Davis Wright Tremaine LLP

Suite 800
505 Montgomery Street
San Francisco, CA 94111-6533

Jean Tom
(415) 276-6538 tel
(415) 276-6599 fax

JeanTom@dwt.com

July 22, 2020

VIA UPS

Anita Garcia Velasco
Deputy Attorney General
Healthcare Rights and Access
California Department of Justice
300 S. Spring Street
Los Angeles, California 90013

Re: Pasadena Hospital Association and Cedars-Sinai Health System — Written Notice and Request for California Attorney General Consent to the Affiliation (Corp. Code §5920 / 11 C.C.R. 4995).

Dear Ms. Garcia Velasco:

Pursuant to California Corporations Code §§ 5920, *et seq.*, Pasadena Hospital Association Ltd., a California nonprofit public benefit corporation ("PHA"), hereby:

(a) Provides written notice through this letter and all attachments hereto ("Notice") to the California Attorney General ("Attorney General") of a proposed change in control transaction involving PHA and Cedars-Sinai Health System, a California nonprofit public benefit corporation ("Cedars-Sinai"), in accordance with the requirements of Section 999.5(a)[1]; and

(b) Requests the Attorney General's consent to such transaction pursuant to California Corporations Code § 5920(a).

The proposed affiliation (the "Affiliation") contemplates that PHA, which owns and operates Huntington Hospital, an acute care hospital located in Pasadena, California, will become a part of Cedars-Sinai's integrated healthcare delivery system, and Cedars-Sinai will become PHA's sole member. PHA currently has no member. The structure and terms of the Affiliation are substantially the same as the terms of the 2018 affiliation between Cedars-Sinai

[1] Section references are to Title 11 of the California Administrative Code, unless otherwise indicated, and capitalized terms have the meanings in Section 999.5.

and Torrance Health Association, Inc., a California nonprofit public benefit corporation, which was approved by the Attorney General pursuant to California Corporations Code Section 5920.

The Affiliation is the culmination of an extensive deliberative process that the PHA Board commenced in late 2018 to secure PHA's future in an increasingly competitive healthcare industry and preserve its mission, values and commitment to the community. The PHA Board began evaluating a variety of potential transactions intended to preserve and strengthen the quality and scope of healthcare services that PHA and its affiliates provide to their communities, including its charity care and community benefit services, as well as to provide PHA with access to additional resources to support its current and anticipated capital needs into the future.

The PHA Board first worked to clarify its priorities and objectives for a strategic transaction, which the Board determined included mission, culture, clinical programs and services, physician alignment, ambulatory strategies, value-based care capabilities, information technology resources, financial resources, and strategic alignment. The PHA Board also considered the effects a transaction might have on its relationship with the Collis P. and Howard Huntington Memorial Hospital Trust (the "Trust"), a California charitable trust which exists for the benefit and support of PHA. The PHA Board authorized the formation of a committee (the "Rose Committee") to explore alternatives for PHA to consider.

The Rose Committee explored alternatives for an affiliation transaction in which PHA could join a health system that best met PHA's priorities. The Rose Committee reconstituted itself as the "Partnership Committee," which consisted solely of volunteer directors, and further pursued strategic alternatives.

Ultimately, after considering proposals from and engaging in confidential discussions with several potential affiliation partners, the PHA Board, upon the recommendation of the Partnership Committee, determined at its meeting in March 2020 that the Affiliation with Cedars-Sinai, which includes commitments to install a new electronic health record system at PHA, support PHA's 9-year strategic capital plan, and preserve key community healthcare programs, was the best choice for PHA. The PHA Board's determined that the Affiliation with Cedars-Sinai would enhance PHA's ability to fulfill its mission and vision and position PHA to be a leader in a value-based care environment. The parties entered into a letter of intent on March 6, 2020, and issued a public announcement on March 9, 2020. And after several months of due diligence and negotiations, PHA and Cedars-Sinai entered into a formal Affiliation Agreement reflecting these deal terms on July 15, 2020 ("Affiliation Agreement").

In pursuing this Affiliation, the parties intend for PHA to continue providing inpatient and outpatient services through Huntington Hospital and its affiliates as part of maintaining and improving healthcare quality and access throughout the communities of Los Angeles and the San Gabriel Valley. The Affiliation Agreement includes commitments for continued investment in Huntington Hospital, including its identified needs in enterprise information technology, ambulatory services, and physician development, and provides for an ongoing commitment to advancing PHA's existing mission and unique culture as a community institution governed by its local community board. PHA's assets will continue to be used for the same purposes for which

they are currently being used, with no change in either ownership or purpose. PHA and its affiliates will continue to provide the full scope of reproductive health services after the Affiliation which are available currently. A more detailed summary of the Affiliation Agreement is provided for in Section 999.5(d)(1)(A) of this Notice and the full Affiliation Agreement is included as Exhibit 3-A to Section 999.5(d)(1)(B). The parties believe the Affiliation will improve the quality of and access to healthcare in their communities, strengthening PHA and its affiliates with the resources and support of Cedars-Sinai and enabling PHA and its affiliates to lead the development and execution of the strategy for ongoing operations to deliver clinical excellence and value-based care in the San Gabriel Valley.

This request for approval, filings pursuant to the Hart-Scott-Rodino Antitrust Improvement Act of 1976, and other consents necessary to close the Affiliation, as required under the Affiliation Agreement, are ongoing at this time. Pursuant to the Affiliation Agreement, the closing of the Affiliation will occur upon satisfaction of each party's respective closing conditions, which we expect to occur before the end of 2020.

Per our previous correspondence, we are submitting this Notice, which contains a complete set of materials containing all of the information and documentation required under Section 999.5, along with a CD-ROM containing an identical set of these materials in PDF format, and simultaneously sending an identical set of these materials (less the CD-ROM) directly to Lily Weaver and Emilio Varanini of the Attorney General's Office and Phil Dalton with JD Healthcare, Inc. A separate set of confidential documents will be sent under separate cover to you, Lily Weaver, Emilio Varanini and Phil Dalton.

Also enclosed is an additional copy of this cover letter. To acknowledge your receipt of this notice, please date stamp and return the copy of this cover letter to the undersigned in the self-addressed and metered envelope provided or via email.

We would be happy to provide any additional information or documentation which you may require or to answer any questions you may have regarding the Notice. Please feel free to contact me at your convenience. We appreciate your consideration of this request and look forward to your response.

Respectfully submitted,

Davis Wright Tremaine LLP

REDACTED

Jean L. Tom

Enclosures

cc: Jason A. Farber, Esq. (w/o enclosures)

Huntington Hospital
Attn: Rita Schmaeler
100 W. California Boulevard
Pasadena, CA 91105
(with two sets of enclosures)

Lily Weaver
Deputy Attorney General
Office of the Attorney General
1300 I Street
Sacramento, CA 95814
(with one set of enclosures)

Emilio Varanini
Supervising Deputy Attorney General
Office of the Attorney General
455 Golden Gate Ave, 11th Floor
San Francisco, CA 94102
(with one set of enclosures)

Phil Dalton
JD Healthcare, Inc.
28140 Braidwood Drive
Rancho Palos Verdes, CA 90275
(with one set of enclosures)

Notice of Proposed Transaction and Request for Consent Under Corporations Code Section 5920 by:

Pasadena Hospital Association, Ltd.

in Connection with an Affiliation Agreement

with

Cedars-Sinai Health System

Prepared for the Office of the Attorney General

California Department of Justice
Charitable Trusts Division

July 22, 2020

#1

Cal. Corp. Code § 5920(b)[1]

List of primary languages spoken at the facilities subject to the transaction and the threshold languages for Medi-Cal beneficiaries for the county in which such facilities are located

Facility	Primary Languages Spoken at Facility	Threshold Languages for Medi-Cal Beneficiaries
Huntington Hospital	English Spanish Mandarin Armenian	Spanish Armenian Cantonese Korean Vietnamese Mandarin Farsi Tagalog Russian Cambodian Other Chinese Arabic

[1] Any matters discussed or addressed in one section of this notice should be considered a discussion or response in all other applicable sections of this notice.

Title 11, California Code of Regulations, § 999.5(d)(1)

DESCRIPTION OF THE TRANSACTION

#2

Title 11, California Code of Regulations, § 999.5(d)(1)(A)

A full description of the proposed agreement and transaction

Pasadena Hospital Association Ltd., a California nonprofit public benefit corporation ("PHA"), submits this Notice to the California Attorney General under California Corporations Code Section 5920 (this "Notice") in accordance with the requirements of Section 999.5(a).[2]

The Parties

The parties to the proposed transaction are PHA, Cedars-Sinai Health System, a California nonprofit public benefit corporation ("Cedars-Sinai"), and the Collis P. and Howard Huntington Memorial Hospital Trust (the "Trust").

Applicant PHA

PHA is the Applicant.[3] PHA owns and operates Huntington Hospital, an acute care hospital located at 100 W. California Boulevard, Pasadena, California 91105 ("Huntington Hospital") and, together with its affiliates, provides inpatient and outpatient services in their communities.

Founded in 1892, Huntington Hospital grew from a small 16-bed hospital to become a nationally recognized healthcare center that is ranked in the top 1% of hospitals in the nation. Huntington Hospital is currently a 619-bed nonprofit hospital with a reputation for providing the highest quality healthcare and emergency services to the members of its community in the San Gabriel Valley.

Transferee Cedars-Sinai

Cedars-Sinai is the Transferee. Cedars-Sinai is the sole member of Cedars-Sinai Medical Center, a California nonprofit public benefit corporation ("CSMC"), and Torrance Health Association, Inc., a California nonprofit public benefit corporation ("Torrance").

CSMC owns and operates a nonprofit acute care hospital located at 8700 Beverly Boulevard, Los Angeles, California, 90048 and is the sole member of the nonprofit corporation that owns and operates a nonprofit acute care hospital located at 4650 Lincoln Boulevard, Marina Del Rey, California 90292. CSMC, together with its affiliates, provides inpatient and outpatient services in their communities. Since its formation in 1902, CSMC has evolved to meet the healthcare needs of one of the most diverse regions in the nation, continually setting new standards in quality and innovation in patient care, research, teaching, and community service. CSMC is one of the largest nonprofit academic medical centers in the country with 886 licensed beds, 2,100 physicians, 2,800 nurses, and thousands of other healthcare professionals and staff. Clinical programs range from primary care for preventing, diagnosing and treating common conditions to specialized treatments for rare, complex, and advanced illnesses. CSMC further serves the community through its affiliated physician network.

