance Improvement Committee and Administration.

- See Annual Evaluation of the Effectiveness of the Emergency Management Program Form.

SOUTHERN INYO HEALTHCARE DISTRICT

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

REVIEWED DATE: 9/10/2019

REVISED DATE:

EFFECTIVE DATE:

DOCUMENT OWNER:	**Shannon Jimerson (Chief Nursing Officer)**
APPROVER(S):	**Shannon Jimerson (Chief Nursing Officer), Emergency Preparedness Committee**
ADDITIONAL APPROVAL(S):	**Policy Review Committee**

SUBJECT: **Emergency Management Program-Southern Inyo Healthcare District**

SOUTHERN INYO HEALTHCARE DISTRICT

Emergency Management Program

2019-2020

REVISIONS
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I. Introduction

A. Hospitals and the communities they reside in have always been vulnerable to disasters that are manmade, technological in origin, naturally occurring or failures of infrastructure. It is the potential of any and all of these threats that drives Southern Inyo Healthcare District.

II. Policy

The Emergency Management Program (EMP) will implement the mission, vision, and strategic goals and objectives as well as the management framework of the program and Southern Inyo Healthcare District by using a comprehensive approach to emergency management as a conceptual framework.

III. Purpose

A. The purpose of the SIHD Emergency Management Program (EMP) is to provide principles and practice guidelines to help the entities within the corporation (Appendix A: SIHD and Affiliates) be prepared, resourced, and organized to efficiently manage multi casualty incidents while approximating the usual standard of medical care as much as possible.

B. The EMP will provide to Southern Inyo Healthcare District an overarching infrastructure for the purpose of emergency management and define specific mitigation strategies, preparedness activities, and response and recovery strategies to be employed during an emergency response.

IV. Scope and Applicability

A. The EMP is applicable to all entities of the Southern Inyo Healthcare District and staff providing management direction or technical oversight that could impact the mitigation, preparedness, response, and recovery efforts of emergency management.

V. Planning Assumptions

A. The following assumptions were considered during the planning and development of the EMP:

Local response is primary – the initial response to any medical event will be almost entirely based upon locally available health and medical organizations. Southern Inyo Healthcare District will collaborate and integrate into the community response coordinated through the Operational Area Emergency Operations Center.

Medical response is complex – The response to a multi casualty incident impacts an entire community and involves a diverse medical and public health healthcare

system including but not limited to: public health departments, emergency medical services, medical laboratories, individual healthcare practitioners, and medical support services

Integration of the public-private organizations – Traditionally, planning the response to emergencies was accomplished as individual entities. A paradigm shift in conceptual models will be needed to accommodate integration into a larger response system. SIHD is reaching out to other community members and participating in planning an integrated community response.

Public Health is an essential partner – Public health departments are not traditionally integrated with other community emergency response operations including the acute care medical and mental health communities. Kern County Department of Public Health Services is an essential partner in any successful multi casualty or mass effect healthcare response. Integration of healthcare systems with the larger response community has been challenging yet SIHD involvement and participation towards a coordinated community response remains a goal.

Robust information processing will be needed – large scale medical responses rarely unfold with clear vision as complex information must be collected from disparate sources, processed and analyzed rapidly in order to determine the most effective, appropriate course of action. Medical response will require a robust information management process that may differ markedly from what is used on an everyday basis.

Effective overall management will be needed – responding to a multi-casualty incident can be exceedingly complex. Response actions must be accomplished by requiring coordination between disparate operating units that do not work together on a regular basis much less under the stress of response. The effectiveness of overall management can be enhanced by broadening our efforts to work together now before a major event comes upon us. Efforts to get to know our stakeholders and community partners better well in advance of a major medical event will help to smooth our differences during an event and offer a more coordinated response. Collective versus isolated planning efforts can mitigate the gaps during future responses.

Resiliency of the medical system – is necessary for the system to maintain its usual effectiveness and provide a strong foundation upon which medical surge may occur.

Regular day-to-day services that SIHD provides to the communities are critical - and every effort will be made to maintain these services during an emergency response and recovery to the extent possible. However, it is recognized that individual scenarios may lead to degradation of these services.

VI. Program Description

A. The Emergency Management Program (EMP) is a program that implements the mission, vision, and strategic goals and objectives as well as the management framework of the program and organization.

B. The EMP uses a comprehensive approach to emergency management as a conceptual framework divided into four categories; program description, mitigation strategies, preparedness activities, and facility-specific Emergency Operations Plans.

C. The EMP uses a systems-based methodology in the development process. The methodology included a cross-sectional, diverse, multi-discipline, multi-level workgroups with sub-workgroups across the organization and emergency preparedness committees, faith-based and community organizations which facilitated integration with the community response plans.

D. The EMP is an inter-disciplinary, trans-organizational, inter-agency and inter-governmental function. The main focus was to develop a community integrated response that would provide effective overall management and build resiliency of the SIHD medical system and maintain regular day-to-day patient services during an emergency response and recovery to the extent possible.

E. The organizational workgroup, who is not always accustomed to collaborating on a day-to-day basis, meet every other month and focused on their area of expertise in each of the SIHD departments. The workgroup member list is located in the facility specific Emergency Operations Plan.

F. Critical evaluation was performed of day-to-day processes, best practice concepts, opportunities to enhance services, organizational policies and procedures, 96 hour capability, utilities management, surge/expansion plans, communications, patient management, disaster privileges, available resources including personnel, supplies, pharmaceuticals, equipment, available facility support, staff management, and existing command structure. Existing specific incident plans were reviewed and updated during the development process.

G. The foundation for the EMP was built on the annual Hazard Vulnerability Assessment. The identified top three vulnerabilities set the framework for the mitigation strategies and preparedness activities.

VII. The Standardized Structure of the EMP (Appendix B- Emergency Management Program Life Cycle and Appendix C: Emergency Management Program Development Flow Chart).

A. The EMP is the overarching umbrella and its components are the program description, mitigation strategies, preparedness activities, and facility-specific Emergency Operations Plans.

B. Each of the facility-specific EOP has the following components: basic plan with the appendices, acronyms, terms and definitions, and the Hazard Vulnerability Assessment.

C. The body of the EOP includes the following sections: response overview, incident command, 96 hour capability, evacuation/shelter-in-place plan, hospital surge/expansion plan, communications, resources and assets, utilities management, security and safety, staff management, patient management and clinical support, disaster privileges, demobilization and recovery.

D. Another component is the Specific Incident Response Guides which includes but not limited to the following: blasts, earthquake, pandemic influenza, bioterrorism, and mass fatality plans.

VIII. Adoption of National Incident Management System (NIMS) Healthcare Objectives

A. The Southern Inyo Healthcare District Emergency Management Program has a conscious effort to integrate all 17 NIMS elements into the program.

1. Element 1: Southern Inyo Healthcare District has adopted NIMS, Standardized Emergency Management System, Incident Command System (ICS), and Hospital Incident Command System (HICS).

Element 2: ICS/HICS is the platform that will be used to manage all emergency incidents, exercises and preplanned events. The facility-specific Emergency Operations Plans will explain the use of the ICS/HICS which ensures element compliance.

Element 3: Multiagency Coordination System – the facility-specific Emergency Operations Plans demonstrates the management and coordination between the Hospital Command Center and multiagency coordination system entities

Element 4: Public Information System – The facility-specific Emergency Operations Plans explains the management of public information with emergency response partners

Element 5: NIMS Implementation Tracking – Implementation activities will be tracked annually with a goal of improving emergency management capability

Element 6: Preparedness Funding – collaboration with state and local government and California Hospital Association to identify and obtain preparedness funding.

The EMP will include information on local, state and federal preparedness grants received and deliverables to be achieved

Element 7: Revise and Update Plans – Revision of facility-specific Emergency Operations Plans to incorporate NIMS

Element 8: Mutual Aid Agreements – Establish mutual aid agreements with neighboring hospitals and healthcare systems, public health departments, medical supply vendors, pharmacies, etc. EMP documentation includes information supporting any mutual aid agreements with Southern Inyo Healthcare District

Element 9: IS-700 – Should be completed of hospital personnel in a leadership role in emergency preparedness, incident management, filling ICS/HICS roles and/or emergency response. EMP training track completion of courses

Element 10: IS-800.A – Ongoing EMP training records track completion, training should be completed by individual(s) responsible for the Southern Inyo Healthcare District Emergency Management Program

Element 11: ICS 100 HC and 200 HC - ICS 100 should be completed by hospital personnel that would have a direct role in emergency preparedness, incident management and/or designated to fulfill ICS roles and ICS 200 should be completed by personnel whose primary responsibility is emergency management and/or personnel designated to fulfill ICS roles

Element 12: Training and Exercises – include NIMS/ICS into trainings and exercises and EMP documentation reflects the use of NIMS/ICS, when applicable.

Element 13: All-Hazards Exercise Program – participate in all-hazards exercises with response partners, when able.

Element 14: Corrective Actions – incorporate corrective actions into response plans and procedures, when applicable.

Element 15: Response Inventory – maintain an inventory of organizational response assets

Element 16: Resource Allocation – Ensure interoperability by establishing common equipment, communications and data interoperability resources with other local response partners, when applicable.

Element 17: Standard and Consistent Terminology – establish common language consistent with local emergency management, public safety and public health, when applicable.

B. Adoption of these standards in the Emergency Management Program will improve Southern Inyo Healthcare District’s preparedness, response and recovery efforts.

IX. Mitigation Strategies

A. Each of the workgroups based their recommendations upon the Concept of Continuity of Operations, management strategies to achieve medical/healthcare surge/expansion of services, engineered (managed) degradation of services that is designed to avoid catastrophic or random failure of emergency response systems when system capacity or capability is exceeded.

B. The multi-faceted workgroups delivered the granularity needed to form the specific “how-to” approach needed for the facility-specific Emergency Operations Plans.

C. The mitigation strategies discussed in the EMP are considered the broad umbrella over the specific facilities within the Southern Inyo Healthcare District Hospital/Affiliates. Each facility will use the corporate mitigation strategies in each of their facility-specific Emergency Operations plan.

1. Continuity of Operations

Any hazard may severely impact the healthcare system creating a potential disruption to normal medical care operations at the same time causing an urgent increase in general or specialized services. While facility-specific Emergency Operations Plans call for postponement and/or transfer of elective and less-than-urgent medical services the majority of everyday patient care services must continue uninterrupted to avoid a significantly adverse effect on the normal patient population.

The EMP includes effective continuity planning for both business and service/product operations across the four phases of emergency management: mitigation, preparedness, response, and recovery. Every effort was made during the planning efforts to assure that the capability exists to continue essential business and service functions across a wide range of potential emergencies, including localized acts of nature, accidents, and technological and/or attack/terrorist-related emergencies.

The formal Continuity of Operation Planning for all entities is in process.

Healthcare Surge

a. “Healthcare surge” has a variance in meaning to participants in the healthcare system. It is defined as: A healthcare surge is proclaimed in a local health jurisdiction when an authorized local official such as a local health officer or other appropriate designee using professional judgment determines, subsequent to a significant emergency or circumstances, that the healthcare delivery system has been impacted resulting in an excess in demand over capacity in hospitals, long term care facilities, community care

clinics, public health departments, other primary and secondary care providers, resources and/or emergency medical services.

During a surge, the challenge to Southern Inyo Healthcare District medical facilities will come through an increase in volume (capacity) and/or through the presentation of patients with unusual or specific care requirements (capability).

Management Strategies to achieve Medical/Healthcare Surge

The ability to maintain operations and achieve the medical surge will depend upon the organization's ability to shift immediately the entire focus to address critical needs.

Maintaining quality and adequacy of services in the face of stress can be obtained by coordinating the redistribution of authority and responsibility throughout the organization so that tasks can still be performed within the quality parameters set by Southern Inyo Healthcare District, but in greater quantity. For example, a large number of victims are arriving at SIHD medical facilities seeking emergency treatment.

The best site to provide standard quality emergency evaluation and treatment is in the Emergency Department (ED).

The Emergency Operations Plan is activated including the activation of the Hospital Command Center.

The ED will be cleared as much as possible of patients holding or waiting for beds by patient treatment units accepting and moving patients quickly out of the area so ED can focus upon the large number of incoming casualties.

Support for the ED will be provided by sending staff and equipment from the critical area units, mobilization of off-duty critical care staff to provide critical care services in the ED and in-patient care overflow sites.

Engineered (managed) degradation of services

a. The concept is when SIHD healthcare system is under extreme stress, each of the departments will identify and select priority activities that should be preserved, while allowing less critical services to degrade.

b. This management strategy is designed to avoid catastrophic or random failure of SIHD emergency response systems when SIHD system capacity and/or capability are exceeded.

c. The guiding principle is the preservation of the functions most important to achieving SIHD organizational goals of maintaining regular day-to-day patient services during an emergency response and recovery to the extent possible.

d. Engineered degradation is distinguished from crisis care.

e. Engineered degradation involves the selection of certain procedures or processes over others that are considered essential for preservation of overall organizational function. Processes are applied equitably across all patient populations (i.e., no distinctions made between patients). A good example is the clinical decision to rapidly clean wounds and apply wet sterile dressings, deferring primary wound closure until all victims are assessed and more serious injuries have been treated.

Crisis Care (previously called Altered Standards of Care)

a. The concept of crisis care generally is assumed to mean a shift to providing care and allocating scarce equipment, supplies, and personnel in a way that saves the largest number of lives in contrast to the traditional focus on saving individuals (Barbera, et al., 2006).

b. Even though this concept involves some of the same concepts as engineered degradation it is more expansive and can translate into more dramatic steps such as rationing of treatment supplies or selection of certain populations for treatment over others.

In a natural progression of actions it will be preferable to implement engineered degradation strategies first, then move to crisis care as a last resort. In managing “failure” of the medical care system the care of patients will be a priority over most other system activities, except for safety of staff and current patients.

X. Preparedness Activities

A. Advanced planning was achieved by the involvement of leadership and medical staff with cross-sectional, diverse, multi-discipline, multi-level workgroups with sub-workgroups across the organization and the emergency preparedness committee, faith-based and community organizations which facilitated integration with the community response plans.

B. SIHD organization bases preparedness activities on the annual Hazard Vulnerability Assessments which are conducted to identify potential emergencies that could affect the organization’s ability to provide services. Documentation of when HVA was reviewed/revised/updated can be found in the facility-specific Emergency Preparedness Meeting Minutes.

C. The organization identifies priorities among the potential emergencies in the HVA together with the community partners during integrated community emergency response meetings/training throughout the year sponsored by SIHD organization, California Hospital Association, HPP Grant Coordinator, and Kern County Department of Public Health Services.

XI. Emergency Management Organizational Learning

A. The Homeland Security Exercise and Evaluation Program (HSEEP) will be used as a capabilities and performance-based exercise program which provides a standardized policy, methodology, and terminology for exercise design, development, conduct, evaluation, and improvement planning, when applicable.

B. The use of HSEEP ensures that SIHD exercise programs conform to established best practices and helps provide unity and consistency of effort for exercises. Exercises performed under the HSEEP standards offer objective assessments of SIHD capabilities so that gaps, deficiencies, and vulnerabilities are easily identified and remedied prior to a real event.

C. Exercises using HSEEP standards allow training and practice prevention, protection, response, and recovery capabilities.

D. Exercises will be used as a valuable tool for assessing and improving performance, while demonstrating commitment to prepare for major incidents.

E. HSEEP integrates the concepts of NIMS, National Preparedness Guidelines, Universal Task List (UTL), and the Target Capabilities List (TCL).

F. Categories of exercises: There are three primary categories of exercises that allow for increasing levels of complexity and involvement. These categories are:

1. Tabletop – scenario-based discussion of elements of the Emergency Operations Plan, allowing individuals and teams to evaluate their emergency operations roles and responsibilities in a relatively low stress environment.

2. Functional – scenario-based execution of specific tasks and/or complex activity within a functional area of the Emergency Operations Plan.

3. Full-Scale – scenario-based extension of a functional exercise to include multiple, if not all, functions and activities of the Emergency Operations Plan

G. The category selected for a specific evaluation will be based upon the maturity of the Emergency Management Program and the facility-specific Emergency Operations Plans, previous evaluations, the turnover of personnel, changing organizational requirements, and the introduction of new technologies.

XII. Emergency Management Program (EMP) Evaluation

A. The EMP will be evaluated for:

1. Compliance with the organization’s mission and strategic objectives

2. Continuity planning

3. Medical surge

4. Four components of mitigation, preparedness, response, and recovery

5. Accountability – if program activities and resource use contribute to the effective and efficient accomplishment of the organizational and program objectives

6. Improvement or Enhancement – determine need for and means to accomplish and monitor organizational change

XIII. Emergency Operations Plan (EOP) and Recovery Plan Evaluation

A. The facility-specific EOP will be evaluated by examination of:

1. Hazard Vulnerability Assessments
2. Actual incidents (emergencies and disasters)
3. Exercises (tabletop, functional, and full-scale
4. Evaluation drills (drills conducted specifically for the purpose of evaluating personnel, policies, procedures, equipment, etc.)
5. After Action Reports (AAR)

B. Southern Inyo Healthcare District as a “learning organization” is committed to continuous improvement based upon evaluation.

C. Evaluation of the EMP and facility-specific EOPs supports organizational learning.

D. The Emergency Management Coordinator with consultation with the Emergency preparedness Steering Committee consisting of Administrators, EOP Workgroup Leaders and Disaster Preparedness Committee defines and administers the process for soliciting, analyzing, processing, tracking, and acting on potential organizational changes.

XIV. Response and Recovery Overview, Concepts, and Principles

A. Southern Inyo Healthcare District may be impacted by hazards in numerous ways in more than one facility at any given time. Hazard impacts may further be complicated by the need to provide surge capacity and/or capability. Potential impacts have been categorized as follows:

1. Internal - Mass Effect and Organizational Resiliency: Hazard impact on operational continuity, or the ability to maintain mission critical business operations and regular day-to-day provision of patient services. Examples: loss of normal water pressure, structural impact after an earthquake or an explosion, or loss of information systems from a power surge.
2. External - Mass Casualties and Surge Capacity: Hazard impact is community wide and creates the service need to evaluate and care for a significant increased volume of patients – one that challenges or exceeds normal operating capacity. Note: surge requirements may extend beyond direct patient care such tasks as extensive laboratory studies, epidemiological investigations, or business operations. Examples: anthrax exposure, multiple victims needing immediate evaluation and prophylaxis, bomb explosion, many patients with chronic medical conditions lacking access to regular care following a natural disaster

3. Internal/External - Unusual Casualties and Surge Capability: Hazard impact may create the need to manage patients requiring unusual or very specialized medical evaluation and care. Examples: A non-burn center receiving a surge in patients requiring burn evaluation and care, non-pediatric center receiving a surge in pediatric patients from trauma event. Surge capability also includes patient problems that require special intervention to protect medical providers, other patients, and the integrity of the medical care facility such as ricin attack.

B. Goals, Objectives, and Roles

1. Primary goal: To provide the best possible care to victims of the incident while maintaining safety for personnel, integrity of the facilities, and the ability to perform service and maintain regular day-to-day patient services during an emergency response and recovery to the extent possible.

2. Objectives:

   a. Protect staff, the patients already under care, and visitors and patients families.

   b. Maintain integrity of structural and operational roles within the community as it relates to maintaining healthcare services.

   c. Provide care to incident patients as indicated.

   d. Efficiently integrate into the community emergency response, including coordination with other healthcare facilities

   e. Address environmental and regulatory concerns where indicated if possible without compromising prior objectives stated.

Roles

   a. Support incident authorities – provide a visible competent response as part of the jurisdictional response thus providing reassurance to the public

   b. Coordinating actions with community response – coordinating strategy and actions with the engaged community response organizations

   c. Giving expert advice – providing medical advice to the jurisdictional response managers, as appropriate

   d. Conveying consistent public messages – maintaining consistent response actions and media messages with the jurisdictional response

C. Description of Hospital Incident Command System

1. HICS Command Function (Appendix D – HICS Command Structure)

The Command function carries the overall responsibility for the emergency response and recovery.

Command provides guidance and establishes the system response and recovery objectives and strategies that coordinate the activities of the various sections and provides guidance for further activities

Activation of Command equates to activation of the appropriate Emergency Operations Plan

Formal incident planning will be instituted, and refining response and recovery strategies will be ongoing through sustained response efforts

D. Command and Management Positions

1. Incident Commander – this position oversees the Command function and the response itself. This position will be taken by an Administrator

Incident Commander Competencies (Barbera, et al., 2006): the knowledge, skills, and abilities to:

a. Identify specific criteria of potential events that indicate the need for the full or partial activation of the Emergency Operations Plan
b. Activate or support full or partial EOP activation for appropriate events
c. Ensure rapid healthcare system mobilization that transitions day-to-day management and operations to a response organizational structure and processes
d. Ensure that HICS command is effective, utilizes EOP procedures and processes, and uses a pro-active “management by objectives” approach
e. Manage continuous incident planning through planning cycle procedures that develop strategic and general tactical guidance to facility personnel
f. Manage efficient information processing regarding response activities
g. Provide information on the healthcare system’s response and recovery activities to patients’ families, facility personnel families, media, and the general public as appropriate
h. Monitor the response and recovery needs of the facility’s functional areas, and if needed, provide support with additional facilities, equipment, communications, personnel, or other assistance.
i. Establish appropriate measures to document, track, or reimburse financial costs associated with the facility’s response and recovery.
j. Manage facility’s response so that it adheres to appropriate regulations and standards or seeks relief as required.
k. Problem-solve issues that aren’t resolved lower in the management structure, but avoid micro-management.

Ensure that business continuity considerations are incorporated into the facility's incident action planning process.

Ensure rapid and effective demobilization of the facility's system response during the transition to recovery operations.

Ensure recovery is accomplished to restore the healthcare system to baseline operations and to capture important lessons for organizational improvement.

Availability and qualification: Incident commander (Administrator) must, therefore, have prerequisite training and must be onsite to perform his/her duties

24-hour coverage – For extended Incident Operations or incidents that require 24-hour staffing, a Deputy Commander may be selected to extend the coverage of this important position

E. Authority of the CEO or designee – retains ultimate authority to meet his/her responsibility for an effective response. Decision-making authority for the response itself is essentially delegated to the Commander. CEO therefore remains available for other important activities such as speaking with the media, liaising with senior political or response authorities, and continuing the management of the overall healthcare system.

F. CEO or designee participation in ICS – may participate in any or all command meetings that establish objectives and strategies and that involve major expenditures. Their focus should be at the strategic level, and focus upon their role of assuring the continuing normal healthcare operations as the incident evolves.

G. Oversight by board of directors or other overseers – CEO or designee retains the role of keeping these bodies informed. If input is requested from them, or they wish to have a formal role, the use of an "emergency policy group" or "Medical/Technical Specialist" group may allow for formal policy-level input without opening up the Command structure to micro-management.

1. Safety Officer

    a. This position is traditionally focused on the workplace safety and occupational health of the responders in the corporation including preventive measures as well as reactive interventions if an injury or illness occurs. Security "safety" is also a vital component during disaster incidents. The actual tasks that address these issues are performed by personnel in the appropriate ICS sections. Facility safety personnel will be used to staff this position. Alternatives include security personnel or others.

    b. Safety Officer responsibilities and activities include:

    Providing input to Command decision-making as it relates to workplace safety, preventive medicine, infection control, and security of healthcare personnel.

Participating in the incident action plan

Monitoring fatigue of responders

Monitoring for nutrition and hydration

Monitoring for adequate hygiene and infection control

Monitoring for incident stress and its effects on responders

Personal Protective Equipment – the type of PPE and the context in which it will be used should be monitored by the Safety Officer for adequacy of equipment for the circumstances, as well as adequate application and adherence to guidelines by responders.

Monitoring of injuries and illnesses – from an epidemiological perspective, looking for any indication that a change in response methodology or safety practices is warranted.

Public Information Officer (PIO)

a. Information Officer will be assigned to coordinate information sharing inside and outside the facility
b. Responsibilities:
    i. Coordinate with and determine from the Incident Commander if any limits exist on information to be released
    ii. Develop material for use in media briefings
    iii. Obtain Incident Commander's approval of media releases
    iv. Inform media and conduct media briefings
    v. Arrange for tours and other interviews or briefings that may be required
    vi. Obtain media information that may be useful to incident planning
    vii. Maintain current information summaries and/or displays on the incident and provide information on status of incident to assigned personnel
    viii. Maintain Unit Log

Liaison Officer

a. The hospital link to outside agencies. In some cases one Liaison Officer may be at the HCC while a second one is assigned to represent the hospital at the local EOC or field incident command post.
b. Responsibilities:

i. Establishing and maintaining coordination with the Command functions of external response organizations, such as public health, fire, EMS, law enforcement, or other hospitals.

ii. May interact with local emergency management authorities

iii. Maintain Situation Report to be used to update external entities.

Technical Specialists

a. These positions provide strategic advice to the command/management group and are established only when needed.

b. Medical/Technical Specialists are persons with specialized expertise in areas such as the infectious disease, legal affairs, risk management, and medical ethics who may be asked to provide the Incident Command staff with needed advice and coordination assistance.

H. Operations Section

1. The Operations Section will be responsible for managing the tactical objectives outlined by the Incident Commander.
2. Type and number of staff assigned is dependent upon the hazard impact or threatened impact and what the organization is attempting to achieve.
3. Typically the largest section in terms of resources to acquire and coordinate.
4. Branches, Divisions, and Units are implemented as needed to maintain a manageable span of control and streamline the organizational management.
5. The degree to which command positions are activated depends on the situational needs and the availability of qualified command officers.

Medical Care Branch

a. Provides services that are essential for maintaining hospital operations, not simply logistical support.

b. Responsible for addressing the provision of acute and continuous care of the incident victims as well as those already in the hospital for medical care.

c. Casualty Care Unit Leader will usually be located in the Emergency Department but can appoint additional command personnel to coordinate triage and treatment activities if needed.

i. Patients arriving at the hospital are expected to be quickly and correctly triaged to a definitive treatment location and medical care is not delayed waiting in a treatment area.

ii. Triage Officers treatment priority should be plainly identified on a START disaster tag or band.

iii. A quick but reliable patient registration process will be implemented to avoid delays in patient care or confusion over patient location.

d. Inpatient services (Inpatient Unit), Outpatient services (Outpatient Unit), and clinical support services (Clinical Support Services Unit) will also be coordinated by the Medical Care Branch.

e. To meet surge capacity needs, the Incident Command Staff should refer to the surge expansion plan in the EOP.

f. The Medical Care Branch Director will work with the Logistics Branch to ensure needed personnel, equipment, medication, and supplies are requested, and with the Staging Manager to ensure their delivery to needed areas.

g. When resources are in short supply the Incident Command Staff should refer to the plans for engineered degradation and altered standards of care.

h. HazMat Branch would not be operationalized for most incidents. However, it would become critical to managing incidents when a hazardous material is involved (either internal or external).

Infrastructure Operations

a. Responsibilities include maintaining the normal operational capability of the facility including power and lighting (Power/Lighting Unit), water and sewer (Water/Sewer Unit), HVAC (HVAC Unit), medical gases (Medical Gases Unit), medical devices (Medical Devices Unit), and building/grounds (Building/Grounds Damage Unit), increasing that capacity when patient surge requirements dictate; and identifying and fixing utility service-delivery failures.

b. The acquisition of equipment parts or outside contractors will be coordinated with the Support Branch.

Business Continuity Operations

a. The function is to assist impacted areas with ensuring that critical business functions are maintained, restored, or augmented to meet the designated Recovery Time Objective (RTO) and recovery strategies

b. Facilitate the acquisition of and access to essential recovery resources, including business records (e.g., patient medical records, purchasing contracts)

c. Support the Infrastructure and Security Branches with needed movement or relocation to alternate business operation sites

d. Coordinate with the Logistics Section Communications Unit Leader, IT/IS Unit Leader, and the impacted area to restore business functions and review technology requirements

e. Assist other branches and impacted areas with the restoring and resuming of normal operations

Security Operations

a. Limited Access vs. Restricted Visitation

i. The decision to restrict access must be made by the Incident Commander in conjunction with other senior personnel such as the Security Branch Director.

ii. If access is to be restricted, then implementing the decision should immediately be carried out according to the EOP:

a. Announcement of the security restrictions to the staff and public should be immediate, followed by assigned personnel rerouting pedestrian and vehicular traffic and doors being locked, either manually or electronically (Access Control Unit).

b. Locked doors will be monitored to ensure no compromise occurs.

c. Internal and external signage indicating the doors are NOT to be opened (and, where appropriate, redirecting would-be entrants) will be posted as soon as possible.

d. Special attention will be given to ensure adequate egress in the event of a fire or other internal emergency.

e. Heightened surveillance procedures include:

i. inspecting suspect packages;

ii. closer scrutiny of personnel at checkpoints, including

iii. verification that each individual, including staff, is wearing a proper identification badge; and

iv. assigning properly protected personnel at patient arrival points,

v. Certain areas such as the emergency department, pharmacy, and HCC will receive enhanced security support.

Supplemental Security Staffing

i. Supplemental personnel may be needed to assist the on-duty Security staff, depending on the type and length of the incident.

ii. Call back will be initiated to bring personnel in from home, reassigning other non-Security personnel to select tasks, and requesting help from local law enforcement.

Traffic Control

i. Victims will likely be arriving by private autos accompanied by quickly escalating numbers of family and friends.

ii. Media will also be arriving at some point and requesting special parking locations for their outside interviewing and “live shots.”

iii. Traffic patterns may need to be revised to optimize EMS and other emergency vehicle arrivals. The area in front of the emergency department should be kept clear along with areas assigned for decontamination.

Vendor deliveries may need special inspections, alternative routing, or cancellation.

Personal Belongings Management

i. The EOP indicates specific plans for managing personal belongings under specific conditions.

ii. Contaminated patient belongings will require special care to avoid cross-contamination as well as to preserve the chain of custody if the incident was deliberate.

Chain of Custody

i. The EOP outlines a fundamental strategy of basic objectives and steps.

ii. These procedures address everything from handling a patient’s personal effects to maintaining evidence

HazMat Branch

a. In situations involving a hazardous material release (internal or external) the Incident Commander may choose to activate the Hazardous Materials Branch (HazMat Branch) per the EOP.

b. The HazMat Branch will have the personnel and equipment to address

i. Agent identification (Detection and Monitoring Unit)

ii. Spill response (Spill Response Unit)

iii. Victim decontamination (Victim Decontamination)

iv. Decontamination of equipment and the facility (Facility/Equipment Decontamination Unit).

v. Personal Protective Equipment (PPE) and decontamination procedures employed will complement whenever possible those used by other hospitals and the fire department.

vi. A decontamination area has been designated that can be quickly established and is suitable in size and flow to accommodate patient processing needs.

vii. Procedures are available for staff donning and doffing PPE and decontamination of ambulatory, non-ambulatory, and patients with access and functional needs.

I. Additional Branch Options

1. Unique situations, usually involving internal emergencies, may occur that require the creation of additional Operational Branches. For example, a Special Operations Branch might be created to address the specific needs of an incident that are not being met by the standard HICS, such as a pending tornado which could require a defensive action to protect the personnel response (e.g., internal shelter-in-place operation or evacuation).

2. Other examples include evacuation, sheltering in place, and a working fire in the facility. The Incident Commander will appoint a qualified individual to be the Special Operations Branch Director. This individual would exercise command over the unique response activities associated with the situation, working with other command officers as appropriate to meet the mission objectives.

J. Concept of Operations (specific procedures and tasks that must be accomplished during each stage of response is detailed in the facility-specific EOPs).

1. Incident Recognition

2. Notification/Activation

3. Mobilization

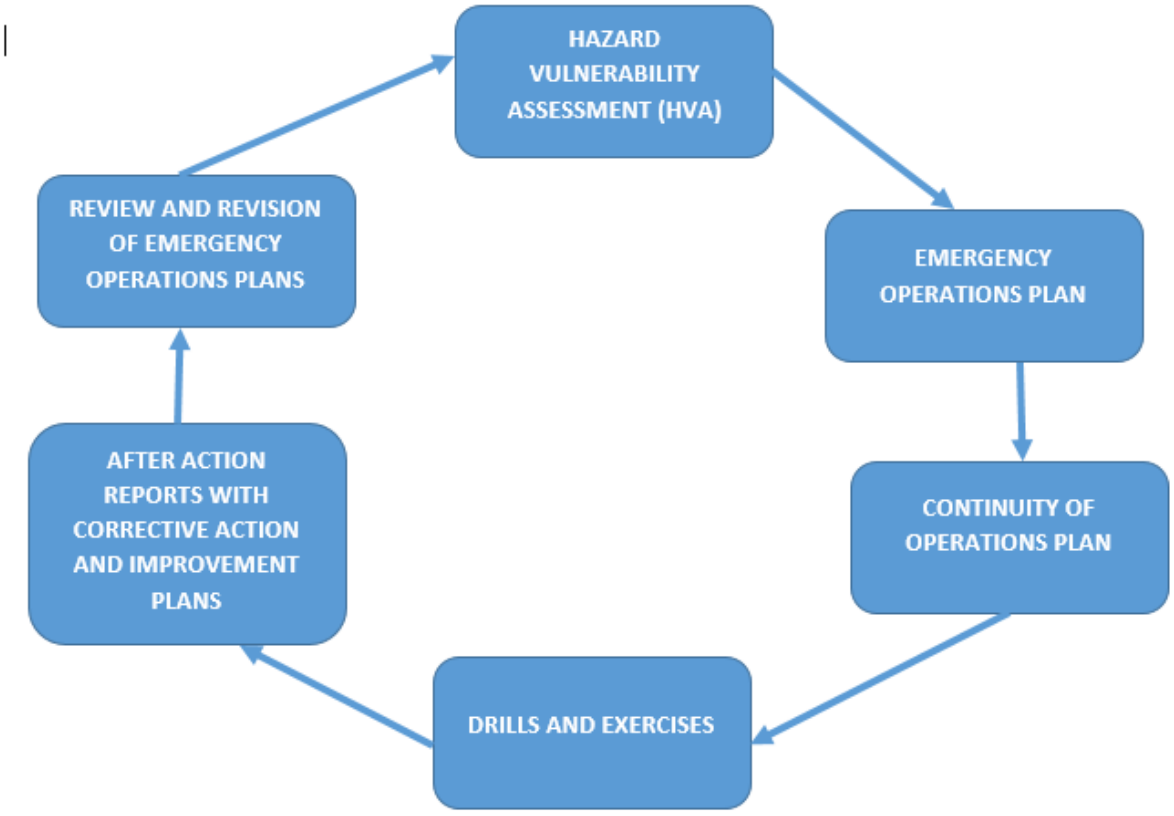
4. Incident Operations

5. Demobilization

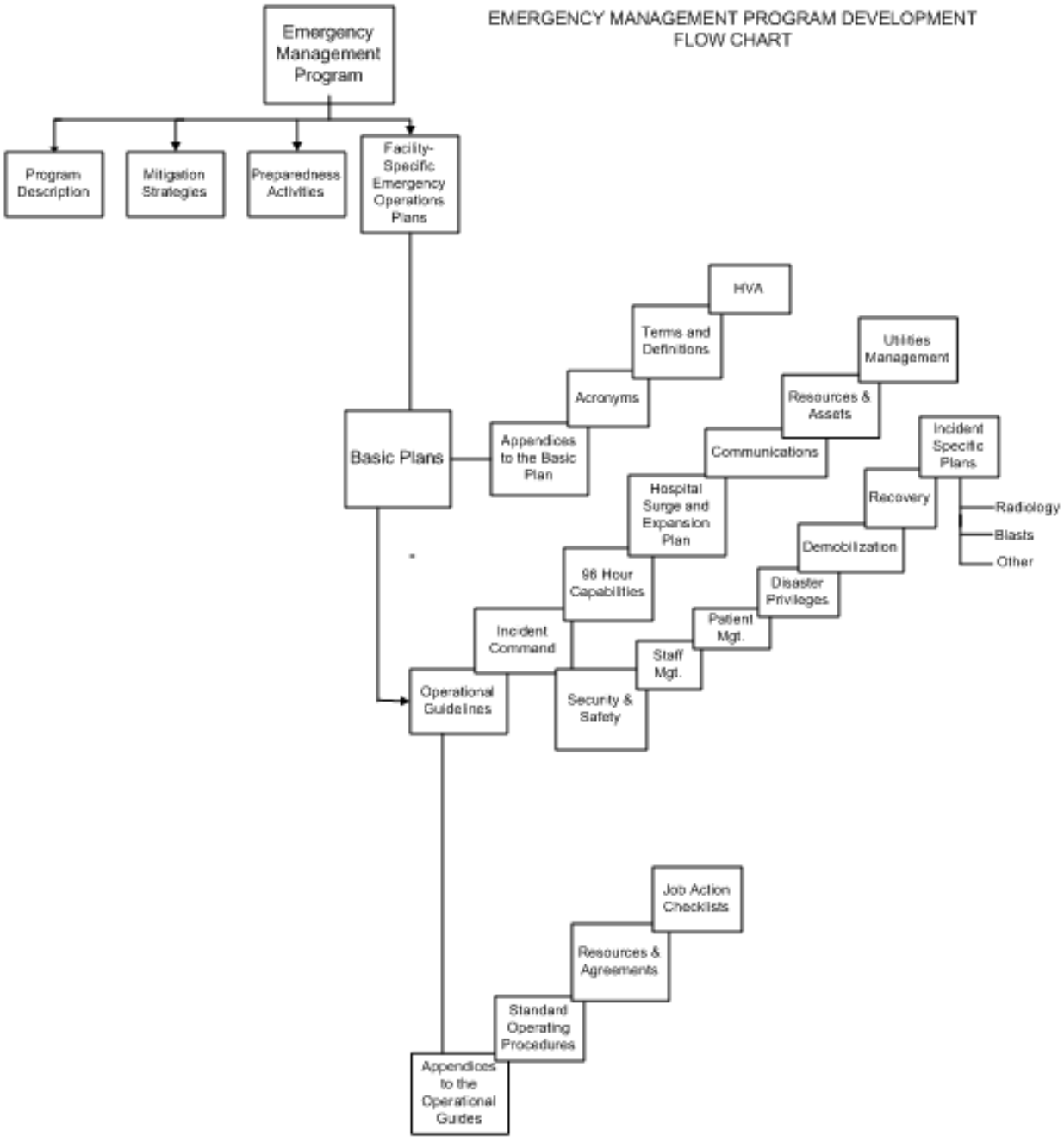
6. Transition to Recovery – actions taken to move from demobilization to recovery so that patients and staff may return and resume normal or “new normal” healthcare services.