CSMC is widely known for its national leadership in transforming healthcare for the benefit of patients. CSMC is a leader in the clinical care and research of heart disease, cancer and brain disorders, among other areas. CSMC also contributes to the future of community health by providing educational programs that include highly competitive medical residency and fellowship programs, a biomedical

[2] Section references are to Title 11 of the California Administrative Code, unless otherwise indicated.
[3] Capitalized terms used but not defined in this Notice have the meanings given in Section 999.5.

science and translational medicine Ph.D. program, advanced training opportunities for nurses, and additional educational opportunities for allied health professionals. Notably, CSMC demonstrates a longstanding commitment to improving the health of its most vulnerable residents.

Torrance and its affiliates own and operate a nonprofit acute care hospital located at 3330 Lomita Boulevard, Torrance, California 90505 and provide inpatient and outpatient services in their communities. Torrance became part of the Cedars-Sinai integrated healthcare delivery system in 2018.

The Trust

The Trust is a California charitable trust which exists for the benefit and support of its sole beneficiary, PHA. The five trustees of the Trust also serve as ex-officio directors on the board of directors of PHA (the "PHA Board"), which currently has 24 directors. The Trust owns the ground on which Huntington Hospital is located (the "Hospital Land") and leases the Hospital Land to PHA under a long-term ground lease.

Key Affiliation Terms

The proposed transaction (the "Affiliation") contemplates Cedars-Sinai becoming the sole member (as such term is defined in California Corporations Code Section 5056) of PHA. PHA currently has no members.

PHA plans to affiliate with Cedars-Sinai in order to join its integrated healthcare delivery system, which, together with CSMC and Torrance, will maintain and improve healthcare quality and access throughout the communities of Los Angeles and the San Gabriel Valley. The Affiliation sustains PHA's 128-year legacy and its connection to the communities it serves and includes commitments for continued investment in Huntington Hospital—including its identified needs in enterprise information technology, ambulatory services and physician development. The Affiliation provides for an ongoing commitment to advancing PHA's existing mission and unique culture as a community institution governed by its local community board. The Affiliation connects PHA's trusted brand of care to Cedars-Sinai's outstanding national reputation and will allow PHA to secure its future and continue to fulfill its historic mission for the benefit of its patients, physicians, employees and the communities of the San Gabriel Valley.

The terms of the Affiliation are described in the Affiliation Agreement dated July 15, 2020 (the "Affiliation Agreement") among Cedars-Sinai, PHA and the Trust. A copy of the Affiliation Agreement is attached as Exhibit 3-A to Section 999.5(d)(1)(B). The structure of the Affiliation and the terms of the Affiliation Agreement are substantially the same as those pertaining to the 2018 affiliation between Cedars-Sinai and Torrance, which was previously approved by the California Attorney General pursuant to California Corporations Code Section 5920.

Changes to Corporate Documents

At the closing of the Affiliation (the "Closing"), PHA will file amended and restated articles of incorporation (the "PHA Amended Articles") with the California Secretary of State. The PHA Amended Articles, upon acceptance for filing and at the time specified in the PHA Amended Articles, will designate Cedars-Sinai as the sole member of PHA. At the Closing, PHA will also adopt amended and restated bylaws (the "PHA Amended Bylaws"), which designate Cedars-Sinai as the sole member of PHA, afford Cedars-Sinai (as sole member of PHA) with certain reserved powers over the governance and operations of PHA and its affiliates, and add positions on the PHA Board to be filled by representatives of Cedars-Sinai. Copies of the PHA Amended Articles and PHA Amended Bylaws are attached as Exhibit 3-B and Exhibit 3-C, respectively, to Section 999.5(d)(1)(B).

Also at Closing, Cedars-Sinai will file amended and restated articles of incorporation (the "Cedars-Sinai Amended Articles") with the California Secretary of State and will adopt amended and restated bylaws (the "Cedars-Sinai Amended Bylaws"). The Cedars-Sinai Amended Articles and Cedars-Sinai Amended Bylaws will designate PHA as one of the supported organizations of Cedars-Sinai and add positions on the board of directors of Cedars-Sinai to be filled by nominees of PHA. Copies of the Cedars-Sinai Amended Articles and Cedars-Sinai Amended Bylaws are attached as Exhibit 3-D and Exhibit 3-E, respectively, to Section 999.5(d)(1)(B).

Financial Benefits to PHA

Cedars-Sinai agrees, within three years after Closing, to install Epic software for an Enterprise Integrated Electronic Health Records system at PHA. Cedars-Sinai agrees to fund the capital costs of this project from sources other than operating cash of PHA.

Cedars-Sinai approves PHA's $560 million strategic capital plan through December 31, 2029. If PHA's days cash on hand falls below 60 days, then Cedars-Sinai will fund up to $300 million of the strategic capital plan from sources other than operating cash of PHA (*e.g.*, borrowings or intercompany loans). Annual capital spending is subject to budget approval processes, except that a current $85 million strategic capital plan is pre-approved for Major Capital Projects.

Employees

Employees of PHA and its affiliates will remain employed at Closing. For 90 days after Closing Cedars-Sinai will not trigger obligations under federal or state WARN laws. For five years after Closing Cedars-Sinai will not reassign employees to other affiliates of Cedars-Sinai without the prior consent of PHA. If such reassignment ever occurs, employees will receive full credit for their years of service to PHA for purposes of eligibility and vesting, to the extent applicable.

Medical Staff

PHA will retain a separate, independent medical staff for Huntington Hospital. At Closing, its leadership will remain the same, and membership status and clinical privileges will remain the same.

Charity Care and Community Benefit

Cedars-Sinai commits to PHA providing charity care and community benefit programs at levels as required by the California Attorney General.

Healthcare Service Commitments

Cedars-Sinai commits to PHA continuing important aspects of its healthcare operations as and for the periods determined by the California Attorney General, including the following:

- Huntington Hospital will continue as a licensed general acute care hospital, including to the extent that Huntington is able to meet the requirements of applicable accreditation agencies, maintaining each of the following with the same types and levels of services as currently provided:

  Level II Trauma Center
  Level III Neonatal Intensive Care Unit
  Comprehensive Stroke Center
  STEMI Receiving Center
  Advanced Cardiology and Cardiovascular Surgery Programs

Advanced Robotic Surgery
Orthopedic Service Line
Oncology Service Line
Neurology Service Line
GME programs
Senior Care Network
Women's Health Services
End of Life Services

- Huntington Hospital will continue to participate in the Medi-Cal and Medicare programs.

- Any future sale or change in control of Huntington Hospital will require the prior approval of the California Attorney General.

- Huntington Hospital will use commercially reasonable efforts to maintain Magnet Status with substantially the same types and levels of services as currently provided.

Trust-Related Terms

The Trust will gift to PHA the legal title to the Hospital Land (PHA already holds the beneficial and lessee interests). As a result, the ground lease for the Hospital Land will be terminated.

The Trust commits to make two types of annual distributions to PHA through the year 2029, so long as PHA and its tax-exempt affiliates continue to be tax-exempt, PHA continues to operate Huntington Hospital as a general acute care hospital, Cedars-Sinai continues to be the sole member of PHA, and Cedars-Sinai complies with its obligations under the Affiliation Agreement.

First, the Trust will make annual distributions to fund the general medical education program at Huntington Hospital. In 2021, the amount of this annual distribution is $5,300,000. The amount of this distribution will increase in subsequent years by 2.5% per year.

Second, the Trust will make annual distributions to fund Huntington Hospital projects selected by the Trust and approved by the PHA Board. The annual amount of this distribution will be 2.5% of the market value of certain cash and marketable securities owned by the Trust.

Conditions to Closing

Conditions to the Closing of the Affiliation include the following, among other standard closing conditions:

- The 30-day period under the Hart-Scott-Rodino Act will have expired or been terminated.

- The California Attorney General will have issued its approval of the Affiliation with terms of approval comparable to other recent nonprofit hospital acquisitions.

- The Trust will have received court approval of the actions to be taken by the Trust in connection with the Affiliation.

- At the Closing, that certain Reimbursement Agreement among Cedars-Sinai, CSMC and the Trust, dated as of July 15, 2020 (the "Reimbursement Agreement"), will continue to be in full force and effect. The Reimbursement provides for CSMC to cause the Trust to be released from its obligations under the master indenture of trust and related agreements involving the bond indebtedness of PHA by 2028, and to hold the Trust and trustees harmless from those

obligations. A copy of the Reimbursement Agreement is included as Exhibit 3-G to Section 999.5(d)(1)(B).

#3

Title 11, California Code of Regulations, § 999.5(d)(1)(B)

A complete copy of all proposed written agreements or contracts to be entered into by the applicant and the transferee that relate to or effectuate any part of the proposed transaction

1. Attached to this Section 999.5(d)(1)(B) as **Exhibit 3-A** is a copy of the Affiliation Agreement.
2. Attached to this Section 999.5(d)(1)(B) as **Exhibit 3-B** is a copy of the PHA Amended Articles of Incorporation.
3. Attached to this Section 999.5(d)(1)(B) as **Exhibit 3-C** is a copy of the PHA Amended Bylaws.
4. Attached to this Section 999.5(d)(1)(B) as **Exhibit 3-D** is a copy of the Cedars-Sinai Amended Articles of Incorporation.
5. Attached to this Section 999.5(d)(1)(B) as **Exhibit 3-E** is a copy of the Cedars-Sinai Amended Bylaws.
6. Attached to this Section 999.5(d)(1)(B) as **Exhibit 3-F** is a copy of the form of deed regarding the transfer of the Hospital Land from the Trust to PHA.
7. Attached to this Section 999.5(d)(1)(B) as **Exhibit 3-G** is a copy of the Reimbursement Agreement regarding the Trust's eventual release from certain bond indebtedness.

Exhibit 3-A

Affiliation Agreement

Final

CEDARS-SINAI HEALTH SYSTEM,
a California nonprofit public benefit corporation

and

PASADENA HOSPITAL ASSOCIATION, LTD.,
a California nonprofit public benefit corporation
d/b/a Huntington Hospital

and

COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

AFFILIATION AGREEMENT

TABLE OF CONTENTS

PAGE

Article I DEFINITIONS AND INTERPRETATION 2
1.1 Definitions 2
1.2 Rules of Interpretation 14
Article II HUNTINGTON MEMBERSHIP 15
2.1 Membership of Huntington 15
Article III PARENT ORGANIZATIONAL DOCUMENTS AND TRUST ACTIONS 15
3.1 Parent Organizational Documents 15
3.2 Trust Actions 15
Article IV REPRESENTATIONS AND WARRANTIES OF HUNTINGTON 16
4.1 Organization, Power, Absence of Conflicts 16
4.2 Third-Party Rights 17
4.3 Legal Compliance 17
4.4 Huntington Financial Statements 18
4.5 Absence of Material Change 19
4.6 Real Property. 19
4.7 Environmental Matters 19
4.8 Employment Matters 20
4.9 Employee Benefit Plans 20
4.10 Litigation 22
4.11 Tax and Tax Exempt Status 22
4.12 Certain Affiliations 23
4.13 Intellectual Property 23
4.14 Insurance 23
4.15 Operation of the Huntington Operations 24
4.16 Membership 24
4.17 Due Diligence 24
Article V REPRESENTATIONS AND WARRANTIES OF TRUST 24
5.1 Power, Absence of Conflicts 24
5.2 Third-Party Rights 25
5.3 Huntington Hospital Land 25
5.4 Environmental Matters 26
5.5 Litigation 26

TABLE OF CONTENTS (CONTINUED)

PAGE

5.6 Tax and Tax Exempt Status 26
5.7 Certain Affiliations 26
Article VI REPRESENTATIONS AND WARRANTIES OF PARENT 27
6.1 Organization, Power, Absence of Conflicts 27
6.2 Third-Party Rights 28
6.3 Legal Compliance 28
6.4 Parent Financial Statements 29
6.5 Absence of Material Change 29
6.6 Real Property 30
6.7 Environmental Matters 30
6.8 Employment Matters 30
6.9 Employee Benefit Plans 31
6.10 Litigation 33
6.11 Tax and Tax Exempt Status 33
6.12 Certain Affiliations 34
6.13 Intellectual Property 34
6.14 Insurance 34
6.15 Operation of the Parent Operations 34
6.16 Membership 35
Article VII PRE-CLOSING COVENANTS 35
7.1 Consents and Approvals 35
7.2 Schedule Updates 36
7.3 Negative Covenants of Parent 37
7.4 Negative Covenants of Huntington and the Trust 37
7.5 Conduct of the Huntington Operations 37
7.6 Due Diligence 38
7.7 No Negotiation 38
7.8 Interim Financials. 39
7.9 Huntington's and Trust's Efforts to Close 39
7.10 Parent's Efforts to Close 39
Article VIII ADDITIONAL COVENANTS AND AGREEMENTS 39
8.1 Government Authorizations and Court Approval 39

TABLE OF CONTENTS (CONTINUED)

PAGE

8.2 Transfer of Huntington Hospital Land 40
8.3 Further Assurances 41
Article IX TERMINATION OF AGREEMENT 41
9.1 Termination of Agreement 41
9.2 Effect of Termination 42
Article X CONDITIONS TO CLOSING 42
10.1 Mutual Conditions 42
10.2 Conditions Precedent to Obligations of Parent 43
10.3 Conditions Precedent to Obligations of Huntington 45
Article XI CLOSING 46
11.1 Closing and Closing Date 46
11.2 Deliveries by Huntington 46
11.3 Deliveries by Parent 47
Article XII PROTECTIVE PROVISIONS 47
12.1 Non-Reliance 47
12.2 AS-IS 48
12.3 Natural Hazards Disclosure 49
12.4 Release. 49
12.5 D&O Protections 50
Article XIII POST-CLOSING RIGHTS AND OBLIGATIONS 50
13.1 Illegality 50
13.2 Closure or Sale of Huntington Hospital 51
13.3 Change to Tax Exempt Status of Huntington Hospital. 52
13.4 Parent Operating Expenses 52
13.5 Capital Contributions to Parent 52
13.6 Gifts, Donations and Endowments 52
13.7 Identification as Affiliate 52
13.8 Legacy Balance Sheets 52
13.9 Employees and Employer Status 53
13.10 Trust Distributions to Huntington 53
13.11 Quality Risk Event Notifications and Response Plans 54
13.12 Administrative Support for Trust 55

TABLE OF CONTENTS (CONTINUED)

PAGE

13.13 Access to Information 55
13.14 Hospital Commitments 55
13.15 Charity Care and Community Benefit 56
13.16 Medical Staff 56
Article XIV HUNTINGTON STRATEGIC CAPITAL PLAN AND EHR PROJECT 56
14.1 Huntington Strategic Capital Plan and Funding Commitment 56
14.2 EHR Project 58
14.3 In-Kind Advisory Support 59
14.4 Approval of Strategic Plans and Budgets 59
Article XV REMEDIES 60
15.1 Remedies Prior to the Closing Date 60
15.2 Remedies After the Closing Date 60
15.3 Damages Waiver 60
15.4 Non-Survival 60
15.5 Exclusive Remedies 60
Article XVI MISCELLANEOUS 62
16.1 Notices 62
16.2 Counterparts 63
16.3 Captions and Section Headings 63
16.4 Cooperation 63
16.5 Time of Essence 63
16.6 Entire Agreement 63
16.7 Governing Laws 63
16.8 Assignment 63
16.9 Expenses 63
16.10 Meet and Confer 63
16.11 Attorneys' Fees and Costs 64
16.12 No Third-Party Beneficiaries 64
16.13 Waiver 64
16.14 Severability 64
16.15 Successors and Assigns 64
16.16 Attorney-Client Privilege and Waiver of Conflicts 64

PAGE

16.17 Trust Party End Date..... 65

AFFILIATION AGREEMENT

THIS AFFILIATION AGREEMENT (this "***Agreement***") is made and effective as of July 15, 2020 (the "***Execution Date***") among Cedars-Sinai Health System, a California nonprofit public benefit corporation ("***Parent***"), Pasadena Hospital Association Ltd., a California nonprofit public benefit corporation doing business as Huntington Hospital ("***Huntington***"), and the Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust (the "***Trust***"). Parent, Huntington and the Trust are referred to herein individually as a "***Party***" and collectively as the "***Parties***."

RECITALS

WHEREAS, Parent is a California nonprofit public benefit corporation and organized exclusively for the benefit of and to support nonprofit health care organizations organized for the purpose of establishing, maintaining, sponsoring and promoting activities relating to the improvement of human health and well-being;

WHEREAS, Parent is the sole corporate member of: (i) Cedars-Sinai Medical Center, a California nonprofit public benefit corporation ("***CSMC***"), which owns and operates acute care hospitals located at 8700 Beverly Boulevard, Los Angeles, California, 90048 ("***CSMC Hospital***") and 4650 Lincoln Boulevard, Marina Del Rey, California 90292, and (ii) Torrance Health Association, Inc., a California nonprofit public benefit corporation ("***THA***"), which owns and operates an acute care hospital located at 3330 Lomita Boulevard, Torrance, California 90505. CSMC and THA also provide various outpatient services in their respective communities through hospital-based and community-based clinics, ambulatory surgical centers, and other health care related businesses and facilities and wholly owned and partially owned subsidiaries;

WHEREAS, Huntington is a California nonprofit public benefit corporation that has been engaged in the charitable mission of delivering healthcare services in the San Gabriel Valley for over 125 years with the support of the Trust. Huntington owns and operates an acute care hospital located at 100 W California Boulevard, Pasadena, California 91105 ("***Huntington Hospital***") and provides various outpatient services in Huntington's community through other health care related businesses and facilities and wholly owned and partially owned subsidiaries;

WHEREAS, the Parties desire for Huntington to affiliate with Parent on the terms and conditions set forth in this Agreement (the "***Affiliation***") for the purpose of Huntington joining Parent's integrated healthcare delivery system in order to benefit patients by increasing access to, and improving outcomes and the quality of care of, healthcare within Parent's and Huntington's communities and to further Parent's and Huntington's mission of advancing quality of care and furthering the charitable activities of Parent and Huntington in a manner consistent with the Parties' charitable missions and purposes;

WHEREAS, to implement the Affiliation, the Parties contemplate, among other things, that Parent will become the sole voting member of Huntington and that Parent and Huntington will amend and restate their organizational documents to address certain structural and governance matters, as set forth herein; and

WHEREAS, once the Affiliation takes effect, it is the Parties' desire to grow the integrated healthcare delivery system created by the Affiliation where such growth is strategically and economically feasible and appropriate.

NOW, THEREFORE, in consideration of the mutual promises and benefits to be derived from this Agreement, the Parties, intending to be legally bound, hereby agree as follows:

Article I

DEFINITIONS AND INTERPRETATION

1.1 Definitions. As used in this Agreement, the following terms have the meanings given:

"Action" shall mean any action, complaint, suit, litigation, proceeding, arbitration, mediation, labor dispute, arbitral action, governmental audit, criminal prosecution or unfair labor practice charge or complaint.

"Affiliate Hospital Organization" means Huntington, CSMC, THA and any other entities defined as Affiliate Hospital Organizations in the bylaws of Parent, as such are amended from time to time.

"Affiliation" is defined in the Recitals to this Agreement and includes the actions contemplated in Section 2.1 and Section 3.1 of this Agreement.

"AG Consent" is defined in Section 13.13(b).

"Agreement" is defined in the Preamble to this Agreement.

"Attorney General" is defined in Section 7.1(a).

"Business Day" means a day other than a Saturday, Sunday or other day on which banks located in California are authorized or required by law to close.

"Capital Plan Period" is defined in Section 14.1(a).