7. Recovery and Organizational Learning – The healthcare system/facility must be restored to a fully functional status, patients and staff returned and backlogs addressed. Notification to the public of the resumption of healthcare services, public confidence restored, and levels of patient activity should return to at least the before-the-incident level. Attention should be given to financial considerations including the pursuit of potential avenues for financial assistance.

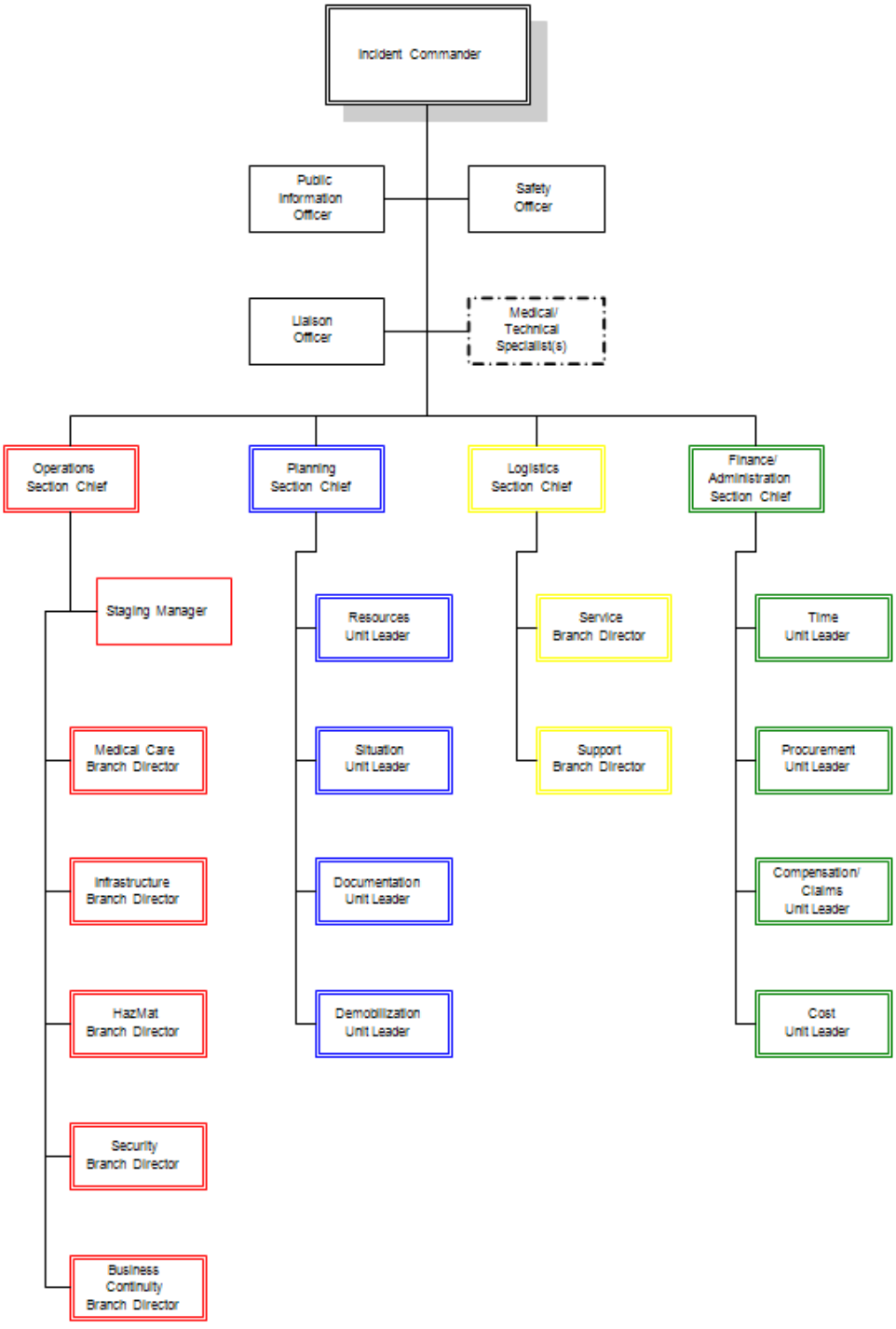
Appendix B: Emergency Management Program Life Cycle



Appendix C: Emergency Management Program Development Flow Chart



Appendix D: Hospital Incident Command Structure (HICS)



SOUTHERN INYO HEALTHCARE DISTRICT **POLICY/PROCEDURE**

TITLE: Hazard Vulnerability Analysis (HVA)

DEPARTMENT: Hospital-wide **PAGE 1 OF 2**

- **POLICY:**

- A Hazard Vulnerability Analysis (HVA) is performed by the Inyo County Health and Human Services to identify areas of vulnerability so that provisions may be undertaken to lessen the severity and/or impact of an emergency/disaster.

    - The Hazard Vulnerability Analysis (HVA) identifies potential emergencies/disasters that could affect the need for the hospital's services or the hospital's ability to provide said services; the likelihood of the emergencies/disasters occurring and the consequences of the emergencies/disasters

- During the Hazard Vulnerability Analysis (HVA), the following are considered potential emergencies/disasters for this hospital:

    - Earthquake
    - Fire
    - Flash Flooding
    - Winter Storm

- Southern Inyo Hospital and its community partners shall prioritize and document the potential emergencies/disasters identified through the Hazard Vulnerability Analysis (HVA), based on the likelihood of occurrence for which mitigation, preparation, response and recovery activities will need to be undertaken. Priorities will be set, and the hospital's role in relationship to the communitywide emergency management plan shall be established.

- Community partners of Southern Inyo Hospital, who shall help with defining priorities in the HVA, include:

ICEMA	DWP
American Red Cross	Lone Pine Tribal Council
CHP	Inyo County Health and Human Services
Inyo County Sheriff	Lone Pine Unified School District

SOUTHERN INYO HEALTHCARE DISTRICT **POLICY/PROCEDURE**

TITLE: Hazard Vulnerability Analysis (HVA)

DEPARTMENT: Hospital-wide **PAGE 2 OF 2**

- The hospital's role is defined in relation to the communitywide Emergency Management Plan.

- The Emergency Management Committee shall communicate the needs and vulnerabilities of the hospital to the community's Emergency Management agencies:

  - The community's abilities to meet the needs of the hospital during an emergency/disaster are identified.

  - At the time of the annual review of the hospitals Emergency Operations Plan (EOP) and whenever the needs and vulnerabilities of the hospital change, the Emergency Management Committee shall communicate the needs of the hospital to the community's Emergency Management agencies and again identify the community's ability to meet the needs of the hospital during an emergency/disaster.

- An "all-hazards" command structure within the hospital shall be established that links with the community's command structure (as applicable).

- The Hazard Vulnerability Analysis (HVA) shall define the hospital's mitigation and preparedness activities.

- The Hazard Vulnerability Analysis (HVA) shall be revised annually by the Emergency Management Committee, and whenever a new threat emerges.

  - Changes to the Hazard Vulnerability Analysis (HVA) shall be updated in the Emergency Operations Plan (EOP).

- Information gleaned from the HVA shall be used to develop the Emergency Operations Plan (EOP).

REFERENCES:

APPROVAL	DATE	APPROVAL	DATE
Department/Division Manager		Interdisciplinary Team	N/A
Unit Medical Director (if applicable)	N/A	Governing Board	
Medical Staff Committee (if applicable)	N/A	Administration	
Reviewed By:		Reviewed By:	
Reviewed By:		Reviewed By:	

SOUTHERN INYO HOSPITAL
Lone Pine, California

POLICY AND PROCEDURE

UPDATE Dept. ASAP!

Subject: Hazard Vulnerability Analysis (HVA)	Reference Number: 1005
Department: Hospital-wide	Date Written: 11/08/2011 Date Reviewed/Revised:
APPROVED BY: Lee Barron	
Signature: Lee Barron	
Title: CEO	Page 1 of 2

POLICY:

- A Hazard Vulnerability Analysis (HVA) is performed by the Inyo County Health and Human Services to identify areas of vulnerability so that provisions may be undertaken to lessen the severity and/or impact of an emergency/disaster.
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- Community partners of Southern Inyo Hospital, who shall help with defining priorities in the HVA, include:

ICEMA	DWP
American Red Cross	Lone Pine Tribal Council
CHP	Inyo County Health and Human Services
Inyo County Sheriff	Lone Pine Unified School District

SOUTHERN INYO HOSPITAL
Lone Pine, California

POLICY AND PROCEDURE

Subject: Hazard Vulnerability Analysis (HVA)	Reference Number: 1005
Department: Hospital-wide	Date Written: 11/08/2011 Date Reviewed/Revised:
APPROVED BY: Lee Barron	
Signature:	
Title: CEO	Page 2 of 2

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- Information gleaned from the HVA shall be used to develop the Emergency Operations Plan (EOP).

NURSE PRACTITIONER

STANDARDIZED PROCEDURES

for

THE SOUTHERN INYO RURAL HEALTH CLINIC

501 E. LOCUST STREET

LONE PINE, CA 93545

Which is owned and operated by the

SOUTHERN INYO HEALTHCARE DISTRICT

TABLE OF CONTENTS

INTRODUCTION TO THE NURSE PRACTITIONER

STANDARDIZED PROCEDURES

The purpose of these Standardized Procedures is to define the scope of practice for Advanced Practice Registered Nurse practitioners who are in practice at the **Southern Inyo Rural Health Clinic** which is owned and operated by the **Southern Inyo Healthcare District** and to meet the legal requirements for the provision of health care by these nurse practitioners. They are established to assist health care providers, Southern Inyo Healthcare District personnel, the community, and others to understand the role and scope of practice of the nurse practitioner; and to provide a safeguard so that health care providers and patients alike may be assured of the best health care possible.
These Standardized Procedures are based on the guidelines established by the California Board of Registered Nursing[1] to incorporate the codes and regulations circumscribing California nurse practitioners, collectively referred to as the Nursing Practice Act[2]. To serve the health and wellness needs of patients in the District and to provide the highest standard of care, these Standardized Procedures incorporate the following qualities:

ADAPTABILITY

- To allow for the unique health care needs of each patient.
- To unique health care settings throughout the healthcare district.

FLEXIBILITY

- To accommodate the dynamic nature of health care.
- To recognize that the practice of medicine is not an exact science.

PRACTICALITY

- To embrace diversity in ethnic, cultural, linguistic, and educational backgrounds and personal management styles.

SPECIFICITY

- To address the intent of the Standardized Procedure Guidelines established by the California Board of Registered Nursing
- To comply with the law and codes regulating nurse practitioners
- To protect the health care consumer

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1 https://govt.westlaw.com/calregs/Document/IB5F41390D48E11DEBC02831C6D6C108E?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

2 https://www.rn.ca.gov/practice/npa.shtml

STANDARDIZED PROCEDURES GUIDELINES

These Standardized Procedures conform to the prescribed guideline and contain each of the following elements of CCR 16 §1474.

(a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision thereof.

(b) Each standardized procedure shall:

(1) Be in writing, dated and signed by the authorized personnel of the organized health care system where it will be used.

(2) Specify which standardized procedure functions the nurse practitioner may perform and under what circumstances.

(3) State any specific requirements which are to be followed by the nurse practitioner in performing particular standardized procedure functions.

(4) Specify the experience, training, and/or education requirements for the performance of standardized procedure functions.

(5) Establish a method for initial and continuing evaluation of the competence of those nurse practitioners who are authorized to perform standardized procedure functions.

(6) Provide for a method of maintaining a written record of those persons authorized to perform nurse practitioner standardized procedure functions.

(7) Specify the scope of supervision required for the performance of standardized procedure functions, for example, on-site availability of supervising physician or telephone contact with the physician.

(8) Set forth any specialized circumstances under which the nurse practitioner is to immediately communicate with the supervising physician concerning the patient's condition.

(9) State the limitations on settings, if any, in which standardized procedure functions may be performed.

(10) Specify patient record-keeping requirements.

(11) Provide for a method of periodic review of the standardized procedures.

DEFINITIONS

Advanced Practice Registered Nurse (APRN)
The Advanced Practice Registered Nurse (APRN) is a nurse with post-graduate education in nursing. APRNs are prepared with advanced didactic and clinical education, knowledge, skills, and scope of practice in nursing. The basis of advanced practice is the high degree of knowledge, skill, and experience that is applied within the nurse-patient/client relationship to achieve optimal outcomes through critical analysis, problem-solving and evidence-based decision making. The nurse practitioner is one type of APRNs.

Delegation of Services Agreement
The nurse practitioner standardized procedures are not in whole or in part a Delegation of Services Agreement (DSA) which applies to the medical practice of physician assistants. It does not meet the requirements of CCR Title 16 Div. 13.8 Article 4 Section 1399.540 for the practice of physician assistants. Likewise, the physician assistant DSA does not meet the requirement of the standardized procedure for the California BRN for nurse practitioners.

Furnishing of drugs or devices (BPC Div 2, Ch 6. Art 8)
The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact or other means when the patient is examined by the nurse practitioner. No physician and surgeon shall supervise more than four (4) nurse practitioners at one time.
Drugs or devices furnished or ordered by a nurse practitioner may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act[3] and shall be further limited to those drugs agreed upon by the nurse practitioner and physician and surgeon and which are specified in the standardized procedure.

When Schedule II or III controlled substances, as defined in Sections 11055 and 11056, respectively, of the Health and Safety Code, are furnished or ordered by a nurse practitioner, the controlled substances *shall be furnished or ordered following a patient-specific protocol approved by the treating or* supervising physician[4, 5].

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3 Division 10 (commencing with Section 11000) of the Health and Safety Code

4 https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=BPC&division=2.&title=&part=&chapter=6.&article=2.5.

5 https://law.justia.com/codes/california/2012/bpc/division-2/chapter-6/article-8/section-2836.1

General Policies
General policies define the general situation or circumstances under which the nurse practitioner is authorized to implement the standardized procedures in this document.

Health Care Management Protocols
Health Care Management Protocols delineate the functions requiring a standardized procedure and, using policies and protocols, defines the circumstances and requirements for their implementation by the nurse practitioner.

Nurse Practitioner (NP)
Nurse practitioners are APRNs who possess additional preparation and skill in physical exam, psychosocial assessment, evaluation/impression, and management of health-illness needs in primary health care, and who have been prepared in a program conforming to the Board standards as specified in CCR §1484 (Standards of Education). The core philosophy includes individualized care prioritizing disease prevention, wellness, and educating the patient and community about health, encouraging patients to participate in health care decisions, and health care advocacy. NP laws and regulations

Process Protocol and Patient-Specific Protocol
Process and patient-specific protocols describe the general and specific nurse practitioner approach to patient care in a flexible and optimal. If the patient care plan includes furnishing or ordering a Schedule II or III controlled drug by the nurse practitioner, the controlled substance shall be furnished or ordered following a patient-specific protocol which has been approved by the supervising physician and surgeon.

Scope of Practice of the Nurse Practitioner
The Medical Practice Act authorizes physicians to diagnose mental and physical conditions, to use drugs in or upon human beings, to sever or penetrate the tissue of human beings and to use other methods in the treatment of diseases, injuries, deformities or other physical or mental conditions. As a general guide, the performance of these functions by the nurse practitioner requires a standardized procedure. – *California BRN website* (http://www.rn.ca.gov/pdfs/regulations/npr-b-20.pdf)

The nurse practitioner is a registered nurse who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, who has been prepared in a program that conforms to Board standards as specified in California Code of Regulations, CCR 1484 Standards of Education. Therefore, the nurse practitioner performs tasks or functions which fall within the scope of nursing practice in addition to tasks or overlapping medical functions within the expanded scope of nursing practice as developed in collaboration with physicians and defined in the standardized procedures.

Standardized Procedures

- Standardized procedures are the legal mechanism for nurse practitioners to perform functions which would otherwise be considered the practice of medicine.
Standardized procedures guidelines are to be adhered to when performing medical functions. The guidelines are outlined in this document and described in the California Code of Regulation. According to the California Board of Nursing, the nurse practitioner relies on standardized procedures for authorization to perform overlapping medical functions – California Board of Nursing

- Standardized procedures are intended and designed to optimize the nurse practitioner's ability to serve the best interests of patients, all in accordance to the California Board of Nursing guidelines, regulations and mandates for practice as a nurse practitioner.

- Standardized procedures further fulfill the requirements that all nurse practitioners are required to practice in accordance to established guidelines and parameters, as agreed upon by the supervising physician/surgeon, and that is consistent with community acceptable standards of practice and evidence-based practice strategies in patient care.

-Standardized procedures are the authorized set of written descriptions of patient care policies and protocol guidelines that a nurse practitioner may perform that would otherwise be considered the practice of medicine.

Following the state regulations, nurse practitioners are advised to work with an established set of *patient care guidelines in a manner that reflects education, clinical experience, and scope of practice.* The standardized procedures included in this Standardized Procedures and Process Protocols are developed, edited, and agreed upon by the personnel listed on the authorization page and address the 11 steps, consistent with the California Board of Registered Nursing standardized procedure guidelines.[6]

Supervision

Supervision of the NP performing an overlapping medical function is addressed in the standardized procedure and may vary from one procedure to another depending upon the judgment of those developing the standardized procedure. As an example, in one women's clinic the supervision requirement for performing a cervical biopsy was that a physician must be physically present in the facility, immediately available in case of emergency. For all other standardized procedure functions, the supervision requirement was for a clinic physician to be available by phone.

6 *California Board of Registered Nursing website* (CA-brn_Std_Pros.pdf)

General Policy

The intent of this document is to authorize the Nurse Practitioner at the Southern Inyo Rural Health Clinic to implement the Nurse Practitioner Standardized Procedures without the immediate supervision or approval of a physician. Standardized procedures are the mechanism whereby the NP are legally able to provide medical services within the approved policies and process protocols, which are also defined in this document and may often be referred to collectively as the "Standardized Procedures". This document is not a physician assistant Delegation of Services Agreement and was not written nor intended to meet the requirements of CCR Title 16 Div. 13.8 Article 4 Section 1399 for the practice of physician assistants[7].

1. Development of Standardized Procedures

a) Standardized Procedures outline the general conditions for the implementation of the standardized procedures and scope of practice.

b) All standardized procedures are developed collaboratively and maintained by the nurse practitioner and physician, and others identified on the authorization page.

2. Future Modification of Standardized Procedures (Title 16, CCR sec. 1474 (a) (b) (1, 5, 11))
a) All additions, revisions, and modifications of the Standardized Procedures will require the initials or signatures of the personnel on the authorization page within a timely manner.

b) Nurse practitioner standardized procedures will be reviewed annually or as needed and appropriate changes will be made collaboratively by the nurse practitioner and supervising/collaborating physician and relevant staff.

c) Any member identified on the authorization form may initiate changes or modifications to the Standardized Procedures.

d) Any modifications to the Standardized Procedures will require approval by all of the parties listed on the authorization page along with signatures and dates.

e) Annual review and modifications will be forwarded for administrative approval and signatures to the interdisciplinary practice committee, to Administration, and the SIH Board.

3. Patient records and File Maintenance (Title 16, CCR sec. 1474 (b) (10))
a) The nurse practitioner is responsible for the preparation of a complete record for each patient encounter per existing policies. Patient encounter information will be documented by the nurse practitioner in the clinic health record, including history, patient and/or family assessment, impression, prescribed medication, education, referrals, and follow-up plan.

b) Safeguards to protect and maintain the confidentiality of Protected Health Information (PHI) will

7 http://carules.elaws.us/code.t.16_d.13.8_art4_sec.1399.540

include physical and technical measures for the security and protection of PHI and to facilitate necessary confidential communication with other health care providers and health care entities to comply with HIPAA privacy rules concerning the protection of patient records.
(http://www.hhs.gov/ocr/privacy/index.html)

c) Standardized Procedures with associated process and patient-specific protocols will be maintained and made available within the facility of nurse practitioner practice to include dates, and relevant signatures of all personnel covered by the procedures.

d) Nurse practitioners, and associate clinic physicians who join the staff mid-year or who provide temporary coverage for the practice must also signify approval of the Standardized Procedures. It is the task of the Clinic Manager to ensure that these clinicians review these documents and that written agreement by the above parties is obtained before providing patient care or consultation.

4. Practice Setting (Sect. 1474 (b) (2, 9))
a) The nurse practitioner will implement these Standardized Procedures at facilities operated by the Southern Inyo Healthcare District (SIHD) which include, but are not limited to:

Southern Inyo Rural Health Clinic
510 East Locust Street
Lone Pine, CA 93545

Southern Inyo Hospital
501 East Locust Street
Lone Pine, CA 93545

b) The RHC Nurse Practitioner may also serve the needs of patients at other sites within the community such as private homes, schools, churches, or community centers.

5. Authorized Nurse Practitioners (Sect. 1474 (b) (6))
a) The signed *Statement of Approval and Agreement* specifies the nurse practitioners authorized to implement the Standardized Procedures and to perform the functions described in the protocols.

b) A list of authorized nurse practitioners is attached to this document and updated as necessary.

c) A signed copy will be maintained by each nurse practitioner, the medical director, and by the administration, and be available at the practice site for reference.

6. Qualifications (Sect. 1474 (b) (3, 4))
a) Nurse practitioners agree to perform following the standardized procedures, including policies, process protocols and patient-specific protocols as outlined in this document.

b) Nurse practitioners meet the following qualifications for credentialing:
- □ Possess a Master's degree in Nursing from an accredited institution
- □ Hold a valid California License as a Registered Nurse
- □ Certification by the State of California, Board of Registered Nursing as a nurse practitioner
- □ National Certification(s) in their Specialty (unless licensed prior to 2011)
- □ Current furnishing number from the State of California, Board of Registered Nursing

- ☐ Obtain or be qualified to apply for a valid DEA registration number.
- ☐ Possess a valid National Provider Identification (NPI) number
- ☐ Maintain American Heart Association Certification for Basic Cardiac Life Support or equivalent.
- ☐ Complete/maintain all applicable screening requirements as required for employment with SIHD
- ☐ Complete or obtain additional education, training and/or experience to carry out the policies and protocols as necessary.

7. Periodic Evaluation (Title 16, CCR sec. 1474 (b) (5))
Evaluation of nurse practitioner competence in the performance of standardized procedure functions will be done in the following manner *based on written criteria* according to the Southern Inyo Human Resources Policy (see: Competency-Based Job Description/ Performance Evaluation; Family Nurse Practitioner). A written record of the review is to be kept on file and provided to the nurse practitioner.

Initial evaluation: During the probationary period, at 3 months, and 6 months, based on written criteria; including frequent chart review by a physician or designated clinical staff; and at 12 months by the physician and/or qualified clinical staff, through feedback from colleagues, physicians, and chart review during the performance period being evaluated.

Routine evaluation: Annual performance evaluation, based on written criteria. The physician or designated clinical staff member will select charts for review at random, at regular intervals and also obtain feedback from colleagues.

Performance improvement: if it is determined based on the initial or routine evaluations that the nurse practitioner demonstrates one or more areas of deficiency, or as expressed by the nurse practitioner to expand clinical competence and proficiency, the physician or appointed staff will assist in providing supervision (and documentation) until the nurse practitioner demonstrates that the acceptable proficiency has been attained.

Professional Development: The nurse practitioner is responsible to provide a record of noteworthy contributions such as; advancing nursing practice through continuing education, leadership in professional organizations, participation in research and grant projects, increasing scope of responsibility, expanding clinical competence, contribution to quality improvement projects, solving workflow concerns, and mentoring nurse practitioner students in the RHC setting. This will assist with the preparation of the periodic performance evaluation.

8. Physician Supervision (Title 16, CCR sec. 1474 (b) (3, 7))
a) Supervising/collaborating physician is required to be available at posted clinic hours, either on-site or electronic communication (telephone or alternative means).

b) Authorized nurse practitioners may implement the Standardized Procedures in this document without the direct or immediate observation, supervision, or approval of a physician, except as may be specified on individual Health Care Management Protocols.

9. Consultation (Title 16, CCR sec. 1474 (b) (8))
a) The authorized nurse practitioner may initiate consultation with other professionals associated with the care of the patient.

b) When a physician is consulted, a notation will be recorded in the patient's chart including the physician's name and any pertinent information will be recorded.

c) Physician consultation is to be obtained as specified in the patient-specific protocols and under the following circumstances.

- Situations or circumstances that exceed or are not adequately addressed or resolved by the Standardized Procedures.
- Situations or circumstances that exceed the educational, clinical experience, and training of the nurse practitioner.
- Emergent conditions requiring prompt medical intervention after initial stabilizing care has been started and/or patient transfer to advanced care.
- Patients not responding to the current treatment and general management approach.
- Patients presenting with acute onset of unexplained signs and symptoms or rapid compromise in health status.
- Patient presenting with signs and symptoms that do not represent common diagnostic disease classifications.
- History, physical, or lab findings inconsistent with the clinical picture.
- When requested by the patient, family, APRN, or supervising physician.

10. Standardized Procedures
a) Standardized procedures have been designed and developed to describe the healthcare management of patient situations.

b) Standardized procedures incorporate a process format to allow for flexibility in patient care and disease management.

c) Disease-specific treatment guidelines in addition to the standardized procedures are included and considered supplemental to providing patient care.

Nurse Practitioner Standards of Practice

I. Process of Care

The Nurse Practitioner utilizes the scientific process and national standards of care within the discipline of nursing as a framework for managing patient care to perform the following functions within his/her specialty area and consistent with his/her experience and credentialing. This includes:

A. Assessment of health status:
Conduct preventative screening, Identify health risks and medical needs, Obtain relevant health and medical history, Perform physical examination based on age and history, Update and record changes in health status, Perform or order preventative and diagnostic procedures based on the patient's age and history

B. Diagnosis:
Utilize critical thinking in the diagnostic process, Synthesize and analyze the collected data, formulate a differential diagnosis based on the patient history, physical examination and clinical findings, establish priorities to meet the health and medical needs of the individual, family, or community as a result of the evaluation of collected data.

C. Develop a treatment plan
Develop an individualized patient education plan, identify appropriate pharmacological agents, identify non-pharmacological interventions, and Order appropriate diagnostic tests when indicated.

D. Implement the plan
Accurately conduct and interpret diagnostic tests, make appropriate referrals to other health care professionals and community agencies, Prescribe, order or furnish appropriate pharmacologic and non-pharmacologic interventions, Provide relevant patient education.

E. Follow-up and evaluation of the patient status
Determine the effectiveness of the treatment plan with documentation of patient care outcomes, Reassess and modify the plan with the patient and family as necessary to achieve health and medical goals.

II. Nurse Practitioner Care Priorities

The nurse practitioner's practice model emphasizes:
A. Patient and family education:
The NP provides health education and utilizes community resource opportunities for the individual and/or family.

B. *Facilitates patient participation in self-care:*

The NP facilitates patient participation in health and medical care by providing the information needed to make decisions and choices about:

- promotion, maintenance, and restoration of health
- consultation with other appropriate health care providers
- appropriate utilization of health care resources

C. Promotion of optimal health
D. Provider of continually competent care
E. Facilitation of entry into the health care system
F. The promotion of a safe environment.

Interdisciplinary and Collaborative Responsibilities

The nurse practitioner participates as a team member in the provision of health and medical care, interacting with professional colleagues to provide comprehensive care to patients and the community.

Accurate Documentation of Patient Status and Care

The nurse practitioner maintains accurate, legible, timely and confidential records of patient interactions.

Responsibility as Patient Advocate

Ethical and legal standards provide the basis for patient advocacy. As an advocate, the nurse practitioner participates in health policy activities at the local, state, national and international levels.

III. Quality Assurance and Continued Competence

Nurse practitioners recognize the importance of continued learning through:

- Participation in quality assurance review, including a systematic review of records and treatment, plans periodically.
- Maintaining current knowledge by attending continuing education programs
- Maintaining certification in compliance with current state law
- Application of standards of care guidelines in clinical practice

IV. Adjunct Roles of Nurse Practitioners

Nurse practitioners combine the roles of provider, mentor, educator, researcher, manager, and consultant. The nurse practitioner interprets the role of the nurse practitioner to individuals, families, and the community and to other professionals.

V. Research as a Basis for Practice

Nurse practitioners support research by developing clinical research questions, conducting or participating in studies, and disseminating and incorporating findings into practice.

STATEMENT OF APPROVAL AND AGREEMENT

This document, NURSE PRACTITIONER STANDARDIZED PROCEDURES for THE SOUTHERN INYO RURAL HEALTH CLINIC, was developed collaboratively by nurse practitioners, medicine, and administration in the organized health care system where they will be implemented according to the guidelines established by the California Board of Registered Nursing (Sect. 1474 (a) (b) (1-11).

Signatures to this statement of Approval indicate:

- Approval of these Nurse Practitioner Standardized Procedures
- Approval of the Policies, Process protocols, and clinical references that accompany this document
- Agreement to maintain a collaborative and collegial relationship between all parties
- Agreement to abide by the Nurse Practitioner Standardized procedures in theory and practice.

MD.	9/4/19
Jules Silver, MD. Medical Director	Date
Sandra Spiedel	9/4/19
Sandra Spiedel, FNP, Rural Health Clinic	Date
JMcFarland	9.3.2019
Teresa McFarland, FNP-C, Rural Health Clinic	Date
Name Title	Date
Name Title	Date
Name Title	Date
Name Title	Date
Name Title	Date

MEDICAL DIRECTOR AGREEMENT

This Medical Director Agreement (this "Agreement") is made on September 19, 2019 (the "Effective Date"), by Southern Inyo Healthcare District, a California Healthcare District ("District") and Eva Wasef, MD (" Medical Director"). The District and Medical Director may be referred to herein singly as "Party" and collectively as the "Parties."

RECITALS

A. District owns and operates an acute care hospital, skilled nursing facility ("SNF"), and clinic all located in Lone Pine, California, and desires to hire a Medical Director to oversee the management of the services described herein.

~~B. District desires that Medical Director furnish the services hereunder as an independent contractor and not an employee of the District.~~

~~C.~~B. ~~-~~Medical Director is willing to furnish to District the professional services to satisfy the needs of the District ~~and the community,~~ and the requirements of accrediting bodies for quality medical direction.

~~D. Medical Director represents that Medical Director is qualified to provide the services as described herein and is licensed as appropriate and Board Certified or Eligible by the American Board of Pathology (the "Specialty").~~

NOW, THEREFORE, in consideration of the foregoing recitals (which by this reference are hereby made a part of this Agreement), the mutual covenants, promises, and agreements herein contained, and for other good and valuable consideration, the sufficiency and receipt of which are hereby acknowledged, the Parties, intending to be legally bound, agree as follows.

TERMS

ARTICLE 1. ENGAGEMENT

1.1 Undertaking of the Parties. District hereby contracts with Medical Director to provide the Medical Director services ("Services") set forth in Section 2.1 below, and Medical Director agrees to provide such Services through the Medical Director on the terms and conditions herein. The Parties believe the services to be provided under this Agreement are reasonable and necessary for the legitimate business purposes of the District.

ARTICLE 2. RESPONSIBILITIES OF DISTRICT AND MEDICAL DIRECTOR

2.1 No Substitute Coverage. The Services in Exhibit 1, attached hereto and incorporated by reference, will be provided exclusively by the Medical Director, and Medical Director understands that the duties and obligations hereunder of Medical Director cannot be delegated to any other person or entity. Notwithstanding the foregoing, if ~~–~~Medical Director becomes temporarily unavailable to provide the Services due to illness, vacation, or is otherwise clinically occupied, ~~-~~Medical Director may designate another qualified physician ("Professional") to provide the Services, subject to the District's prior consent, and who shall be deemed the "Medical Director"

hereunder, and the covenants, terms, and other provisions hereunder applicable to "Medical Director" shall apply to such Professional as well.

2.2 Coordination. Medical Director shall inform the Administrator of the District of any extended periods (greater than one week) during which Medical Director will be unavailable due to vacation, professional meetings, or other personal or professional commitments.

ARTICLE 3. REPRESENTATIONS, WARRANTIES AND COVENANTS OF DISTRICT AND MEDICAL DIRECTOR

To induce the District to enter into this Agreement, Medical Director represents and warrants to and covenants with the District as follows:

3.1 License to Practice. Medical Director is, and during the term of this Agreement shall remain, fully authorized to practice medicine in the State of California, and holds all appropriate licenses from the Medical Board of California. Medical Director shall maintain such license for the full term of this Agreement, and shall promptly report to the District any suspension, restriction, reduction, revocation, or termination thereof. Medical Director represents that no license heretofore granted to Medical Director to practice medicine in any other jurisdiction has been suspended, restricted, reduced, revoked, or terminated.

3.2 Specialty Board. Medical Director is Board Certified/Eligible by the American Board of Pathology. Medical Director shall retain such Board certifications/eligibility during the term of this Agreement.

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3.3 Medical Staff Membership. Medical Director shall, throughout the term of this Agreement, maintain Active membership on the Medical Staff of the District with clinical privileges sufficient to perform all duties hereunder. All information contained on Medical Director's applications for Medical Staff membership and privileges is or will be true and correct, and no information necessary for a thorough consideration of Medical Director's qualifications has been or will be omitted from such application.

3.4 Medical Staff Privileges: Reports.

(a) No medical staff or similar privileges granted to Medical Director by any District or similar institution have been denied, suspended, revoked, curtailed, reduced or limited in any manner, nor has Medical Director resigned or voluntarily reduced or limited any such privileges in response to or after any investigation or disciplinary action instituted with respect to his care of patients.

(b) Medical Director shall promptly report to the District any denial, suspension, revocation, curtailment, reduction or limitation imposed at any time during the term of this Agreement upon any medical staff or similar privileges held by Medical Director from any other District or similar institution.

3.5 Claims/Reports.

(a) Except as set forth on Schedule A, no action or claim is presently pending against Medical Director alleging professional negligence (malpractice), nor has any judgment been rendered or settlement paid in such an action or in response to such a claim within the past five years.

(b) Medical Director shall promptly report to the District (i) the receipt of any formal claim or demand alleging professional negligence, (ii) the institution of any litigation against Medical Director alleging professional negligence and (iii) the settlement of any claim alleging professional negligence involving the payment of funds by or on behalf of Medical Director. Medical Director will, from time to time, provide District with information about such claims, demands or suits as the District may request, provided that such reports will not in the opinion of counsel on such matter constitute privileged communication or compromise the defense or settlement of any suit.

3.6 DEA Number. [Deleted]

3.7 Good Standing: Reports.

(a) Medical Director represents and warrants, and Medical Director acknowledges, that District may independently verify, that Medical Director is not nor has been (i) suspended, excluded, barred or sanctioned by Medicare, Medicaid, or any other state or federal health care program (or notified of such action); (ii) convicted of or indicted for any criminal offense related to health care; or (iii) otherwise engaged in conduct for which a person or entity can be so convicted, or indicted. Medical Director shall immediately notify District in the event it becomes aware of any such conviction, indictment, or notification pertaining to Medical Director at any time during the Term or during the three (3) year period following termination or expiration of this Agreement. Upon the receipt of such notice by District or if District otherwise becomes aware of such conviction, indictment, listing, or notification, District shall have the right to terminate this Agreement immediately, if such Agreement is still in effect. Medical Director agrees to indemnify District and hold it harmless from all liabilities, damages, penalties, losses (including those losses or reduction in funding from any federally-funded health care program), claims, and expenses (including, without limitation, reasonable attorney's fees) arising from Medical Director's misrepresentation of the foregoing information or failure to provide notification required under this Section. A breach of this Section 3.7 shall be a material breach of this Agreement and shall constitute grounds for termination of this Agreement by District pursuant to Article 7 hereof.

(b) Medical Director shall promptly report to District (i) the receipt of any subpoena or other inquiry alleging fraud, abuse, or other misconduct under the Medicare, Medicaid, or other state or federal health care program; (ii) the naming of Medical Director as a subject or a target of any federal investigation involving allegations of fraud, abuse, or other misconduct under Medicare, Medicaid, or any other state or federal health care program; or (iii) if Medical Director is suspended, excluded, barred or sanctioned by Medicare, Medicaid, or any other state or federal health care program, or convicted of any criminal offense related to health care.

(c) The provisions of this Section 3.7 shall survive the expiration or termination of this Agreement.

3.8 Continuing Medical Education. Medical Director shall ensure that Medical Director at all times remains in compliance with the Medical Board of California's requirements for continuing medical education.

3.9 Confidentiality.

(a) Except as required by law, "Confidential Information" includes any and all policies, procedures, contracts, quality assurance techniques, managed care initiatives, utilization management, patient records, credentialing, financial, statistical, peer review, medical review committee and other information of the District, including, without limitation, information embodied on magnetic tape, computer software or any other medium for the storage of information, together with all notes, analyses, compilations, studies or other documents prepared by the District or others on behalf of the District containing or reflecting such information. Confidential Information does not include information which: (i) was lawfully made available to or known by third persons on a non-confidential basis prior to disclosure by Medical Director; (ii) is or becomes publicly known through no wrongful act of Medical Director; (iii) is received by Medical Director from a third party other than in breach of confidence; or (iv) as required by law.

(b) Medical Director acknowledges that Confidential Information is valuable property of the District and agrees that during the full term of this Agreement, and for a period of two (2) years thereafter, Medical Director shall:

(i) treat the Confidential Information as secret and confidential;

(ii) not disclose (directly or indirectly, in whole or in part) the Confidential Information to any third party except with the prior written consent of District or as required by law;

(iii) not use (or in any way appropriate) the Confidential Information for any purpose other than the performance of the business of the District and otherwise in accordance with the provisions of this Agreement; and

(iv) limit the dissemination of and access to the Confidential Information to such of the Medical Director's agents or representatives as may reasonably require such information for the performance of Services and ensure that any and all such persons observe all the obligations of confidentiality contained in this Section 3.9, provided that any Confidential Information that rises to the level of a "trade secret" as defined under the California Trade Secrets Act, shall be protected by Medical Director for so long after such two (2) year period as such information retains its status as a trade secret under the California Trade Secret Act and, provided further, medical peer review committee information, peer review organization information and patient information shall be protected for so long as allowed by applicable law.