"CARP" is defined in Section 13.11.

"Claims and Losses" means Actions, executions, judgments, duties, debts, dues, accounts, bonds, Contracts and covenants (whether express or implied), damages (including direct, consequential, punitive or any other kind of damages), penalties, fines, liens, costs and expenses (including reasonable attorneys' fees and costs), losses, liabilities, legal or administrative proceedings, claims and demands whatsoever whether in law or in equity (whether based upon contract, tort or otherwise).

"Closing" is defined in Section 11.1.

"Closing Date" is defined in Section 11.1.

"Closure or Sale of Hospital Unwind Event" is defined in Section 13.2(a).

"Code" means the Internal Revenue Code of 1986, as amended.

"Competing Transaction" is defined in Section 7.7(b).

"Congress Services Corporation" means Congress Services Corporation, a California corporation.

"Contracts" means all commitments, contracts, leases, licenses, agreements and understandings, written or oral, including agreements with payors, physicians and other providers, agreements with health maintenance organizations, independent practice associations, preferred provider organizations and other managed care plans and alternative delivery systems, joint venture and partnership agreements, management, employment, retention and severance agreements, vendor agreements, real and personal property leases and schedules, maintenance agreements and schedules, agreements with municipalities and labor organizations, and bonds, mortgages and other loan agreements.

"Control" (including, with correlative meanings, the terms "controlled by" and "under common control with") means the power or possession of the power, direct or indirect, to direct or cause the direction of the management and policies of an entity, whether through the ownership of securities, election or appointment of directors, by contract or otherwise.

"Court Approval" means such court approval of the actions to be taken by the Trust in connection with the Affiliation as determined necessary by the Trust.

"CSMC" is defined in the Recitals to this Agreement.

"CSMC Hospital" is defined in the Recitals to this Agreement.

"Disclosure Schedules" means the Huntington Schedules, Trust Schedules and Parent Schedules.

"Dispute" is defined in Section 16.10.

"Dispute Notice" is defined in Section 16.10.

"DOL" is defined in Section 4.9(b).

"Drop Dead Date" is defined in Section 9.1(d).

"Effective Time" is defined in Section 11.1.

"EHR Project" is defined in Section 14.2(a).

"EHR Project Capital Costs" is defined in Section 14.2(d).

"EHR Project Committee" is defined in Section 14.2(b).

"Employee Welfare Benefit Plan" shall have the meaning set forth in Section 3(1) of ERISA.

"Encumbrances" means all liabilities, levies, claims, charges, assessments, mortgages, security interests, liens, pledges, conditional sales agreements, title retention contracts, leases, subleases, rights of first refusal, options to purchase, restrictions and other encumbrances, and agreements or commitments to create or suffer any of the foregoing.

"Enforceability Exceptions" means exceptions to enforceability resulting from applicable bankruptcy, reorganization, insolvency, moratorium or other Laws affecting the enforcement of creditors' rights generally and by general principles of equity, regardless of whether such enforceability is considered in a proceeding at law or in equity.

"Environmental Claim" means any written or threatened, claim, action, cause of action, investigation or notice by any Person alleging potential liability arising out of, based on or resulting from (a) the presence, release, or threatened release, of any Hazardous Materials in violation of Environmental Law or an Environmental License, or in an amount or concentration requiring remedial action under Environmental Laws, at or from any location owned or operated by a Huntington Entity, the Trust or a Parent Entity, as applicable, or (b) any violation or alleged violation of any Environmental Law.

"Environmental Laws" means any and all Laws relating to pollution, contamination or protection of human health or the environment (including ground water, land surface or subsurface strata), including Laws relating to emissions, discharges, releases or threatened releases of Hazardous Materials, or otherwise relating to the manufacture, processing, distribution, use, treatment, storage, disposal, transport, recycling, reporting or handling of Hazardous Materials.

"Environmental Licenses" means any and all Licenses issued pursuant to Environmental Laws.

"Epic" is defined in Section 14.1(a).

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"ERISA Affiliate" means an any person or entity that directly controls, is controlled by, or is under common control with a Person if it is considered a single employer with such Person under ERISA Section 4001(b) or Section 414 of the Code, or part of the same "controlled group" as such Person for purposes of ERISA Section 302(d)(3).

"Funding Commitment" is defined in Section 14.1(b).

"Execution Date" is defined in the Preamble to this Agreement.

"GAAP" means United States generally accepted accounting principles.

"GME Distributions" is defined in Section 13.10(a).

"Governing Documents" means (a) if a corporation, the articles of incorporation and bylaws; (b) if a general partnership, the partnership agreement and any statement of partnership; (c) if a limited partnership, the limited partnership agreement and the certificate of limited partnership; (d) if a limited liability company, the articles of organization and operating agreement; (e) if another type of entity, any other charter or similar document adopted or filed in connection with the creation, formation or organization of the entity; (f) if a trust, the declaration of trust or trust agreement and any related court orders; and (g) any amendment or restatement to any of the foregoing.

"Government Authorizations" means all Licenses, consents or approvals of any Governmental Entity that are required for each Huntington Entity to continue operating the Huntington Operations after the consummation of the Affiliation described herein.

"Governmental Entity" means any United States federal, state, provincial, county, municipal, regional or local governmental, or any political subdivision thereof, and any entity, department, commission, bureau, agency, authority, board, court or other similar body or quasi-governmental body exercising executive, legislative, judicial, regulatory or administrative functions of or pertaining to any government or other political subdivision thereof.

"Government Payment Programs" means federal and state Medicare, Medicaid and TRICARE (f/k/a CHAMPUS) programs, and similar or successor programs with or for the benefit of Governmental Entities.

"Hazardous Materials" means all chemicals, pollutants, contaminants, wastes (including medical waste), toxic substances, petroleum and petroleum products regulated under Environmental Laws, including hazardous wastes as defined under the Resource, Conservation and Recovery Act, 42 U.S.C. §§ 6903 et seq., hazardous substances as defined under the Comprehensive Environmental Response, Compensation and Liability Act of 1980, 42 U.S.C. §§ 9601 et seq., asbestos, polychlorinated biphenyls and urea formaldehyde, and low-level nuclear materials, special nuclear materials or nuclear-byproduct materials, all within the meaning of the Atomic Energy Act of 1954, as amended, and any rules, regulations or policies promulgated thereunder.

"Health Information Laws" means all federal and state Laws relating to the privacy and security of patient, medical or individual health information, including the Health Insurance Portability and Accountability Act of 1996, as amended and supplemented by the Health Information Technology for Clinical Health Act of the American Recovery and Reinvestment Act of 2009, Pub. Law No. 111-5 and its implementing regulations, when each is effective and as each is amended from time to time.

"Health System" means the integrated healthcare delivery system comprised of Parent, Huntington, THA, CSMC and other Affiliate Hospital Organizations.

"HHP" means The Huntington Medical Foundation, a California nonprofit public benefit corporation d/b/a Huntington Health Physicians.

"HMRI Lease" means that certain Standard Industrial/Commercial Single-Tenant Lease – Net, dated as of July 1, 2012, including an Addendum thereto, as amended by amendments dated

as of June 30, 2015 and March 15, 2017, by and between the Trust, as lessor, and Huntington Medical Research Institutes, a California nonprofit corporation, as lessee, pertaining to real property located at 734 South Fairmount Avenue, Pasadena, California.

"HSR Act" means the Hart-Scott-Rodino Antitrust Improvements Act of 1976 and the rules and regulations promulgated thereunder.

"Huntington" is defined in the Preamble to this Agreement.

"Huntington Amended Articles" is defined in Section 2.1.

"Huntington Amended Bylaws" is defined in Section 2.1.

"Huntington Assets" means any and all assets owned by a Huntington Entity and used in the ordinary course of the Huntington Operations taken as a whole or in the individual operations of any Huntington Entity, including: (i) the Huntington Real Property, (ii) all tangible personal property owned by Huntington and used in connection with the Huntington Operations, of every kind and nature, including all furniture, fixtures, equipment, machinery, vehicles, and owned or licensed computer systems, (iii) all inventories of useable supplies, drugs, food, janitorial and office supplies, maintenance and shop supplies, and other disposables and consumables owned by any Huntington Entity and used in connection with the Huntington Operations, and (iv) all goodwill and other intangible assets of a Huntington Entity, and all marks, names, trademarks, service marks, patents, patent rights, assumed names, logos, copyrights, trade secrets and similar intangibles (including variants of and applications for any of the foregoing) owned by a Huntington Entity used in the ordinary course of the Huntington Operations taken as a whole or in the individual operations of Huntington Hospital or any Huntington Entity. The term "Huntington Assets" excludes any assets of the Trust.

"Huntington Consolidated Group" means Huntington, HHP and Congress Services Corporation. After the Closing, the Huntington Consolidated Group will include any entity that is consolidated on the audited financial statements of Huntington, and will exclude any entity that is not consolidated on the audited financial statements of Huntington. Notwithstanding anything to the contrary, the Huntington Consolidated Group specifically excludes the Trust.

"Huntington Employee Benefit Program" means any pension, profit-sharing, savings, retirement, employment, collective bargaining, severance pay, termination, executive compensation, incentive compensation, deferred compensation, bonus, phantom stock or other equity-based compensation, change-in-control, retention, salary continuation, vacation, sick leave, disability, death benefit, group insurance, hospitalization, medical, dental, life, Code Section 125 "cafeteria" or "flexible" benefit, or other material employee or fringe benefit plan, program, policy, practice, agreement or arrangement, whether written or oral, formal or informal, legally binding or not (including, but not limited to, every "employee benefit plan," within the meaning of ERISA Section 3(3)) (i) currently maintained, sponsored or contributed to (or with respect to which any obligation to maintain, sponsor or contribute has been undertaken) by any Huntington Entity or any ERISA Affiliate, (ii) under which any current or former employee or director of any Huntington Entity has any present or future right to benefits, and (iii) with respect to which any Huntington Entity has any liability.

"Huntington Entities" means: (i) Huntington, (ii) HHP, (iii) Congress Services Corporation, a California corporation, and (iv) Huntington Ambulatory Surgery Center, LLC, a California limited liability company. The Huntington Entities specifically exclude the Trust.

"Huntington Entity Insurance Policies" is defined in Section 4.14(a).

"Huntington Entity Intellectual Property Assets" is defined in Section 4.13.

"Huntington Financial Statements" means the audited consolidated balance sheet of the Huntington Consolidated Group as of December 31, 2019, and the consolidated statements of operations of the Huntington Consolidated Group for the year then ended; and the unaudited interim consolidated balance sheet of the Huntington Consolidated Group as of May 31, 2020, and the unaudited interim consolidated statements of operations of the Huntington Consolidated Group for the 5-month period then ended.

"Huntington Healthcare Service" means any licensed or license-exempt healthcare service provided by any Huntington Entity.

"Huntington Hospital" is defined in the Recitals to this Agreement.

"Huntington Hospital Land" means the land on which the main campus of the Huntington Hospital is situated, as described on Exhibit G, attached hereto and incorporated herein.

"Huntington Hospital Land Deed" is defined in Section 8.2(d).

"Huntington's Knowledge" means the actual knowledge of the Chief Executive Officer, Chief Financial Officer or Chief Strategy Officer of a Huntington Entity.

"Huntington Nominated Directors" is defined in Section 3.1(b).

"Huntington Operations" means any and all operations conducted by any Huntington Entity, whether at Huntington Hospital or elsewhere, including, without limitation, all Huntington Healthcare Services.

"Huntington Real Property" means: (i) the Huntington Hospital Land and (ii) all real property interests owned by any Huntington Entity, and all of Huntington's and a Huntington Entity's interests therein, and all right, title and interest of Huntington and a Huntington Entity in all appurtenances, options, easements, servitudes, rights-of-way and other rights associated therewith.

"Huntington Schedules" is defined in the introductory language in Article IV.

"Huntington Strategic Capital Plan" is defined in Section 14.1(a).

"Huntington Subsidiary" means each Huntington Entity as well as any entity that, directly or indirectly through one or more intermediaries, is Controlled by Huntington. Without limiting the generality of the foregoing, "Huntington Subsidiary" shall include those entities of which Huntington is a corporate member and those entities in which Huntington owns more than

fifty-percent (50%) of the voting securities. The Huntington Subsidiaries specifically exclude the Trust.

"Huntington Unwind Event" is defined in Section 13.3.

"Illegality Dispute" is defined in Section 13.1.

"Illegality Unwind Event" is defined in Section 13.1.

"Imaging Center JVs" is defined in Section 10.2(j).

"Interim Period" means the period of time between the Execution Date and the Closing Date or earlier termination of this Agreement.

"Law" or "Laws" means all laws, codes, regulations, rules, orders, common law and ordinances including, but not limited to: state corporate practice of medicine Laws and regulations, state professional fee-splitting laws and regulations, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act (the "Affordable Care Act"), the federal Anti-kickback Statute (42 U.S.C. § 1320a-7b(b)), the Stark Law (42 U.S.C. § 1395nn), any applicable state fraud and abuse prohibitions, including those that apply to all payors (governmental, commercial insurance and self-payors), the Anti-Inducement Law (42 U.S.C. § 1320a-7a(a)(5)), the civil False Claims Act (31 U.S.C. §§ 3729 et seq.), the administrative False Claims Law (42 U.S.C. § 1320a-7b(a)), the civil monetary penalty laws (42 U.S.C. § 1320a-7a), and any other local, state or federal law, regulation, guidance document, manual provision, program memorandum, opinion letter, or other public issuance.

"Licenses" means licenses, permits, authorizations, certifications, accreditations, registrations and franchises.

"Lookback Period" means the four-year period ending on the Execution Date.

"Lot Line Adjustment" is defined in Section 8.2(a).

"Master Lease" means, collectively, the Lease dated as of April 13, 1942 by and between the Trust, as lessor, and Huntington, as lessee, as amended by amendments dated June 23, 1942, February 23, 1945, June 18, 1946, December 1, 1952, January 5, 1959, September 6, 1968, December 28, 1972, July 22, 1982, November 5, 1985, September 27, 1990, November 19, 1992, August 12, 1996, September 18, 1997, April 28, 2005, May 1, 2014 and April1, 2018.

"Material Adverse Change" means, with respect to a Party, an event, change or circumstance, which, individually or together with any other event, change or circumstance, has or is reasonably expected to have a material and adverse effect on, or cause a material and adverse change in, the financial condition, business or results of operations of the Party (the Huntington Entities, taken as a whole, or the Parent Entities, taken as a whole, or the Trust, as applicable) or on the ability of the Party to consummate the Affiliation; provided, however, that none of the following (or any results thereof), alone or in combination, will constitute or be considered or taken into account in determining the existence of a Material Adverse Change:

(i) changes in the financial or operating performance due to or caused by the announcement, pendency or consummation of the Affiliation, or the execution of this Agreement or the performance of obligations hereunder, or seasonal changes;

(ii) the failure to meet any revenue, earnings or other projections, forecasts or predictions, provided that the cause of any such failure may be taken into account when determining the existence of a Material Adverse Change;

(iii) any condition appearing in the Disclosure Schedules as of the Execution Date, provided that a change in such condition occurring after the Execution Date, even if communicated by way of an update to the Disclosure Schedule, may be taken into account when determining the existence of a Material Adverse Change;

(iv) requirements, reimbursement rates, policies or procedures of third-party payors or accreditation commissions or organizations that are generally applicable to hospitals or health care facilities;

(v) general business, industry or economic conditions, including such conditions related to the Party;

(vi) local, regional, national or international political or social conditions, including the engagement or continuation of the United States in hostilities or the escalation thereof, or the occurrence or the escalation of any military or terrorist attack upon the United States, or any of its territories, possessions, or diplomatic or consular offices or upon any military installation, equipment or personnel of the United States, whether or not pursuant to the declaration of a national emergency or war, or the occurrence of any military or terrorist attack;

(vii) changes in financial, banking or securities markets in the United States or any other country (including any disruption thereof and any decline in the price of any security or commodity or any market index);

(viii) changes in, adoption of, or change in the interpretation or adoption of any applicable Law or GAAP;

(ix) pandemics, earthquakes, hurricanes, floods or other natural disasters, including a declaration or continuation of a state or national emergency;

(x) the effects of or response to novel coronavirus or COVID-19;

(xi) any action taken by, or with the consent of, the other Party; or

(xii) any action by a Party or any of its trustees, directors, officers, employees or representatives required to be taken, or expressly permitted to be taken, by this Agreement.

Notwithstanding the foregoing, changes or effects that pertain to the actions or events described in clauses (iii) – (ix) above may constitute, be considered or taken into account in determining the existence of a Material Adverse Change to the extent such changes or effects have a materially

disproportionate effect on the Party compared to other Persons in the industries and geographic regions in which the Party does business.

"Meet and Confer" is defined in Section 16.10.

"Multiemployer Plan" shall have the meaning set forth in Section 3(37) of ERISA or Section 4001(a)(3) of ERISA.

"NDA" is defined in Section 7.6.

"New Huntington Organizational Documents" is defined in Section 2.1.

"New Parent Organizational Documents" is defined in Section 3.1(a).

"Nonrecourse Person" is defined in Section 15.5(b).

"Notice of Illegality" is defined in Section 13.1.

"Parent" is defined in the Preamble to this Agreement.

"Parent Amended Articles" is defined in Section 3.1(a).

"Parent Amended Bylaws" is defined in Section 3.1(a).

"Parent Assets" means any and all assets owned by a Parent Entity and used in the ordinary course of the Parent Operations taken as a whole or in the individual operations of any Parent Entity, including: (i) the Parent Real Property, (ii) all tangible personal property owned by Parent and used in connection with the Parent Operations, of every kind and nature, including all furniture, fixtures, equipment, machinery, vehicles, and owned or licensed computer systems, (iii) all inventories of useable supplies, drugs, food, janitorial and office supplies, maintenance and shop supplies, and other disposables and consumables owned by any Parent Entity and used in connection with the Parent Operations, and (iv) all goodwill and other intangible assets of a Parent Entity, and all marks, names, trademarks, service marks, patents, patent rights, assumed names, logos, copyrights, trade secrets and similar intangibles (including variants of and applications for any of the foregoing) owned by a Parent Entity and used in the ordinary course of the Parent Operations taken as a whole or in the individual operations of CSMC Hospital or any Parent Entity.

"Parent Employee Benefit Program" means any pension, profit-sharing, savings, retirement, employment, collective bargaining, severance pay, termination, executive compensation, incentive compensation, deferred compensation, bonus, phantom stock or other equity-based compensation, change-in-control, retention, salary continuation, vacation, sick leave, disability, death benefit, group insurance, hospitalization, medical, dental, life, Code Section 125 "cafeteria" or "flexible" benefit, or other material employee or fringe benefit plan, program, policy, practice, agreement or arrangement, whether written or oral, formal or informal, legally binding or not (including, but not limited to, every "employee benefit plan," within the meaning of ERISA Section 3(3)) (i) currently maintained, sponsored or contributed to (or with respect to which any obligation to maintain, sponsor or contribute has been undertaken) by any

Parent Entity or any ERISA Affiliate, (ii) under which any current or former employee or director of any Parent Entity has any present or future right to benefits, and (iii) with respect to which any Parent Entity has any liability.

"Parent Entity" means Parent and CSMC.

"Parent Entity Insurance Policies" is defined in Section 6.14(a).

"Parent Entity Intellectual Property Assets" is defined in Section 6.13.

"Parent Financial Statements" means Parent's audited consolidated balance sheet as of June 30, 2019, and Parent's audited consolidated income statement for the year then ended; and Parent's unaudited consolidated balance sheet as of May 31, 2020, and Parent's unaudited consolidated income statement for the 11-months then ended.

"Parent Healthcare Service" means any licensed or license-exempt healthcare service provided by any Parent Entity.

"Parent's Knowledge" means the actual knowledge of the Chief Executive Officer, Chief Financial Officer or Chief Strategy Officer of a Parent Entity.

"Parent Operating Expenses Payments" is defined in Section 13.4.