(i) Confidential Information constituting the proceedings or records of a medical review committee or of a review organization shall be used and disclosed by Medical Director solely for the purposes and use of such medical review committee or review organization, and no materials relating to the proceedings or records of a medical review committee or review organization shall be removed from District by Medical Director.

(j) Confidential Information consisting of patient medical records and patient information shall be used by Medical Director solely for the purposes of providing Services hereunder and Medical Director shall maintain the confidentiality of such records and information in accordance with this Agreement and applicable laws and regulations, including without limitation, the requirements of the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated and adopted pursuant thereto ("HIPAA"), the Health Information Technology for Clinical and Economic Health Act of 2009 (the "HITECH Act"), this Section 3.9(d) and the obligations contained in a Business agreement to be executed between District and Medical Director.

3.10 Compliance with Regulations. Medical Director shall comply with all material aspects of applicable laws and regulations governing the licensing and conduct of physicians and with the ethical standards of the profession; and with the applicable policies, procedures, rules and regulations of District. Medical Director shall cooperate with District in satisfying all requirements needed to aid District in maintaining its accreditation, licensure and Medicare provider status.

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3.11 ~~Diligent Performance. In performance of Services under this Agreement, Medical Director shall: (1) use sound medical judgment and diligent efforts and professional skills and judgment, (2) perform professional services and render care to patients consistent with the applicable standards of the medical profession, (3) perform in a manner consistent with the Principles of Medical Ethics of the American Medical Association, and (4) comply with all provisions of the Bylaws and the applicable Rules and Regulations of the Medical Staff of District. Medical Director shall participate at a reasonable level in Medical Staff and District activities and serve on committees as reasonably requested by District.~~

3.12 Litigation Cooperation. Medical Director shall, and shall cause Medical Director to, cooperate with District and its representatives in the prevention, investigation, management and defense of malpractice claims or other claims and actions against District, without regard to whether Medical Director is a party to such claim or action. Such covenant of cooperation shall not, however, preclude a claim by Medical Director against District or require Medical Director to take action that reasonably would compromise a claim against Medical Director arising from the same incident.

3.13 Quality Improvement. Medical Director shall ensure that Medical Director participates, and Medical Director shall participate, as requested in Medical Staff and District utilization review, quality improvement, peer review and similar programs and committees. Medical Director shall address practice or professional quality issues identified by any such program or committee in an appropriate and timely manner. Whether such issues have been

addressed in an appropriate and timely manner shall be determined by the District in its sole discretion.

3.14 Insurance. The District shall provide general and professional liability insurance covering Medical Director in an amount of not less than One Million Dollars ($1,000,000) for each occurrence and three Million Dollars ($3,000,000) annual aggregate, or such other amount as may be required. In addition, District shall provide "tail" coverage in the same amounts. District shall not terminate this insurance coverage while this Agreement is in effect and for a period of time covering the "tail" coverage.

3.15 Financial Relationships; Conflicts of Interest. Medical Director shall disclose to District in writing any financial or other relationship with the manufacturer, distributor, vendor or supplier of any equipment, supplies or services recommended by Medical Director and/or to be purchased or obtained by District in connection with this Agreement or otherwise. Further, Medical Director represents and warrants that as of the Effective Date, they have disclosed to District any and all arrangements, financial or otherwise, that Medical Director (or employer, any affiliated entity or any family member of Medical Director (including a spouse, child, parent or sibling, stepparent, stepchild or stepsibling, parent-in-law, child-in-law or sibling-in-law; or grandparent, grandchild, or spouse of such person)) has with any vendor, supplier, distributor, or manufacturer of, or other entity or provider providing, services, equipment, supplies or materials to District. Medical Director further represents and warrants that as of the Effective Date, and covenants that throughout the term of this Agreement, neither Medical Director nor any affiliated entity nor any family member of Medical Director, as identified above, has or will have any conflicts or other obligations or arrangements that may interfere with the duties and obligations of Medical Director hereunder, the performance by Medical Director of the Services or the exercise of Medical Director's independent professional judgment in connection with the duties and obligations hereunder. Medical Director shall promptly notify District of any changes or updates in any such arrangements or obligations. Further, Medical Director shall comply with any and all District policies and procedures regarding or relating to conflicts of interest. Medical Director is and at all times shall be a participating physician in the Medicare and Medi-Cal programs.

3.16 Compliance. Medical Director will meet with District's Compliance Officer and other District designees at reasonable times and places to assess compliance with District's compliance obligations, and to provide additional information regarding same, in writing, if District so requests. Medical Director shall provide full and complete responses, in connection with such an assessment or request for information. Upon request, Medical Director shall attend compliance and other training programs requested by District from time to time with respect to the services provided hereunder.

3.17 Code of Conduct. By Medical Director's signature on this Agreement, Medical Director acknowledges receipt and has reviewed or will review District's Compliance Policies and Procedures, including the Code of Conduct and the Physician Referral, Stark Law and Anti-kickback policies and procedures. Medical Director shall read, and abide the Code of Conduct and Policies and Procedures provided by District, as such may be revised from time-to-time. If requested, Medical Director will acknowledge receipt of any such revision.

3.18 Non-Discrimination/Other Law. In the performance of this Agreement, Medical Director will not unlawfully discriminate against individuals under the applicable Federal or state laws. The parties will comply with the Civil Rights Act of 1964 as amended and all other applicable antidiscrimination laws, regulations, and policies. As a recipient of Federal financial assistance, District does not exclude, deny benefits to, or otherwise unlawfully discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by District directly or through Medical Director or any other entity with which Medical Director arranges to carry out her obligations, program and activities. Medical Director agrees to abide by District's nondiscrimination policies and the rules, procedures and regulations District may adopt to effect such policies and will cooperate in any investigation District may have related to a complaint implicated by District's nondiscrimination policy. Medical Director agrees to comply with applicable law, including without limitation, laws and regulations applicable to patient confidentiality, access, and patient care.

3.19 No Conflicts. Medical Director is not bound by any agreement or arrangement which would preclude Medical Director from entering into, or from fully performing the services required under, this Agreement.

ARTICLE 4. RESPONSIBILITIES OF DISTRICT

4.1 Equipment. District shall provide, maintain and make available the equipment reasonably necessary, as determined by the District, for the provision at District of the Services provided. However, Medical Director acknowledges that District's inspection of any equipment does not relieve Medical Director or any other person or entity from their applicable obligation of pre-procedure inspections prior to operating the equipment. Medical Director shall promptly notify District of any defect in, malfunction of or other deficiency in such equipment of which he is aware. New equipment may be recommended by Medical Director through District's standard capital equipment budgetary process as a part of the Department's budget. District shall also provide all supplies necessary to provide the Services. Medical Director shall make reasonable efforts to advise District concerning the supplies needed. Medical Director shall disclose to District in writing any financial or other relationship with the manufacturer, distributor or vendor or any equipment or supplies recommended to District by Medical Director, which disclosure must be given to District (l) with respect to the initial recommendation, prior to or at the time of any such recommendation by Medical Director, or (2) with respect to previous recommendations, at any time during the term of this Agreement that Medical Director enter into any financial or other relationship with the manufacturer, distributor or vendor of any equipment or supplies previously recommended by Medical Director. District equipment and supplies shall be used only in connection with performance of the duties hereunder involving District operations and District patients.

Commented [SN2]: I don't think this should be part of a med dir contract

4.2 Personnel. District shall provide personnel to give technical assistance and support to Medical Director in the performance of the Services hereunder. Any District personnel providing assistance to Medical Director hereunder shall be and remain employees of District, and may be

disciplined, transferred or discharged only by District. District shall provide Medical Director with opportunities to provide input about the performance of such personnel to appropriate departmental directors. District personnel shall be used only in connection with performance of the duties hereunder involving District operations and District patients.

4.3 Facilities. District facilities shall be used only in connection with performance of the duties hereunder involving District operations and District patients.

4.4 Clinical Management. Subject to the other provisions of this Article 4, District delegates to Medical Director the management responsibility for clinical operations of delivery of the Services. Consistent with the provisions of Article 6 of this Agreement, District will not exercise control over Medical Director's clinical methods and procedures. Pursuant to and to the extent required by 22 C.C.R. § 70713 and without diminishing Medical Director's liabilities and obligations hereunder, District retains professional and administrative responsibility for the services rendered by Medical Director hereunder. Medical Director, when acting as a consultant, shall apprise the District's administrator of recommendations, plans for implementation and continuing assessment through dated and signed reports which shall be retained by the District's administrator, as required by 22 C.C.R. §70713, for follow-up action and evaluation of performance.

Medical Director shall develop and recommend to District clinical policies relevant to provision of the Services. Medical Director shall assist District personnel in maintaining adequate service statistics and reports, and providing such administrative departmental reports, as requested by District. Regarding clinical issues, Medical Director shall report to the Medical Chief of Staff and Administrator. Regarding administrative issues, Medical Director shall report to the District's Administrator.

ARTICLE 5. COMPENSATION

5.1 Compensation for Medical Director Services. Subject to Section 5.2 below, for all Services to be provided by Medical Director under this Agreement, District shall pay Medical Director Two Thousand Dollars ($2,000.00) per month for the Services actually provided and documented by Medical Director. Such compensation shall be paid as set forth in Section 5.2 below and shall be payable in arrears monthly for Services rendered during the immediately preceding month during the term of this Agreement.

5.2 Required Documentation.

(a) Prior to and as a condition for receipt by Medical Director of any payment hereunder, Medical Director shall furnish reasonably contemporaneous written time records, signed and certified as accurate by Medical Director, that document, for each day worked during the immediately preceding month, the hours worked by Medical Director and the Services provided by Medical Director for each day in the month, all in a form approved by District (a sample of which is attached as Exhibit 2 to this Agreement and made a part hereof), and such other documentary evidence as may be requested by the District. All such time records shall be submitted prior to the fifteenth (15-th) of the month

for Services rendered during the immediately preceding calendar month. Subject to District receipt, review and approval of all such time records, District shall pay to Medical Director the applicable monthly compensation set forth in Section 5.1 above within forty-five (45) days after District's approval of such time records and upon termination of this Agreement the term of this Agreement shall be deemed to have extended to the date of such payment so that District can make any final payment to Medical Director. Such payment may be reviewed from time to time as considered appropriate by Medical Director and District. Failure to comply with this Section 5.2 shall be considered a material breach of this Agreement and shall be grounds for termination under Section 7.2 below.

Commented [SN3]: Is this correct?

(b) As one of District's remedies, but not by way of limitation, District may delay or cease payment, if District does not have Medical Director's cooperation and compliance with meeting, consulting, certifying and reporting requirements of this Agreement or if in good faith District believes ceasing a payment or practice hereunder would assist in the settlement of matters that may arise between District and the Federal government, its agencies, or contractors under any Federally funded or Federally required health care program or between the State, its agencies or contractors under any State funded or State required health care programs. In the event Medical Director does not cooperate or comply with District's written request concerning the foregoing within 10 days of such request, District shall be relieved of any obligation to pay sums then due, in addition to any other remedy it may have. If District shall notify Medical Director not to refer a patient to District for any in- or out-patient District service by reason of its good faith belief that the referrals under Stark Law may not be billed or paid, Medical Director shall cooperate with such notice and refer such patients other than in an emergency, to a facility other than District. No additional damages, including, without limitation, interest charges on a delayed or withheld payment, can be sought against District if it deposits or places such delayed or unpaid funds in a segregated account to be distributed according to a declaratory or other judgment of a court or arbitrator.

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. (c) Notwithstanding the foregoing, no compensation shall be payable to Medical Director in the event documentation as reasonably required by District, including, without limitation, the IRS Form W-9 "Request for Taxpayer Identification Number and Certification" is not submitted. Medical Director further expressly acknowledges and agrees that, with respect to any period during the Term in which Medical Director shall be suspended from the medical staff for delinquent medical records, compensation owed hereunder by District to Medical Director shall continue to accrue in accordance with the provisions of this Agreement but shall not be payable by District until such time as Medical Director is no longer suspended for delinquent medical records.

5.3 Billings. [Deleted]

5.4 Regulatory Compliance. Medical Director and District agree as follows:

(a) There is no requirement that the Medical Director make any referrals to or be in a position to make or influence referrals to, or otherwise generate business for, District as a condition for entering into and performing under this Agreement. There is no

requirement that District make any referrals to, or be in a position to make or influence referrals to, or otherwise generate business for, Medical Director as a condition for entering into and performing under this Agreement.

(b) Medical Director is not restricted from establishing or maintaining staff privileges at any other entity.

(c) The amount or value of the compensation and benefits provided to Medical Director hereunder shall not vary based on the value or volume of any referrals among the Medical Director and District, or based on any business otherwise generated by Medical Director for District.

5.5 Fair Market Value. Payments hereunder reflect fair market value for the aggregate services rendered by Medical Director, and all amounts paid under this Agreement, and any and all amounts paid under all other agreements between Medical Director and District, shall not exceed fair market value for services rendered. Notwithstanding the foregoing, if any amount should be determined in good faith to be in excess of fair market value or in violation of any health care fraud and abuse law, such amount shall not be required to be paid hereunder and, shall be subject to recoupment, as provided in Section 5.6.

5.6 Offset. In the event District determines in writing, in good faith, that Medical Director owes a repayment to District pursuant to this Agreement or otherwise (a "Repayment Amount"), District shall have the right to offset, in whole or in part, any Repayment Amount against any payment due Medical Director under this Agreement until the Repayment Amount is paid in full. District shall provide to Medical Director an accounting of the handling of the Repayment Amount. In the event the payment due to Medical Director hereunder is not sufficient to offset fully the applicable Repayment Amount, District shall roll forward the remaining portion of the Repayment Amount against any compensation due hereunder until such Repayment Amount is paid in full.

5.7 Audit by District. District shall have the right, at its cost and expense, to audit the timesheets and other documentation provided by Medical Director pursuant to Section 5.2, including any backup documentation and records maintained by Medical Director in connection therewith, and such audit may be undertaken by District, its employees or agents, including an independent consultant engaged by District.

ARTICLE 6. INDEPENDENT CONTRACTOR RELATIONSHIP

6.1 No Control. Any provision hereof to the contrary notwithstanding, nothing herein shall be construed as giving District control over the professional judgment of Medical Director, or over the time, manner, method or means in which Medical Director performs professional services. The Parties stipulate and agree that Medical Director and District are independent contractors with respect to all duties hereunder and the practice of medicine at District; this Agreement describes and identifies the work to be performed by Medical Director, but does not reserve to District control in the time, manner, method or means in which such services are to be performed; District shall not exercise and shall have no right to exercise control over Medical Director's practice of medicine or the provision of services hereunder. This Agreement sets forth results to be achieved

by Medical Director and standards to be satisfied by Medical Director, but does not create the relationship of an employer and employee.

6.2 No Benefits. Because Medical Director is not an employee of District, Medical Director will not be eligible to participate in any pension plan or other benefit plan for employees or be entitled to any fringe benefits of District employees. Moreover, District will not deduct from the payments made to Medical Director hereunder state or federal income taxes, FICA or other amounts normally withheld from compensation due employees. Medical Director shall make and be responsible for all tax filings, withholdings and payments required by law, owed in connection with any monies received by Medical Director hereunder or as a result of the Services provided by Medical Director under this Agreement, including but not limited to federal, state and local income taxes, Social Security, unemployment, disability and all other taxes, assessments and benefits. Medical Director shall indemnify, defend and hold harmless District and its officers, directors, employees, agents, representatives, affiliates and assigns from any loss, liability, damage, action, cause or action, cost or expense (including but not limited to reasonable attorneys' fees and costs, court costs, and costs of settlement) incurred as a result of Medical Director's failure or refusal to comply with the terms and provisions of this Section 6.3. The provisions in this Section 6.2 shall survive the expiration or termination of this Agreement.

ARTICLE 7. TERM; TERMINATION

7.1 Term. The initial term of this Agreement shall be for a one (1) year term beginning on the Effective Date, and shall expire on the first anniversary thereof unless earlier terminated as provided herein. At the end of the initial term and any renewal term, this Agreement will automatically renew for successive additional one-year terms unless either Party gives the other Party 30 days written notice of its intention to cancel this Agreement. The provisions of this Section 7.1 shall not be construed to modify or limit any provision in Sections 7.2 through 7.6 of this Agreement and other provisions of this Agreement regarding termination, which shall be applicable at all times.

7.2 Termination by District. District shall have the right to terminate this Agreement immediately:

(a) If any of the representations and warranties contained in Article 3 of this Agreement shall have been false in any material respect; or

(b) Upon material breach of or default under this Agreement, which is not cured within thirty (30) days after written notice thereof is given to Medical Director, provided that (i) such breach or default is reasonably curable within such thirty (30) days period and (ii) Medical Director pursues cure of the breach or default with reasonable diligence; or

(c) Upon the substantial inability or failure of Medical Director to fulfill the provisions of this Agreement; or

(d) Upon the death of Medical Director; or

(e) Upon the suspension, exclusion or debarment of Medical Director from the Medicare, Medicaid, or any other governmental health care programs; or

(f) Upon any intentional or grossly negligent act or omission by Medical Director that materially injures or may injure the reputation or interests of District; or

(g) Upon an act of fraud or theft by Medical Director, or the conviction of Medical Director of any felony or any crime involving moral turpitude or any crime relating to health care; or

(h) Upon any failure of Medical Director to comply with Section 3.9 of this Agreement; or

(i) Upon the revocation, suspension, resignation or substantial curtailment or limitation of the medical staff privileges at the District or any other health care facility or a license to practice medicine in any state of Medical Director; or

(j) Upon the failure of Medical Director to adhere to the Rules and Regulations and Bylaws of the Medical Staff of District; or

(k) In the event Medical Director cannot perform the Services for more than thirty (30) continuous days; or

(l) Upon thirty (30) days' notice to Medical Director in the event of any attempted assignment of this Agreement by Medical Director without the prior consent of District; or

(m) The termination, revocation, restriction or relinquishment of Medical Director's Drug Enforcement Agency number; or

(n) The failure of Medical Director to make a timely disclosure in accordance with Section 3.16 hereof; or

(o) Any conduct by Medical Director which, in the sole discretion of District, could affect the quality of professional care provided to District patients or the performance of duties required hereunder, or be prejudicial or adverse to the best interest and welfare of the District or its patients; or

(p) The failure by Medical Director to maintain the insurance required under this Agreement; or

The provisions of this Section 7.2 shall not be construed to modify or limit any provision in Sections 7.1 through 7.4 of this Agreement and other provisions of this Agreement regarding termination, which shall be applicable at all times.

7.3 Changes in Applicable Law. Subject to Sections 5.4 and 5.5 above, the Parties hereto agree that in the event there is a material change in any laws, rules, regulations, or interpretations thereof which would (in the opinion of counsel of either Party) (i) require the Parties hereto to restructure this service arrangement or any provision of this Agreement, (ii) so materially affect any of the Parties hereto that continued performance under this Agreement shall become impossible, intolerable, or a violation of any law or regulation, or (iii) jeopardize District's tax-exempt status or comparable provisions of state law, or any of its bonded indebtedness, then, in any such instance, the Parties shall cooperate and renegotiate this Agreement in good faith and in such a manner that the essence of this Agreement is maintained to the greatest extent possible.

Renegotiation of the terms of this Agreement shall commence promptly after either Party gives written notice to the other Party of such change. Immediately upon the giving of such notice, the Parties shall suspend performance of all noncomplying (in the opinion of the Party giving such notice) obligations hereunder, including but not limited to the payment of any amounts payable hereunder, pending renegotiation of this Agreement. If the Parties are unable to renegotiate this Agreement within thirty (30) days after the date of such notice, then Medical Director or District may, by written notice to the other Party, immediately terminate this Agreement.

7.4 Effect on Medical Staff Membership: No Interference. The termination of this Agreement by either Party shall not terminate or otherwise affect Medical Director's medical staff membership at District. Termination of this Agreement shall not, however, afford Medical Director any right to a hearing or access to any other due process or similar procedure set forth in the Rules and Regulations and Bylaws of the Medical Staff of District or otherwise available.

7.5 Cross Termination. If a cause for termination arises under this Agreement, District may also terminate any other agreements between District and Medical Director for cause. A termination of one, any or all such agreements shall not limit available rights and remedies of District.

7.6 Financial Arrangements Following Termination. Upon any termination of this Agreement, District, Medical Director shall not enter into any compensation or other financial arrangement for the Services covered by this Agreement for the period of time that would have remained in the initial term or renewal term, as the case may be, had notice of termination not been given unless such arrangement is in compliance with the terms of 42 U.S.C. § 1395m et seq. and regulations adopted pursuant thereto, and 42 U.S.C. § 1320a 7b and regulations adopted pursuant thereto.

7.7 Survival. No termination of this Agreement shall affect (a) any rights or liabilities that arose or accrued prior to the date of termination or (b) any obligations that by their terms or nature must extend beyond the date of termination to be effective.

ARTICLE 8. MISCELLANEOUS

~~8.1 Rights in Property; Use of Premises. All title to supplies, fiscal records (except Medical Director's personal records), charts, medical records, equipment and furnishings shall remain the sole property of District. District recognizes that Medical Director may see private patients at District and that normal medical records (including copies of District patient records normally provided physicians and research files) of Medical Director may be removed upon any termination of this Agreement. Medical Director shall not use, or knowingly permit any other person who is under its or his direction to use, any part of District's premises for any purpose other than the performance of Services for District and its patients.~~

8.2 Amendments. This Agreement may not be modified or amended except by written agreement executed by the Parties, and may not be amended orally. ~~This provision is material and is intended to prevent the alteration of the terms and conditions of this Agreement and the acceptance of partial performance in violation of applicable Federal regulation and District policy.~~

A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

8.3 Severability. The provisions of this Agreement are severable, and if any term or provision of this Agreement or the application thereof to any person or circumstance is breached or shall, to any extent, be held invalid or unenforceable by a court of competent jurisdiction, the remainder of this Agreement or the application of any such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable shall not be affected thereby, and each term and provision of this Agreement shall be valid and enforceable to the fullest extent permitted by law. ~~If any of the provisions contained in this Agreement shall for any reason be held to be excessively broad as to duration, scope, activity or subject, it shall be construed by limiting and reducing it, so as to be valid and enforceable to the extent compatible with the applicable law or the determination by a court of competent jurisdiction. No breach of this Agreement shall in any way affect the enforceability of Section 3.9.~~

8.4 No Assignment: Successors. Medical Director may not assign this Agreement or any rights hereunder without the prior written consent of the District, and no such attempted assignment shall be effective or binding. This Agreement shall be binding upon and shall inure to the benefit of the Parties, and any permitted successors and assigns.

8.5 No Third-Party Beneficiaries. All the conditions, representations, and obligations imposed hereunder are imposed or made solely and exclusively for the benefit of the Parties to this Agreement and their permitted successors and assigns. ~~No other persons shall have standing to require the satisfaction of any condition, representation, or covenant made herein in accordance with its terms, or be entitled to assume the existence or absence of strict compliance with all of the terms and conditions hereof.~~ No other person shall, under any circumstances, be deemed a beneficiary of this Agreement.

8.6 Headings. The headings of the various paragraphs of this Agreement are for purposes of reference only, and shall not expand, limit or otherwise affect any of the terms or provisions hereof.

8.7 Notice. Any notices required or permitted hereunder shall be effective on the day on which personally delivered to any Party and, if sent by registered or certified mail, return receipt requested, such notice shall be deemed to have been delivered to the Party to whom such notice was addressed on the third business day after the day on which mailed to such Party at the following address:

(a) District:

Southern Inyo Healthcare District
501 East Locust Street | PO BOX 1009
Lone Pine, CA 93545
Attention: Brian Cotter, CEO

(b) Medical Director.

Eva Wasef

8.8 Bylaws Control; Other Arrangements. In the event of any conflict between the provisions of this Agreement and the Bylaws of the Medical Staff of the District, the provisions of the Bylaws of the Medical Staff of the District shall, with respect to Medical Director, control. This Agreement supersedes and replaces any prior agreement between the Parties regarding Medical Director services in connection with the hospital, SNF, and clinic. This Agreement is intended to include all services provided by or compensation paid to each Party by the other Party, except for those other arrangements or agreements set forth in Schedule D, attached hereto and made a part hereof, which are in effect on the Effective Date, together with any other agreements as may be reflected on a master listing of contracts maintained by the District.

Commented [SN5]: Does this apply?

8.9 Governing Law. This Agreement and the rights and obligations of the Parties hereunder shall be governed by, and construed and interpreted in accordance with, the laws of the State of California.

8.10 Access Clause. If this Agreement is subject to Section 952 of the Omnibus Reconciliation Act of 180, 42 U.S.C. § 1395x(v)(1)(I) (the "Statute") and the regulations promulgated thereunder, 42 C.F.R. Part 420, Subpart D (the "Regulations'), Medical Director shall, until the expiration of four (4) years after furnishing of services pursuant to this Agreement, make available, upon proper request, to the Secretary of Health and Human Services (the "Secretary") and to the Comptroller General of the United States (the "Comptroller General"), or any of their duly authorized representatives, this Agreement and any other documents of Medical Director that are necessary to certify the nature and extent of the cost of services furnished pursuant to this Agreement for which payment may be made to District under the Medicare program.

If this Agreement is subject to the Statute and Regulations and Medical Director carries out any of the duties of this Agreement through a subcontract (to the extent permitted herein), with a value or cost of $10,000 or more over a twelve month period, with a related organization, that subcontract shall contain a clause to the effect that until the expiration of four (4) years after the furnishing of services pursuant to such subcontract, the related organization shall make available, upon proper request, to the Secretary and the Comptroller General, or any of their duly authorized representatives, the subcontract and the books, documents and records of such related organization that are necessary to verify the nature and extent of such costs.

8.1 1 Attorney Fees. Notwithstanding any other provision of this Agreement, should a Party hereto institute any action or proceeding against the other Party to enforce any provisions of this Agreement or for damages by reason of any alleged breach of any provision hereof or for declaration of such Parties' rights or obligations hereunder, or for any other judicial or administrative remedy with respect to this Agreement, the prevailing Party shall be entitled to receive from the other Party reasonable attorneys' fees actually incurred by the prevailing Party.

8.12 Counterparts This Agreement may be executed in more than one counterpart (any one of which may be by facsimile, electronic scan or .pdf), each of which shall be deemed an original and all of which when taken together shall constitute one and the same agreement.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by its respective duly authorized representatives and its corporate seal affixed on the date specified by each Parties' signature below, to be effective as of the Effective Date.

Date: _____ SOUTHERN INYO HEALTHCARE DISTRICT

By _____
Peter Spiers, Ph.D., Chief Executive Officer

Date: _____ Eva Wasef, MD

_____

EXHIBIT 1

RESPONSIBILITIES OF MEDICAL DIRECTOR

In performing the general responsibilities described in Section 2.1, the Medical Director shall:

1. Scope of Services. The Medical Director shall serve as Medical Director of the Districts' Pathology Department. The Medical Director shall participate in the formulation, review and/or revision of the scope of services provided in the Facilities.

2. Operational. Medical Director shall:

   a. Consult with the CEO of hospital or designee regarding the operation of the department
   b. Assisting the Service's compliance with accrediting bodies and conditions of participation in the Medi-Care program
   c. Advise Hospital regarding technical developments and capital expenditures
   d. Provide education and in-service instruction programs for the Facility's Lab and Nursing personnel in the operation of the Service.
   e. Make recommendations to the Facility's administration regarding the use of facility personnel, the necessary equipment, and general quality standards of patient care in connection with the Service.
   f. Develop medical education programs for the Facility's medical staff in the appropriate role of the Service.
   g. Be a liaison to appropriate medical staff committees relevant to the Service. In no event shall duties pursuant to this Agreement include attendance at meetings that the Director is required to attend as a result of Director's licensure or medical staff membership including mandatory medical staff meetings or Governing Board Meetings.
   h. Maintain communication with attending physicians or clients regarding test results performed by the Service.
   i. At least annually, review and make recommendations as necessary to revise the Service's policies and procedures.
   j. Assist the medical staff committee in reviewing and revising medical staff rules and regulations which pertain to the Service.
   k. Review patient records ad reports, Quality Control reports, Proficiency reports, correlation studies in the Service to promote quality of patient care.
   l. At Hospital's request, accompany the CEO or his/her designed to meetings in which Hospital and Director discuss issues relating to Director's duties under this Agreement.
   m. Oversight and review of Transfusion medicine.

3. Quality input. Medical Director shall participate in programs and provide input in collaboration with administrative and clinical staff to:

a. Improve quality indicators, develop, and monitor goals and performance objectives for the Facilities.
b. Develop and design protocols relevant to the Facilities patient population that will result in positive patient outcomes.
c. Review records and reports of patient service in the Service to promote quality of patient care and for data analysis and presentation and develop plans to reduce the number and severity of medical errors and adverse events.
d. Assist with the collection of data on use and appropriateness of cases performed in the Facilities.
e. Assist in initiating best practices and analyzing clinical outcomes that are required to be reported externally.
f. Present clinical outcomes to the appropriate forum.
g. Participate on appropriate District wide medical staff committees and serve as a Service liaison. Provided, however, in no event shall duties pursuant to this Agreement include attendance at meetings that Medical Director is required to attend as a result of Medical Director's licensure or medical staff membership including mandatory medical staff meetings or governing board meetings.
h. Assist the appropriate medical staff committee in reviewing and revising medical staff rules and regulations, which pertain to the Service.
i. Lead quality initiatives in collaboration with District leadership that will positively impact patient care.
j. Coordinate educational needs for unit-based, as well as general District personnel and the public.
k. Provide education and in-service instruction programs for the District's nursing and ancillary personnel in the operation of the Service.
l. Meet monthly with the District to discuss quality improvement and/or other service issues; consult with medical and departmental directors as needed should either party require such consultation.
m. Annually review and make written recommendations regarding policy and procedure manuals.

4. Expertise. The Medical Director shall serve as a consultant and resource for the District in the development and implementation of programs for its services, and on an ongoing basis following implementation of such program.

5. Medical Staff Liaison. The Medical Director shall serve as a liaison for the Medical Staff and the District staff.

6. Policies and Procedures. The Medical Director shall participate in the recommendation, development and review of policies and procedures affecting the Facilities.

7. Regulatory Compliance. The Medical Director shall be responsible for assisting with regulatory compliance, including compliance with accreditation standards, including but not limited to those utilized by OSHA, the Joint Commission, state and local health departments, and the CDC; and assisting District in maintaining appropriate certifications/accreditations by certifying or accrediting bodies.
8. Ethics. The Medical Director will assist in addressing ethical issues involving patient care in the Facilities and will participate in ethics consultations as appropriate.
9. Other Duties. Additional duties on behalf of the District with respect to the Facilities as requested by District, including but not limited to participation in or attendance at CME programs or marketing events as specifically requested in writing by the District.

SCHEDULE A

CLAIMS AND LIABILITIES

Medical Director warrants that there are no claims or suits pending against Medical Director at this time except as follows: (if none, state "none")

EXHIBIT 2

Name:_____Calendar Month of Service: _____, 20_____
Unit: _____

MEDICAL DIRECTOR TIME SHEET

DATE	DESCRIPTION OF SPECIFIC SERVICES PROVIDED (Services must be described in detail) Administrative Services Only - No Clinical or Medical Staff Services	Total Time Spent On Task (Time In .25 Increments)
	Provide administrative supervision of Service including managing the Service coverage and call arrangements.	
	Assist in the development or selection of clinical practice guidelines and standard order sets.	
	Maintain communication with attending physicians admitting patients to the Service	
	Review the clinical functions of the physicians and technicians caring for patients in the Facilities.	
	Review admissions to and discharges from the Facilities in collaboration with referring physicians and management.	
	Maintain communications with all disciplines within the Facilities, with other departments, and physicians involved in patient care in the Facilities.	
	Collaborate with department leadership to assure and maintain current technology and equipment.	
	Provide input and active participation in the marketing of the Facilities to the medical staff.	
	Make recommendations to the District's administration regarding the use of District personnel, the necessary equipment, and general quality standards of patient care in connection with the Service.	
	Assist District in the development of a budget for the Facilities and the services to be provided therein.	
	Participate in the interview process of candidates for management positions with respect to services at District.	

	Ensure that a credentialed physician (i.e. member of the Medical Staff of District who has been approved by District for clinical privileges is available.	
	Improve quality indicators.	
	Develop and design protocols relevant to the patient population that will result in positive patient outcomes.	
	Review records and reports of patient service in the Service to promote quality of patient care and for data analysis and presentation.	
	Assist with collection of data on use and appropriateness of cases performed in the Facilities.	
	Assist the Facilities in initiating best practices and analyzing clinical outcomes.	
	Present clinical outcomes to the appropriate forum.	
	Participate on appropriate District wide medical staff committees and serve as a Service liaison.	
	Assist the appropriate medical staff committee.	
	Lead quality initiatives in collaboration with Facilities leadership.	
	Coordinate and provide education and in-service instructions programs for the District's staff.	
	Meet with the District to discuss quality improvement and/or other service issues; consult with medical and departmental directors.	
	Review and make written recommendations regarding Facilities policy and procedure manuals.	
	Other (Describe):	

TOTAL HOURS

ATTESTATION

By signing this document, I affirm and attest that the services described herein and the number of hours recorded for such services were performed by me.

_____ Date: _____
_____, MD

By signing this document the Compliance Officer and CEO/ Administrator affirm and attest that they have confirmed that the services rendered and number of hours recorded for such services satisfy the duties set forth in the Agreement, and that the number of calendar months remaining in the Agreement term as stated on pages I and 2 are accurate.

REVIEWED AND APPROVED BY:

_____ CEO Date: _____

_____ Compliance Officer Date: _____

REVIEWED AND APPROVED BY CEO:

_____, CEO/ADMINISTRATOR Date: _____

ACCOUNTING USE ONLY: Calendar Month of Service:_____, 201__
OF HOURS_____X Rate per hour $_____= Total $_____
The above hours, rate and total compensation has been verified by:_____ CEO
The above hours, rate and total compensation has been verified by:_____ CCO

RURAL HEALTH CLINIC PHYSICIAN AGREEMENT

This Rural Health Clinic Physician Agreement ("Agreement") is entered into by and between Southern Inyo Healthcare District ("District") and Kevin Flanigan ("PHYSICIAN"), as of September 19, 2019.

RECITALS

A. District owns and operates Southern Inyo Hospital ("Hospital") located in Lone Pine, California, a Critical Access Hospital, and desires to retain Physician to provide services in District's rural health clinic ("RHC").

A. Physician is a physician duly licensed in California with a background and experience in providing clinic medical services, and desires to be retained by District.

NOW, THEREFORE, the parties agree as follows:

TERMS

1. SCOPE OF SERVICES

District retains Physician, and Physician agrees, to provide those services identified in Exhibit A, attached hereto and incorporated by reference (the "Services").

2. PHYSICIAN'S REPRESENTATIONS AND WARRANTIES

Physician represents and warrants at the time of signing this Agreement, and at all times during the term of this Agreement, that:

2.1 Physician and any alternate physicians are duly licensed, registered and in good standing, or will become duly licensed, registered and in good standing under the laws of the State of California, to engage in the practice of medicine, and that said license and registration have not been suspended, revoked, or restricted in any manner.

2.2 Physician is qualified and has applied for, or will apply for within a reasonable time after the signing of this Agreement, and has obtained, or will obtain within a reasonable time after the signing of this Agreement, membership (including appropriate clinical privileges) in good standing with the Medical Staff of District.

2.3 Physician has disclosed and will at all times during the term of this Agreement promptly disclose to the District: (a) the existence and basis of any legal, regulatory, professional or other proceeding against Physician instituted by any person, organization, governmental agency, health care facility, peer review organization, or professional society which involves any allegation of substandard care or professional misconduct raised against Physician and (b) any allegation of substandard care or professional misconduct raised against Physician by any person, organization, governmental agency, health care facility, peer review organization or professional society;

2.4 Physician– is board certified or board qualified in family practice or internal medicine, or possesses knowledge and skill in clinic medicine comparable to other physicians practicing clinic medicine in the District's service area.

2.5 Physician shall at all times render the Services in a competent, professional, and ethical manner, in accordance with prevailing standards of medical care and practice, and all applicable statutes, regulations, rules, orders, and directives of any and all applicable governmental and regulatory bodies having competent jurisdiction.

2.6 In connection with the provision of the Services, Physician shall use the equipment, instruments, electronic medical record system, and supplies of the District for the purposes for which they are intended and in a manner consistent with sound medical practice.

2.7 Physician shall complete and maintain, in a timely manner and on the electronic medical record system, adequate, legible and proper medical records, claims, and correspondence with respect to the Services.

2.8 Physician shall participate in Medicare, Medi-Cal and other federal and state reimbursement programs, commercial insurance reimbursement programs, health maintenance organization, preferred provider organizations, self-insured employer reimbursement programs, and any other health benefit program with which the District may contract for the provision of professional medical services.

2.9 Physician shall abide by the Medical Staff Bylaws, rules, regulations, and policies.

2.10 Physician shall participate in continuing medical education and training programs required to maintain skills comparable with the standards of care in clinic medicine in the District's service area.

2.11 Physician shall satisfy all qualifications of insurability for professional liability policy or policies required, maintained, or reimbursed by the District.

2.12 Physician shall deliver to the District promptly upon request copies of all certificates, registrations, certificates of insurance, and other evidence of Physician's compliance with the foregoing as reasonably requested by the District.

2.13 Physician will provide references for past performance and allow the District to rely on those references for meeting the qualifications required by this contract.

3. RESPONSIBILITIES OF HOSPITAL

3.1 HOSPITAL shall provide appropriate space and necessary equipment within the rural health clinic and Hospital for the use of Physician in the performance of the Services under this Agreement.

3.2 HOSPITAL shall make all reasonable efforts to make available ancillary services necessary for effective operation of the RHC, including laboratory, imaging, pharmacy, and physical therapy.

3.3 HOSPITAL shall not involve itself in those aspects of Physician's professional practice of medicine for which a license to practice medicine is required.

4. COVERAGE.

PHYSICIAN will provide ~~RHC~~ coverage in the RHC every Wednesday, as scheduled by the RHC Manager and PHYSICIAN.

5. COMPLIANCE WITH LAWS

PHYSICIAN shall comply with all applicable provisions of law, and other valid rules and regulations of all governmental agencies having jurisdiction over: ~~-~~(i) the operation of the RHC; (ii) the licensing of health care practitioners; and (iii) the delivery of services to patients of governmentally regulated third party payers whose members/beneficiaries receive services at HOSPITAL. This shall specifically include, but not by way of limitation: ~~-~~(i) ~~-~~compliance with applicable provisions of Title 22, California Administrative Code; and (ii) compliance with Medicare billing, time allocation, record keeping, and record access requirements.

6. PHYSICIAN COMPENSATION.

6.1 District agrees to pay the following fees to Physician:

6.1.1 Patient Visits. District will bill patients and their payors for services provided by PHYSICIAN to those patients. Such charges shall be consistent with prevailing community charges.

6.1.2 Payment for Patient Visits. District will pay PHYSICIAN $200.00 per visit for all patients treated in the rural health clinic.

6.1.3 Group Health Plan and Continuing Medical Education. PHYSICIAN may participate in the District employee group health plan at the same premium rate as other District employees.

6.1.4 First Month Guarantee. PHYSICIAN will be guaranteed compensation of $1,000 per day worked for the first month of this Agreement based upon the Medicare safe harbor provisions covering income guarantees for physicians.

6.1.5 District is responsible for the payments due to PHYSICIAN. Therefore, physician should only look to the District for amounts due.

6.2 Timing of Payment. District will pay PHYSICIAN monthly by the 15th day of the next month following that month in which the services are rendered.

6.3 Holiday Minimum. The Rural Health Clinic is closed on all District-observed holidays.

7. INDEPENDENT CONTRACTOR

7.1 PHYSICIAN is an independent contractor, and is not, by virtue of this Agreement, an employee, partner of, or joint venturer with District.

7.2 Physician may not make any claim against District under this Agreement for social security benefits, worker's compensation benefits, unemployment insurance benefits, health benefits, vacation pay, sick leave, or any other employee benefits of any kind.

7.3 District shall not exercise any direct control over any medical decisions made by Physician in the course of performing the Services at the Rural Health Clinic or Hospital.

8. INSURANCE AND INDEMNIFICATION

8.1. Coverage. PHYSICIAN and any alternate physicians will be covered by the District's Professional and Liability Insurance through BETA Healthcare Group ("BETA") for a minimum of $1,000,000 per occurrence, $3,000,000 aggregate, for the Services rendered under this Agreement. It is understood and agreed that BETA provides Continuous Coverage for departed providers, except the coverage is limited to claims made and reported against the provider for Services provided during the term of this Agreement.

8.2. Indemnification. Each party ("Indemnitor") agrees to defend, indemnify and hold the other party ("Indemnitee") and its representatives, agents, successors and assigns harmless from any and all damages, claims, judgments, losses, costs and expenses, including attorney's fees, which may hereinafter at any time be incurred, suffered, sustained by or imposed upon Indemnitee or its representatives, agents, successors or assigns, which may be due or required to be paid or performed by reason of, arising out of, by virtue of, or incident to the performance or the rendering of any of the obligations of Indemnitor hereunder, including but not limited to, any such damages, claims, judgments, losses, costs or expenses attributable to bodily injury, sickness, disease or death or injury or to destruction of tangible property which is caused in whole or in part by the negligent act or omission of Indemnitor, or anyone directly employed by or acting on behalf of Indemnitor but not as a result of the negligence of Indemnitee, its representatives, servants or agents.

9. NONDISCRIMINATION

Services are to be available to all patients, in accordance with District's nondiscrimination policies, and in accordance with any established policies relating to free or charity care. Physician shall not refuse to provide services to any patient at the Hospital, regardless of ability to pay.

10. TERM AND TERMINATION

10.1 Term. This Agreement shall be effective as of February 1, 2019, and shall terminate on January 31, 2020. Upon mutual agreement, not later than 90 days prior to expiration of the current term, the District and Physician may extend this Agreement for two additional one-year terms.

10.2 Termination without cause. During the initial 120 days of this Agreement, either party may, without cause, terminate this Agreement with 30-days written notice to the other party. Thereafter, this Agreement may be terminated upon 60-days written notice to the other party. This agreement may be terminated at any time by the mutual consent of both parties.

10.3 Termination for cause. Either party may terminate this Agreement for cause if the other party is in material breach of this Agreement and the default is not cured within seven days of receipt of written notice specifying the material breach.

10.4 Other grounds for termination. This Agreement may be terminated immediately for the following reasons:

10.4.1 Physician's loss or restriction of their license for any reason.

10.4.2 Physician becomes legally incompetent; is convicted of a felony; or uses, possesses, or is found under the influence of alcohol, drugs, or other controlled substances while performing his duties under this Agreement.

10.4.3 Physician fails to maintain a professional standard of conduct in accordance with District policies.

10.4.4 Physician becomes ineligible to participate in the Medi-cal or Medicare programs for any reason.

10.4.5 A fraud control unit of a state or federal agency determines Medical Director has or may be placing the health and safety of a patient at risk.

10.4.6 Loss or restriction of DISTRICT'S license to operate the clinic.

10.5 Change in Law. In the event that any federal, state or local law or regulation, or any final, non-appealable interpretation of law or regulations by a court of law or governmental agency, makes or will make substantial performance of this Agreement illegal or renders any provision hereof illegal or unenforceable, the parties shall meet and negotiate and use best efforts to modify the Agreement to resolve the concern. If the parties are unable to resolve the issue within ten (10) days after it arose, either party may elect to terminate this Agreement on ten (10) days prior written notice.

10.6 Rights on Expiration or Termination. Custody of all District records, including patient medical records, equipment, and supplies shall be turned over to District upon termination for any reason. Duplicate copies of records may be retained by PHYSICIAN, at its own expense.

11. GENERAL PROVISIONS

11.1. Other Agreements. The PHYSICIAN is the Medical Director of the hospital's Skilled Nursing Facility.

11.2. Assignment. Neither party may assign, delegate or transfer any rights, obligations or duties hereunder without the express written approval of the other party, which approval shall not be unreasonably withheld.

11.3. Notice. All notices required by this Agreement shall be in writing, and shall be deemed effective when personally delivered; when mailed by certified or registered mail, return receipt requested; or when deposited with a comparably reliable postage delivery service (such as Federal Express); addressed to the other party as follows:

IF TO PHYSICIAN:
Kevin Flanigan

If TO DISTRICT:
Southern Inyo Healthcare District
Attn: Brian Cotter, CEO
P.O. Box 1009
Lone Pine, CA 93545

11.4. Records. Until the expiration of four (4) years after the furnishing of any service pursuant to this Agreement, PHYSICIAN shall make available upon written request, to the Secretary of the United States Department of Health and Human Services, or upon written request to the United States Comptroller, or any of their duly authorized representatives, under 42 C.F.R. & 420.300 et seq., or the California Department of Health Services, this Agreement, and such books, documents and records of the Physician that are necessary to certify the nature and extent of the reasonable costs of services.

11.5. No Third Party Beneficiaries. Nothing contained in this Agreement is intended, nor shall it be construed, to create rights running to the benefit of third parties.

11.6. Attorney's Fees. In the event of a legal action or proceeding between the parties arising from this Agreement, the prevailing party shall be entitled to receive reasonable attorney's fees, costs, and other expenses, including those incurred on appeal and in the enforcement of a judgment, in addition to whatever other relief may be awarded.

11.7 Force Majeure. Neither party shall be liable or deemed in default of this Agreement for any delay or failure to perform caused by acts of God, war, disasters, strikes, or any cause reasonably beyond the control of the non-performing party.

11.8 Severability. In the event any portion of this Agreement is declared invalid or void by a court or arbitrator, such portion shall be severed from this Agreement, and the remaining provisions shall remain in effect, unless the effect of such severance would be to substantially alter the agreement or obligations of the parties, or would place either party in violation of its articles of incorporation or its bylaws, in which case the Agreement may be immediately terminated.

11.9 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of California, without regard to its conflict of laws principles, and is made and to be performed in the County of Inyo, California.

11.10 No Referrals. Nothing in this Agreement is intended to obligate, and shall not obligate, any party to this Agreement to refer patients to any other party.

11.11 Waiver. Any failure of a party to insist upon strict compliance with any term, undertaking or condition of this Agreement shall not be deemed to be a waiver of such term, undertaking or condition. To be effective, a waiver must be in writing, signed and dated by the parties.

11.12 Entire Agreement; Modification. This Agreement contains the entire agreement of the parties relating to this subject matter. The Agreement may only be modified in writing, signed by both parties, effective on the date set forth therein.

11.13 Execution. By their signatures below, each of the following represent that they have authority to execute this Agreement and to bind the party on whose behalf their execution is made.

Southern Inyo Healthcare District	Physician
By _____	By_____
Jaque Hickman, Board President	Kevin Flanigan M.D.

EXHIBIT A

SCOPE OF SERVICES

PHYSICIAN shall devote sufficient time and his or her best abilities to the responsibility of treating patients in the normal and customary hours of operation of the Rural Health Clinic.

Patient Referrals. PHYSICIAN shall make referrals of Rural Health Clinic patients in accordance with patient's insurance and established Rural Health Clinic networks in place, but not in violation of any federal or state law.

Medical Care Plan System. PHYSICIAN shall participate in the development and review of a system for providing a medical care plan for RHC patient covering medications, nursing care, ancillary services, admission, discharge or transfer planning, and other relevant services.

Medical Records. PHYSICIAN shall be responsible for the development and maintenance of an adequate medical record in the RHC. This shall include assuring that the appropriate medical record entries are made by PHYSICIAN, including using any existing electronic medical system concerning all medical procedures and other services performed in the RHC.

Service and Equipment Adequacy. PHYSICIAN shall ensure the adequacy of the patient care services and medical equipment.

Responses to Administrative Questions. PHYSICIAN shall be available to respond to administrative questions regarding patients, referral problems, and patient status.

Responses to Nursing Questions. PHYSICIAN shall be available to assist with nursing or mid-level practitioner questions at the RHC, including questions regarding patient referrals and patient clinical status.

Responses to Patient Problems. PHYSICIAN and alternate physicians, when on duty, shall be available to respond to patient problems in the RHC by means of chart review and patient visits, as appropriate, and respond to all patient emergencies when required.

Medical Staff Commitments. Physician shall serve on such committees of Medical Staff of the District as may be appropriate after consultation with the Chief of Staff and Hospital CEO.

Utilization Review Services. Physician shall, as requested by the District, assist in the RHC utilization review program of the District.

EMERGENCY DEPARTMENT PHYSICIAN AGREEMENT

This Emergency Department Physician Agreement ("Agreement") is made by Southern Inyo Healthcare District ("District") and Kevin Flanigan, M.D. ("PHYSICIAN"), as of September 19, 2019.

RECITALS

A. District owns and operates Southern Inyo Hospital ("Hospital") located in Lone Pine, California, a Critical Access Hospital, and desires to retain Physician to provide emergency medicine services in Hospital's Emergency Department ("ED").

A. Physician is a physician duly licensed in California with a background and experience in providing emergency medicine services, and desires to be retained by District.

NOW, THEREFORE, the parties agree as follows:

TERMS

1. SCOPE OF SERVICES

District retains Physician, and Physician agrees, to provide those services identified in Exhibit A, attached hereto and incorporated by reference (the "Services").

2. PHYSICIAN'S REPRESENTATIONS AND WARRANTIES

Physician represents and warrants at the time of signing this Agreement, and at all times during the term of this Agreement, that:

2.1 Physician is duly licensed, registered and in good standing, or will become duly licensed, registered and in good standing under the laws of the State of California, to engage in the practice of medicine, and that said license and registration have not been suspended, revoked, or restricted in any manner.

2.2 Physician is qualified for and has applied for, or will apply for within a reasonable time after the signing of this Agreement, and has obtained, or will obtain within a reasonable time after the signing of this Agreement, membership (including appropriate clinical privileges) in good standing with the Medical Staff of District.

2.3 Physician has disclosed and will at all times during the term of this Agreement promptly disclose to the District: (a) the existence and basis of any legal, regulatory, professional or other proceeding against Physician instituted by any person, organization, governmental agency, health care facility, peer review organization, or professional society which involves any allegation of substandard care or professional misconduct raised against Physician and (b) any allegation of substandard care or professional misconduct raised against Physician by any person, organization, governmental agency, health care facility, peer review organization or professional society;

2.4 Physician is board certified or board qualified in emergency medicine, or possesses knowledge and skill in emergency medicine comparable to other physicians practicing emergency medicine in the District's service area.

2.5 Physician shall at all times render the Services in a competent, professional, and ethical manner, in accordance with prevailing standards of medical care and practice, and all applicable statutes, regulations, rules, orders, and directives of all applicable governmental and regulatory bodies having competent jurisdiction.

2.6 In connection with the provision of the Services, Physician shall use the equipment, instruments, electronic medical record documentation system and supplies of the District for the purposes for which they are intended and in a manner consistent with sound medical practice and District policies and procedures.

2.7 Physician shall complete and maintain, in a timely manner, adequate, legible and proper medical records, claims and correspondence with respect to the Services.

2.8 Physician shall participate in Medicare, Medi-Cal and other federal and state reimbursement programs, commercial insurance reimbursement programs, health maintenance organization, preferred provider organizations, self-insured employer reimbursement programs and any other health benefit program with which the District may contract for the provision of professional medical services.

2.9 Physician shall abide by the Medical Staff Bylaws, rules, regulations and policies.

2.10 Physician shall participate in continuing medical education and training programs required to maintain skills comparable with the standards of care in emergency medicine in the District's service area.

2.11 Physician shall satisfy all qualifications of insurability for professional liability policy or policies required, maintained or reimbursed by the District.

2.12 Physician shall deliver to the District promptly upon request copies of all certificates, registrations, certificates of insurance and other evidence of Physician's compliance with the foregoing as reasonably requested by the District.

3. RESPONSIBILITIES OF HOSPITAL

3.1 HOSPITAL shall provide appropriate space and necessary equipment within the ED for the use of Physician in the performance of the Services under this Agreement.

3.2 HOSPITAL shall make all reasonable efforts to make available ancillary services necessary for effective operation of the ER, including laboratory, imaging, pharmacy, etc.

3.3 HOSPITAL shall not involve itself in those aspects of Physician's professional practice of medicine for which a license to practice medicine is required.

4. COVERAGE.

PHYSICIAN will provide emergency physician coverage in the ED as scheduled by HOSPITAL and MEDICAL DIRECTOR. ~~However, PHYSICIAN will cover no less than _N/A__ shifts per month.~~

5. COMPLIANCE WITH LAWS

PHYSICIAN shall comply with all applicable provisions of law, and other valid rules and regulations of all governmental agencies having jurisdiction over: (i) the operation of the ED; (ii) the licensing of health care practitioners; and (iii) the delivery of services to patients of governmentally regulated third party payers whose members/beneficiaries receive services at HOSPITAL. This shall specifically include, but not by way of limitation (i) compliance with applicable provisions of Title 22, California Administrative Code; and (ii) compliance with Medicare billing, time allocation, record keeping, and record access requirements.

6. PHYSICIAN COMPENSATION.

6.1 District agrees to pay the following fees to Physician:

6.1.1 Patient Visits. District will bill patients and their payors for services provided by PHYSICIAN to those patients. Such charges shall be consistent with prevailing community charges.

6.1.2 Emergency Department Patient Visit Fees. District will pay PHYSICIAN $_N/A_ per visit for all patients treated with their charts completed by _N/A__.

Commented [SN1]: Not getting paid?

6.1.3 Stand-By Hours. In addition to the compensation in 6.1.2, District will compensate PHYSICIAN at $100.00 per hour for all hours worked on site covering the Emergency Department.

6.1.6 HOSPITAL is responsible for the payments due to PHYSICIAN. Therefore, physician should only look to the HOSPITAL for amounts due and not to MEDICAL DIRECTOR or HOSPITAL'S patients.

6.2 Timing of Payment. HOSPITAL will pay PHYSICIAN monthly by the 15 day of the next month following that month in which the services are rendered.

6.3 Holiday Minimum. The minimum payment for the following holidays will be _Time and a Half_: New Year's Day, Easter Sunday, Memorial Day, 4th of July, Labor Day, Thanksgiving Day, and Christmas Day.

6.4 Continuing Medical Education. PHYSICIAN shall be entitled to N/A hours of paid continuing medical education time after each six-month period in which PHYSICIAN has worked at least the minimum shifts in the emergency department as required under article 4.0 of this agreement.

6.5 PHYSICIAN will be entitled to purchase group health insurance through the DISTRICT plan at the then current cost of the health insurance to the District or the COBRA rate.

7. INDEPENDENT CONTRACTOR

7.1 PHYSICIAN is an independent contractor, and is not, by virtue of this Agreement, an employee, partner of, or joint venturer with District.

7.2 Physician may not make any claim against District under this Agreement for social security benefits, worker's compensation benefits, unemployment insurance benefits, health benefits, vacation pay, sick leave, or any other employee benefits of any kind.

7.3 District shall not exercise any direct control over any medical decisions made by Physician while performing the Services at the ED.

8. INSURANCE AND INDEMNIFICATION

8.1. Coverage. PHYSICIAN will be covered by the District's Professional and Liability Insurance through BETA Healthcare Group ("BETA") for a minimum of $1,000,000 per occurrence, $3,000,000 aggregate, for the Services rendered under this Agreement. It is understood and agreed that BETA provides Continuous Coverage for departed providers, except the coverage is limited to claims made and reported against the provider for Services provided during the term of this Agreement.

8.2. Indemnification. Each party ("Indemnitor")agrees to defend, indemnify and hold the other party ("Indemnitee") and its representatives, agents, successors and assigns harmless from any and all damages, claims, judgments, losses, costs and expenses, including attorney's fees, which may hereinafter at any time be incurred, suffered, sustained by or imposed upon Indemnitee or its representatives, agents, successors or assigns, which may be due or required to be paid or performed by reason of, arising out of, by virtue of, or incident to the performance or the rendering of any of the obligations of Indemnitor hereunder, including but not limited to, any such damages, claims, judgments, losses, costs or expenses attributable to bodily injury, sickness, disease or death or injury or to destruction of tangible property which is caused in whole or in part by the negligent act or omission of Indemnitor, or anyone directly employed by or acting on behalf of Indemnitor but not as a result of the negligence of Indemnitee, its representatives, servants or agents.

9. NONDISCRIMINATION

Services are to be available to all patients, in accordance with District's nondiscrimination policies, and in accordance with any established policies relating to free or charity care. Physician shall not refuse to provide services to any patient at the Hospital, regardless of ability to pay.

10. TERM AND TERMINATION

10.1 Term. This Agreement shall be effective as of September 19, 2019 and shall terminate on September 20, 2020. Upon mutual agreement, not later than 90 days prior to

expiration of the current term, the District and Physician may extend this Agreement for two additional one-year terms.

10.2 Termination without cause. During the initial 120 days of this Agreement, either party may, without cause, terminate this Agreement with 10-days written notice to the other party. Thereafter, this Agreement may be terminated upon 60-days written notice to the other party. This agreement may be terminated at any time by the mutual consent of both parties.

10.3 Termination for cause. Either party may terminate this Agreement for cause if the other party is in material breach of this Agreement and the default is not cured within seven days of receipt of written notice specifying the material breach.

10.4 Other grounds for termination. This Agreement may be terminated immediately for the following reasons:

10.4.1 Physician's loss or restriction of their license for any reason.

10.4.2 Physician becomes legally incompetent; is convicted of a felony; or uses, possesses, or is found under the influence of alcohol, drugs, or other controlled substances while performing his duties under this Agreement.

10.4.3 Physician fails to maintain a professional standard of conduct in accordance with District policies.

10.4.4 Physician becomes ineligible to participate in the Medi-Cal or Medicare programs for any reason.

10.4.5 A fraud control unit of a state or federal agency determines Medical Director has or may be placing the health and safety of a patient at risk.

10.4.6 Loss or restriction of DISTRICT'S license to operate the Hospital.

10.5 Change in Law. If any federal, state or local law or regulation, or any final, non-appealable interpretation of law or regulations by a court of law or governmental agency, makes or will make substantial performance of this Agreement illegal or renders any provision hereof illegal or unenforceable, the parties shall meet and negotiate and use best efforts to modify the Agreement to resolve the concern. If the parties are unable to resolve the issue within ten (10) days after it arose, either party may elect to terminate this Agreement on ten (10) days prior written notice.

10.6 Rights on Expiration or Termination. Custody of all District records, including patient medical records, equipment, and supplies shall be turned over to District upon termination for any reason. Duplicate copies of records may be retained by PHYSICIAN, at its own expense.

11. GENERAL PROVISIONS

11.1. Other Agreements. No other agreements between the parties exist at this time.

11.2. Assignment. Neither party may assign, delegate or transfer any rights, obligations or duties hereunder without the express written approval of the other party, which approval shall not be unreasonably withheld.

11.3. Notice. All notices required by this Agreement shall be in writing, and shall be deemed effective when personally delivered; when mailed by certified or registered mail, return receipt requested; or when deposited with a comparably reliable postage delivery service (such as Federal Express); addressed to the other party as follows:

IF TO PHYSICIAN:

If TO DISTRICT:

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11.4. Records. Until the expiration of four (4) years after the furnishing of any service pursuant to this Agreement, PHYSICIAN shall make available upon written request, to the Secretary of the United States Department of Health and Human Services, or upon written request to the United States Comptroller, or any of their duly authorized representatives, under 42 C.F.R. & 420.300 et seq., or the California Department of Health Services, this Agreement, and such books, documents and records of the Physician that are necessary to certify the nature and extent of the reasonable costs of services.

11.5. No Third-Party Beneficiaries. Nothing contained in this Agreement is intended, nor shall it be construed, to create rights running to the benefit of third parties.

11.6. Attorney's Fees. In the event of a legal action or proceeding between the parties arising from this Agreement, the prevailing party shall be entitled to receive reasonable attorney's fees, costs, and other expenses, including those incurred on appeal and in the enforcement of a judgment, in addition to whatever other relief may be awarded.

11.7 Force Majeure. Neither party shall be liable or deemed in default of this Agreement for any delay or failure to perform caused by acts of God, war, disasters, strikes, or any cause reasonably beyond the control of the non-performing party.

11.8 Severability. In the event any portion of this Agreement is declared invalid or void by a court or arbitrator, such portion shall be severed from this Agreement, and the remaining provisions shall remain in effect, unless the effect of such severance would be to substantially alter the agreement or obligations of the parties, or would place either party in violation of its articles of in District or its bylaws, in which case the Agreement may be immediately terminated.

11.9 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of California, without regard to its conflict of laws principles, and is made and to be performed in the County of Inyo, California.

11.10 No Referrals. Nothing in this Agreement is intended to obligate, and shall not obligate, any party to this Agreement to refer patients to any other party.

11.11 Waiver. Any failure of a party to insist upon strict compliance with any term, undertaking or condition of this Agreement shall not be deemed to be a waiver of such term, undertaking or condition. To be effective, a waiver must be in writing, signed and dated by the parties.

11.12 Entire Agreement; Modification. This Agreement contains the entire agreement of the parties relating to this subject matter. The Agreement may only be modified in writing, signed by both parties, effective on the date set forth therein.

11.13 Execution. By their signatures below, each of the following represent that they have authority to execute this Agreement and to bind the party on whose behalf their execution is made.

Southern Inyo Healthcare District	Physician
By _____	_____

EXHIBIT A

SCOPE OF SERVICES

PHYSICIAN shall devote sufficient time and his or her best abilities to the responsibility of treating patients in the normal and customary hours of operation of the ED.

Patient Transfers. Except in circumstances of immediate jeopardy for the life of the patient, PHYSICIAN shall consult with the hospitalist of the Hospital prior to the permanent transfer of patients from the ED to other hospitals or health care providers.

Medical Care Plan System. PHYSICIAN shall participate in the development and review of a system for providing a medical care plan for ED patient covering medications, nursing care, ancillary services, admission, discharge or transfer planning, and other relevant services.

Medical Records. PHYSICIAN shall be responsible for the development and maintenance of an adequate medical record in the ED. This shall include assuring that the appropriate medical record entries are made by PHYSICIAN concerning all medical procedures and other services performed in the ED on the electronic medical record system of HOSPITAL.

Service and Equipment Adequacy. PHYSICIAN shall advise the ED Medical Director concerning the adequacy of the patient care services and medical equipment.

Responses to Administrative Questions. PHYSICIAN shall be available to respond to administrative questions regarding patients, facility bed availability, intra-facility transfer problems, and patient status.

Responses to Nursing Questions. PHYSICIAN shall be available to assist with nursing questions at the ED, including questions regarding patient transfers and patient clinical status.

Responses to Patient Problems. PHYSICIAN, when on duty, shall be available to respond to patient problems in the ED by means of chart review and patient visits, as appropriate, and respond to all in-house patient emergencies when required.

Medical Staff Commitments. Physician shall serve on such committees of Medical Staff of the District as may be appropriate after consultation with the ED Medical Director and Hospital CEO.

Utilization Review Services. Physician shall, as requested by the District, assist in the ED utilization review program of the District.

EMERGENCY DEPARTMENT PHYSICIAN AGREEMENT

This Emergency Department Physician Agreement ("Agreement") is made by Southern Inyo Healthcare District ("District") and Jasiri Kennedy, M.D. ("PHYSICIAN"), as of September 19, 2019.

RECITALS

A. District owns and operates Southern Inyo Hospital ("Hospital") located in Lone Pine, California, a Critical Access Hospital, and desires to retain Physician to provide emergency medicine services in Hospital's Emergency Department ("ED").

A. Physician is a physician duly licensed in California with a background and experience in providing emergency medicine services, and desires to be retained by District.

NOW, THEREFORE, the parties agree as follows:

TERMS

1. SCOPE OF SERVICES

District retains Physician, and Physician agrees, to provide those services identified in Exhibit A, attached hereto and incorporated by reference (the "Services").

2. PHYSICIAN'S REPRESENTATIONS AND WARRANTIES

Physician represents and warrants at the time of signing this Agreement, and at all times during the term of this Agreement, that:

2.1 Physician is duly licensed, registered and in good standing, or will become duly licensed, registered and in good standing under the laws of the State of California, to engage in the practice of medicine, and that said license and registration have not been suspended, revoked, or restricted in any manner.

2.2 Physician is qualified for and has applied for, or will apply for within a reasonable time after the signing of this Agreement, and has obtained, or will obtain within a reasonable time after the signing of this Agreement, membership (including appropriate clinical privileges) in good standing with the Medical Staff of District.

2.3 Physician has disclosed and will at all times during the term of this Agreement promptly disclose to the District: (a) the existence and basis of any legal, regulatory, professional or other proceeding against Physician instituted by any person, organization, governmental agency, health care facility, peer review organization, or professional society which involves any allegation of substandard care or professional misconduct raised against Physician and (b) any allegation of substandard care or professional misconduct raised against Physician by any person, organization, governmental agency, health care facility, peer review organization or professional society;

2.4 Physician is board certified or board qualified in emergency medicine, or possesses knowledge and skill in emergency medicine comparable to other physicians practicing emergency medicine in the District's service area.

2.5 Physician shall at all times render the Services in a competent, professional, and ethical manner, in accordance with prevailing standards of medical care and practice, and all applicable statutes, regulations, rules, orders, and directives of all applicable governmental and regulatory bodies having competent jurisdiction.

2.6 In connection with the provision of the Services, Physician shall use the equipment, instruments, electronic medical record documentation system and supplies of the District for the purposes for which they are intended and in a manner consistent with sound medical practice and District policies and procedures.

2.7 Physician shall complete and maintain, in a timely manner, adequate, legible and proper medical records, claims and correspondence with respect to the Services.

2.8 Physician shall participate in Medicare, Medi-Cal and other federal and state reimbursement programs, commercial insurance reimbursement programs, health maintenance organization, preferred provider organizations, self-insured employer reimbursement programs and any other health benefit program with which the District may contract for the provision of professional medical services.

2.9 Physician shall abide by the Medical Staff Bylaws, rules, regulations and policies.

2.10 Physician shall participate in continuing medical education and training programs required to maintain skills comparable with the standards of care in emergency medicine in the District's service area.

2.11 Physician shall satisfy all qualifications of insurability for professional liability policy or policies required, maintained or reimbursed by the District.

2.12 Physician shall deliver to the District promptly upon request copies of all certificates, registrations, certificates of insurance and other evidence of Physician's compliance with the foregoing as reasonably requested by the District.

3. RESPONSIBILITIES OF HOSPITAL

3.1 HOSPITAL shall provide appropriate space and necessary equipment within the ED for the use of Physician in the performance of the Services under this Agreement.

3.2 HOSPITAL shall make all reasonable efforts to make available ancillary services necessary for effective operation of the ER, including laboratory, imaging, pharmacy, etc.

3.3 HOSPITAL shall not involve itself in those aspects of Physician's professional practice of medicine for which a license to practice medicine is required.

4. COVERAGE.

PHYSICIAN will provide emergency physician coverage in the ED as scheduled by HOSPITAL and MEDICAL DIRECTOR. ~~However, PHYSICIAN will cover no less than _N/A__ shifts per month.~~

5. COMPLIANCE WITH LAWS

PHYSICIAN shall comply with all applicable provisions of law, and other valid rules and regulations of all governmental agencies having jurisdiction over: (i) the operation of the ED; (ii) the licensing of health care practitioners; and (iii) the delivery of services to patients of governmentally regulated third party payers whose members/beneficiaries receive services at HOSPITAL. This shall specifically include, but not by way of limitation (i) compliance with applicable provisions of Title 22, California Administrative Code; and (ii) compliance with Medicare billing, time allocation, record keeping, and record access requirements.

6. PHYSICIAN COMPENSATION.

6.1 District agrees to pay the following fees to Physician:

6.1.1 Patient Visits. District will bill patients and their payors for services provided by PHYSICIAN to those patients. Such charges shall be consistent with prevailing community charges.

6.1.2 Emergency Department Patient Visit Fees. District will pay PHYSICIAN $_N/A_ per visit for all patients treated with their charts completed by _N/A__.

Commented [SN1]: The doctor is only getting paid for standby time?

6.1.3 Stand-By Hours. In addition to the compensation in 6.1.2, District will compensate PHYSICIAN at $100.00 per hour for all hours worked on site covering the Emergency Department.

6.1.6 HOSPITAL is responsible for the payments due to PHYSICIAN. Therefore, physician should only look to the HOSPITAL for amounts due and not to MEDICAL DIRECTOR or HOSPITAL'S patients.

6.2 Timing of Payment. HOSPITAL will pay PHYSICIAN monthly by the 15 day of the next month following that month in which the services are rendered.

Commented [SN2]: Is this correct?

6.3 Holiday Minimum. The minimum payment for the following holidays will be –Time and a Half–: New Year's Day, Easter Sunday, Memorial Day, 4th of July, Labor Day, Thanksgiving Day, and Christmas Day.

6.4 Continuing Medical Education. PHYSICIAN shall be entitled to N/A hours of paid continuing medical education time after each six-month period in which PHYSICIAN has worked at least the minimum shifts in the emergency department as required under article 4.0 of this agreement.

6.5 PHYSICIAN will be entitled to purchase group health insurance through the DISTRICT plan at the then current cost of the health insurance to the District or the COBRA rate.

7. INDEPENDENT CONTRACTOR

7.1 PHYSICIAN is an independent contractor, and is not, by virtue of this Agreement, an employee, partner of, or joint venturer with District.

7.2 Physician may not make any claim against District under this Agreement for social security benefits, worker's compensation benefits, unemployment insurance benefits, health benefits, vacation pay, sick leave, or any other employee benefits of any kind.

7.3 District shall not exercise any direct control over any medical decisions made by Physician while performing the Services at the ED.

8. INSURANCE AND INDEMNIFICATION

8.1. Coverage. PHYSICIAN will be covered by the District's Professional and Liability Insurance through BETA Healthcare Group ("BETA") for a minimum of $1,000,000 per occurrence, $3,000,000 aggregate, for the Services rendered under this Agreement. It is understood and agreed that BETA provides Continuous Coverage for departed providers, except the coverage is limited to claims made and reported against the provider for Services provided during the term of this Agreement.

8.2. Indemnification. Each party ("Indemnitor")agrees to defend, indemnify and hold the other party ("Indemnitee") and its representatives, agents, successors and assigns harmless from any and all damages, claims, judgments, losses, costs and expenses, including attorney's fees, which may hereinafter at any time be incurred, suffered, sustained by or imposed upon Indemnitee or its representatives, agents, successors or assigns, which may be due or required to be paid or performed by reason of, arising out of, by virtue of, or incident to the performance or the rendering of any of the obligations of Indemnitor hereunder, including but not limited to, any such damages, claims, judgments, losses, costs or expenses attributable to bodily injury, sickness, disease or death or injury or to destruction of tangible property which is caused in whole or in part by the negligent act or omission of Indemnitor, or anyone directly employed by or acting on behalf of Indemnitor but not as a result of the negligence of Indemnitee, its representatives, servants or agents.

9. NONDISCRIMINATION

Services are to be available to all patients, in accordance with District's nondiscrimination policies, and in accordance with any established policies relating to free or charity care. Physician shall not refuse to provide services to any patient at the Hospital, regardless of ability to pay.

10. TERM AND TERMINATION

10.1 Term. This Agreement shall be effective as of September 19, 2019 and shall terminate on September 20, 2020. Upon mutual agreement, not later than 90 days prior to

expiration of the current term, the District and Physician may extend this Agreement for two additional one-year terms.

10.2 Termination without cause. During the initial 120 days of this Agreement, either party may, without cause, terminate this Agreement with 10-days written notice to the other party. Thereafter, this Agreement may be terminated upon 60-days written notice to the other party. This agreement may be terminated at any time by the mutual consent of both parties.

10.3 Termination for cause. Either party may terminate this Agreement for cause if the other party is in material breach of this Agreement and the default is not cured within seven days of receipt of written notice specifying the material breach.

10.4 Other grounds for termination. This Agreement may be terminated immediately for the following reasons:

10.4.1 Physician's loss or restriction of their license for any reason.

10.4.2 Physician becomes legally incompetent; is convicted of a felony; or uses, possesses, or is found under the influence of alcohol, drugs, or other controlled substances while performing his duties under this Agreement.

10.4.3 Physician fails to maintain a professional standard of conduct in accordance with District policies.

10.4.4 Physician becomes ineligible to participate in the Medi-Cal or Medicare programs for any reason.

10.4.5 A fraud control unit of a state or federal agency determines Medical Director has or may be placing the health and safety of a patient at risk.

10.4.6 Loss or restriction of DISTRICT'S license to operate the Hospital.

10.5 Change in Law. If any federal, state or local law or regulation, or any final, non-appealable interpretation of law or regulations by a court of law or governmental agency, makes or will make substantial performance of this Agreement illegal or renders any provision hereof illegal or unenforceable, the parties shall meet and negotiate and use best efforts to modify the Agreement to resolve the concern. If the parties are unable to resolve the issue within ten (10) days after it arose, either party may elect to terminate this Agreement on ten (10) days prior written notice.

10.6 Rights on Expiration or Termination. Custody of all District records, including patient medical records, equipment, and supplies shall be turned over to District upon termination for any reason. Duplicate copies of records may be retained by PHYSICIAN, at its own expense.

11. GENERAL PROVISIONS

11.1. Other Agreements. No other agreements between the parties exist at this time.

11.2. Assignment. Neither party may assign, delegate or transfer any rights, obligations or duties hereunder without the express written approval of the other party, which approval shall not be unreasonably withheld.

11.3. Notice. All notices required by this Agreement shall be in writing, and shall be deemed effective when personally delivered; when mailed by certified or registered mail, return receipt requested; or when deposited with a comparably reliable postage delivery service (such as Federal Express); addressed to the other party as follows:

IF TO PHYSICIAN:

If TO DISTRICT:

Formatted: Highlight

11.4. Records. Until the expiration of four (4) years after the furnishing of any service pursuant to this Agreement, PHYSICIAN shall make available upon written request, to the Secretary of the United States Department of Health and Human Services, or upon written request to the United States Comptroller, or any of their duly authorized representatives, under 42 C.F.R. & 420.300 et seq., or the California Department of Health Services, this Agreement, and such books, documents and records of the Physician that are necessary to certify the nature and extent of the reasonable costs of services.

11.5. No Third-Party Beneficiaries. Nothing contained in this Agreement is intended, nor shall it be construed, to create rights running to the benefit of third parties.

11.6. Attorney's Fees. In the event of a legal action or proceeding between the parties arising from this Agreement, the prevailing party shall be entitled to receive reasonable attorney's fees, costs, and other expenses, including those incurred on appeal and in the enforcement of a judgment, in addition to whatever other relief may be awarded.

11.7 Force Majeure. Neither party shall be liable or deemed in default of this Agreement for any delay or failure to perform caused by acts of God, war, disasters, strikes, or any cause reasonably beyond the control of the non-performing party.

11.8 Severability. In the event any portion of this Agreement is declared invalid or void by a court or arbitrator, such portion shall be severed from this Agreement, and the remaining provisions shall remain in effect, unless the effect of such severance would be to substantially alter the agreement or obligations of the parties, or would place either party in violation of its articles of in District or its bylaws, in which case the Agreement may be immediately terminated.

11.9 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of California, without regard to its conflict of laws principles, and is made and to be performed in the County of Inyo, California.

11.10 No Referrals. Nothing in this Agreement is intended to obligate, and shall not obligate, any party to this Agreement to refer patients to any other party.

11.11 Waiver. Any failure of a party to insist upon strict compliance with any term, undertaking or condition of this Agreement shall not be deemed to be a waiver of such term, undertaking or condition. To be effective, a waiver must be in writing, signed and dated by the parties.

11.12 Entire Agreement; Modification. This Agreement contains the entire agreement of the parties relating to this subject matter. The Agreement may only be modified in writing, signed by both parties, effective on the date set forth therein.

11.13 Execution. By their signatures below, each of the following represent that they have authority to execute this Agreement and to bind the party on whose behalf their execution is made.