"Parent Operations" means any and all operations conducted by any Parent Entity, whether at CSMC Hospital or elsewhere, including, without limitation, all Parent Healthcare Services.

"Parent Real Property" means all real property interests owned by any Parent Entity, and all of Parent's and a Parent Entity's interests therein, and all right, title and interest of Parent and a Parent Entity in all appurtenances, options, easements, servitudes, rights-of-way and other rights associated therewith.

"Parent Schedules" is defined in the introductory language in Article VI.

"Party" is defined in the Preamble to this Agreement.

"PBGC" is defined in Section 4.9(b).

"Permitted Liens" means (i) statutory liens for current taxes and assessments not yet due and payable or which are being contested in accordance with applicable law; (ii) statutory, mechanics', carriers', workmen's, repairmen's and similar statutory liens not yet due or payable or which are being contested in good faith, or the value of which are not material in relationship to the value of the encumbered asset; (iii) matters set forth on Exhibit H, attached hereto and incorporated herein; (iv) matters shown on the Surveys (1) which do not materially adversely affect the use of the Huntington Hospital Land for the purpose for which it is used as of the Closing Date or (2) which do not materially impair the title or marketability, or materially adversely affect the value of the Huntington Hospital Land for its current use; and (v) the HMRI Lease.

"Person" means an individual, corporation, partnership, limited liability company, firm, joint venture, association, joint stock company, trust, unincorporated organization or other entity, or any Governmental Entity or quasi-governmental body or regulatory authority.

"Plant Closure Laws" means any "plant closure" or "mass layoff" Law, which includes the Federal Worker Adjustment and Retraining Notification Act (29 U.S.C. §§ 2101 et seq.) and its California counterpart (California Labor Code Sections 1400 et seq.).

"Pre-Closing Communications" is defined in Section 16.16.

"Prior Counsel" is defined in Section 16.16.

"Project Distributions" is defined in Section 13.10(b).

"Protected Persons" is defined in Section 12.5.

"Quality Risk Event" is defined in Section 13.11.

"Reimbursement Agreement" is defined in Section 10.3(i).

"Releasing Parties" is defined in Section 15.5(c).

"Related Person" of any Person means another Person that directly or indirectly, through one or more intermediaries, Controls, is Controlled by, or is under common Control with, such first Person.

"Restricted Assets" is defined in Section 13.6.

"Section 5920" is defined in Section 7.1(a).

"SEC" is defined in Section 4.9(b).

"Sixty Days Expenses" means, for each fiscal year of Huntington, a dollar amount equal to sixty (60) times the fraction in which (i) the numerator is the total expenses of the Huntington Consolidated Group (excluding depreciation and amortization), in each case based on the audited consolidated statements of operations of the Huntington Consolidated Group from the preceding fiscal year, and (ii) the denominator is three hundred and sixty-five (365). The prior fiscal year's Sixty Days Expenses will be used for the current fiscal year until the prior fiscal year's final audited consolidated statements of operations is delivered to Huntington. For example, Sixty Days Expenses for fiscal year ending in 2021 will equal sixty (60) times the fraction in which the numerator is the total expenses of the Huntington Consolidated Group (excluding depreciation and amortization), in each case based on the fiscal year ending in 2020 audited consolidated income statement of the Huntington Consolidated Group, and the denominator is three hundred and sixty-five (365).

"Surveys" is defined in Section 8.2(b).

"State" means the State of California.

"Tax" means (a) (i) any federal, state, local or foreign income, gross receipts, franchise, estimated, alternative minimum, add-on minimum, sales, use, transfer, real property gains, registration, value added, excise, natural resources, severance, stamp, occupation, windfall profits, environmental (under Section 59A of the Code), customs, duties, real property, personal property, capital stock, social security (or similar), unemployment, disability, payroll, license, employee, service, ad valorem, profits, capital, premium, production, consumption, commercial rent, capital gains, business privilege, recording, inventory, merchandise, intangibles, transaction, title, business, deduction at source or other withholding (including withholding liability as a representative taxpayer), or other tax, (ii) any impost, fee, levy, charge, or assessment, in each case, in the nature of taxes, (iii) any liability under unclaimed property, escheat or any similar Law, and (iv) any interest, penalties or additions in respect of the foregoing (whether disputed or not) or in respect to failure to comply with any requirement with respect to Tax Returns and (b) any liability for the payment of any amounts of the type described in clause (a) as a result of any Contract to pay or assume any such amounts or to indemnify any other Person for such amounts, any transferee or successor liability, the operation of Law (including pursuant to Treasury Regulations Section 1.1502-6 or any similar provision of state, local or foreign Law) or otherwise.

"Tax-Exempt Status Unwind Event" is defined in Section 13.3.

"Tax Return" means any return, declaration, report, claim for refund, information return or statement, including schedules and attachments thereto and amendments, relating to Taxes.

"THA" is defined in the Recitals to this Agreement.

"Title Company" is defined in Section 8.2(d).

"Title Commitment" is defined in Section 8.2(e).

"Title Policy" is defined in Section 8.2(e).

"Total Capital Plan Costs" is defined in Section 14.1(a).

"Transaction Documents" means the New Huntington Organizational Documents, the New Parent Organizational Documents and each of the other documents, certificates and instruments to be delivered under this Agreement.

"Trust" is defined in the Preamble to this Agreement.

"Trust Distributions" means GME Distributions and Project Distributions.

"Trust Monetary Liens" is defined in Section 8.2(c).

"Trust Party End Date" is defined in Section 16.17(a).

"Trust Released Parties" is defined in Section 12.4.

"Trust Schedules" is defined in the introductory language in Article V.

"Trust Securities Portfolio" is defined in Section 13.10(b).

"Trust's Knowledge" means the actual knowledge of any trustee of the Trust. For purposes of this Agreement, any reference to a "trustee of the Trust" means Jaynie Studenmund, Armando L. Gonzalez, Michelle Quinones Chino, Paul Johnson, and Wayne Brandt.

"Unrestricted Cash on Hand" means cash, cash equivalents and marketable securities of the Huntington Consolidated Group other than: (i) Trust Distributions; (ii) cash equivalents pledged or held as collateral or a security deposit; (iii) gifts, grants, bequests, donations or contributions, to the extent specifically restricted by the donor to a particular purpose; (iv) amounts drawn and unrepaid from any line of credit; and (v) cash and cash equivalents that are subject to any restrictions. A restriction to use cash, cash equivalents or marketable securities to fund an expenditure in the Huntington Strategic Capital Plan will not be treated as a restriction under clause (iii) or (v) of this definition.

1.2 Rules of Interpretation.

(a) In this Agreement and its schedules and exhibits: "Include" and its permutations will be deemed to be followed by the words "without limitation." In any determination of a period of time, "from" means "from and including" and "to" means "to but excluding." Reference to a "copy" of any document means a copy that is complete and correct. Reference to a list, or any like compilation, means that the list or compilation is complete and correct. Reference to a notice or report means a written notice or written report. Words denoting any gender will include all genders (including the neutral gender). References to the singular include references to the plural and vice versa. Where specific language is used to clarify by example a general statement, the specific language does not modify, limit or restrict in any manner the construction of the general statement to which it relates. All references to a day or days will be deemed to refer to a calendar day or calendar days, as applicable, unless otherwise specifically provided and whenever action is required on a day that is not a Business Day such action may be validly taken on the next Business Day. Reference to a contract is a reference to such contract as amended, restated, modified, supplemented or waived. References to a Section, Attachment, Schedule or Exhibit refers to such Section, Attachment, Schedule or Exhibit of this Agreement, unless otherwise specified. The terms "hereby," "hereof," "herein," "hereinafter," "hereunder" and derivative words refer to this entire Agreement, unless the context otherwise requires. The contents of the Attachments, Schedules and Exhibits are an integral part of this Agreement and reference to "this Agreement" includes the Attachments, Schedules and Exhibits. If a Party or its representative transmits a document to the other Party and such document is accessible to the other Party, such document will be deemed to have been "delivered," "furnished" or "made available" (or any phrase of similar import) to the other Party and its representatives. The headings and captions used in this Agreement, the table of contents to this Agreement and descriptions of the Schedules are for convenience of reference only and do not constitute a part of this Agreement and will not be deemed to limit, characterize or in any way affect any provision of this Agreement.

(b) Disclosure of any fact or item in the Disclosure Schedules will not necessarily mean that such item or fact, individually or in the aggregate, is material or adverse to the business, results of operations or financial condition of the Party, or that such item or fact has

had or is expected to have a Material Adverse Change or that such item or fact is required to be disclosed pursuant to this Agreement. The disclosure of any information concerning an item or fact in the Disclosure Schedules does not imply that any other, undisclosed item or fact that has a greater significance or value is material.

Article II

HUNTINGTON MEMBERSHIP

2.1 Membership of Huntington. On the terms and subject to the conditions of this Agreement, at the Closing, effective as of the Effective Time, Huntington shall (a) cause the amendment of its articles of incorporation in the form attached hereto as Attachment 2.1(a) (the "***Huntington Amended Articles***") to be filed with the California Secretary of State and (b) cause the amendment of its bylaws in the form attached hereto as Attachment 2.1(b) (the "***Huntington Amended Bylaws***" and collectively with the Huntington Amended Articles, the "***New Huntington Organizational Documents***") to provide that Parent is the sole member (as defined in Section 5056(a) of the California Corporations Code) of Huntington.

Article III

PARENT ORGANIZATIONAL DOCUMENTS AND TRUST ACTIONS

3.1 Parent Organizational Documents.

(a) On the terms and subject to the conditions of this Agreement, at the Closing, effective as of the Effective Time, Parent shall: (i) cause the amendment of its articles of incorporation in the form attached hereto as Attachment 3.1(a)(i) (the "***Parent Amended Articles***") to be filed with the California Secretary of State and (ii) cause the amendment of its bylaws in the form attached hereto as Attachment 3.1(a)(ii) (the "***Parent Amended Bylaws***" and collectively with the Parent Amended Articles, the "***New Parent Organizational Documents***").