Southern Inyo Healthcare District	Physician
By _____	_____

EXHIBIT A

SCOPE OF SERVICES

PHYSICIAN shall devote sufficient time and his or her best abilities to the responsibility of treating patients in the normal and customary hours of operation of the ED.

Patient Transfers. Except in circumstances of immediate jeopardy for the life of the patient, PHYSICIAN shall consult with the hospitalist of the Hospital prior to the permanent transfer of patients from the ED to other hospitals or health care providers.

Medical Care Plan System. PHYSICIAN shall participate in the development and review of a system for providing a medical care plan for ED patient covering medications, nursing care, ancillary services, admission, discharge or transfer planning, and other relevant services.

Medical Records. PHYSICIAN shall be responsible for the development and maintenance of an adequate medical record in the ED. This shall include assuring that the appropriate medical record entries are made by PHYSICIAN concerning all medical procedures and other services performed in the ED on the electronic medical record system of HOSPITAL.

Service and Equipment Adequacy. PHYSICIAN shall advise the ED Medical Director concerning the adequacy of the patient care services and medical equipment.

Responses to Administrative Questions. PHYSICIAN shall be available to respond to administrative questions regarding patients, facility bed availability, intra-facility transfer problems, and patient status.

Responses to Nursing Questions. PHYSICIAN shall be available to assist with nursing questions at the ED, including questions regarding patient transfers and patient clinical status.

Responses to Patient Problems. PHYSICIAN, when on duty, shall be available to respond to patient problems in the ED by means of chart review and patient visits, as appropriate, and respond to all in-house patient emergencies when required.

Medical Staff Commitments. Physician shall serve on such committees of Medical Staff of the District as may be appropriate after consultation with the ED Medical Director and Hospital CEO.

Utilization Review Services. Physician shall, as requested by the District, assist in the ED utilization review program of the District.

OSHPD Office of Statewide Health Planning and Development

Facilities Development Division
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
(916) 440-8300
(916) 324-9188 Fax
www.oshpd.ca.gov/fdd

September 3, 2019

Peter Spiers
CEO
Southern Inyo Hospital
PO Box 1009
Lone Pine, CA 93545

RE: AB 2190 Attestation Reminder
Southern Inyo Hospital - 10202
501 East Locust Street, Lone Pine, CA 93545

Dear Ms. Spiers:

This letter is to advise you that Assembly Bill 2190 (2018) requires the governing board for each hospital facility that is not in full compliance with the Hospital Facilities Seismic Safety Act to submit an attestation of their awareness of the January 1, 2030 deadline in a form of their choice to the Office of Statewide Planning and Development.

> *Health & Safety Code Section 130066: Before January 1 2020, the owner of an acute care inpatient hospital whose building does not substantially comply with the seismic safety regulations or standards described in Section 130065 shall submit to the office an attestation that the board of directors of that hospital is aware that the hospital building is required to meet the January 1, 2030, deadline for substantial compliance with those regulations and standards.*

You are receiving this reminder because one or more of the buildings at your facility has performance ratings less than SPC-3 or NPC-5 as required by January 1, 2030. A previous reminder was sent on July 23, 2019.

Attestations may be mailed to the address above or emailed to SeismicComplianceUnit@oshpd.ca.gov not later than January 1, 2020. Please specify the facility name and number for each facility for which attestation is made.

If you need further information regarding AB 2190, you may visit our web site at http://www.oshpd.ca.gov.

Sincerely

Carl Scheuerman
Compliance Officer
Seismic Compliance Unit
Facility Development Division
t: 916.440.8330
f: 916.324.9188
e: carl.scheuerman@oshpd.ca.gov

SOUTHERN INYO
HEALTHCARE DISTRICT

Volunteer Program

Onboarding Process:

- Application: Student Specific Application (Attached)
    - Parent's permission slip to volunteer for underage (must create)
- Interview: Group or Individual
    - Find specific areas of interest of volunteers and find related tasks if possible
- Job Description: Activities Aide
    - Optional job duties: Other department tasks
- Orientation: Volunteer orientation includes HIPPA, Infection Control, Harassment…ect. (Checklist attached)
    - Fire safety tour
    - Facility tour
    - Employee speakers: Peter Heil (Activities Director), Jay Hinek (SNF DSD), Barbara Southey (Human Resources Manager), Department manager (in regards to specific job duties)
    - Volunteer Badge
    - Uniform: Hospital Color (Blue shirt) possible requirement
- After volunteer hours completed: Certification/Letter of Completion given (must create)

Notes:

Volunteers are covered under District Workman's Compensation

Southern Inyo Healthcare District
501 E. Locust St. P.O. Box 1009 Lone Pine, CA 93545
Phone: 760-876-5501 Fax: 760-876-2268 (Administration)

VOLUNTEER APPLICATION FORM

Name: _____
(last) (first) (middle)

Birth Date: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____STUDENT_____

Hobbies, Activities, Skills, Special Interest: _____

_____

Community Affiliations (clubs, committees, church, etc.): _____

_____

Days Preferred for Routine Work: _____

Hours Preferred for Routine Work: _____

Would you consider volunteering for Special Events? _____

IN CASE OF AN EMERGENCY:

First Contact: _____ Phone: _____

Second Contact: _____ Phone: _____

Signature: _____ Date: _____

Southern Inyo Healthcare District

Contractor, Volunteer & Student Orientation

Hospital Wide Orientation (HR)

1. __ The following information has been discussed with me from the Personnel Policies:
   a. Harassment Information.
   b. Rest breaks, meal breaks, smoking, parking.
   c. The importance of wearing my name badge.
2. __ I have received, read and understand the following SIHD policies:
   a. Alcohol and Substance Abuse.
   b. Personal Appearance of Staff.
   c. Privacy of Residents/Patients.
   d. Confidentiality (HIPPA).
   e. Use of Telephones and Cell Phones.
   f. Theft and Loss Program.
3. __ I have been in-serviced on (video/presentation):
   a. Respecting Confidentiality.
   b. HIPPA Privacy Compliance.
   c. Safety Orientation for Healthcare (Proper hand washing, PPE).
   d. Infection Control (Blood borne pathogens, Body Substance Isolation).
   e. Harassment Is… (Video).
   f. Disruptive Behavior (Video).
4. __ SNF EMPLOYEES ONLY: I have completed the Dementia In-Service Packet: Dementia Fact Sheets, Alzheimer's Patient Prayer, Word Search, Dementia Exercises (1hour).
5. __ I have been trained on the following SIHD policies and procedures:
   a. Elder Justice Act/Abuse Prevention and Reporting (Video and P&P).
   b. Resident Rights (Video).
   c. Dementia & Alzheimer's Caregiving (Video)..
6. __ I have been given a tour of the facility.

_____ _____
Human Resources Signature Date

Fire Safety Orientation (Maintenance/HR)

1. __ I have been shown the Code Red-Fire Policy & Procedure, Fire Exits, Extinguishers/Alarm Pulls, Evacuation Plan, Red Plugs and the location of Material Safety Data Sheets (MSDS).

_____ _____
Maintenance Rep/HR Signature Date

Emergency/Disaster Orientation (Nursing Services/HR)

1. __ I have received training on the Hospital Emergency Codes and Disaster Plan.

_____ _____
Nursing Services Rep/HR Signature Date

__ I have been given an opportunity to ask any questions regarding the above topics, or questions regarding other areas not previously discussed.

_____ _____ _____
Staff's Name, Position (Please Print) Signature Date

Southern Inyo Healthcare District

COMPETENCY BASED JOB DESCRIPTION/PERFORMANCE EVALUATION

SNF Activity Aide

Name: Student Volunteer
Job Title: Activity Aide
Department: SNF
Supervisor: Activities Director
SNF DON
Supervises:

Level:
Date Created: 5/5/2011
Last Revision:

JOB SUMMARY: Ensures maintenance of a quality activity program designed to meet the interests and the physical, mental, and psychosocial well-being of each resident, utilizing staff expertise, family and community resources under the direction of the Activities Directors.

MINIMUM QUALIFICATIONS:

Education:
High School

Experience:
Have one year of experience in a social or recreational program preferred

License or Certification:
CNA and CPR Preferred

OTHER QUALIFICATIONS REQUIRED:
Ability to communicate clearly in both oral and written forms using the English language. Ability to respond to common inquiries or complaints from residents, patients, physicians, peers, regulatory agencies, or members of the business community.

Specialized Skills:

General Measurement Criteria:

Meets Expectations/standards: Successfully meets established goals. Demonstrates competencies critical to job performance. Maintains knowledge base required to perform job responsibilities.

Does Not Meet Expectations/standards: Established goals and responsibilities are not met. Does not demonstrate competencies critical to job performance. Continued guidance or supervision required to meet expectations. Needs to improve performance immediately. **Note:** A performance improvement plan is required for employees receiving a **Does Not Meet** rating.

Southern Inyo Healthcare District

COMPETENCY BASED JOB DESCRIPTION/PERFORMANCE EVALUATION

ESSENTIAL DUTIES AND RESPONSIBILITIES:

- Carry out monthly activities based on calendar
- Assist with the Resident Council.
- Maintain participation records reflecting the implementation of each resident's plan.
- Assist with shopping needs, appointments, special program and decorations for residents.
- Assist departmental volunteers
- Maintain compliance with State and Federal regulations and facility policies regarding activity programs.
- Complete proper documentation to include but not limited to: Psycho/Social response to progress in activity program, Response to introduction, continuation or changes in psychotropic medications, Quarterly and annual review of resident programs through the MDS process to include MDS documentation, RAPS as indicated, care plan review, psycho/social interactions and discharge potential review.
- Seeks assistance and/or resources appropriately
- Other duties as assigned by the Activities Directors, SNF Supervisor or Director of Nurses Services

Note: The above statements are intended to describe the general nature and level of work being performed by people assigned to this job. This document is not intended to be an exhaustive list of all responsibilities, skills and working conditions for the personnel that are classified.

I accept the responsibilities and authorities of this position. I realize that my evaluation will be based on this job description.

_____ _____

Employee/Volunteer Signature Date

Progress on program:

Currently in talks with the Lone Pine High School Principal, Joseph Garza, in regards to the volunteer program. He is very interested in having a set agreement that would involve having a steady stream of students volunteering their time and (hopefully) eventually a C.N.A. program with the facility.

Joseph has mentioned using their generalized permission slips for parent approval for the underage students in regards to the program.

He also mentioned a job fair which is still in its first steps to be set up and ready in February 2020. He is hoping we will be able to attend.

Joseph's contact information

(760) 912-5215

JGARZA@LPUSD.K12.CA.US

RESOLUTION NO. 19-7

A RESOLUTION OF THE BOARD OF DIRECTORS TO CHANGE THE AUTHORIZED SIGNATORY FOR THE SOUTHERN INYO HEALTHCARE DISTRICT BANK ACCOUNTS

Whereas, Southern Inyo Healthcare District, a public entity, has funds held in accounts at El Dorado Savings Bank.

Whereas, the authorized persons for the District accounts require updating based on the hiring of a new Chief Executive Officer; and

Whereas, the following persons be added and hereby are authorized to sign/execute and submit all the necessary papers, letters, agreements, documents, and writings to El Dorado Savings Bank as may be required for day-to-day transactions, operations, and correspondence:

Name of Authorized Signatory	**Title/Position**
Peter Spiers	**Chief Executive Officer**

Now, therefore, be it resolved that the Board of Directors approves the above individuals to be added to the authorized persons listed for all District bank accounts (General Acct. 24-300-75106, Payroll Acct. 24-30-217508, Patient Trust Acct. 2430-217207, Special Tax Acct. 243-04-6398 and Business Acct. 243-053865), and authorizes the Board President to take all necessary actions to update the authorized signatories.

Passed, approved, and adopted on the _19_ day of September 2019.

_____
Jaque Hickman, President

ATTEST

_____
Carma Roper, Secretary

Southern Inyo Healthcare District
501 E. Locust St. P.O. Box 1009 Lone Pine, CA 93545
Phone: 760-876-5501 Fax: 760-264-4292

STAFF MEMORANDUM

TO: Board of Directors

FROM: **Accounts Payable**

SUBJECT: **Proposed changes to Accounts Payable Clerk Position Description**

MEETING DATE: 09.10.2019

Purpose:

In order to recruit a more qualified Accounts Payable Clerk I have requested HR to include additional requirements of Essential Duties & Responsibilities along with Physical Demands.

In particular, under Essential Duties and Responsibilities: "Other duties and responsibilities as assigned by Staff Accountant and/or CFO"; under Physical Demands and Requirements: "Must be able to read small print and have visual dexterity to work with computers".

Impacts:

Fiscal: None – Part Time position was previously occupied and now vacant.

Regulatory: None
Environmental: NA

Legal Review: Reviewed by counsel….yes

Recommended Action:

Approve the amended Accounts Payable Clerk Position Description as presented. Authorized Human Resources to post the position, accept applications and schedule interviews.

Requested by: Anita Sonke, Staff Accountant and Barbara Southey, HR Director

Southern Inyo Healthcare District
Accounts Payable Clerk

Part-Time (24 hours per week as assigned)

Position Summary:

Under the general direction of the Staff Accountant, prepare invoices for payment processing, process accounts payable checks, research problem invoices, maintain computer and paper account payable files.

Qualifications and Experience Required:

- Ability to communicate clearly in both oral and written forms using the English Language.
- Prior experience with accounting software programs, minimum 2 years.
- Experience using Microsoft Windows and Microsoft Office Applications (Excel, Word, and Outlook).
- Ability to respond to common inquiries or complaints from physicians, peers, regulatory agencies, or members of the business community.
- Strong organizational and communication (written and verbal) skills.
- Ability to build good professional report and interpersonal relationships across multiple departments and outside entities.
- Minimum High School education.

Essential Duties and Responsibilities:

Demonstrates Competency in the following areas;

- Enters accurate vendor data into accounting software and ensure all invoices are coded to the correct G/L Accounts and cost centers.
- Verify that there are no duplicates from Vendor.
- Reviews accounting data for accuracy.
- Prepare check runs, submit checks for signature(s).
- Process expedite/special check requests in a timely and positive manner.
- File paid vouchers and payment evidence to serve as an audit trail.
- Reconcile vendor accounts for accuracy relating to paid and un-paid balances
- Respond to vendor phone and e-mail requests in a professional manner and include supervisor, CEO, CFO in all correspondence back to vendors.
- Other duties and responsibilities as assigned by Staff Accountant and/or CFO.

Physical Demands and Requirements:

- Must be able to walk, sit, and stand for long periods of time.
- Frequently lifts, pulls, pushes and moves various weights up to 15 pounds. (Office equipment, storage boxes, etc.).
- Requires manual dexterity for operating office equipment and devices.
- Must be able to read small print and have visual dexterity to work with computers.
- Must be able to complete assessments to hear telephone and general conversation.

Application Process:

- Qualified candidates can obtain an employment application online at: www.sihd.org/careers and submit to: hr@sihd.org, send by US Mail or drop off in person to SIHD's Human Resources Department.
- Internal applicants will be considered upon completion of an Internal Job Application Form.
- Position will close when filled.

Southern Inyo Healthcare District
COMPETENCY BASED JOB DESCRIPTION/PERFORMANCE EVALUATION

ACCOUNTS PAYABLE CLERK
Part-Time (24 hours per week as assigned)

Name:			
Job Title:	Accounts Payable Clerk	**Level:**	Non-exempt
Department:	Accounting	**Date Created:**	
Supervisor:	Staff Accountant	**Last Revision:**	9/19
Supervises:			

JOB SUMMARY: Under the general direction of the Staff Accountant, prepare invoices for payment processing, process accounts payable checks, research problem invoices, maintain computer and paper account payable files.

MINIMUM QUALIFICATIONS:

Education:

High School

Experience:

Hospital accounting experience preferred

Experience with computerized accounting systems

License or Certification:

None

QUALIFICATIONS AND EXPERIENCE REQUIRED:

- Ability to communicate clearly in both oral and written forms using the English Language.
- Prior experience with accounting software programs, minimum 2 years.
- Experience using Microsoft Windows and Microsoft Office Applications (Excel, Word, and Outlook).
- Ability to respond to common inquiries or complaints from physicians, peers, regulatory agencies, or members of the business community.
- Strong organizational and communication (written and verbal) skills.
- Ability to build good professional report and interpersonal relationships across multiple departments and outside entities.

ESSENTIAL DUTIES AND RESPONSIBILITIES:

Demonstrates Competency in the following areas;

1. Enters accurate vendor data into accounting software and ensure all invoices are coded to the correct G/L Accounts and cost centers.
2. Verify that there are no duplicates from Vendor.
3. Reviews accounting data for accuracy.
4. Prepare check runs, submit checks for signature(s).
5. Process expedite/special check requests in a timely and positive manner.
6. File paid vouchers and payment evidence to serve as an audit trail.
7. Reconcile vendor accounts for accuracy relating to paid and un-paid balances.
8. Respond to vendor phone and e-mail requests in a professional manner and include supervisor, CEO, CFO in all correspondence back to vendors.
9. Other duties and responsibilities as assigned by Staff Accountant and/or CFO.

Southern Inyo Healthcare District
COMPETENCY BASED JOB DESCRIPTION/PERFORMANCE EVALUATION

PHYSICAL DEMANDS AND REQUIREMENTS

1. Must be able to walk, sit, and stand for long periods of time.
2. Frequently lifts, pulls, pushes and moves various weights up to 15 pounds. (Office equipment, storage boxes, etc.).
3. Requires manual dexterity for operating office equipment and devices.
4. Must be able to read small print and have visual dexterity to work with computers.
5. Must be able to complete assessments to hear telephone and general conversation.

General Measurement Criteria:

Meets Expectations/standards: Successfully meets established goals. Demonstrates competencies critical to job performance. Maintains knowledge base required to perform job responsibilities.

Does Not Meet Expectations/standards: Established goals and responsibilities are not met. Does not demonstrate competencies critical to job performance. Continued guidance or supervision required to meet expectations. Needs to improve performance immediately. **Note:** A performance improvement plan is required for employees receiving a **Does Not Meet** rating.

Note: The above statements are intended to describe the general nature and level of work being performed by people assigned to this job. This document is not intended to be an exhaustive list of all responsibilities, skills and working conditions for the personnel that are classified.

I accept the responsibilities and authorities of this position. I realize that my evaluation will be based on this job description.

_____ _____
Employee Signature Date

Southern Inyo Healthcare District
COMPETENCY BASED JOB DESCRIPTION/PERFORMANCE EVALUATION

ACCOUNTS PAYABLE CLERK

POTENTIAL JOB HAZARDS:	**PHYSICAL DEMANDS:**
Hazardous materials pertinent to this position are described in the department's Material Safety Data Sheets (MSDS) manual.	The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

WORK ENVIRONMENT:
The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable the individuals to perform the essential functions.

C = Constant (76-100%)	**F** = Frequent (51-76%)	**O** = Occasional (26-50%)	**S** = Seldom (1-25%)	**N** = Never (0%)

E – Regardless of frequency, this activity is indispensable. **M** – This activity is useful and helpful but not absolutely essential.

Basic Skills:	**C**	**F**	**O**	**S**	**N**	**E**	**M**
Reading		X				X	
Writing		X				X	
Math		X				X	
Talking			X			X	
Hearing		X				X	
Hand Functions:	**C**	**F**	**O**	**S**	**N**	**E**	**M**
Pinch					X	X	
Simple Grasp		X				X	
Power Grasp			X			X	
Fine Manipulations		X				X	
Physical:	**C**	**F**	**O**	**S**	**N**	**E**	**M**
Sitting		X				X	
Walking			X			X	
Standing				X		X	
Bending (waist)			X			X	
Twisting (waist)		X				X	
Squatting				X			
Climbing					X		
Knelling					X		
Crawling					X		
Balance					X		
Bending (neck)			X			X	
Turning (neck)			X			X	
Reach (below waist				X			
Reach (above waist				X			
Reach(shoulder)				X			
Reach(over should				X			
Pushing					X	X	Force
Pulling					X	X	Force

Office: (State Frequency)		
Key Board		E
Mouse		E

D=Day W=Week M=Month

Driving (list hrs.	D	W	M
Truck			
Van			
Forklift			

Environment Factors: (State Freq.)		
Outdoor	N	
Heights	N	
Dust	N	
Gas	N	
Fumes	N	
Uneven Ground	N	
Excessive Noise	S	
Extreme Heat	N	
Extreme Cold	N	
Wet	N	
Humid	N	
Steam	N	
Bloodborne Path.	N	
Radiation	N	
Latex	N	
Sharps	N	
Hostility	S	
Foot Controls	N	
Machinery	S	
Hazardous Materials	N	

Check: ☐Min ☐Mod ☐Max

Check: ☐Min ☐Mod ☐Max

Key **: Below waist=BW Waist=W Shoulder=S Above Shoulder=AS

	Lifting		**Carrying**		
Weight:	Frequency	Height**	Frequency	Distance	
0-10 lbs	O	1-2'	O	1-2 yards	
11-25 lbs	N				
26-50 lbs	N				
Over 50 lbs.	N				

List objects lifted or carried: Binders, computer paper, storage boxes,

Vision: ☒ close vision ☒ distance vision ☒ color vision ☒ ability to adjust focus ☐ peripheral vision ☐ depth perception

Southern Inyo Healthcare District
COMPETENCY BASED JOB DESCRIPTION/PERFORMANCE EVALUATION

ACCOUNTS PAYABLE CLERK

New employees are expected to be able to demonstrate competence in the job duties listed on the following page(s) within 90 days of hire.

Orientation Checklist and Competency Confirmation

This job description is not intended to be all-inclusive and employee will also perform other reasonably related duties as assigned by their Supervisor or his/her designee as needed.

Employee Name: _____ Date of Hire:_____

Supervisor: _____ Evaluation Period:_____

Competency Demonstrated by: (Obs.) = Observation (Art.) = Articulation (Doc.) = Documentation Review (Ts) = Test						
Job Function Description	***Emp Initial**	**Competency Demonstration Method(s)**	**Notes on Demonstrated Results (including method)**	**MS**	**DNMS ***	**OTHER**
Maintains orderly system for invoice/purchase order matching and filing						
Correctly expenses invoices to general ledger						
Prompt and accurate entry of invoices into computer system				☐	☐	☐
Accurately balances invoices to computer reports. Audits reports prior to payment processing				☐	☐	☐
Processes payment checks according to schedules set by management				☐	☐	☐
Organizes work load and schedules payment processing with minimum supervision				☐	☐	☐
Contacts vendors promptly to resolve any invoicing problems				☐	☐	☐
Prepares non-computerized checks promptly and accurately when necessary				☐	☐	☐
Insures all required levels of approval are present prior to payment of invoices.				☐	☐	☐
All other duties as				☐	☐	☐

Southern Inyo Healthcare District
COMPETENCY BASED JOB DESCRIPTION/PERFORMANCE EVALUATION

assigned						
MS = Meets Standards **DNMS** = Does Not Meet Standards **OTHER** = **LME**- Limited or No Experience at this time **NA** – Not Applicable at this time for this position ***Must Comment**						

☐ **Job Competency Demonstrated** ***Note: Employee initials acknowledges receipt of training on each job duty above.**

☐ **Job Competency not demonstrated, plan for additional training and review:**

_____ _____ _____

Supervisor Signature Employee Signature Date of Review

Southern Inyo Healthcare District
COMPETENCY BASED JOB DESCRIPTION/PERFORMANCE EVALUATION

	ORGANIZATION-WIDE COMPETENCIES	MS	DNMS *
1.	**Initiative** • Ability to originate constructive ideas. • Accepts responsibility without the need for follow-up and acts independently without special instructions.	☐	☐
2.	**Dependability** • Ability to follow directions and complete assigned responsibilities on time. • Follows through on assignments to conclusion.	☐	☐
3.	**Safety and Infection Control** • Conscientiously follows department safety regulations and guidelines.	☐	☐
4.	**Time Management** • Is able to organize daily activity and complete assigned tasks in a reasonable amount of time. • Performs routine work without being told/reminded/directed.	☐	☐
5.	**Flexibility** • Accepts change positively. • Works multiple tasks simultaneously and absorbs and accepts additional responsibilities. • Is able and willing to accept alternate assignments as necessary.	☐	☐
6.	**Unit/Department Meetings** • Demonstrates regular attendance. • Actively participates in and contributes ideas/suggestions at meetings.	☐	☐
7.	**Employee Conduct / Policies & Procedures / Compliance / Confidentiality** • Maintains compliance with principles of accepted employee conduct as identified in the Employee Handbook. • Maintains compliance with Southern Inyo Healthcare District and/or Departmental policies, procedures and/practices. • Adheres to compliance principles as set forth in the District's Compliance Program. • Maintains confidentiality as per SIHD policy and/or complies with the Health Insurance Portability and Accountability Act (HIPAA) regulations. • Demonstrates good judgment concerning sensitive verbal and written communications. • Refrains from discussing internal and external customers (patients, residents, visitors, peers, physicians, volunteers, and others) in public areas or anywhere conversation can be overheard. • Works effectively as a team member, offering assistance to other staff when own tasks are completed.	☐	☐
Overall rating for Organization-Wide Competencies *(Must have "MS" on at least 6 for overall "MS" rating.)*		☐	☐
Areas for Growth/Comments (optional) _____			

Southern Inyo Healthcare District
COMPETENCY BASED JOB DESCRIPTION/PERFORMANCE EVALUATION

	WORK HABITS	MS	DNMS *
1.	**Maintains up-to-date licensure and registrations, certifications and health records as applicable to position**. Examples are: • Professional license/certification, CPR certification, ACLS/PALS certification. • TB Screening and annual physical completed on time with minimal reminders.	☐	☐
2.	**Completes required annual mandatory training.** • Received passing score. • Completes modules on time, with minimal reminders.	☐	☐
3.	**Adheres to hospital policy and procedure regarding absenteeism and tardiness.** • Is on time, dressed in work attire and begins work at the start of the shift. • Plans for vacation and personal time away from work. • Follows procedures to request time off. • Anticipates and plans for fluctuations in workload. • Consults manager regarding scheduling issues in advance or as soon as practicable. • Responds to adjustment in schedule with professionalism.	☐	☐
4.	**Adheres to the dress code policy.** • Wears ID badge displayed according to policy. • Complies with the hospital and departmental dress code and maintains a professional image at all times.	☐	☐
5.	**Does not allow personal issues (good or bad) to interfere with completing duties or to disrupt the work setting.** • Uses work time to complete work and uses break time for personal business and/or discussions. • Limits personal phone calls using work phone lines during work hours. • Asks for a day off to take care of personal business rather than leaving the workplace during the shift. • Does not distract coworkers.	☐	☐
6.	**Uses ergonomic principles and good body mechanics.** • Adjusts chair, computer keyboard, telephone and monitor to prevent injury. • Uses lift/transfer equipment according to policy. • Obtains assistance when load is too heavy.	☐	☐
Overall rating for Work Habits Competencies *(Must have "MS" on at least 5 for overall "MS" rating.)*		☐	☐
Areas for Growth/Comments (optional) _____			

Southern Inyo Healthcare District

COMPETENCY BASED JOB DESCRIPTION/PERFORMANCE EVALUATION

CUSTOMER SERVICE		MS	DNMS *
Promotes a cooperative working relationship with all team members, physicians, peers, other disciplines and all other internal and external customers by:			
1.	**Displaying honesty, respect and integrity – for others and for the organization as evidenced by:** • Supporting of patients rights. • Treating internal and external customers as the most important part of the job. • Being sensitive to customer's emotions, thoughts and feelings. • Supporting the hospital's mission. • Refraining from negative comments of any kind where the public and/or others can hear. Instead, takes appropriate actions to resolve the concern. • Adhering to the hospital's Parking and, if applicable, Smoking Policies for the convenience and safety of hospital visitors and volunteers.	☐	☐
2.	**Displaying sensitivity to cultural, age differences and persons with disabilities as evidenced by:** • Refraining from judging other individuals based on their age, ethnic or cultural origin or disability. • Refraining from making generalizing statements about ethnic or cultural groups. • Understanding and respecting the needs of different age groups, such as the very elderly and the young.	☐	☐
Overall rating for Customer Service *(Must have "MS" on at least 1 for overall "MS" rating.)*		☐	☐
Areas for Growth/Comments (optional) _____			

Southern Inyo Healthcare District
COMPETENCY BASED JOB DESCRIPTION/PERFORMANCE EVALUATION

Employee Comments (optional):

_____

_____

_____

_____

_____

Supervisor's Comments (optional):

_____

_____

_____

_____

_____

_____

ANNUAL COMPETENCY BASED PERFORMANCE EVALUATION RATING

MEETS SIHD STANDARDS _____ (Must have overall "MS" for each performance category.)

DOES NOT MEET SIHD STANDARDS _____ (Developmental Action Plan Attached)

Evaluator's Signature _____ Date: _____

Administrative Approval _____ Date: _____

I have reviewed my job description and this evaluation with my manager. My signature below does not necessarily reflect agreement with the contents of the evaluation.

Employee's Signature _____ Date: _____

Southern Inyo Healthcare District
COMPETENCY BASED JOB DESCRIPTION/PERFORMANCE EVALUATION

Employee's Name: _____ Job Title: _____ Date: _____

Developmental Goals / Training Needs / Improvement

Failure to successfully complete a Plan for Improvement may result in disciplinary action, up to and including termination**.**

Signature: _____ _____
Employee Date

_____ _____
Department Manager Date

AMERICAN MEDICAL ASSOCIATION
INTERNAL USE LICENSE AGREEMENT

Vistex Company ID: 3055
Vistex Contract ID: 101689
Access Contract ID: 9126

This Internal Use License Agreement ("Agreement"), dated as of September 1, 2019 ("Effective Date") is made by and between the American Medical Association, an Illinois not-for-profit corporation located at 330 North Wabash Avenue, Suite 39300, Chicago, Illinois 60611-5885, United States of America ("AMA") and Southern Inyo Hospital, 501 E. Locust Street, Lone Pine, CA 93545, United States of America ("Licensee").

In consideration of the mutual covenants, terms, and conditions set forth herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. **Licensed Content**. "Licensed Content" means the data file(s) published by the AMA in the English Language as used in the United States, as identified on Schedule A-1. The Licensed Content is licensed, not sold, to Licensee.

2. **Grant of Rights**. Subject to the terms and conditions of this Agreement, the AMA grants to Licensee during the Term (as defined in Section 8), a limited, non-exclusive, non-sublicensable, non-transferable license to reproduce, display, and use the Licensed Content in only the Electronic Product(s) identified in Schedule A-1, and only for the internal Licensed Uses defined in Section 3, in the Territory (as defined in Section 6).

3. **Licensed Uses**: "Licensed Uses" shall mean use of Licensed Content in the Electronic Products (as identified in Schedule A-1) internally by Licensee, its employees and agents, and only for the specified quantity of the applicable unit of licensure (as identified in Schedule A-1).

4. **Electronic Product(s)**. "Electronic Product(s)" shall mean products and any updates thereto that Licensee owns or has the right to license that (a) incorporate Licensed Content and (b) are identified on Schedule A-1.

5. **No Derivative Works**. Licensee may technically adapt and merge the Licensed Content into the Electronic Product(s) and copy the Licensed Content into any machine readable or printed form for backup or archival purposes, subject to the terms and conditions of this Agreement. Except as strictly necessary and as authorized in this Agreement, Licensee shall not alter or modify the Licensed Content. The parties acknowledge that to the extent that the Licensed Content is changed, such modification shall constitute a derivative work owned by the AMA.

6. **Territory**. "Territory" means United States and its territories.

7. **Reservation of Rights**. AMA reserves all rights not expressly granted to Licensee under this Agreement. This license specifically excludes (a) distribution of Licensed Content to third parties; (b) use of Licensed Content outside the Territory; (c) broadcasting, displaying, or making available the Licensed Content in any unsecured environment or public computer-based information system, including the internet, and (d) creating derivative works, including translations of Licensed Content. Licensee does not acquire any title or proprietary interest in the Licensed Content by use of the Licensed Content under this Agreement. Licensed Content is copyrighted by the American Medical Association. CPT codes, descriptions and other data are copyright 1966, 1970, 1973, 1977, 1981, 1983-2019 American Medical Association. All rights reserved. AMA retains all ownership rights and interest, including copyright in the Licensed Content and rights in the AMA and CPT names, which are registered trademarks of the AMA. Use of other copyrighted works not licensed under this Agreement, including other copyrighted works owned by the AMA or works owned by third parties, are subject to separate terms and conditions and Licensee is responsible for securing the necessary rights or licenses for use of other copyrighted works. AMA claims no copyright to government data that is in the public domain.

8. **Term**. This Agreement is effective until terminated.

9. **Royalties**.

9.1. **Timing of Royalties Payments**. Unless otherwise stated, royalties and applicable taxes, are due upon execution of this Agreement. Payment of royalties and applicable taxes is required before access or delivery of the Licensed Content is provided or completed.

9.2. **Calculation of Royalties**. Royalties shall be calculated for each Electronic Product, in accordance with Appendix B, *Licensing Models*. The licensing model to be applied depends on the type of the Electronic Product.

9.3. **Royalty Rates**. Appendix C, *Royalty Rates*, identifies the current royalty rates for Licensed Content under each licensing model.

9.4. **Additional Royalties**. In the event (a) Licensee elects to update Electronic Product(s) with subsequent annual releases of the Licensed Content or additional content not yet identified in Schedule A-1, and/or (b) Licensee identifies additional Licensed Uses (including increases in quantity of the applicable unit of licensure), Licensee shall pay additional royalties to the AMA, as calculated by applying the then-current royalty rates for Licensed Content under the

applicable licensing model. For the avoidance of doubt, the licensing of subsequent annual releases of the Licensed Content (which is generally designated by a calendar year) will require payment of additional royalties, at the then-current royalty rates. Upon request, AMA will make available information concerning other data files or content that is separately marketed and licensed that is generally available to be licensed under this Agreement and that is not identified as Licensed Content in Schedule A-1. Additional content may be added as Licensed Content (and identified in Schedule A-1) upon execution of a written amendment, or such use may be subject to a separate license agreement.

9.5. **Royalties Not Required**. Licensee shall not be required to pay a royalty for (a) use of AMA's minor revisions that are available or issued to Licensee prior to the release of the subsequent annual release of the Licensed Content or (b) use of prior annual releases of the Licensed Content for which a royalty has already been paid in connection with the Electronic Product.

9.6. **NO REFUNDS**. In no event will the AMA refund to Licensee royalties paid to the AMA under this Agreement.

9.7. **Method of Payment**. Royalties, plus applicable taxes, will be paid in United States dollars to the AMA (tax identification number 36-0727175). Payment of royalties shall be by wire transfer, automated clearinghouse (ACH), or other method of electronic transfer made available by the AMA and will include Licensee's name and the notation "CPT Royalties AAA 2654." Any payment of $100,000 or more will be made by wire transfer or automated clearinghouse (ACH). Payment of royalties by wire transfer or ACH should be sent to the following address:

The Northern Trust Company
50 South LaSalle Street, Chicago, IL 60603
ABA# 071000152 (US)
Account Number: 54070
Account Name: AMA General Checking Account
Descriptor: "CPT AAA 2654 Royalty"
SWIFT No. CNORUS44 (International)

10. Records and Audit. Licensee will keep complete and accurate books and records concerning this Agreement for at least three (3) years following the year to which they pertain. The AMA or its representative shall have the right to audit Licensee's books and records to ensure compliance with this Agreement no more than once per twelve (12) month period. AMA shall provide Licensee with reasonable notice of such audit and such audits shall not occur on less than fourteen (14) business days' prior written request. The books and records shall be made available to AMA at a single location in the United States, during normal business hours. AMA may employ an independent auditor or AMA may choose to conduct such audit on its own behalf. Interest of the prime rate plus 1% per year will be due for any royalties found due and not paid. The prime rate will be determined by the rate listed in the Wall Street Journal on the first day of the month. AMA shall be responsible for paying the auditor's fees unless such audit discloses an aggregate under payment for the audited period in excess of five percent (5%); in which case Licensee will reimburse AMA's reasonable audit expenses. Licensee shall immediately pay the AMA any amounts due as a result of an audit. AMA will keep Licensee's records confidential. This paragraph shall survive termination of this Agreement for one (1) year.

11. Delivery / Usage of Licensed Content. AMA shall deliver or make available to Licensee the Licensed Content after AMA's receipt of the royalties, plus applicable taxes, for the specified Licensed Content. Notwithstanding any other provision to the contrary contained in this Agreement:

11.1. **Copyright Notices and Disclaimers**. Licensee shall not modify or otherwise obscure any copyright, trademark and other intellectual property rights notices which may appear on or in association with copies (whether print or electronic) of any Licensed Content. Copyright notices in Electronic Product(s) shall be promptly revised if a subsequent annual release of the Licensed Content is used and Licensee will include additional notices and disclaimers, as requested by the AMA.

11.2. **Security for Electronic Product(s)**. Licensee will maintain reasonable and appropriate physical, technical and administrative safeguards to provide a secure environment for the Electronic Product(s) to ensure that Licensed Content is only accessible for Licensed Uses. Such controls shall include, without limitation, user registration technology and firewall technology.

11.3. **Changes in Licensed Uses**. In the event of an acquisition, addition of a new line of business, or other event resulting in a change in the Licensed Uses that constitutes an increase in the quantity of the applicable unit of licensure greater than ten percent (10%) and/or equaling royalties of one thousand dollars ($1,000) or more, Licensee shall report that change pursuant to a written amendment and pay to the AMA the additional required royalties within thirty (30) days of that event. If the increase is less than ten percent (10%) and/or one thousand dollars ($1,000), Licensee must report and pay the applicable royalties for the additional Licensed Uses along with the royalties for use of updated Licensed Content, pursuant to a written amendment, upon availability of the next annual release.

12. **No Sublicense, Assignment or Transfer.** Licensee may not sublicense, assign or transfer this Agreement or any of the rights herein without the prior written approval of the AMA which shall not be unreasonably withheld. Any attempt to sublicense, assign or transfer this Agreement or any of the rights, duties or obligations hereunder in violation of this provision shall be null and void.

13. **Government End Users.** CPT is commercial technical data, which was developed exclusively at private expense by the American Medical Association (AMA), 330 North Wabash Avenue, Chicago, Illinois 60611. This Agreement does not grant the Federal government a direct license to CPT based on the license in FAR 52.227-14 (Data Rights - General) and DFARS 252.227-7015 (Technical Data - Commercial Items) or any other license provision. The AMA reserves all rights to approve any license with any Federal agency.

14. **Cooperation of the Parties.** Except for the licenses expressly granted to Licensee in this Agreement, Licensee acknowledges that all right, title, and interest in and to the Licensed Content, as well as any modifications or updates to Licensed Content are owned by AMA. Without limiting the AMA's rights in Section 10, *Records and Audit*, Licensee shall cooperate with the AMA and provide additional commercially reasonable information to AMA to facilitate updates to the Agreement and Schedules, and to verify compliance with the terms of this Agreement. Licensee agrees not to take any action adverse to the AMA's copyright, trademark, and other intellectual property rights in Licensed Content. Licensee agrees to make all reasonable efforts to prevent any infringement of AMA's copyrights in Licensed Content. Licensee further agrees it will not engage in activities resulting in damage to the reputation of the Licensed Content or the AMA. The parties hereby agree to reasonably cooperate with each other in any claim or litigation against a third party for infringement of the copyrights and/or proprietary rights residing in the Licensed Content or Electronic Product(s), but without cost to the party not bringing the suit and the parties agree to execute such additional documents that may be reasonably necessary to cooperate in the prosecution of such litigation.

15. **Confidentiality**. The AMA acknowledges that it may receive data or information regarding Licensee's business operations which are not generally known to the public and affords a competitive advantage, including but not limited to, information regarding Licensee's products and product development, suppliers, marketing strategies, finance, operations, customers, sales, and internal performance results ("Proprietary Information"). AMA shall: (a) maintain the Proprietary Information in strict confidence and take all reasonable steps to prevent its disclosure to third parties, (b) use at least the same degree of care as it uses in maintaining the confidentiality of its own Proprietary Information (but no less than a reasonable degree of care) and (c) prevent the removal of any proprietary, confidential or copyright notices placed on any Proprietary Information in its possession. The AMA will not use the name, logo, or initials of Licensee in promotional or marketing materials without Licensee's prior written approval in each instance. The AMA acknowledges that any remedy at law for the breach or threatened breach of this Section 15 may be inadequate to fully and properly protect Licensee and, therefore, the parties agree that Licensee may be entitled to injunctive relief in addition to other available remedies; provided, however, that nothing contained herein shall be construed as prohibiting Licensee from pursuing any other remedies available in law or in equity for such breach or threatened breach.

16. **Representations**. AMA represents that it has the authority to grant the rights herein and that the Licensed Content does not violate the copyright or trademark rights of any third party. Licensee represents it has the legal authority to enter into this Agreement and that the information provided to the AMA under this Agreement is true, accurate, and complete.

17. **Disclaimer of Warranties**. LICENSEE EXPRESSLY ACKNOWLEDGES AND AGREES THAT: (i) TO THE EXTENT PERMITTED BY APPLICABLE LAW, USE OF THE LICENSED CONTENT IS AT LICENSEE'S SOLE RISK; (ii) THE ENTIRE RISK AS TO SATISFACTORY QUALITY, PERFORMANCE, ACCURACY AND EFFORT IS WITH LICENSEE; AND (iii) THE LICENSED CONTENT IS PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND, EITHER EXPRESSED OR IMPLIED, INCLUDING, WITHOUT LIMITATION, THE IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE, AND WITHOUT ANY REPRESENTATION OR WARRANTY WHATSOEVER, INCLUDING THAT THE LICENSED CONTENT IS ACCESSIBLE OR UNINTERRUPTED. TO THE FULLEST EXTENT PERMITTED BY LAW, THE AMA DISCLAIMS RESPONSIBILITY AND ANY LIABILITY FOR (A) ANY ERRORS IN THE LICENSED CONTENT AND ANY CONSEQUENCES, DECISIONS, JUDGMENTS OR RESULTS ATTRIBUTABLE TO OR RELATED TO ANY USES, NON-USES OR INTERPRETATIONS OF INFORMATION OR DATA CONTAINED IN OR NOT CONTAINED IN THE LICENSED CONTENT; (B) ANY DAMAGE TO LICENSEE'S EQUIPMENT OR ANY OTHER INFORMATION OR FILE OR APPLICATION; (C) ANY INTERRUPTION OF ANY SERVICE OR APPLICATION; AND (D) ANY OTHER DAMAGE NO MATTER THE CAUSE. THE AMA DOES NOT DIRECTLY OR INDIRECTLY PRACTICE MEDICINE OR DISPENSE MEDICAL SERVICES. FEE SCHEDULES, RELATIVE VALUE UNITS, CONVERSION FACTORS AND/OR RELATED

COMPONENTS ARE NOT ASSIGNED BY THE AMA, ARE NOT PART OF CPT, AND THE AMA IS NOT RECOMMENDING THEIR USE. THE LICENSED CONTENT DOES NOT REPLACE THE AMA'S *CURRENT PROCEDURAL TERMINOLOGY* BOOK OR OTHER APPROPRIATE CODING AUTHORITY. THE CODING INFORMATION CONTAINED IN THE LICENSED CONTENT SHOULD BE USED ONLY AS A GUIDE.

18. **Indemnification**. Licensee and the AMA (each the "Indemnifying Party") will each indemnify and defend the other (the "Indemnified Party") from any claims, liabilities, proceedings, actions, and settlements brought by third parties, including fees, costs, fines, and penalties, including reasonable attorneys' fees, arising out of any material breach by the Indemnifying Party of any representation, warranty, covenant, or other obligation in this Agreement provided that (a) the Indemnifying Party is notified of the action, proceeding, or claim immediately upon service of summons, (b) the Indemnifying Party has sole control of the defense and settlement of the action, proceeding, or claim, provided that the Indemnifying Party may not settle any such claim without the Indemnified Party's written consent, unless such settlement (i) includes a release of all covered claims pending against the Indemnified Party; (ii) contains no admission of liability or wrongdoing by the Indemnified Party; (iii) imposes no obligations upon the Indemnified Party; and (iv) the settlement does not materially reduce the Indemnified Party's rights and benefits under this Agreement; and (c) the Indemnified Party provides reasonable assistance in connection with the defense and settlement of the action, proceeding, or claim. The Indemnified Party may participate in the defense or prosecution of any claim with counsel of its choice at its own expense.

19. **Equitable Relief**. Licensee acknowledges that a breach by Licensee of this Agreement may cause AMA irreparable damages, for which an award of damages would not be adequate compensation, and agrees that, in the event of such breach or threatened breach, AMA will be entitled to seek equitable relief, including a restraining order, injunctive relief, specific performance, and any other relief that may be available from any court, in addition to any other remedy to which AMA may be entitled at law or in equity. Such remedies are not exclusive but are in addition to all other remedies available at law or in equity to the AMA.

20. **Limitation of Liability**. To the extent not prohibited by applicable law, in no event shall AMA be liable for any incidental, special, indirect or consequential damages whatsoever, including, without limitation, damages for loss of profits, loss of data or information, business interruption or any other commercial damages or losses, arising (a) out of the use or inability to use the Licensed Content; (b) from any interruption in availability of the Licensed Content; (c) from any loss of data and/or from any equipment failure; (d) from unauthorized access to or alteration of Licensee's transmissions or data; (e) out of the use of, reference to, or reliance on the Licensed Content; (f) out of any content, materials, accuracy of information, and/or quality of the Licensed Content; or (g) out of any other matter relating to the Licensed Content. In the event Licensee is dissatisfied with or disputes this Agreement or the Licensed Content, Licensee's sole right and exclusive remedy is to terminate Licensee's use of the Licensed Content, even if that right or remedy is deemed to fail of its essential purpose, and to the maximum extent permitted by applicable law, Licensee's exclusive remedy and AMA's entire liability for any claim related to the subject matter of this Agreement, whether in contract, warranty, tort, or any other legal theory, shall be limited to the total amount Licensee paid to use the Licensed Content provided hereunder, upon which the liability is based. Licensee confirms the AMA has no other obligation, liability or responsibility to Licensee or any other party.

21. **Exclusions Permitted by Law**. Some jurisdictions do not allow the exclusion of certain warranties or conditions, or the limitation or exclusion of liability for loss or damage caused by negligence, breach of contract or breach of implied terms, or incidental or consequential damages. Accordingly, only the above limitations which are lawful will apply in such jurisdictions.

22. **Termination**. This Agreement and the license granted hereunder shall be terminated in whole or with regard to any particular Licensed Content (a) at AMA's option if Licensee fails to fulfill any material obligation (including payment of royalties) and continues to do so for thirty (30) days after notice from the AMA or as otherwise expressly provided in this Agreement; (b) at Licensee's option at any time by ceasing use of and destroying the Licensed Content (without refund); (c) at AMA's option if there is an imposition of a governmental prohibition or restriction rendering it unlawful or jeopardizing the AMA's rights to the Licensed Content, including copyright; or (d) at AMA's option upon ninety (90) days written notice to Licensee if the AMA no longer produces the Licensed Content. Licensee agrees that the AMA will be awarded court costs and reasonable attorneys' fees if it prevails in any action or proceeding against Licensee due to Licensee's breach of this Agreement. Upon termination of this Agreement, all rights granted hereunder shall terminate and Licensee may no longer use the Licensed Content in Electronic Product(s) or provide updates to Electronic Product(s) with updated Licensed Content. Any rights or obligations of the parties in this Agreement which, by their nature, should survive termination of this Agreement, will survive such termination.

23. **Notices**. Notices to Licensee will be sent by email or by overnight delivery service to the individual(s) specified in Schedule A-1, or to such recipients designated by Licensee and provided in writing to AMA. Notices and requests for approval to the AMA will be sent to the attention of Vice President, Business Development and Account Management, (intellectual.property.services@ ama-assn.org), with a copy of the notice to the Office of General Counsel (OGC@ama-assn.org).

24. **Controlling Law**. This Agreement will be governed by the internal laws of the State of Illinois without regard to choice of law principles and by the laws of the United States of America in the English language as it is used in the United States. The courts of the State of Illinois and/or the United States District Court for the Northern District of Illinois shall have exclusive jurisdiction over any action concerning the subject matter of this Agreement, and the parties agree to submit to the jurisdiction of the courts of the State of Illinois and the United States District Court for the Northern District of Illinois.

25. **Complete Agreement**. This Agreement includes all attached appendixes and schedules, and constitutes the entire agreement between AMA and Licensee relating to the internal use of the Licensed Content and supersedes all prior or contemporaneous understandings and agreements, both written and oral, with respect to such subject matter.

26. **General**. Both parties shall hold the terms of this Agreement confidential. Licensee shall be responsible for all sales, use, or other taxes, except taxes based on the income of the AMA. Payment of royalties to be made under this Agreement to the AMA shall be made without any deduction or set-off of any taxes, levies, imposts, imports, duties, charges, fees and withholdings of any nature now or hereafter imposed by any governmental, fiscal or other authority save as required by law. If Licensee is tax-exempt, Licensee will provide a copy of its Tax-Exempt Certificate prior to execution of this Agreement. No amendment to or modification to this Agreement will be binding unless it is in writing and signed by authorized individuals of both parties. Nothing contained in this Agreement shall be deemed to constitute a joint venture, partnership or agency between parties. Licensee acknowledges that Licensee has read this Agreement, understands it, and agrees to be bound by its terms and conditions. Licensee represents Licensee is a legal entity having authority to enter into this Agreement. The delay or failure to assert a right hereunder shall not constitute a waiver of that right or excuse a subsequent failure to perform under this Agreement. If for any reason a court of competent jurisdiction finds any provision, or portion thereof, to be unenforceable, the remainder of this Agreement shall continue in full force and effect. This Agreement only becomes effective upon execution by both parties.

ACCEPTED AND AGREED:

American Medical Association	**Southern Inyo Hospital**
By:	By:
Print Name: Denise Foy	Print Name: Maritza Perkins
Title: VP, HSG Operations	Title:
Date:	Date:

IU/21062019F

ATTACHMENTS:

APPENDIX A: INTENTIONALLY NOT USED
APPENDIX B: LICENSING MODELS
APPENDIX C: ROYALTY RATES
SCHEDULE A-1: LICENSE SPECIFICATIONS
SCHEDULE A-2: CONTACT INFORMATION
SCHEDULE A-3: INTENTIONALLY NOT USED

APPENDIX B: LICENSING MODELS

I. Intentionally Not Used.

II. User Proxy Model.

A. Unit of Licensure.

For Electronic Products licensed under the User Proxy Model, the unit of licensure is "User," as defined below.

B. Definitions.

User. An individual who: (i) accesses, uses, or manipulates the Licensed Content; or (ii) accesses, uses, or manipulates a program which includes the Licensed Content to produce or enable an output (data, reports or the like) that could not have been created without the Licensed Content embedded in the program even though the Licensed Content may not be visible or directly accessible; or (iii) makes use of an output of a program which includes the Licensed Content that relies on or could not have been created without the Licensed Content embedded in the program even though the Licensed Content may not be visible or directly accessible.

Staffed Beds. The total facility beds set up and staffed at the end of reporting period. For purposes of this Agreement, "the end of reporting period" shall mean the date of Licensee's execution of this Agreement

Billing Provider. A healthcare provider who renders medical services for which a fee is charged.

Ambulatory Facility. A facility that provides health services that do not require an overnight stay.

Hospital. A facility that provides health services often requiring overnight stays in Staffed Beds.

C. Calculator.

For Electronic Product(s) that fall within a User Proxy Model Product Category (identified below), Licensee will use the User Proxy Model to calculate the number of Users of the Electronic Product(s). Total royalties shall be based on the total number of Users, calculated as the product of either Staffed Beds or Billing Providers and a factor as determined by the type of Product Category that best describes the Electronic Product, as identified in the table below.

User Proxy Model Product Categories	Applicable User Proxy (Staffed Beds or Billing Providers)	User Proxy Model Factor
Clinical EMR (CEMR). A product installed in a hospital that includes functions for clinical documentation, order entry, clinical data repository, provider order entry, physician clinical documentation, etc.	**Staffed Beds**	**2**
Integrated Ambulatory EMR (IAEMR). A product installed in an ambulatory setting that includes functions for clinical documentation, order entry, clinical data repository, provider order entry, physician clinical documentation, etc., where the product is integrated with a Clinical EMR.	**Staffed Beds**	**3**
Patient Billing System (PBS). A product installed in a hospital that automates institutional and professional billing for inpatient and outpatient services and discharged accounts receivable. It may stand alone or integrate with an EMR.	**Staffed Beds**	**1**
Ambulatory EMR (AEMR). A product installed in an ambulatory setting/clinic/physician office environment that includes functions for clinical documentation, order entry, clinical data repository, provider order entry, physician clinical documentation, etc. May stand alone or may be integrated with a Practice Management product.	**Billing Providers (FTE)**	**4**
Practice Management (PM). A product installed in an ambulatory setting/clinic/physician office environment that provides the registration, scheduling, and billing functions for a physician office or clinic.	**Billing Providers (FTE)**	**1**

III. Intentionally Not Used.

APPENDIX C: ROYALTY RATES

Table 1 Intentionally Not Used

Table 2 User Proxy Model

Name of Data File	Date Available	Royalty Rate
Current Procedural Terminology (CPT®) 2020 – Standard	September 2019	Calculated as $82.50 plus $17.00 for each User
CPT Link 2020	September 2019	Calculated as $13,000 plus $17.00 for each User
2020 CPT® to SNOMED CT® and SNOMED CT® to CPT® Maps	February 2020	Calculated as $1,050 plus $5.20 for each User, in addition to $17.00 CPT Standard royalty for each User
AMA's Version of Healthcare Common Procedure Coding System, Level II 2020	December 2019	Calculated as $400 for the first 25 Users plus $18.00 for each additional User
AMA's Version of International Classification of Diseases, 10th Revision, Clinical Modification and Procedure Coding System 2020 File	September 2019	Calculated as $400 for the first 25 Users plus $20.50 for each additional User
Current Procedural Terminology (CPT®) Relative Value Units 2020	February 2020	Calculated as $270 for the first 10 Users plus $17.00 for each additional User

Table 3 Intentionally Not Used

SCHEDULE A-1: LICENSE SPECIFICATIONS

1. Licensee:

Licensee:	***Southern Inyo Hospital, 501 E. Locust Street, Lone Pine, CA 93545***

Notices to Licensee:	***Brian Cotter, Southern Inyo Hospital, 501 E. Locust Street, Lone Pine, CA 93545*** bcotter@sihd.org

Licensee shall also complete Schedule A-2 with its additional contact information.

2. Licensed Content:

Current Procedural Terminology (CPT®) 2020 – Standard

3. Royalties.

3.1 Internal Use Royalty. As consideration for the rights granted herein, Licensee shall pay royalties in the total amount of **$711.50** U.S. Dollars, plus applicable taxes, for the Licensed Uses of the Licensed Content specified in Section 2 of this Schedule A-1. Unless otherwise stated, royalties are due upon execution of this Agreement, in accordance with Section 9 of this Agreement. For the avoidance of doubt, Licensee shall pay additional royalties to the AMA for Licensed Uses of subsequent annual releases of the Licensed Content (which is generally designated by a calendar year), as calculated by applying the then-current royalty rates. AMA will deliver to Licensee subsequent annual release(s) of Licensed Content when available, and only after Licensee has paid all additional royalties due, at the then-current royalty rates.

4. Electronic Product(s): Subject to Section 9, royalties payable to the AMA for Licensed Uses of the identified Licensed Content are calculated in accordance with the licensing model (and unit of licensure) that has been identified for each Electronic Product and the applicable royalty rate, as follows:

Table 4.1 Intentionally Not Used

Table 4.2 User Proxy Model

Licensee's Electronic Product (Name and Description)	Vendor of Licensee's Electronic Product (if applicable)	Licensed Content used in Electronic Product	User Proxy Model Product Category*	Proxy to Determine Number of Users (BP = Billing Providers, or SB = Staffed Beds)	Number of Billing Providers or Staffed Beds	User Proxy Model Factor	Calculated Number of Users	Royalty Rate	Total Royalty Amount
Medworks		2020 CPT Standard	PBS	SB	37	1	37	Calculated as $82.50 plus $17.00/ User	**$711.50**

***CEMR = Clinical EMR; IAEMR = Integrated Ambulatory EMR; PBS = Patient Billing System; AEMR = Ambulatory EMR; PM = Practice Management**

Table 4.3 Intentionally Not Used

SCHEDULE A-2: CONTACT INFORMATION

Primary Contact:

Legal Name:	***Phone*:** ***ex:***	***Email*:**	
***Title*:**	***Dept*:**	***Company Name:***	
Mailing Address:	***City:***	***State*:**	***Zip*:**
Country: ***(International Use Only)***			

Secondary/Purchasing Agent:

Legal Name:	***Phone*:** ***ex:***	***Email*:**	
***Title*:**	***Dept*:**	***Company Name:***	
Mailing Address: ***(if different from primary mailing address)***	***City:***	***State*:**	***Zip*:**
Country: ***(International Use Only)***			

Licensed Content Recipient:

Legal Name:	***Phone*:** ***ex:***	***Email*:**	
***Title*:**	***Dept*:**	***Company Name:***	
Mailing Address: ***(if different from primary mailing address)***	***City:***	***State*:**	***Zip*:**
Country: ***(International Use Only)***			

AMENDMENT EMERGENCY DEPARTMENT PHYSICIAN AGREEMENT

This Emergency Department Physician Agreement ("Agreement") is made by Southern Inyo Healthcare District ("District") and Michael Dillon, M.D. ("PHYSICIAN"), as of September 19, 2019.

RECITALS

A. District owns and operates Southern Inyo Hospital ("Hospital") located in Lone Pine, California, a Critical Access Hospital, and desires to retain Physician to provide emergency medicine services in Hospital's Emergency Department ("ED").

A. Physician is a physician duly licensed in California with a background and experience in providing emergency medicine services, and desires to be retained by District.

NOW, THEREFORE, the parties agree as follows:

TERMS

1. SCOPE OF SERVICES

District retains Physician, and Physician agrees, to provide those services identified in Exhibit A, attached hereto and incorporated by reference (the "Services").

2. PHYSICIAN'S REPRESENTATIONS AND WARRANTIES

Physician represents and warrants at the time of signing this Agreement, and at all times during the term of this Agreement, that:

2.1 Physician is duly licensed, registered and in good standing, or will become duly licensed, registered and in good standing under the laws of the State of California, to engage in the practice of medicine, and that said license and registration have not been suspended, revoked, or restricted in any manner.

2.2 Physician is qualified for and has applied for, or will apply for within a reasonable time after the signing of this Agreement, and has obtained, or will obtain within a reasonable time after the signing of this Agreement, membership (including appropriate clinical privileges) in good standing with the Medical Staff of District.

2.3 Physician has disclosed and will at all times during the term of this Agreement promptly disclose to the District: (a) the existence and basis of any legal, regulatory, professional or other proceeding against Physician instituted by any person, organization, governmental agency, health care facility, peer review organization, or professional society which involves any allegation of substandard care or professional misconduct raised against Physician and (b) any allegation of substandard care or professional misconduct raised against Physician by any person, organization, governmental agency, health care facility, peer review organization or professional society;

2.4 Physician is board certified or board qualified in emergency medicine, or possesses knowledge and skill in emergency medicine comparable to other physicians practicing emergency medicine in the District's service area.

2.5 Physician shall at all times render the Services in a competent, professional, and ethical manner, in accordance with prevailing standards of medical care and practice, and all applicable statutes, regulations, rules, orders, and directives of all applicable governmental and regulatory bodies having competent jurisdiction.

2.6 In connection with the provision of the Services, Physician shall use the equipment, instruments, electronic medical record documentation system and supplies of the District for the purposes for which they are intended and in a manner consistent with sound medical practice and District policies and procedures.

2.7 Physician shall complete and maintain, in a timely manner, adequate, legible and proper medical records, claims and correspondence with respect to the Services.

2.8 Physician shall participate in Medicare, Medi-Cal and other federal and state reimbursement programs, commercial insurance reimbursement programs, health maintenance organization, preferred provider organizations, self-insured employer reimbursement programs and any other health benefit program with which the District may contract for the provision of professional medical services.

2.9 Physician shall abide by the Medical Staff Bylaws, rules, regulations and policies.

2.10 Physician shall participate in continuing medical education and training programs required to maintain skills comparable with the standards of care in emergency medicine in the District's service area.

2.11 Physician shall satisfy all qualifications of insurability for professional liability policy or policies required, maintained or reimbursed by the District.

2.12 Physician shall deliver to the District promptly upon request copies of all certificates, registrations, certificates of insurance and other evidence of Physician's compliance with the foregoing as reasonably requested by the District.

3. RESPONSIBILITIES OF HOSPITAL

3.1 HOSPITAL shall provide appropriate space and necessary equipment within the ED for the use of Physician in the performance of the Services under this Agreement.

3.2 HOSPITAL shall make all reasonable efforts to make available ancillary services necessary for effective operation of the ER, including laboratory, imaging, pharmacy, etc.

3.3 HOSPITAL shall not involve itself in those aspects of Physician's professional practice of medicine for which a license to practice medicine is required.

4. COVERAGE.

PHYSICIAN will provide emergency physician coverage in the ED as scheduled by HOSPITAL and MEDICAL DIRECTOR. However, PHYSICIAN will cover no less than _N/A__ shifts per month.

5. COMPLIANCE WITH LAWS

PHYSICIAN shall comply with all applicable provisions of law, and other valid rules and regulations of all governmental agencies having jurisdiction over: (i) the operation of the ED; (ii) the licensing of health care practitioners; and (iii) the delivery of services to patients of governmentally regulated third party payers whose members/beneficiaries receive services at HOSPITAL. This shall specifically include, but not by way of limitation (i) compliance with applicable provisions of Title 22, California Administrative Code; and (ii) compliance with Medicare billing, time allocation, record keeping, and record access requirements.

6. PHYSICIAN COMPENSATION.

6.1 District agrees to pay the following fees to Physician:

6.1.1 Patient Visits. District will bill patients and their payors for services provided by PHYSICIAN to those patients. Such charges shall be consistent with prevailing community charges.

6.1.2 Emergency Department Patient Visit Fees. District will pay PHYSICIAN $_N/A_ per visit for all patients treated with their charts completed by _N/A__.

6.1.3 Stand-By Hours. In addition to the compensation in 6.1.2, District will compensate PHYSICIAN at $95.00 per hour for all hours worked on site covering the Emergency Department.

6.1.6 HOSPITAL is responsible for the payments due to PHYSICIAN. Therefore, physician should only look to the HOSPITAL for amounts due and not to MEDICAL DIRECTOR or HOSPITAL'S patients.

6.2 Timing of Payment. HOSPITAL will pay PHYSICIAN monthly by the 15 day of the next month following that month in which the services are rendered.

6.3 Holiday Minimum. The minimum payment for the following holidays will be _Time and a Half_: New Year's Day, Easter Sunday, Memorial Day, 4th of July, Labor Day, Thanksgiving Day, and Christmas Day.

6.4 Continuing Medical Education. PHYSICIAN shall be entitled to N/A hours of paid continuing medical education time after each six-month period in which PHYSICIAN has worked at least the minimum shifts in the emergency department as required under article 4.0 of this agreement.

6.5 PHYSICIAN will be entitled to purchase group health insurance through the DISTRICT plan at the then current cost of the health insurance to the District or the COBRA rate.

7. INDEPENDENT CONTRACTOR

7.1 PHYSICIAN is an independent contractor, and is not, by virtue of this Agreement, an employee, partner of, or joint venturer with District.

7.2 Physician may not make any claim against District under this Agreement for social security benefits, worker's compensation benefits, unemployment insurance benefits, health benefits, vacation pay, sick leave, or any other employee benefits of any kind.

7.3 District shall not exercise any direct control over any medical decisions made by Physician while performing the Services at the ED.

8. INSURANCE AND INDEMNIFICATION

8.1. Coverage. PHYSICIAN will be covered by the District's Professional and Liability Insurance through BETA Healthcare Group ("BETA") for a minimum of $1,000,000 per occurrence, $3,000,000 aggregate, for the Services rendered under this Agreement. It is understood and agreed that BETA provides Continuous Coverage for departed providers, except the coverage is limited to claims made and reported against the provider for Services provided during the term of this Agreement.

8.2. Indemnification. Each party ("Indemnitor")agrees to defend, indemnify and hold the other party ("Indemnitee") and its representatives, agents, successors and assigns harmless from any and all damages, claims, judgments, losses, costs and expenses, including attorney's fees, which may hereinafter at any time be incurred, suffered, sustained by or imposed upon Indemnitee or its representatives, agents, successors or assigns, which may be due or required to be paid or performed by reason of, arising out of, by virtue of, or incident to the performance or the rendering of any of the obligations of Indemnitor hereunder, including but not limited to, any such damages, claims, judgments, losses, costs or expenses attributable to bodily injury, sickness, disease or death or injury or to destruction of tangible property which is caused in whole or in part by the negligent act or omission of Indemnitor, or anyone directly employed by or acting on behalf of Indemnitor but not as a result of the negligence of Indemnitee, its representatives, servants or agents.

9. NONDISCRIMINATION

Services are to be available to all patients, in accordance with District's nondiscrimination policies, and in accordance with any established policies relating to free or charity care. Physician shall not refuse to provide services to any patient at the Hospital, regardless of ability to pay.

10. TERM AND TERMINATION

10.1 Term. This Agreement shall be effective as of September 19, 2019and shall terminate on September 20, 2020. Upon mutual agreement, not later than 90 days prior to

expiration of the current term, the District and Physician may extend this Agreement for two additional one-year terms.

10.2 Termination without cause. During the initial 120 days of this Agreement, either party may, without cause, terminate this Agreement with 10-days written notice to the other party. Thereafter, this Agreement may be terminated upon 60-days written notice to the other party. This agreement may be terminated at any time by the mutual consent of both parties.

10.3 Termination for cause. Either party may terminate this Agreement for cause if the other party is in material breach of this Agreement and the default is not cured within seven days of receipt of written notice specifying the material breach.

10.4 Other grounds for termination. This Agreement may be terminated immediately for the following reasons:

10.4.1 Physician's loss or restriction of their license for any reason.

10.4.2 Physician becomes legally incompetent; is convicted of a felony; or uses, possesses, or is found under the influence of alcohol, drugs, or other controlled substances while performing his duties under this Agreement.

10.4.3 Physician fails to maintain a professional standard of conduct in accordance with District policies.

10.4.4 Physician becomes ineligible to participate in the Medi-Cal or Medicare programs for any reason.

10.4.5 A fraud control unit of a state or federal agency determines Medical Director has or may be placing the health and safety of a patient at risk.

10.4.6 Loss or restriction of DISTRICT'S license to operate the Hospital.

10.5 Change in Law. If any federal, state or local law or regulation, or any final, non-appealable interpretation of law or regulations by a court of law or governmental agency, makes or will make substantial performance of this Agreement illegal or renders any provision hereof illegal or unenforceable, the parties shall meet and negotiate and use best efforts to modify the Agreement to resolve the concern. If the parties are unable to resolve the issue within ten (10) days after it arose, either party may elect to terminate this Agreement on ten (10) days prior written notice.

10.6 Rights on Expiration or Termination. Custody of all District records, including patient medical records, equipment, and supplies shall be turned over to District upon termination for any reason. Duplicate copies of records may be retained by PHYSICIAN, at its own expense.

11. GENERAL PROVISIONS

11.1. Other Agreements. No other agreements between the parties exist at this time.

11.2. Assignment. Neither party may assign, delegate or transfer any rights, obligations or duties hereunder without the express written approval of the other party, which approval shall not be unreasonably withheld.

11.3. Notice. All notices required by this Agreement shall be in writing, and shall be deemed effective when personally delivered; when mailed by certified or registered mail, return receipt requested; or when deposited with a comparably reliable postage delivery service (such as Federal Express); addressed to the other party as follows:

IF TO PHYSICIAN:
Michael Dillon, MD

If TO DISTRICT:
Southern Inyo Healthcare District
PO BOX 1009
Lone Pine, CA 93545

11.4. Records. Until the expiration of four (4) years after the furnishing of any service pursuant to this Agreement, PHYSICIAN shall make available upon written request, to the Secretary of the United States Department of Health and Human Services, or upon written request to the United States Comptroller, or any of their duly authorized representatives, under 42 C.F.R. & 420.300 et seq., or the California Department of Health Services, this Agreement, and such books, documents and records of the Physician that are necessary to certify the nature and extent of the reasonable costs of services.

11.5. No Third-Party Beneficiaries. Nothing contained in this Agreement is intended, nor shall it be construed, to create rights running to the benefit of third parties.

11.6. Attorney's Fees. In the event of a legal action or proceeding between the parties arising from this Agreement, the prevailing party shall be entitled to receive reasonable attorney's fees, costs, and other expenses, including those incurred on appeal and in the enforcement of a judgment, in addition to whatever other relief may be awarded.

11.7 Force Majeure. Neither party shall be liable or deemed in default of this Agreement for any delay or failure to perform caused by acts of God, war, disasters, strikes, or any cause reasonably beyond the control of the non-performing party.

11.8 Severability. In the event any portion of this Agreement is declared invalid or void by a court or arbitrator, such portion shall be severed from this Agreement, and the remaining provisions shall remain in effect, unless the effect of such severance would be to substantially alter the agreement or obligations of the parties, or would place either party in

violation of its articles of in District or its bylaws, in which case the Agreement may be immediately terminated.

11.9 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of California, without regard to its conflict of laws principles, and is made and to be performed in the County of Inyo, California.

11.10 No Referrals. Nothing in this Agreement is intended to obligate, and shall not obligate, any party to this Agreement to refer patients to any other party.

11.11 Waiver. Any failure of a party to insist upon strict compliance with any term, undertaking or condition of this Agreement shall not be deemed to be a waiver of such term, undertaking or condition. To be effective, a waiver must be in writing, signed and dated by the parties.

11.12 Entire Agreement; Modification. This Agreement contains the entire agreement of the parties relating to this subject matter. The Agreement may only be modified in writing, signed by both parties, effective on the date set forth therein.

11.13 Execution. By their signatures below, each of the following represent that they have authority to execute this Agreement and to bind the party on whose behalf their execution is made.

Southern Inyo Healthcare District	Physician Michael Dillon, MD
By _____	_____

EXHIBIT A

SCOPE OF SERVICES

PHYSICIAN shall devote sufficient time and his or her best abilities to the responsibility of treating patients in the normal and customary hours of operation of the ED.

Patient Transfers. Except in circumstances of immediate jeopardy for the life of the patient, PHYSICIAN shall consult with the hospitalist of the Hospital prior to the permanent transfer of patients from the ED to other hospitals or health care providers.

Medical Care Plan System. PHYSICIAN shall participate in the development and review of a system for providing a medical care plan for ED patient covering medications, nursing care, ancillary services, admission, discharge or transfer planning, and other relevant services.

Medical Records. PHYSICIAN shall be responsible for the development and maintenance of an adequate medical record in the ED. This shall include assuring that the appropriate medical record entries are made by PHYSICIAN concerning all medical procedures and other services performed in the ED on the electronic medical record system of HOSPITAL.

Service and Equipment Adequacy. PHYSICIAN shall advise the Medical Director concerning the adequacy of the patient care services and medical equipment.

Responses to Administrative Questions. PHYSICIAN shall be available to respond to administrative questions regarding patients, facility bed availability, intra-facility transfer problems, and patient status.

Responses to Nursing Questions. PHYSICIAN shall be available to assist with nursing questions at the ED, including questions regarding patient transfers and patient clinical status.

Responses to Patient Problems. PHYSICIAN, when on duty, shall be available to respond to patient problems in the ED by means of chart review and patient visits, as appropriate, and respond to all in-house patient emergencies when required.

Medical Staff Commitments. Physician shall serve on such committees of Medical Staff of the District as may be appropriate after consultation with the ED Medical Director and Hospital CEO.

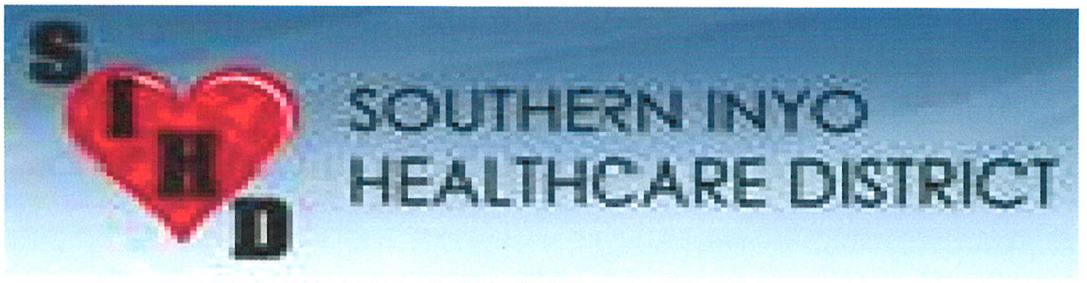
Utilization Review Services. Physician shall, as requested by the District, assist in the ED utilization review program of the District.