(b) The Parties acknowledge that, pursuant to the Parent Amended Bylaws, prior to the Closing Date: (i) Huntington shall nominate three (3) individuals (the "***Huntington Nominated Directors***") to serve on the Board of Directors of Parent as of the Effective Time, and (ii) Parent shall elect the Huntington Nominated Directors to serve on the Board of Directors of Parent as of the Effective Time and for the terms agreed to by Huntington and Parent.

3.2 Trust Actions. On the terms and subject to the conditions of this Agreement, at the Closing, the Trust shall transfer the Huntington Hospital Land to Huntington pursuant to Section 8.2. Before and after the Closing, the Trust will retain ownership of all other assets of the Trust.

Article IV

REPRESENTATIONS AND WARRANTIES OF HUNTINGTON

Except as otherwise set forth on the schedules prepared by Huntington, dated as of the Execution Date and updated pursuant to Section 7.2 (collectively, "***Huntington Schedules***"), Huntington represents and warrants to Parent as of the Execution Date, as follows:

4.1 Organization, Power, Absence of Conflicts.

(a) Organization and Good Standing of Huntington. Huntington is a nonprofit corporation duly incorporated, validly existing and in good standing under the laws of the State and has all requisite corporate power and authority to carry on its business in the State as now conducted and to own or lease and operate the Huntington Assets now owned or leased and operated by it. Huntington is not licensed, qualified or admitted to do business in any jurisdiction other than the State, and there is no other jurisdiction in which the ownership, use or leasing of any Huntington Asset, or the conduct or nature of the Huntington Operations, makes such licensing, qualification or admission necessary.

(b) Authority; No Conflict; Required Filings and Consents.

(i) Huntington has all requisite corporate power and authority to execute, deliver and enter into this Agreement, to consummate the Affiliation and to perform its obligations hereunder. The execution and delivery of this Agreement, and the consummation of the Affiliation, have been duly authorized by all necessary corporate action on the part of Huntington, as required by Law. No other corporate proceeding on the part of Huntington is necessary to authorize this Agreement and the Affiliation. This Agreement has been duly executed and delivered by Huntington and (assuming that this Agreement constitutes the valid and binding agreement of the other Parties) is a legal, valid and binding obligation of Huntington, enforceable against Huntington in accordance with its terms, except to the extent of the Enforceability Exceptions.

(ii) The execution and delivery by Huntington of this Agreement does not, and the consummation of the Affiliation does not, (A) result in any breach or contravention of, or permit the acceleration of the maturity of, any material Encumbrances of any Huntington Entity, (B) result in the creation of any material Encumbrances on the Huntington Assets (other than Encumbrances created pursuant to the terms of this Agreement and the other agreements and documents executed in connection with the consummation of the Affiliation), (C) conflict with, or result in any violation or breach of any provision of the Governing Documents of any Huntington Entity, or (D) conflict with or result in a breach of, or give rise to a right of termination or amendment of or loss of benefit under, or accelerate the performance required by the terms of any judgment, court order or consent decree, or any material Contract or constitute a default thereunder for any Huntington Entity; except, in the case of clauses (A), (B), (C) and (D) above, for any matter which is not, individually or in the aggregate, reasonably expected to constitute a Material Adverse Change of Huntington.

(c) Organization and Good Standing of Huntington Subsidiaries. Each Huntington Subsidiary is a corporation or limited liability company, as the case may be, duly incorporated or formed, validly existing and in good standing under the laws of the State and has all requisite corporate or limited liability company power and authority to carry on its respective business in the State and to own or lease and operate the Huntington Assets now owned or leased and operated by it. No Huntington Subsidiary is licensed, qualified or admitted to do business in any jurisdiction other than the State, and there is no other jurisdiction in which the ownership, use or leasing of any Huntington Asset, or the conduct or nature of the Huntington Operations, makes such licensing, qualification or admission necessary.

4.2 Third-Party Rights. Except for this Agreement, the Master Lease, the HMRI Lease and Permitted Liens, there are no Contracts with, or rights of, any Person to acquire, directly or indirectly, any material Huntington Assets, or any interest therein.

4.3 Legal Compliance.

(a) To Huntington's Knowledge, no Huntington Entity is or, during the Lookback Period, has been in material violation of any Laws. To Huntington's Knowledge, during the Lookback Period, each Huntington Entity has timely filed all reports, data and other information required to be filed with Governmental Entities. To Huntington's Knowledge, during the Lookback Period, no Huntington Entity has received written notice of any proceeding or investigation by Governmental Entities against the Huntington Entity alleging or based upon a material violation of any Laws that is currently pending. To Huntington's Knowledge, no Huntington Entity has been threatened by any Person with any proceeding or investigation by Governmental Entities against the Huntington Entity alleging a violation of any Laws with respect to the Huntington Operations.

(b) To Huntington's Knowledge, each Huntington Entity has (i) developed a compliance plan for being in compliance with the Health Information Laws, and (ii) used commercially reasonable efforts to implement those provisions of such compliance plan in all respects necessary to ensure that the applicable Huntington Operations are not in violation of the Health Information Laws.

(c) Each Huntington Entity and each Huntington Healthcare Service meets all requirements of participation, claims submission and payment of the Government Payment Programs and, to Huntington's Knowledge, other third-party payment programs and is a party to valid participation agreements for payment by such Government Payment Programs and, to Huntington's Knowledge, other third-party payment programs, as applicable. No Huntington Entity nor, to Huntington's Knowledge, any of their respective officers, directors, employees, agents or contractors is currently excluded from participation in any Government Payment Program.

(d) Each Huntington Entity and Huntington Healthcare Service, as applicable, is qualified for participation in and has current and valid provider Contracts with, the Government Payment Programs and/or their fiscal intermediaries or paying agents and is not in material violation of the conditions of participation therein. To Huntington's Knowledge, there are no material Government Payment Program recoupments or material recoupments of any

third-party payor being sought, requested, claimed, or threatened against any Huntington Entity. To Huntington's Knowledge, (i) there is no Action or investigation pending, received or threatened against any Huntington Entity which relates in any way to a violation of any Law pertaining to the Government Payment Programs or which is reasonably expected to result in the imposition of material penalties on or the exclusion of any Huntington Entity or any Huntington Healthcare Service from participation in any Government Payment Programs, and (ii) no Huntington Entity is engaged in any activities which are cause for civil penalties or mandatory or permissive exclusion from any Government Payment Program. No Huntington Entity is a party to any corporate integrity agreements, deferred prosecution agreements, monitoring agreements, consent decrees, settlement orders, plans of correction or similar agreements imposed by any Governmental Entity.

(e) No Huntington Entity, as applicable, is in material violation of any Laws regarding the selection, deselection, and credentialing of contracted providers, including verification of licensing status and eligibility for reimbursement under the Government Payment Programs. Each Huntington Entity's contracted providers are properly licensed and hold appropriate clinical privileges, as applicable, for the services which they provide, and, with respect to providers that perform services eligible for reimbursement under any Government Payment Program, are not debarred or excluded from any such Government Payment Program.

(f) During the Lookback Period all material reports, data, and information required to be filed by any Huntington Entity in connection with any Government Payment Program have been timely filed and were true and complete at the time filed (or were corrected in or supplemented by a subsequent filing). There are no Actions or appeals pending (and no Huntington Entity has made any filing or submission that, to Huntington's Knowledge, is reasonably expect to result in any Actions or appeals) before any court, regulatory body, administrative agency, governmental body, arbitrator or other Governmental Entity (including governmental administrative contractors) with respect to any Government Payment Program reports or claims filed by any Huntington Entity during the Lookback Period or with respect to any disallowances by any regulatory body, administrative agency, governmental body or other authority (including governmental administrative contractors) in connection with any audit taking place during the Lookback Period. No material validation review or program integrity review related to any Huntington Entity or any Huntington Healthcare Service has been conducted by any regulatory body, administrative agency, governmental body or other authority (including governmental administrative contractors) in connection with any Government Payment Program within the past five (5) years and, to Huntington's Knowledge, no such reviews are scheduled, pending, or threatened against or affecting any Huntington Entity or any Huntington Healthcare Service.

(g) Each Huntington Entity holds all Licenses set forth on Schedule 4.3(g) that are necessary for its respective part of the Huntington Operations. All such Licenses are in good standing and, to Huntington's Knowledge, are not subject to meritorious challenge. To Huntington's Knowledge, the Huntington Operations and Huntington Healthcare Services are not in material violation of such Licenses.

4.4 Huntington Financial Statements. Copies of the Huntington Financial Statements have been made available to Parent. The Huntington Financial Statements fairly present in all

material respects the financial condition and results of operations of the Huntington Operations as of the respective dates thereof and for the period therein referred to, subject to normal recurring year-end adjustments and the absence of notes; and the Huntington Financial Statements reflect the consistent application of GAAP throughout the periods involved.

4.5 Absence of Material Change. Since the date of the last Huntington Financial Statements, to Huntington's Knowledge, there has not been any event, change, occurrence or circumstance that has had or is reasonably expected to have a Material Adverse Change of Huntington.

4.6 Real Property.

(a) The Huntington Real Property comprises all of the real property owned or leased by the Huntington Entities.

(b) To Huntington's Knowledge, no Huntington Entity has received from any Governmental Entity any written notice of condemnation relating to the Huntington Real Property or any part thereof.

(c) Except for those tenants in possession of the Huntington Real Property under Contracts, to Huntington's Knowledge there are no Persons in possession of, or claiming any possession, adverse or not, to or other interest in, any portion of the Huntington Real Property other than a Huntington Entity, whether as lessees, tenants at sufferance, trespassers or otherwise. To Huntington's Knowledge, during the Lookback Period no Huntington Entity has received any written notice of any material default or breach on the part of the landlord under any lease of Huntington Real Property which has not been cured, nor does there exist any such default or breach on the part of the landlord.

(d) Schedule 4.6(d) identifies all those construction or capital projects currently in progress with respect to the Huntington Real Property for which all final approvals needed from Governmental Entities have not been obtained.