Southern Inyo Healthcare District
Operational Cash Flow Actual w/Projections
Actual FY 2020

	Actual	*Actual*	*Proj*	*Proj*	*Proj*	*Proj*	*Proj*	*Proj*	*Proj*	*Proj*	*Proj*	*Proj*	***FY***
	Jul-19	*Aug-19*	*Sep-19*	*Oct-19*	*Nov-19*	*Dec-19*	*Jan-20*	*Feb-20*	*Mar-20*	*Apr-20*	*May-20*	*Jun-20*	***TOTAL***
Ave. Daily Census													
Acute Care	0.6	0.07	1.4	1.1	1.1	0.7	0.4	0.4	0.3	0.2	0.6	0.70	0.64
Swing	0.0	0.00	0.4	0.4	0.4	0.0	0.0	0.0	0.0	0.0	0.0	2.50	0.31
SNF	28.0	25.15	24	23.3	23.3	26.5	26.3	26.3	23.3	24.6	28.0	27.00	25.48
Beginning Balance	527,701	353,586	272,290	232,330	91,573	-38,605	-39,161	97,723	-190,203	-149,907	-186,162	-121,462	527,701
Cash Receipts													
Medicare	56,215	253,261	161,975	201,526	270,827	380,334	182,702	244,917	346,454	91,878	142,227	151,320	2,483,635
Medi-Cal	214,777	204,069	186,815	207,235	145,299	166,803	122,648	141,402	209,365	188,737	142,852	112,243	2,042,244
Insurance	168,229	81,226	263,633	122,590	70,506	40,380	44,151	62,342	72,049	67,077	47,861	94,121	1,134,165
Bad Debt Recovery	2,249	4,208	9,835	9,061	89,536	62,089	75,203	38,069	38,069	21,077	77,567	14,231	441,193
Credit Card Payments	9,283	6,551	19,884	18,889	14,913	6,597	3,617	8,654	54,587	15,026	0	5,121	163,122
Private Pay	28,226	21,452	31,555	16,610	30,842	61,122	55,740	31,427	60,796	25,172	29,426	36,240	428,607
Rebates & Refunds/Taxes/IGT	0	259,615	0	0	0	0	773,756	0	0	335,531	1,166,958	75,000	2,610,860
Miscellaneous Cash	16,049	883	850	10,355	73,237	7,466	42,351	51,851	56,114	24,873	60,811	31,258	376,097
Unapplied/Withholds	-67,668	-247,850	0	0	0	0	0	3,456	0	0	0	55,581	(256,481)
Total Cash Received	427,360	583,415	674,547	586,265	695,159	724,791	1,300,168	582,116	837,433	769,371	1,667,702	575,115	9,423,441
Salaries	402,690	400,736	416,136	479,393	461,000	519,984	434,187	426,627	431,538	410,000	426,400	441,000	5,249,692
Professional Fees	176,911	121,821	93,939	102,789	125,512	147,369	128,349	121,657	73,832	72,053	102,031	99,981	1,366,246
Supplies	21,873	11,766	49,428	34,143	46,762	43,859	53,897	111,859	38,426	18,696	16,146	54,200	501,054
Other/Purch Serv/Contract Labor	0	0	130,476	110,696	192,063	14,135	159,899	209,899	253,341	303,467	652,595	36,516	2,063,086
Inyo County Treas Repay/Medsphere	0	130,389	0	0	0	0	386,953	0	0	1,410	142,776	82,000	743,527
IGT Matching	0	0	24,527	0	0	0	0	0	0	0	0	0	24,527
TOTAL EXPENSE	601,474	664,711	714,507	727,022	825,337	725,347	1,163,285	870,042	797,137	805,626	1,353,002	713,697	9,948,132
Return of Medicare/Cal Overpmt.	0	0	0	0	0	0	0	0	0	0	0	0	0
Investment Account (LAiF)*	0	0	0	0	0	0	0	0	0	0	250,000	0	250,000
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Payments	601,474	664,711	714,507	727,022	825,337	725,347	1,163,285	870,042	797,137	805,626	1,603,002	713,697	10,198,132
	0			0	0	0	0	0	0	0	0		
Cash Over/(Under)	353,586	272,290	232,330	91,573	(38,605)	(39,161)	97,723	(190,203)	(149,907)	(186,162)	(121,462)	(260,044)	(260,044)
Operating Reserve	0	7,724	0	0	0	0	0	0	0	0	0	0	0
Property Tax Fund	7,724	(4,948)	7,613	7,613	7,613	7,613	7,613	7,613	7,613	7,613	7,613	7,613	7,613
Med Ovpmt./IGT/Grants	0	0	0	0	0	0	0	0	0	0	0	0	0
Reserve Add or Transfer	0	0	0	0	0	0	0	0	0	0	0	0	-
Net Cash Balance	361,310	275,066	239,943	99,186	(30,992)	(31,548)	105,336	(182,590)	(142,294)	(178,549)	(113,848)	(252,431)	(252,431)

Southern Inyo Healthcare District
Operational Cash Flow Actual w/Projections
Budget FY 2020

	Proj Jul-19	Proj Aug-19	Proj Sep-19	Proj Oct-19	Proj Nov-19	Proj Dec-19	Proj Jan-20	Proj Feb-20	Proj Mar-20	Proj Apr-20	Proj May-20	Proj Jun-20	FY TOTAL
Ave. Daily Census													
Acute Care	0.7	0.3	1.4	1.1	1.1	0.7	0.4	0.4	0.3	0.2	0.6	0.70	0.67
Swing	2.5	2.1	0.4	0.4	0.4	0.0	0.0	0.0	0.0	0.0	0.0	2.50	0.69
SNF	22	26	24	23.3	23.3	26.5	26.3	26.3	23.3	24.6	28.0	27.00	25.05
Beginning Balance	403,831	92,132	165,741	125,781	-14,976	-145,154	-145,710	-8,827	-296,752	-256,456	-292,711	-228,011	403,831
Cash Receipts													
Medicare	55,305	511,028	161,975	201,526	270,827	380,334	182,702	244,917	346,454	91,878	142,227	151,320	2,740,492
Medi-Cal	178,834	120,275	186,815	207,235	145,299	166,803	122,648	141,402	209,365	188,737	142,852	112,243	1,922,507
Insurance	116,252	78,020	263,633	122,590	70,506	40,380	44,151	62,342	72,049	67,077	47,861	94,121	1,078,982
Bad Debt Recovery	9,035	9,511	9,835	9,061	89,536	62,089	75,203	38,069	38,069	21,077	77,567	14,231	453,282
Credit Card Payments	3,947	10,789	19,884	18,889	14,913	6,597	3,617	8,654	54,587	15,026	0	5,121	162,025
Private Pay	18,061	15,216	31,555	16,610	30,842	61,122	55,740	31,427	60,796	25,172	29,426	36,240	412,206
Rebates & Refunds/Taxes/IGT	0	0	0	0	0	0	773,756	0	0	335,531	1,166,958	75,000	2,351,245
Miscellaneous Cash	375,887	56,395	850	10,355	73,237	7,466	42,351	51,851	56,114	24,873	60,811	31,258	791,448
Unapplied/Growth	83,201	888	0	0	0	0	0	3,456	0	0	0	55,581	143,125
Total Cash Received	840,522	802,122	674,547	586,265	695,159	724,791	1,300,168	582,116	837,433	769,371	1,667,702	575,115	10,055,310
Salaries	409,286	426,589	416,136	479,393	461,000	519,984	434,187	426,627	431,538	410,000	426,400	441,000	5,282,141
Professional Fees	96,891	88,265	93,939	102,789	125,512	147,369	128,349	121,657	73,832	72,053	102,031	99,981	1,252,669
Supplies	39,676	46,065	49,428	34,143	46,762	43,859	53,897	111,859	38,426	18,696	16,146	54,200	553,156
Other/Purch Serv/Contract Labor	232,133	167,595	130,476	110,696	192,063	14,135	159,899	209,899	253,341	303,467	652,595	36,516	2,462,814
Inyo County Treas Repay/Medsphere	374,235	0	0	0	0	0	386,953	0	0	1,410	142,776	82,000	987,374
IGT Matching	0	0	24,527	0	0	0	0	0	0	0	0	0	24,527
TOTAL EXPENSE	1,152,220	728,514	714,507	727,022	825,337	725,347	1,163,285	870,042	797,137	805,626	1,353,002	713,697	10,562,681
Return of Medicare/Cal Overpmt.	0	0	0	0	0	0	0	0	0	0	0	0	0
Investment Account (LAiF)*	0	0	0	0	0	0	0	0	0	0	250,000	0	250,000
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Payments	1,152,220	728,514	714,507	727,022	825,337	725,347	1,163,285	870,042	797,137	805,626	1,603,002	713,697	10,812,681
				0	0	0	0	0	0	0	0		
Cash Over/(Under)	92,132	165,741	125,781	(14,976)	(145,154)	(145,710)	(8,827)	(296,752)	(256,456)	(292,711)	(228,011)	(366,593)	(366,593)
Operating Reserve	0	0	0	0	0	0	0	0	0	0	0	0	0
Property Tax Fund	7,613	7,613	7,613	7,613	7,613	7,613	7,613	7,613	7,613	7,613	7,613	7,613	7,613
Med Ovpmt./IGT/Grants	0	0	0	0	0	0	0	0	0	0	0	0	0
Reserve Add or Transfer	0	0	0	0	0	0	0	0	0	0	0	0	-
Net Cash Balance	99,745	173,354	133,394	(7,363)	(137,541)	(138,097)	(1,214)	(289,139)	(248,843)	(285,098)	(220,397)	(358,980)	(358,980)



Unaudited Financial Statements

for

Twelve Months Ended June 30, 2019

Certification Statement:

To the best of my knowledge, I certify for the hospital that the attached financial statements do not contain any untrue statement of a material fact or omit to state a material fact that would make the financial statements misleading. I further certify that the financial statements present in all material respects the financial condition and results of operation of the hospital and all related organizations reported herein.

Certified by:

Chester Beedle
Chief Financial Officer

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SOUTHERN INYO HEALTHCARE DISTRICT

EXECUTIVE FINANCIAL SUMMARY

Twelve Months Ended June 30, 2019

BALANCE SHEET

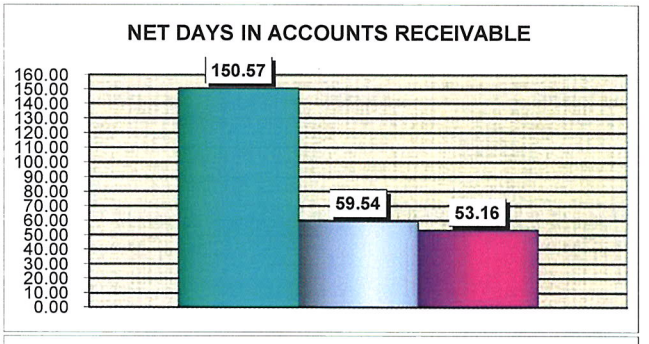
	6/30/2019	6/30/2018
ASSETS		
Current Assets	$4,706,581	$2,540,681
Assets Whose Use is Limited	7,936	8,613
Property, Plant and Equipment (Net)	1,061,248	1,189,917
Other Assets	0	0
Total Unrestricted Assets	**5,775,765**	**3,739,211**
Restricted Assets	0	0
Total Assets	**$5,775,765**	**$3,739,211**
LIABILITIES AND NET ASSETS		
Current Liabilities	$5,408,473	$8,354,180
Long-Term Debt	17,122	0
Other Long-Term Liabilities	422,898	0
Total Liabilities	**5,848,493**	**8,354,180**
Net Assets	(77,087)	(4,614,969)
Total Liabilities and Net Assets	**$5,771,406**	**$3,739,211**

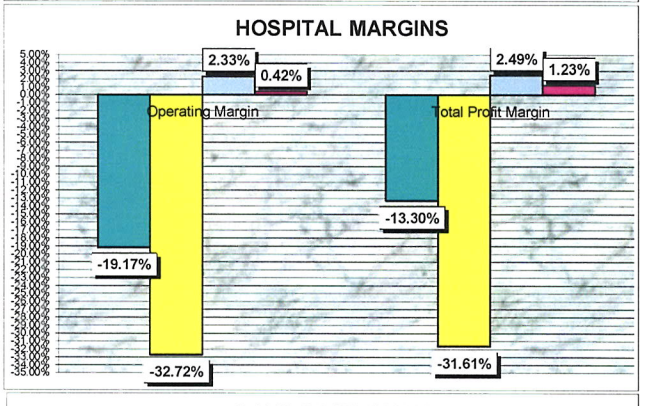
STATEMENT OF REVENUE AND EXPENSES - YTD

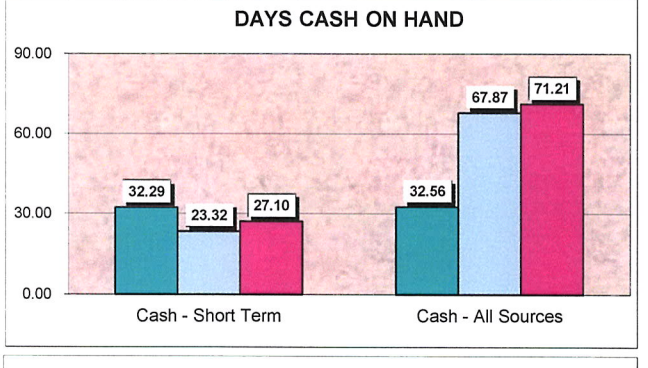
	ACTUAL	*BUDGET*
Revenue:		
Gross Patient Revenues	$12,335,148	$8,787,397
Deductions From Revenue	(3,841,449)	(2,421,807)
Net Patient Revenues	8,493,699	6,365,590
Other Operating Revenue	281,932	375,531
Total Operating Revenues	**8,775,631**	**6,741,121**
Expenses:		
Salaries, Benefits & Contract Labor	6,896,094	6,789,902
Purchased Services & Physician Fees	1,508,711	852,340
Supply Expenses	419,772	362,837
Other Operating Expenses	1,540,699	779,623
Bad Debt Expense	0	0
Depreciation & Interest Expense	92,824	162,396
Total Expenses	**10,458,099**	**8,947,097**
NET OPERATING SURPLUS	**(1,682,468)**	**(2,205,976)**
Non-Operating Revenue/(Expenses)	514,953	74,886
TOTAL NET SURPLUS	**($1,167,515)**	**($2,131,089)**

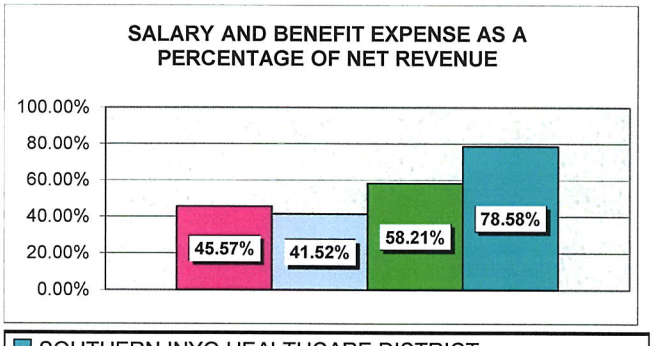
KEY STATISTICS AND RATIOS - YTD

	ACTUAL	*BUDGET*
Total Acute Patient Days	161	72
Average Acute Length of Stay	3.2	2.1
Total Emergency Room Visits	1,542	1,720
Outpatient Visits	3,831	3,005
Total Surgeries	0	0
Total Worked FTE's	95.72	95.20
Total Paid FTE's	104.68	105.86
Productivity Index	0.9946	1.0000
EBITDA - YTD	-200.00%	-34.41%
Current Ratio	0.87	
Days Expense in Accounts Payable	274.44	









SOUTHERN INYO HEALTHCARE DISTRICT	
Budget	06/30/19
California	Hospitals
CAH Hospitals	Rural
Prior Fiscal Year End	06/30/18

FINANCIAL STRENGTH INDEX - (3.65)

Excellent - Greater than 3.0 Good - 3.0 to 0.0

Fair - 0.0 to (2.0) Poor - Less than (2.0)

Balance Sheet - Assets

SOUTHERN INYO HEALTHCARE DISTRICT

LONE PINE, CALIFORNIA

Twelve Months Ended June 30, 2019

	Current Month 6/30/2019	Prior Month 5/31/2019	ASSETS Positive/ (Negative) Variance	Percentage Variance	Prior Year End 6/30/2018
Current Assets					
Cash and Cash Equivalents	$916,834	$1,351,419	($434,585)	-32.16%	$346,635
Gross Patient Accounts Receivable	8,742,913	6,530,554	2,212,359	33.88%	6,944,937
Less: Bad Debt and Allowance Reserves	(5,070,890)	(3,787,721)	(1,283,169)	-33.88%	(5,744,764)
Net Patient Accounts Receivable	3,672,024	2,742,833	929,191	33.88%	1,200,173
Interest Receivable	0	0	0	0.00%	0
Other Receivables	0	0	0	0.00%	688,912
Inventories	110,223	103,068	7,155	6.94%	64,198
Prepaid Expenses	7,500	7,500	0	0.00%	88,409
Due From Third Party Payers	0	0	0	0.00%	152,354
Due From Affiliates/Related Organizations	0	0	0	0.00%	0
Other Current Assets	0	0	0	0.00%	0
Total Current Assets	**4,706,581**	**4,204,820**	**501,761**	**11.93%**	**2,540,681**
Assets Whose Use is Limited					
Cash	7,786	7,613	173	2.27%	8,613
Investments	0	0	0	0.00%	0
Bond Reserve/Debt Retirement Fund	0	0	0	0.00%	0
Trustee Held Funds	0	0	0	0.00%	0
Funded Depreciation	0	0	0	0.00%	0
Board Designated Funds	0	0	0	0.00%	0
Other Limited Use Assets	150	1,111	(961)	-86.50%	0
Total Limited Use Assets	**7,936**	**8,724**	**(788)**	**-9.03%**	**8,613**
Property, Plant, and Equipment					
Land and Land Improvements	693,510	693,510	0	0.00%	693,510
Building and Building Improvements	2,587,666	2,587,666	0	0.00%	2,587,666
Equipment	3,041,639	3,041,639	0	0.00%	2,966,485
Construction In Progress	0	0	0	0.00%	0
Capitalized Interest	0	0	0	0.00%	0
Gross Property, Plant, and Equipment	6,322,815	6,322,815	0	0.00%	6,247,661
Less: Accumulated Depreciation	(5,261,567)	(5,261,288)	(279)	-0.01%	(5,057,744)
Net Property, Plant, and Equipment	**1,061,248**	**1,061,527**	**(279)**	**-0.03%**	**1,189,917**
Other Assets					
Unamortized Loan Costs	0	0	0	0.00%	0
Assets Held for Future Use	0	0	0	0.00%	0
Investments in Subsidiary/Affiliated Org.	0	0	0	0.00%	0
Other	0	0	0	0.00%	0
Total Other Assets	**0**	**0**	**0**	**0.00%**	**0**
TOTAL UNRESTRICTED ASSETS	**5,775,765**	**5,275,071**	**500,694**	**9.49%**	**3,739,211**
Restricted Assets	0	0	0	0.00%	0
TOTAL ASSETS	**$5,775,765**	**$5,275,071**	**$500,694**	**9.49%**	**$3,739,211**

Balance Sheet - Liabilities and Net Assets

SOUTHERN INYO HEALTHCARE DISTRICT

LONE PINE, CALIFORNIA

Twelve Months Ended June 30, 2019

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	LIABILITIES AND FUND BALANCE				
	Current Month 6/30/2019	Prior Month 5/31/2019	Positive/ (Negative) Variance	Percentage Variance	Prior Year End 6/30/2018
Current Liabilities					
Accounts Payable	$4,933,871	$4,514,569	($419,302)	-9.29%	$8,163,834
Notes and Loans Payable	3,607	25,870	22,263	86.06%	0
Accrued Payroll	104,291	107,767	3,476	3.23%	190,346
Accrued Payroll Taxes	34,570	47,516	12,946	27.24%	0
Accrued Benefits	12,932	34,105	21,173	62.08%	0
Accrued Pension Expense (Current Portion)	0	0	0	0.00%	0
Other Accrued Expenses	0	2,997	2,997	100.00%	0
Patient Refunds Payable	0	2,287	2,287	100.00%	0
Property Tax Payable	0	0	0	0.00%	0
Due to Third Party Payers	85,439	0	(85,439)	0.00%	0
Advances From Third Party Payers	0	0	0	0.00%	0
Current Portion of LTD (Bonds/Mortgages)	0	0	0	0.00%	0
Current Portion of LTD (Leases)	3,607	3,640	33	0.91%	0
Other Current Liabilities	230,155	202,292	(27,863)	-13.77%	0
Total Current Liabilities	**5,408,473**	**4,941,043**	**(467,430)**	**-9.46%**	**8,354,180**
Long Term Debt					
Bonds/Mortgages Payable	0	0	0	0.00%	0
Leases/Notes Payable	20,729	17,815	(2,914)	-16.36%	0
Less: Current Portion Of Long Term Debt	3,607	3,640	33	0.91%	0
Total Long Term Debt (Net of Current)	**17,122**	**14,175**	**(2,947)**	**-20.79%**	**0**
Other Long Term Liabilities					
Deferred Revenue	0	0	0	0.00%	0
Accrued Pension Expense (Net of Current)	0	0	0	0.00%	0
Other	422,898	673,166	250,268	37.18%	0
Total Other Long Term Liabilities	**422,898**	**673,166**	**250,268**	**37.18%**	**0**
TOTAL LIABILITIES	**5,848,493**	**5,628,384**	**(220,109)**	**-3.91%**	**8,354,180**
Net Assets:					
Unrestricted Fund Balance	1,090,428	1,777,777	687,349	38.66%	(4,311,834)
Inter-Departmental Transfer (DSH)	0	0	0	0.00%	0
Restricted Fund Balance	0	0	0	0.00%	0
Net Revenue/(Expenses)	(1,167,515)	(2,131,089)	(963,574)	45.22%	(303,135)
TOTAL NET ASSETS	**(77,087)**	**(353,312)**	**(276,226)**	**78.18%**	**(4,614,969)**
TOTAL LIABILITIES AND NET ASSETS	**$5,771,406**	**$5,275,071**	**($496,335)**	**-9.41%**	**$3,739,211**

Statement of Revenue and Expense
SOUTHERN INYO HEALTHCARE DISTRICT
LONE PINE, CALIFORNIA
Twelve Months Ended June 30, 2019

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	CURRENT MONTH				
	Actual 06/30/19	Budget 06/30/19	Positive (Negative) Variance	Percentage Variance	Prior Year 06/30/18
Gross Patient Revenue					
Inpatient Revenue	$81,612	$24,685	$56,927	230.62%	$23,070
Clinic Revenue	65,872	28,003	37,869	135.23%	26,171
Outpatient Revenue	556,244	298,530	257,715	86.33%	279,000
Long Term Care Revenue	397,365	278,448	118,917	42.71%	260,232
Other	0	890	(890)	-100.00%	831
Total Gross Patient Revenue	1,101,094	630,555	470,538	74.62%	589,304
Deductions From Revenue					
Discounts and Allowances	(308,306)	(160,539)	(147,767)	-92.04%	(149,975)
Bad Debt Expense (Governmental Providers Only)	(33,033)	(12,611)	(20,422)	-161.93%	(17,679)
	0	0	0	0.00%	0
Charity Care	(7,500)	(631)	(6,869)	-1089.43%	(5,893)
Total Deductions From Revenue	(348,839)	(173,781)	(175,058)	-100.73%	(173,547)
Net Patient Revenue	752,255	456,774	295,480	64.69%	415,757
Deduction % of Gross Revenue	-31.7%	-27.6%			-29.4%
Other Operating Revenue	6,487	30,181	(23,694)	-78.51%	34,285
Total Operating Revenue	**758,742**	**486,956**	**271,786**	**55.81%**	**450,042**
Operating Expenses				Exp %/Net Rev	
Salaries and Wages	443,211	477,315	(34,104)	98.0%	458,957
Fringe Benefits	110,803	119,329	(8,526)	24.5%	114,739
Contract Labor	18,625	9,473	9,152	1.9%	9,108
Physicians Fees	156,258	140,877	15,381	28.9%	135,459
Purchased Services	21,837	585	21,252	0.1%	562
Supply Expense	21,218	21,550	(332)	4.4%	20,922
Utilities	20,910	6,915	13,995	1.4%	6,586
Repairs and Maintenance	(28,516)	3,407	(31,923)	0.7%	3,276
Insurance Expense	13,463	7,681	5,782	1.6%	7,315
All Other Operating Expenses	50,000	18,026	31,974	3.7%	17,416
Bad Debt Expense (Non-Governmental Providers)	0	0	-	0.0%	0
Leases and Rentals	12,193	3,447	8,746	0.7%	3,447
Depreciation and Amortization	33,962	13,533	20,429	2.8%	13,533
Interest Expense (Non-Governmental Providers)	0	0	-	0.0%	0
Total Operating Expenses	**873,963**	**822,136**	51,827	168.8%	**791,319**
Net Operating Surplus/(Loss)	**(115,221)**	**(335,180)**	**219,959**	**-65.62%**	**(341,277)**
Non-Operating Revenue:					
Contributions	0	0	0	0.00%	15,845
Investment Income	0	0	0	0.00%	358
Income Derived from Property Taxes	55,070	23,536	31,534	133.98%	123,863
Interest Expense (Governmental Providers Only)	(21,624)	(41,982)	(20,358)	48.49%	(5,007)
Other Non-Operating Revenue/(Expenses)	9,048	5,426	3,622	66.74%	10,303
Total Non Operating Revenue/(Expense)	**42,494**	**(13,020)**	**55,514**	**-426.39%**	**145,362**
Total Net Surplus/(Loss)	**($72,727)**	**($348,200)**	**$275,472**	**-79.11%**	**($195,915)**
Operating Margin	**-15.19%**	**-68.83%**			**-75.83%**
Total Profit Margin	**-9.59%**	**-71.51%**			**-43.53%**
EBITDA	**-13.56%**	**-74.67%**			**-73.94%**
Cash Flow Margin	**-2.26%**	**-60.11%**			**-39.41%**

Statement of Revenue and Expense

SOUTHERN INYO HEALTHCARE DISTRICT

LONE PINE, CALIFORNIA

Twelve Months Ended June 30, 2019

PAGE 6

	YEAR-TO-DATE				
	Actual 06/30/19	Budget 06/30/19	Positive (Negative) Variance	Percentage Variance	Prior Year 06/30/18
Gross Patient Revenue					
Inpatient Revenue	$839,841	$338,549	$501,292	148.07%	$453,249
Clinic Revenue	731,127	388,525	342,601	88.18%	367,339
Outpatient Revenue	6,109,463	4,151,847	1,957,616	47.15%	3,913,551
Long Term Care Revenue	4,648,637	3,880,572	768,065	19.79%	3,655,434
Other	6,081	27,903	(21,823)	-78.21%	23,032
Total Gross Patient Revenue	12,335,148	8,787,397	3,547,751	40.37%	8,412,605
Deductions From Revenue					
Discounts and Allowances	(3,432,155)	(2,237,271)	(1,194,883)	-53.41%	(2,141,379)
Bad Debt Expense (Governmental Providers Only)	(341,794)	(175,748)	(166,046)	-94.48%	(224,538)
	0	0	0	0.00%	0
Charity Care	(67,500)	(8,787)	(58,713)	-668.15%	(74,846)
Total Deductions From Revenue	(3,841,449)	(2,421,807)	(1,419,642)	-58.62%	(2,440,763)
Deductions as % of Gross Revenue	-31.1%	-27.6%			-29.0%
Net Patient Revenue	8,493,699	6,365,590	2,128,109	33.43%	5,971,842
Other Operating Revenue	281,932	375,531	(93,599)	-24.92%	330,919
Total Operating Revenue	**8,775,631**	**6,741,121**	**2,034,510**	**30.18%**	**6,302,762**
Operating Expenses				Exp %/Net Rev	
Salaries and Wages	5,082,283	5,223,895	141,613	77.5%	5,022,976
Fringe Benefits	1,270,571	1,305,974	35,403	19.4%	1,255,744
Contract Labor	543,240	260,033	(283,208)	3.9%	250,032
Physicians Fees	1,353,154	830,899	(522,255)	12.3%	798,942
Purchased Services	155,556	21,441	(134,115)	0.3%	20,616
Supply Expense	419,772	362,837	(56,935)	5.4%	352,269
Utilities	189,738	118,000	(71,738)	1.8%	112,381
Repairs and Maintenance	41,311	72,696	31,385	1.1%	69,900
Insurance Expense	207,186	139,452	(67,734)	2.1%	132,812
All Other Operating Expenses	994,466	374,795	(619,671)	5.6%	362,121
Bad Debt Expense (Non-Governmental Providers)	0	0	0	0.0%	0
Leases and Rentals	107,998	74,679	(33,318)	1.1%	74,679
Depreciation and Amortization	92,824	162,396	69,573	2.4%	162,396
Interest Expense (Non-Governmental Providers)	0	0	0	0.0%	0
Total Operating Expenses	**10,458,099**	**8,947,097**	**(1,511,002)**	132.7%	**8,614,867**
Net Operating Surplus/(Loss)	**(1,682,468)**	**(2,205,976)**	**523,508**	**-23.73%**	**(2,312,105)**
Non-Operating Revenue:					
Contributions	0	0	0	0.00%	15,845
Investment Income	0	0	0	0.00%	358
Income Derived from Property Taxes	665,867	282,757	383,110	135.49%	386,353
Interest Expense (Governmental Providers Only)	(259,490)	(276,109)	16,619	-6.02%	(60,834)
Other Non-Operating Revenue/(Expenses)	108,576	68,238	40,337	59.11%	120,060
Total Non Operating Revenue/(Expense)	**514,953**	**74,886**	**440,066**	**587.64%**	**461,782**
Total Net Surplus/(Loss)	**($1,167,515)**	**($2,131,089)**	**$963,574**	**-45.22%**	**($1,850,323)**
Operating Margin	**-19.17%**	**-32.72%**			**-36.68%**
Total Profit Margin	**-13.30%**	**-31.61%**			**-29.36%**
EBITDA	**-21.07%**	**-34.41%**			**-35.07%**
Cash Flow Margin	**-9.29%**	**-25.11%**			**-25.82%**

Statement of Revenue and Expense - 13 Month Trend

SOUTHERN INYO HEALTHCARE DISTRICT

LONE PINE, CALIFORNIA

	Actual 6/30/2018	Actual 7/31/2018	Actual 8/31/2018	Actual 9/30/2018	Actual 10/31/2018
Gross Patient Revenue					
Inpatient Revenue	$155,738	$144,006	$126,525	$56,063	$58,832
Clinic Revenue	59,053	38,668	41,384	69,875	107,871
Outpatient Revenue	547,017	489,492	502,826	473,329	401,154
Long Term Care Revenue	408,805	331,035	418,027	361,149	458,729
Other	0	6,081	0	0	0
Total Gross Patient Revenue	1,170,613	1,009,282	1,088,762	960,416	1,026,586
Deductions From Revenue					
Discounts and Allowances	(327,772)	(260,912)	(304,854)	(268,916)	(287,444)
Bad Debt Expense (Governmental Providers Only)	(39,185)	(2,019)	(32,663)	(28,812)	(30,798)
Prior Year Settlements	0	0	0	0	0
Charity Care	(14,427)	24,851	(10,088)	(9,604)	(7,500)
Total Deductions From Revenue	(381,384)	(238,080)	(347,605)	(307,333)	(325,742)
Net Patient Revenue	789,229	771,202	741,157	653,083	700,844
Other Operating Revenue	0	192,504	25,000	850	0
Total Operating Revenue	**789,229**	**963,706**	**766,157**	**653,933**	**700,844**
Operating Expenses					
Salaries and Wages	247,247	362,000	326,589	382,500	395,250
Fringe Benefits	55,573	90,500	81,647	95,625	98,813
Contract Labor	31,728	33,097	2,253	24,767	45,502
Physicians Fees	116,425	103,963	107,799	78,567	110,089
Purchased Services	19,703	18,169	24,891	17,734	19,290
Supply Expense	16,131	8,329	14,092	57,110	63,047
Utilities	20,856	4,305	14,183	22,639	15,226
Repairs and Maintenance	5,636	7,262	1,132	3,745	17,610
Insurance Expense	12,507	18,257	18,167	9,097	17,316
All Other Operating Expenses	185,242	311,507	161,149	60,245	20,990
Bad Debt Expense (Non-Governmental Providers)	0	0	0	0	0
Leases and Rentals	4,650	8,333	17,175	9,922	19,837
Depreciation and Amortization	53,401	27,673	27,673	781	781
Interest Expense (Non-Governmental Providers)	0	0	0	0	0
Total Operating Expenses	**769,099**	**993,395**	**796,750**	**762,732**	**823,751**
Net Operating Surplus/(Loss)	**20,131**	**(29,689)**	**(30,593)**	**(108,799)**	**(122,907)**
Non-Operating Revenue:					
Contributions	$0	0	0	0	0
Investment Income	0	0	0	0	0
Income Derived from Property Taxes	56,327	56,327	56,327	56,327	56,327
Interest Expense (Governmental Providers Only)	(5,382)	(5,382)	(5,382)	(5,382)	(5,382)
Other Non-Operating Revenue/(Expenses)	0	9,049	9,048	9,048	9,048
Total Non Operating Revenue/(Expense)	**$50,945**	**$59,994**	**$59,993**	**59,993**	**59,993**
Total Net Surplus/(Loss)	**$71,076**	**$30,305**	**$29,400**	**($48,806)**	**($62,914)**
Operating Margin	**2.55%**	**-3.08%**	**-3.99%**	**-16.64%**	**-17.54%**
Total Profit Margin	**9.01%**	**3.14%**	**3.84%**	**-7.46%**	**-8.98%**
EBITDA	**8.63%**	**-0.77%**	**-1.08%**	**-17.34%**	**-18.19%**
Cash Flow Margin	**16.45%**	**6.57%**	**8.15%**	**-6.52%**	**-8.10%**

Actual 11/30/2018	Actual 12/31/2018	Actual 1/31/2019	Actual 2/28/2019	Actual 3/31/2019	Actual 4/30/2019	Actual 5/31/2019	Actual 6/30/2019
$59,417	$81,121	$37,974	$60,551	$42,830	$36,939	$53,970	$81,612
$50,528	50,867	50,599	41,075	65,373	70,205	78,809	65,872
486,424	473,457	585,705	539,612	497,101	611,829	492,290	556,244
$335,371	510,328	424,064	381,661	328,580	363,234	339,093	397,365
0	0	0	0	0	0	0	0
931,740	1,115,773	1,098,342	1,022,899	933,884	1,082,207	964,162	1,101,093
($260,887)	(312,417)	(307,535)	(286,412)	(261,488)	(303,018)	(269,965)	(308,306)
($27,952)	(33,473)	(32,950)	(30,687)	(28,017)	(32,466)	(28,925)	(33,033)
$0	0	0	0	0	0	0	0
($7,500)	(7,500)	(7,500)	(7,500)	(7,500)	(7,500)	(7,500)	(7,500)
(296,339)	(353,390)	(347,985)	(324,599)	(297,005)	(342,984)	(306,390)	(348,839)
635,401	762,383	750,357	698,300	636,879	739,223	657,772	752,254
$18,167	6,487	6,487	6,487	6,487	6,487	6,487	6,487
653,568	**768,870**	**756,844**	**704,787**	**643,366**	**745,710**	**664,259**	**758,741**
$379,286	442,857	451,714	422,010	467,225	517,285	492,355	443,211
$94,821	110,714	112,929	105,503	116,806	129,321	123,089	110,803
$153,788	83,541	45,222	30,484	28,066	30,875	47,023	18,625
$70,690	119,712	165,877	73,748	85,280	143,591	137,582	156,258
$6,510	6,461	3,548	3,896	18,366	6,382	8,471	21,837
$39,060	29,518	35,977	39,400	33,510	23,737	54,774	21,218
$21,417	22,852	21,810	11,002	11,212	16,626	7,555	20,910
$6,048	4,051	7,742	2,418	10,335	3,064	6,421	(28,516)
$32,754	19,923	17,317	19,816	0	17,316	23,758	13,463
$16,397	11,245	65,113	77,664	103,966	57,293	58,896	50,000
$0	0	0	0	0	0	0	0
$9,269	4,167	10,987	2,750	4,600	4,600	4,167	12,193
$279	279	279	279	279	279	279	33,962
$0	0	0	0	0	0	0	0
830,318	**855,320**	**938,515**	**788,970**	**879,645**	**950,369**	**964,370**	**873,964**
(176,750)	**(86,450)**	**(181,671)**	**(84,183)**	**(236,279)**	**(204,659)**	**(300,111)**	**(115,223)**
0	$0	$0	0	$0	0	0	$0
$0	0	0	0	0	0	0	0
$55,070	55,070	55,070	55,070	55,070	55,070	55,070	55,070
($5,382)	(5,382)	(5,382)	(21,624)	(21,624)	(21,624)	(21,624)	(21,624)
$9,048	9,048	9,048	9,048	9,048	9,048	9,048	9,048
58,736	**58,736**	**58,736**	**42,494**	**42,494**	**42,494**	**42,494**	**42,494**
($118,015)	**($27,714)**	**($122,935)**	**($41,689)**	**($193,785)**	**($162,165)**	**($257,617)**	**($72,729)**
-27.04%	**-11.24%**	**-24.00%**	**-11.94%**	**-36.73%**	**-27.44%**	**-45.18%**	**-15.19%**
-18.06%	**-3.60%**	**-16.24%**	**-5.92%**	**-30.12%**	**-21.75%**	**-38.78%**	**-9.59%**
-27.82%	**-11.91%**	**-24.68%**	**-14.97%**	**-40.04%**	**-30.31%**	**-48.39%**	**-13.56%**
-17.19%	**-2.87%**	**-15.50%**	**-2.81%**	**-26.72%**	**-18.81%**	**-35.49%**	**-2.26%**

Patient Statistics

SOUTHERN INYO HEALTHCARE DISTRICT

LONE PINE, CALIFORNIA

Twelve Months Ended June 30, 2019

Current Month					Year-To-Date			
Actual 06/30/19	Budget 06/30/19	Positive/ (Negative) Variance	Prior Year 06/30/18	STATISTICS	Actual 06/30/19	Budget 06/30/19	Positive/ (Negative) Variance	Prior Year 06/30/18
				Discharges				
3	3	0	2	Acute	51	34	17	18
0	0	0	0	Swing Beds	8	4	4	2
0	0	0	0	Psychiatric/Rehab	0	0	0	0
0	0	0	0	Respite	0	0	0	0
3	3	0	2	Total Adult Discharges	59	38	21	20
0	0	0	0	Newborn	0	0	0	0
3	3	0	2	Total Discharges	59	38	21	20
				Patient Days:				
11	8	3	6	Acute	161	72	89	58
0	0	0	0	Swing Beds	12	0	12	0
0	0	0	0	Psychiatric/Rehab	0	0	0	0
0	0	0	0	Respite	0	0	0	0
11	8	3	6	Total Adult Patient Days	173	72	101	58
0	0	0	0	Newborn	0	0	0	0
11	8	3	6	Total Patient Days	173	72	101	58
				Average Length of Stay (ALOS)				
3.7	2.7	(1.0)	3.0	Acute	3.2	2.1	(1.0)	3.2
N/A	N/A	N/A	N/A	Swing Bed	1.5	0.0	(1.5)	0.0
N/A	N/A	N/A	N/A	Psychiatric/Rehab	N/A	N/A	N/A	N/A
3.7	2.7	(1.0)	3.0	Total Adult ALOS	2.9	1.9	(1.0)	2.9
N/A	N/A	N/A	N/A	Newborn ALOS	N/A	N/A	N/A	N/A
				Average Daily Census (ADC)				
0.4	0.3	0.1	0.2	Acute	0.4	0.2	0.2	0.2
0.0	0.0	0.0	0.0	Swing Beds	0.0	0.0	0.0	0.0
0.0	0.0	0.0	0.0	All Other Adult	0.0	0.0	0.0	0.0
0.4	0.3	0.1	0.2	Total Adult ADC	0.5	0.2	0.3	0.2
0.0	0.0	0.0	0.0	Newborn	0.0	0.0	0.0	0.0
				Long Term Care:				
798	744	54	775	SNF/ECF Resident Days	8,601	8,283	318	8,525
4	2	2	2	SNF/ECF Resident Discharges	34	34	0	28
0	0	0	0	CBRF/Assisted Living Days	0	0	0	0
26.6	24.8	1.8	25.8	Average Daily Census	23.6	22.7	0.9	23.4
				Emergency Room Statistics				
4	1	3	0	ER Visits - Admitted	15	9	6	0
158	145	13	140	ER Visits - Discharged	1,383	1,601	(218)	1,620
15	10	5	8	ER - Urgent Care Visits	144	110	34	88
177	156	21	148	Total ER Visits	1,542	1,720	(178)	1,708
2.26%	0.64%		0.00%	% of ER Visits Admitted	0.97%	0.52%		0.00%
100.00%	33.33%		0.00%	ER Admissions as a % of Total	26.79%	26.47%		0.00%
				Outpatient Statistics:				
272	355	(83)	350	Total Outpatients Visits	3,831	3,005	826	2,744
2	0	2	0	Observation Bed Days	13	0	13	0
262	375	(113)	371	Clinic Visits - Primary Care	2,526	3,680	(1,154)	3,646
42	0	42	0	Clinic Visits - Specialty Clinics	184	0	184	0
0	0	0	0	IP Surgeries	0	0	0	0
0	0	0	0	OP Surgeries	0	0	0	0
0	0	0	0	Outpatient Scopes	0	0	0	0
0	0	0	0	Retail Pharmacy Scripts	0	0	0	0
0	0	0	0		0	0	0	0
				Productivity Statistics:				
93.95	95.20	1.25	97.84	FTE's - Worked	95.72	95.20	(0.52)	92.41
104.17	100.60	(3.57)	104.68	FTE's - Paid	104.68	105.86	1.18	103.27
0.9160	0.8560	(0.06)	0.8560	Case Mix Index -Medicare	0.9456	0.9768	0.03	0.9768
0.8990	0.8050	(0.09)	0.8050	Case Mix Index - All payers	0.8990	0.9769	0.08	0.9769

Key Financial Ratios

SOUTHERN INYO HEALTHCARE DISTRICT

LONE PINE, CALIFORNIA

Twelve Months Ended June 30, 2019

	Year to Date 6/30/2019	Prior Year to Date 6/30/2018	Prior Fiscal Year End 6/30/2018	Peer California Hospitals (See Note 1)	National Rural CAH Hospitals (See Note 2)
Profitability:					
Operating Margin	-19.17%	2.66%	2.66%	2.33%	0.42%
Total Profit Margin	-13.30%	2.37%	2.37%	2.49%	1.23%
Cash Flow Margin	-12.25%	3.91%	3.91%	8.40%	5.91%
Contractual Allowance %	28.37%	48.00%	48.00%	50.62%	39.92%
Inpatient Gross Revenue as a % of Total	47.07%	36.74%	36.74%	38.85%	28.48%
Outpatient Gross Revenue as % of Total	52.93%	63.26%	63.26%	64.83%	74.43%
Average Daily Census Acute Care	0.37	0.00	0.00	5.57	3.22
Average Daily Census Swing Bed	0.00	0.00	0.00	0.37	1.52
Liquidity:					
Days of Cash on Hand, Short Term	32.29	3.20	3.20	23.32	27.10
Days Cash, All Sources	32.56	4.70	4.70	67.87	71.21
Net Days in Accounts Receivable	150.57	97.15.	97.15.	59.54	53.16
Average Payment Period	175.71	231.47	231.47	56.65	53.00
Current Ratio	0.87	0.69	0.69	2.31	1.12
Medicare Cost to charge ratio	59.08%	53.20%	53.20%	38.00%	47.00%
Capital Structure:					
Average Age of Plant (Annualized)	13.88	13.87	13.87	11.13	11.45
Capital Costs as a % of Total Expenses	3.29%	3.58%	3.58%	7.51%	5.30%
Long Term Debt to Equity	-22.2%	-202.7%	-202.7%	53.99%	60.32%
Long Term Debt to Capitalization	-28.6%	197.3%	197.3%	20.13%	29.00%
Debt Service Coverage Ratio	(3.10)	0.92	0.92	2.27	3.16
Medicare IN Patient Payer mix	32.30%	37.84%	37.84%	57.90%	73.01%
Medicare Out Patient Payer mix	34.55%	33.46%	33.46%	38.89%	37.90%
Productivity and Efficiency:					
Paid FTE's per Adjusted Occupied Bed	15.04	9.91	9.91	10.34	5.86
Total Net Revenue per FTE	$83,833	$37,092	$37,092	$117,848	$77,243
Salary Expense per Paid FTE	$53,141	$50,287	$50,287	$59,647	$50,845
Salary and Benefits as a % of Net Revenue	78.58%	58.21%	58.21%	41.52%	45.57%
Employee Benefits %	25.00%	24.57%	24.57%	41.29%	25.20%
Supply Expense Per Adj. Discharge - CMI Ad	$538.83	$499.95	$499.95	$2,476.27	$1,050.00
FTE's Per Occupied Bed	8.86	4.97	4.97	5.31	5.80

	YTD - Actual 6/30/2019	YTD - Actual 7/31/2017	YTD - Actual 6/30/2018	YTD - Budget 6/30/2019
Other Ratios:				
Gross Days in Accounts Receivable	247.35	671.65	671.65	60.00
Net Revenue per Adjusted Discharge	$10,127	$9,886	$9,886	$6,835
Operating Expenses per Adj. Discharge	$12,069	$14,668	$14,668	$9,071

Note 1 - CHA Financial Indicators Report 2016 (U. of North Carolina)

Note 2 - Per CAH Financial Indicators Report 2016 (U. of North Carolina)

BOARD OF DIRECTORS MEETING

Thursday, September 19, 2019

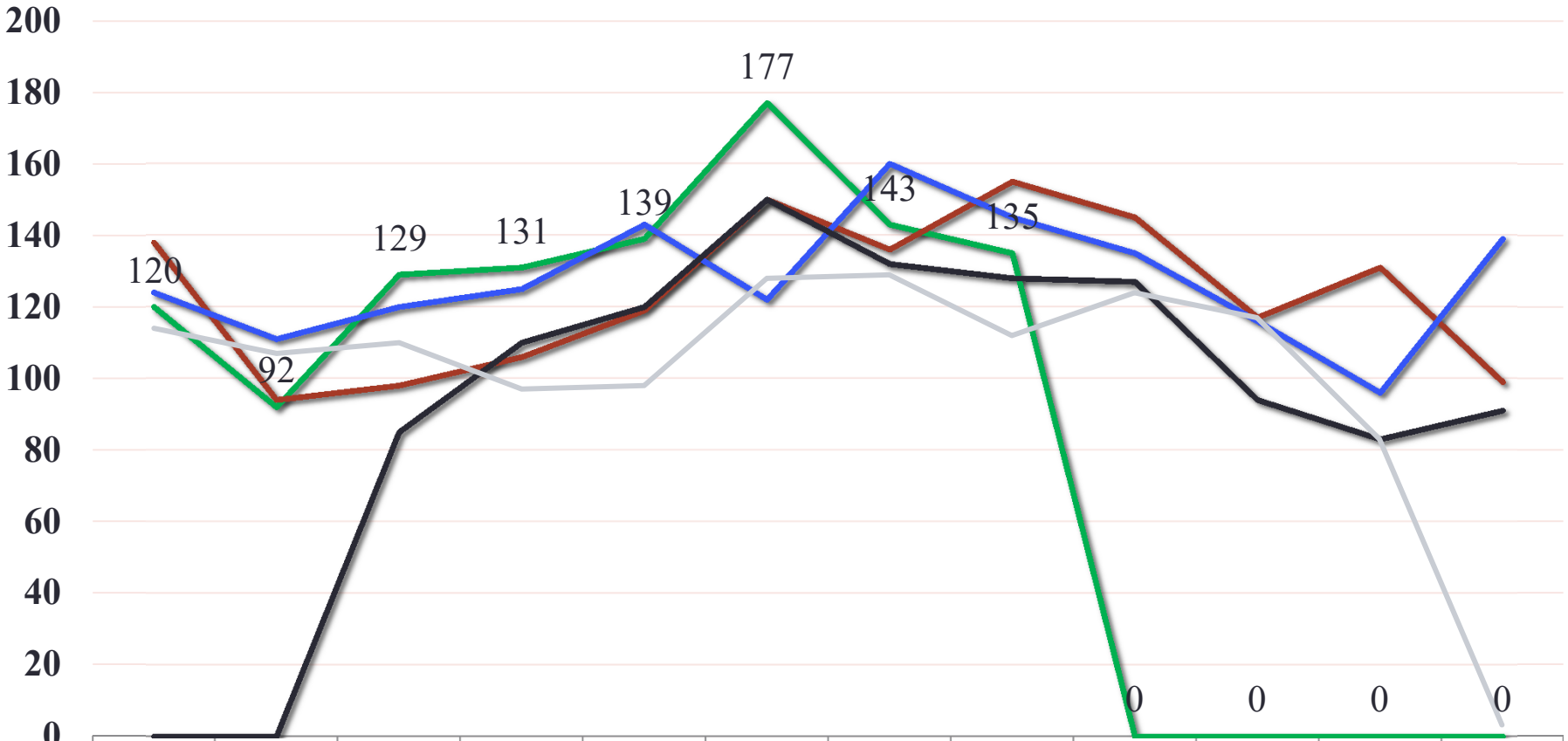
Southern Inyo Healthcare District

Emergency Room Volume

Average Visits Per Day

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	**3.87**	**3.28**	**4.16**	**4.36**	**4.48**	**5.9**	**4.61**	**4.35**				
2018	**4.46**	**3.36**	**3.17**	**3.54**	**3.84**	**5**	**4.39**	**5**	**4.83**	**3.78**	**4.37**	**4**
2017	4.4	3.9	3.8	4.2	4.6	4.1	5.2	4.7	4.5	3.7	3.2	4.49
2016	-	-	2.7	3.7	3.9	5.0	4.3	4.1	4.1	3.0	2.8	2.9
2015	3.7	3.8	3.5	3.2	3.2	4.3	4.2	3.6	4.1	3.8	2.8	0.1
2014	2.7	2.4	2.1	2.6	2.7	3.1	5.1	4.2	3.2	3.5	2.8	2.9
2013	2.9	2.4	2.5	2.2	2.8	3.3	3.4	3.0	3.3	2.0	2.3	2.1
2012	2.7	2.9	2.7	3.5	3.2	4.2	3.8	3.9	3.2	3.0	2.7	2.9

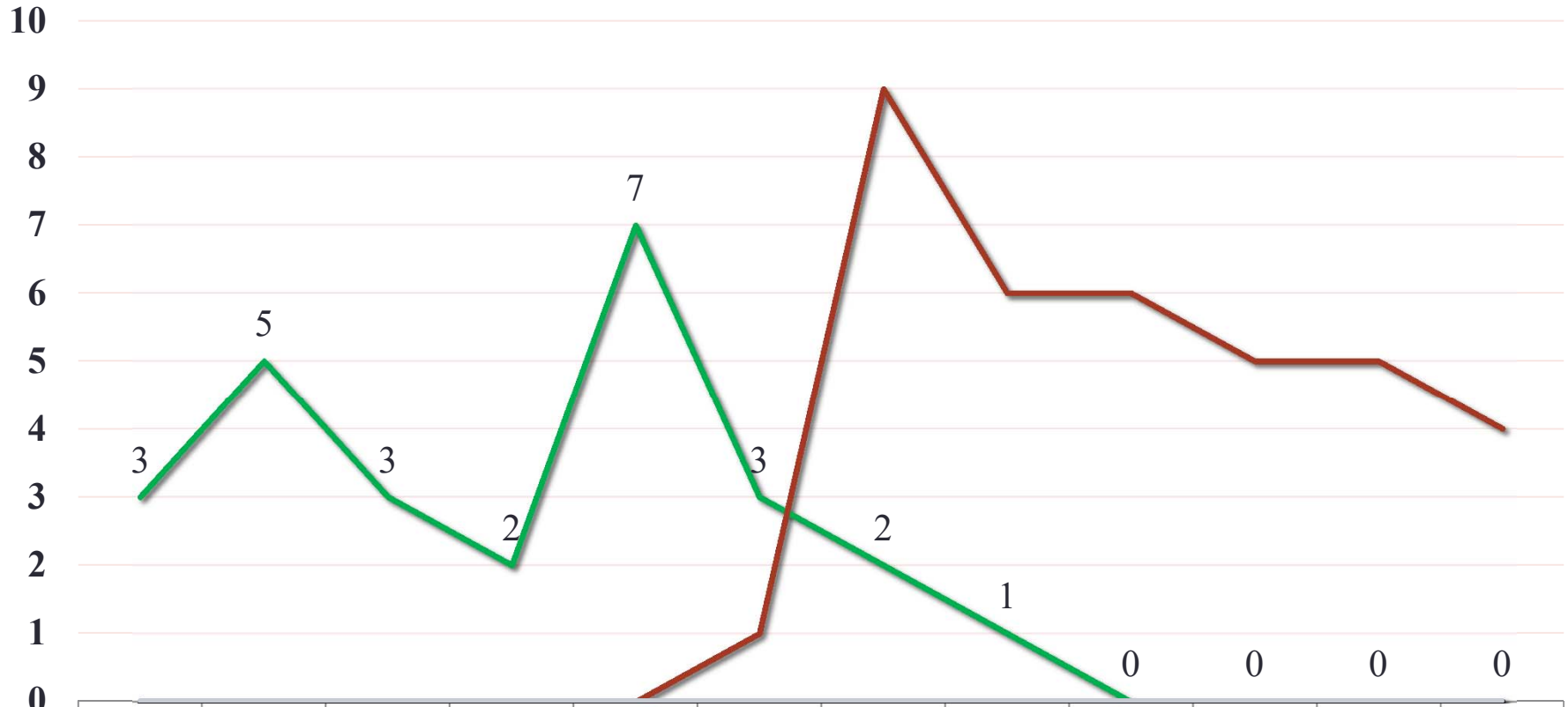
Emergency Room Volume – Visits Per Month



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	120	92	129	131	139	177	143	135				
2018	138	94	98	106	119	150	136	155	145	117	131	99
2017	124	111	120	125	143	122	160	145	135	116	96	139
2016	-	-	85	110	120	150	132	128	127	94	83	91
2015	114	107	110	97	98	128	129	112	124	117	83	3

2019 2018 2017 2016 2015

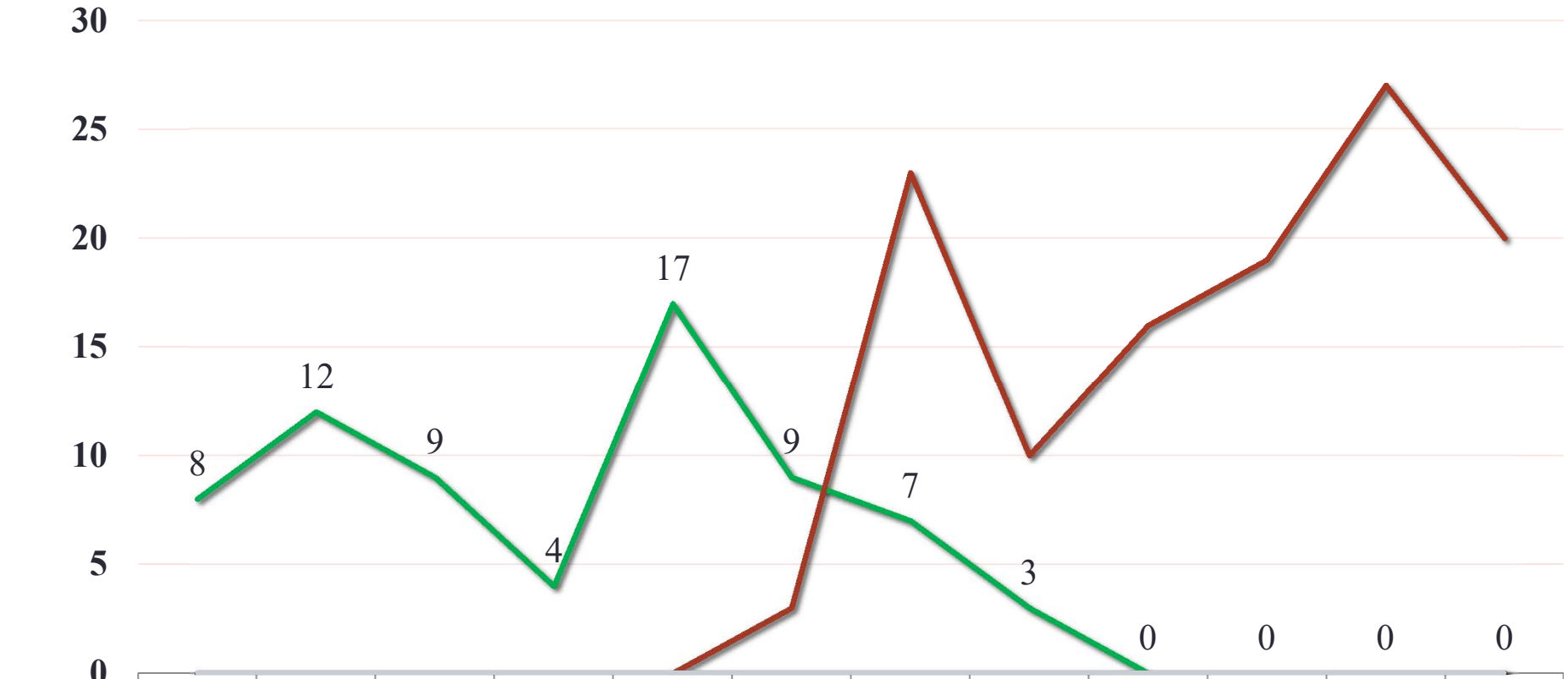
Acute & Swing Room – Patients Per Month



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	3	5	3	2	7	3	2	1				
2018						1	9	6	6	5	5	4
2017												
2016												
2015												

2019 2018 2017 2016 2015

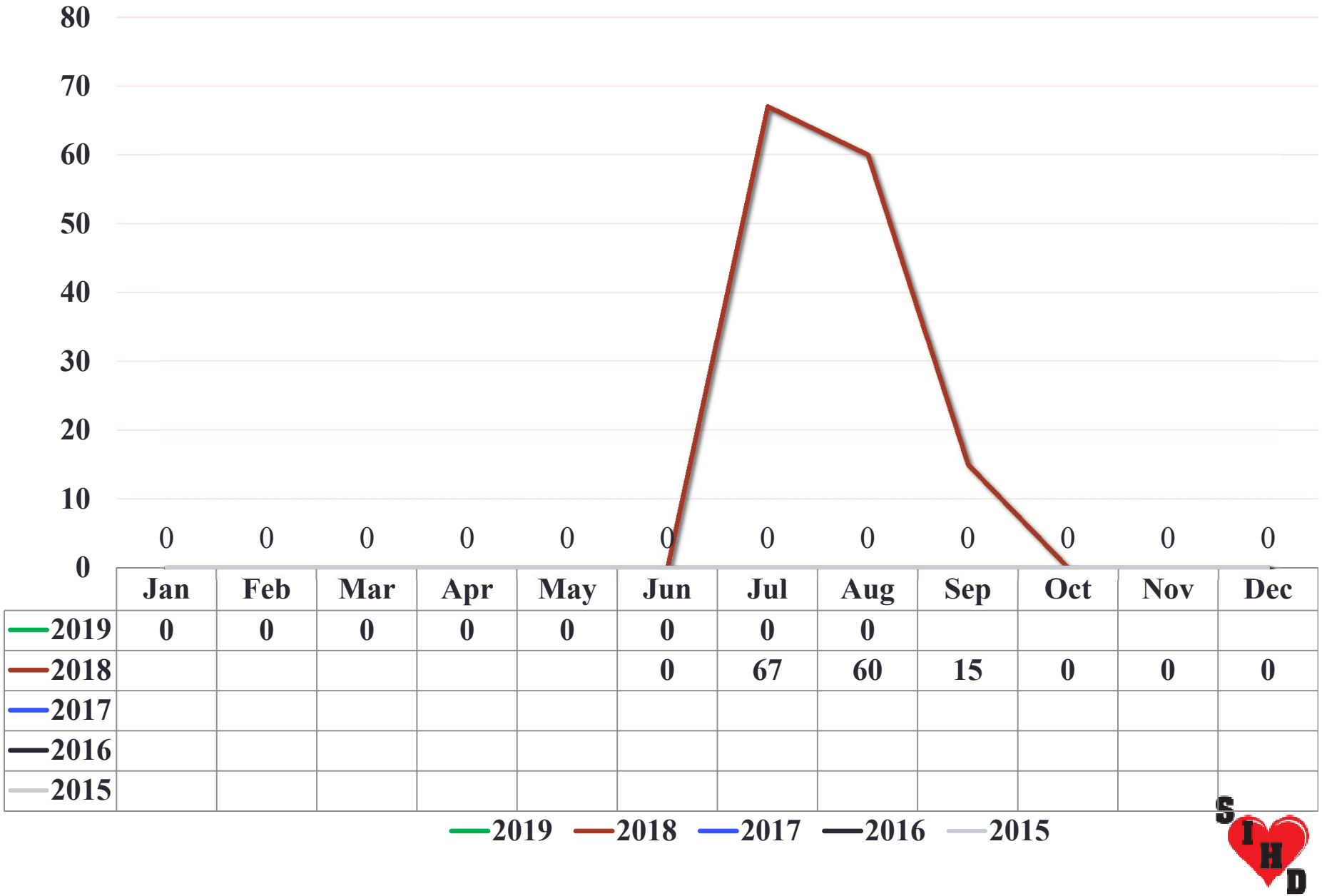
Acute Room – Total Days in Acute



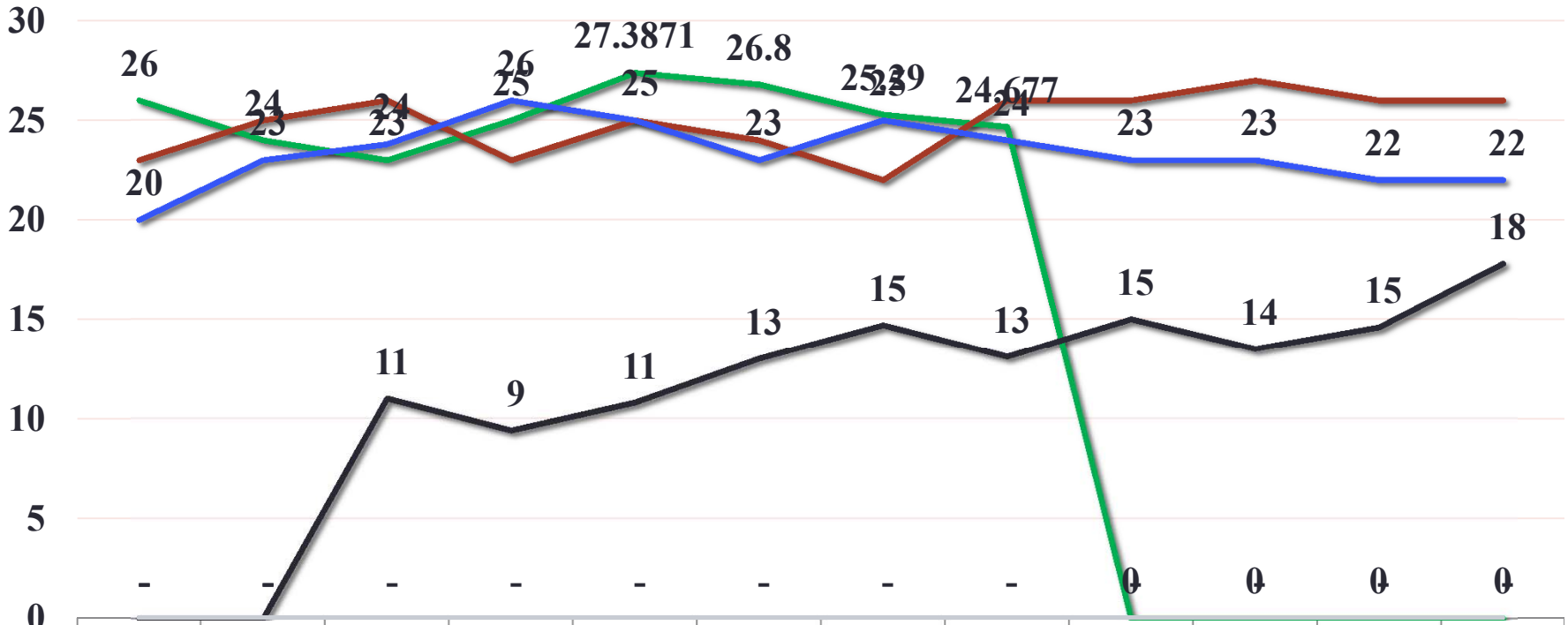
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	8	12	9	4	17	9	7	3				
2018						3	23	10	16	19	27	20
2017												
2016												
2015												

2019 2018 2017 2016 2015

Swing Bed Room – Total Days in Swing Bed

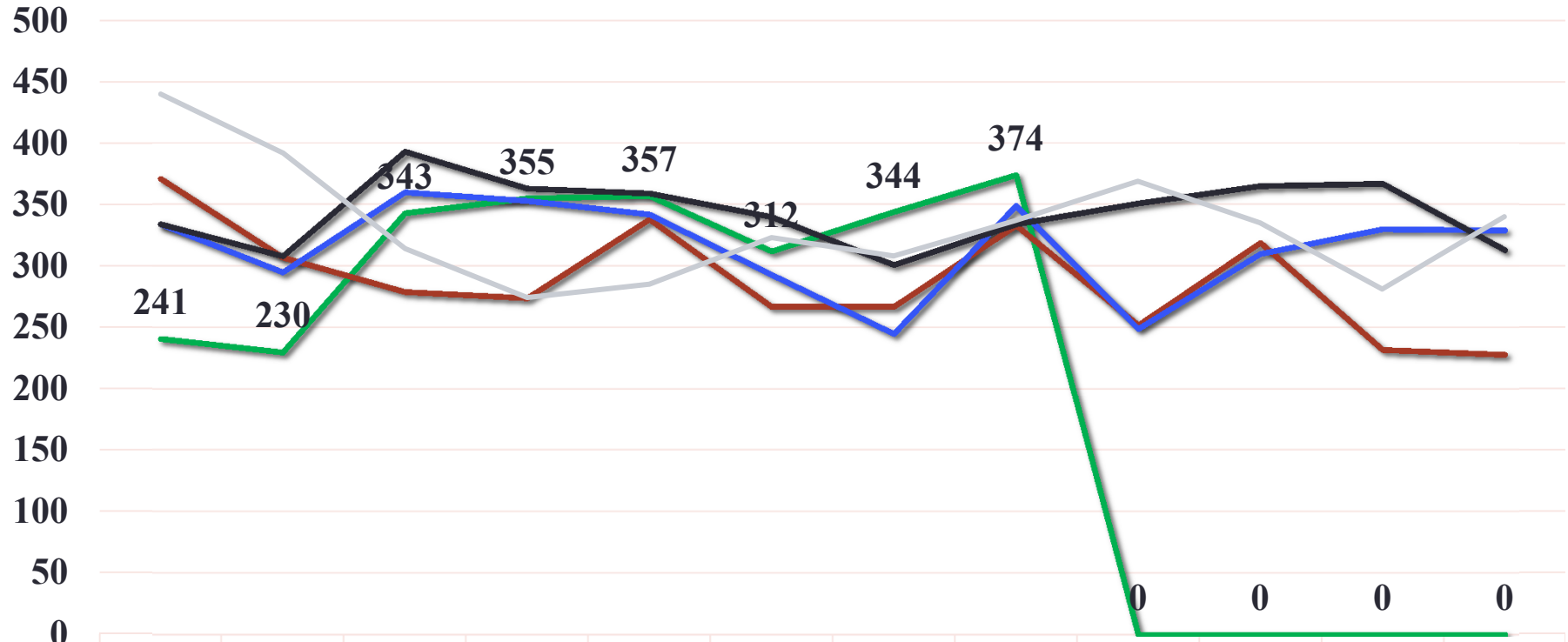


Skilled Nursing Facility Volumes – Monthly Census



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	26	24	23	25	27.387	26.8	25.29	24.677				
2018	23	25	26	23	25	24	22	26	26	27	26	26
2017	20	23	24	26	25	23	25	24	23	23	22	22
2016	-	-	11	9	11	13	15	13	15	14	15	18
2015	-	-	-	-	-	-	-	-	-	-	-	-

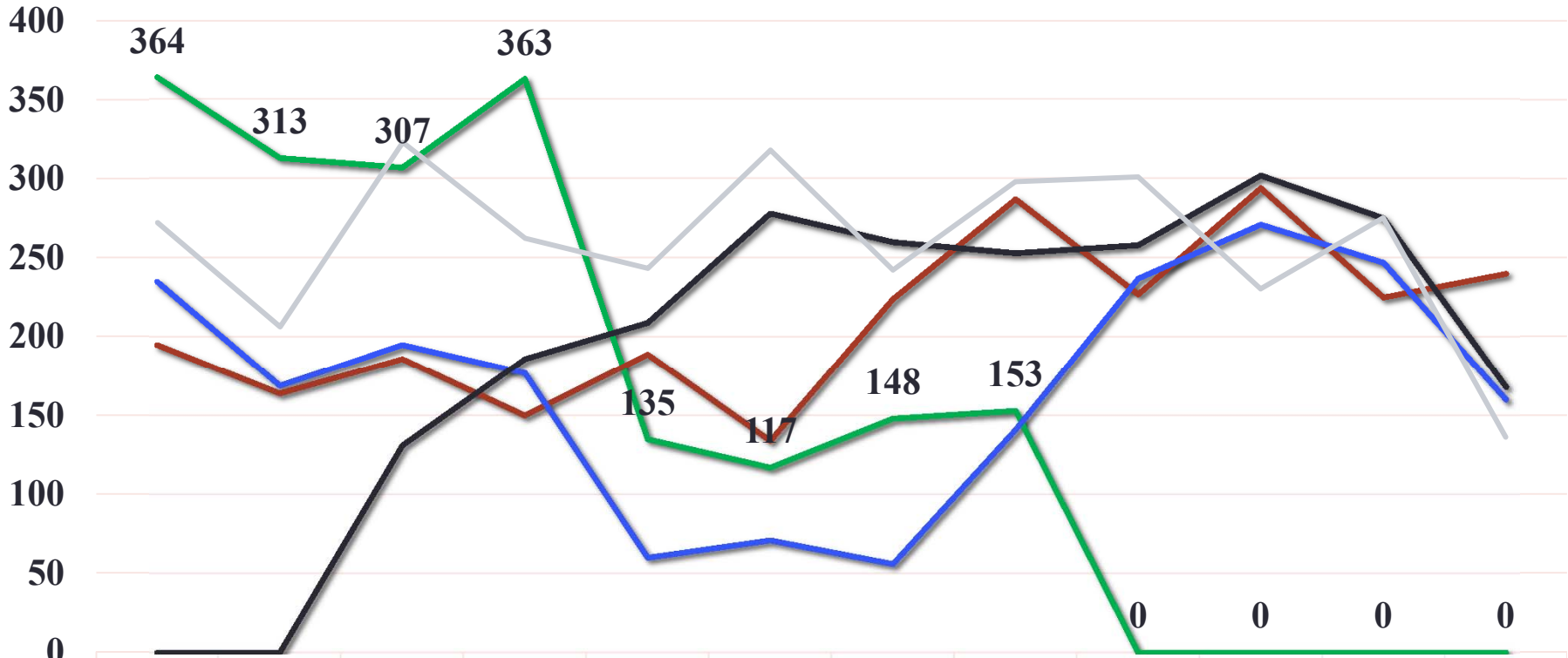
SIHD Rural Clinic Volumes – Visits Per Month



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	241	230	343	355	357	312	344	374				
2018	371	307	279	274	338	267	267	333	252	319	232	228
2017	334	295	360	353	342	293	245	349	249	310	330	329
2016	334	308	393	363	359	340	301	334	351	365	367	313
2015	440	392	314	274	285	323	308	337	369	335	281	340

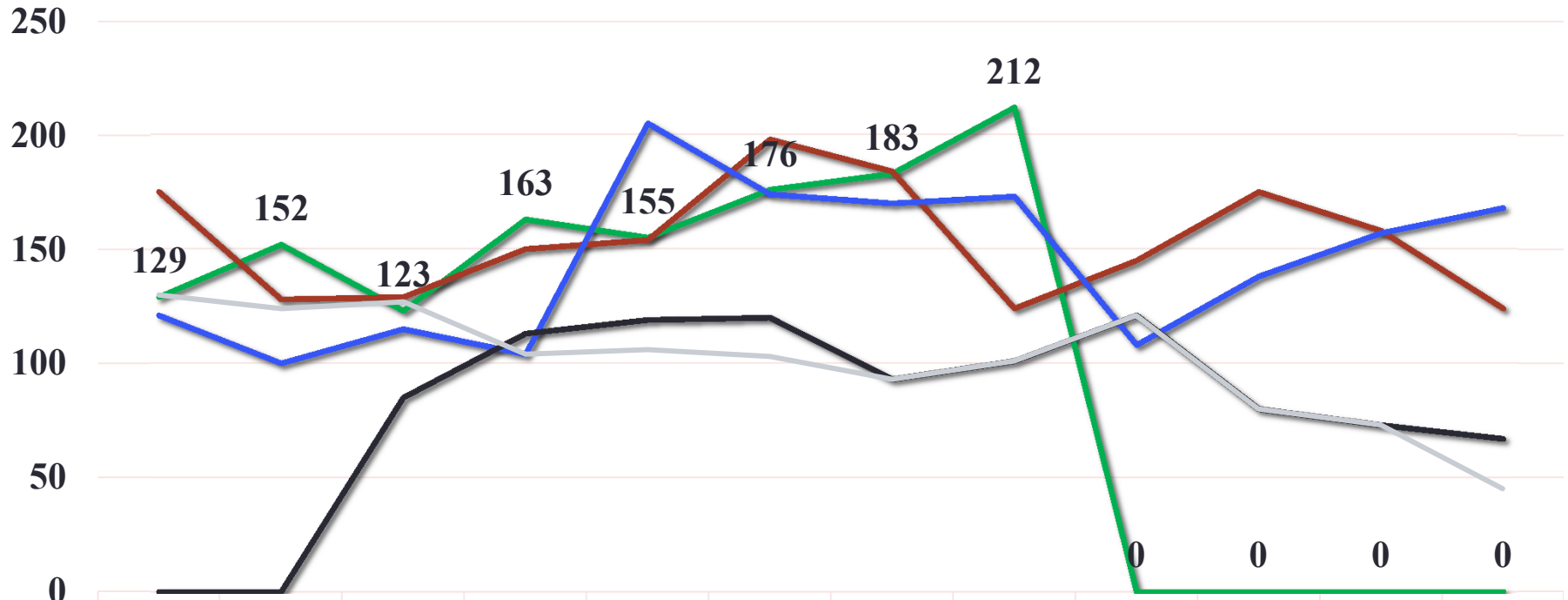
2019 2018 2017 2016 2015

Physical Therapy Volumes



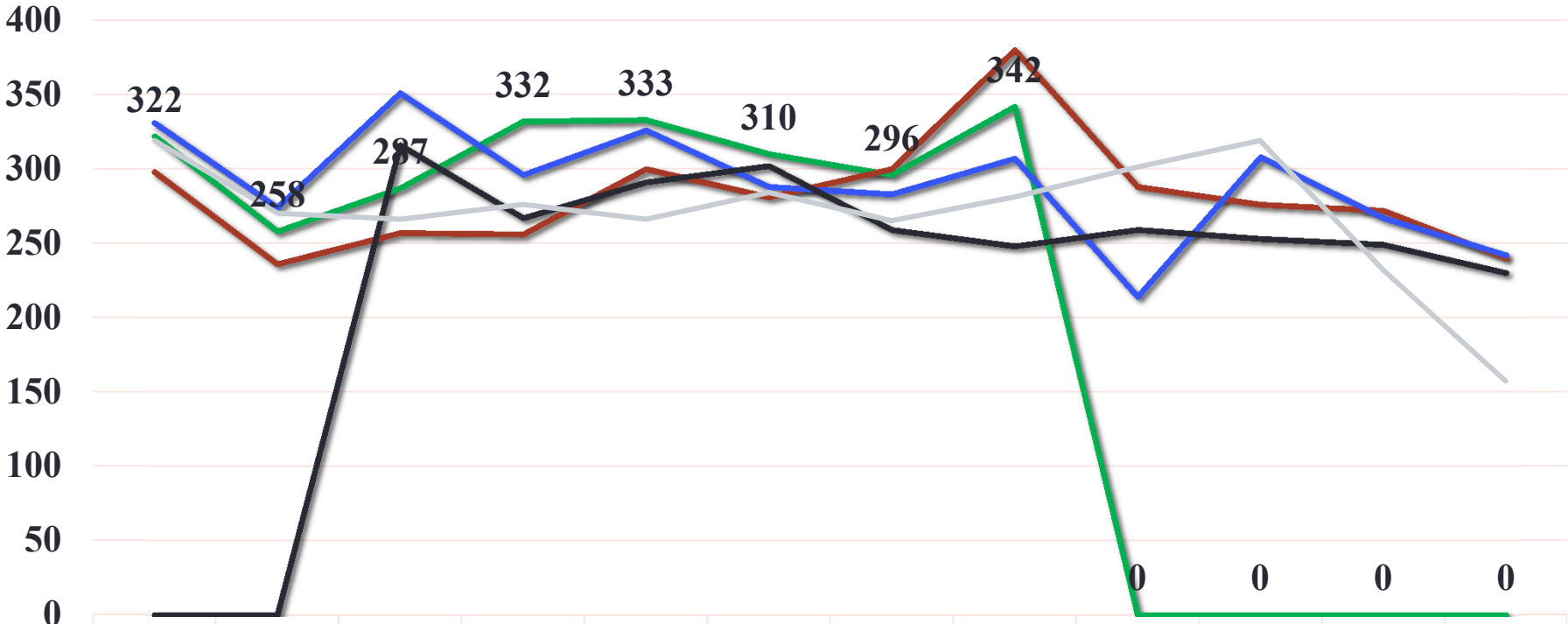
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	364	313	307	363	135	117	148	153				
2018	195	164	186	150	189	134	224	287	227	294	225	240
2017	235	169	195	177	60	71	56	141	237	271	247	160
2016	-	-	131	186	209	278	260	253	258	302	275	168
2015	272	206	323	262	243	318	242	298	301	230	275	136

X Ray Volumes – Visits-Exams Per Month



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	129	152	123	163	155	176	183	212				
2018	175	128	129	150	154	198	184	124	145	175	158	124
2017	121	100	115	104	205	174	170	173	108	138	157	168
2016	-	-	85	113	119	120	93	101	121	80	73	67
2015	130	124	127	104	106	103	93	101	121	80	73	45

Laboratory Volumes



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	322	258	287	332	333	310	296	342				
2018	298	236	257	256	300	281	300	380	288	276	272	240
2017	331	274	351	296	326	288	283	307	214	308	267	242
2016	-	-	316	267	291	302	259	248	259	253	249	230
2015	319	270	266	276	266	284	265	281	301	319	232	157