4.7 Environmental Matters.

(a) To Huntington's Knowledge, (i) no Huntington Entity is subject to any Action or any other material liability arising under any Environmental Laws and (ii) no circumstances exist that are reasonably expected to constitute a material violation of Environmental Laws by any Huntington Entity. During the three (3) year period prior to the Execution Date, to Huntington's Knowledge, no Huntington Entity has received any written communication from any Person alleging that any Huntington Entity is in violation of Environmental Laws.

(b) No Huntington Entity is in material violation of Environmental Laws, and during the three (3) year period prior to the Execution Date, there has been no material Environmental Claim pending or, to Huntington's Knowledge, threatened against any Person whose liability for any Environmental Claim has been retained or assumed either contractually or by operation of law by a Huntington Entity.

4.8 Employment Matters.

(a) Employee and Employee Relations.

(i) There is no pending or, to Huntington's Knowledge, threatened employee strike, work stoppage or slowdown, labor dispute or unfair labor practices in connection with the Huntington Operations.

(ii) To Huntington's Knowledge, no employees of any Huntington Entity are represented by, or are demanding recognition of, a labor union or employee organization with respect to their work at the Huntington Operations.

(iii) To Huntington's Knowledge, there are no other union organizing or collective bargaining activities by or with respect to any employees of any Huntington Entity with respect to such employment.

(iv) To Huntington's Knowledge, Huntington is not and during the Lookback Period has not been in material violation of any material obligations under any Plant Closure Laws as a result of the Huntington Operations.

(b) Pending Proceedings. There are no active, pending or, to Huntington's Knowledge, threatened material administrative or judicial proceedings under Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act, the Fair Labor Standards Act, the Occupational Safety and Health Act, the National Labor Relations Act, the Fair Employment and Housing Act, the California Labor Code, ERISA or any other foreign, federal, state or local law (including common law), ordinance or regulation relating to current employees or contingent workers, or former employees or contingent workers, of any Huntington Entity. No employee or independent contractor of a Huntington Entity is entitled to receive any compensation, payment, or remuneration from any Party as a result of the execution and delivery of this Agreement or the occurrence of the Closing.

4.9 Employee Benefit Plans.

(a) Schedule 4.9 sets forth a list of the Huntington Employee Benefit Programs.

(b) Each Huntington Employee Benefit Program that is intended to qualify under Section 401(a) of the Code has received a favorable determination or opinion letter from the IRS regarding its qualification thereunder, and to Huntington's Knowledge no event has occurred during the Lookback Period and no condition exists that is reasonably expected to result in the loss of such tax-qualified status or the imposition of any liability, penalty or tax under ERISA, the Code or any other Laws. To Huntington's Knowledge, with respect to each Huntington Employee Benefit Program, all material reports, returns, notices, and other documentation that are required to have been filed with or furnished by Huntington to the IRS, the United States Department of Labor (the "***DOL***"), the Pension Benefit Guaranty Corporation (the "***PBGC***"), the Securities and Exchange Commission (the "***SEC***") or any other Governmental Entity, or to the participants or beneficiaries of such Huntington Employee Benefit Program, during the Lookback Period have been filed or furnished on a timely basis.

(c) With respect to each Huntington Employee Benefit Program, Huntington has made available to Parent (if applicable to such Huntington Employee Benefit Program): (i) all documents embodying or governing such Huntington Employee Benefit Program, including summary plan descriptions, and any funding medium for such Huntington Employee Benefit Program (including plan documents, trust agreements and amendments thereto); (ii) the most recent IRS determination or opinion letter with respect to such Huntington Employee Benefit Program under Code Section 401(a); (iii) Form 5500 annual reports for the last three (3) plan years for all Huntington Employee Benefit Programs that require such filings; and (iv) any insurance policy related to such Huntington Employee Benefit Program.

(d) Each Huntington Employee Benefit Program has been established, operated, and administered in all material respects in accordance with the requirements of Law, including ERISA and the Code, and is being administered and operated in all material respects in accordance with its terms, and is being administrated in a manner that avoids the imposition of material penalties imposed by Law, including penalty taxes. No Huntington Employee Benefit Program is subject to Title IV of ERISA or is a Multiemployer Plan, within the meaning of ERISA Section 3(37) and no Huntington Entity or any ERISA Affiliate has within the past six (6) years sponsored, maintained, contributed to or had any liability in respect to any employee benefit plan subject to Title IV of ERISA or any Multiemployer Plan.

(e) Neither any Huntington Employee Benefit Program fiduciary nor any Huntington Employee Benefit Program has engaged in any transaction in violation of Section 406 of ERISA or any "prohibited transaction" (as defined in Section 4975(c)(1) of the Code), which transaction is not exempt under Section 4975(d) of the Code or Section 408 of ERISA and which is reasonably expected to result in material liability to Huntington under ERISA or the Code. To Huntington's Knowledge, no Huntington Entity or ERISA Affiliate or any Person appointed or otherwise designated to act on behalf of such Huntington Entity or such ERISA Affiliate, has engaged in any transactions in connection with any Huntington Employee Benefit Program that is reasonably expected to result in the imposition of a material penalty pursuant to Section 502(i) of ERISA, material damages pursuant to Section 409 of ERISA or a material Tax pursuant to Section 4975(a) of the Code.

(f) To Huntington's Knowledge, no administrative investigation, audit or other administrative proceeding by the DOL, the PBGC, the Internal Revenue Service or any other Governmental Entity is pending, with respect to any Huntington Employee Benefit Program. There is no pending, or to Huntington's Knowledge, threatened, legal action, proceeding, or investigation, other than routine claims for benefits, concerning any of the Huntington Employee Benefit Programs, or, any fiduciary or service provider thereof. No Huntington Entity has liability by virtue of its being a member of a controlled group with a person who has liability under the Code or ERISA.

(g) No Employee Welfare Benefit Plan which is a group health plan (within the meaning of Section 5000(b)(1) of the Code) is in material violation of the requirements of Section 4980B of the Code and Part 6 of Subtitle B of Title I of ERISA. As presently constituted, no Huntington Employee Benefit Program provides for health or welfare benefits (other than as required pursuant to Section 4980B of the Code or pursuant to State health continuation laws) to any current or future retiree or former employee beyond the month of termination. No

Huntington Entity is in material violation of requirements to report to the Internal Revenue Services under the Affordable Care Act, and the Internal Revenue Service has not imposed any penalties or assessments as a result of such reporting obligations.

(h) The execution and delivery of this Agreement and the consummation of the Affiliation do not result in (A) any increase in severance pay otherwise due upon any termination of employment after the Execution Date; (B) the acceleration of the time of payment or vesting or result in any funding of compensation or benefits; (C) any payment, compensation or benefit becoming due, or increase in the amount of any payment, compensation or benefit due, to any current or former employee of any Huntington Entity; (D) any new obligation pursuant to any Huntington Employee Benefit Program; (E) payment of compensation that results in an "excess parachute payment" within the meaning of Section 280G of the Code; or (F) any limitation or restriction on the right of any Huntington Entity to merge, amend or terminate any Huntington Employee Benefit Program.

(i) No Huntington Employee Benefit Program that is a "nonqualified deferred compensation plan" (as defined under Section 409A of the Code) has been operated and administered in material violation of Section 409A of the Code, and no compensation is includable in the gross income of any current or former employee, officer, director or consultant of any Huntington Entity or any ERISA Affiliate as a result of the operation of Section 409A of the Code with respect to any applicable arrangements or agreements in effect prior to the Closing. No agreements to provide Code Section 409A gross-ups are in place with respect to any employee or director of a Huntington Entity.

4.10 Litigation. There are no material Actions pending or, to Huntington's Knowledge, threatened in writing against any Huntington Entity or, to Huntington's Knowledge, with respect to any Huntington Assets. To Huntington's Knowledge, there are no material investigations pending or threatened in writing against any Huntington Entity. There is no pending or, to Huntington's Knowledge, threatened in writing, litigation, arbitration or other proceeding involving any Huntington Entity or, to Huntington's Knowledge, Huntington Assets before any court, arbitrator or governmental, regulatory or administrative body or authority that is reasonably expected to prevent or materially delay or adversely affect the consummation of the Affiliation.

4.11 Tax and Tax Exempt Status.

(a) Huntington and HHP are recognized as exempt from federal income taxation under Code Section 501(a) as organizations described in Code Section 501(c)(3), and are also recognized as exempt from State income taxation.

(b) Each Huntington Entity has filed or caused to be filed, on a timely basis, all Tax Returns that were required to be filed during the Lookback Period by such Huntington Entity in accordance with applicable Law. All such Tax Returns are true, correct and complete in all material respects. Each Huntington Entity has paid all Taxes due and payable by such Huntington Entity (whether or not shown on any Tax Return).

(c) There are no audits or administrative or judicial Tax Actions that are being conducted with respect to a Huntington Entity, and during the Lookback Period no Huntington Entity has received any written notices from any Governmental Entity that any such Tax Action is currently pending.

(d) There exists no outstanding notice of deficiency or proposed Tax assessment against a Huntington Entity.

(e) All Taxes that a Huntington Entity was required by applicable Law to withhold or collect during the Lookback Period have been duly withheld or collected and, to the extent required by applicable Law, have been paid to the proper Governmental Entity.

(f) No Huntington Entity is a party to any Tax allocation, sharing, indemnity, or reimbursement agreement or arrangement that is primarily related to Taxes, and no Huntington Entity is liable for the Taxes of any other Person as a transferee or successor.

4.12 Certain Affiliations.

(a) The Affiliation does not confer any personal financial benefit on any officer, director, employee, doctor, medical group or other entity affiliated with Huntington or any family member of any such person as identified in California Corporations Code section 5227(b)(2).

(b) No officer, trustee or director of Huntington (or any family member of such persons as identified in California Corporations Code section 5227(b)(2)) or any Affiliate of Huntington has any personal financial interest in any company, firm, partnership, or business entity (other than salary and directors/trustees' fees) currently doing business with Huntington or any Affiliate of Huntington.

4.13 Intellectual Property. Each Huntington Entity owns or has sufficient right to use all Huntington Entity Intellectual Property Assets (as defined below) that are necessary for the operation of the business of such Huntington Entity as it is currently conducted. For purposes of this Agreement, "***Huntington Entity Intellectual Property Assets***" means, for each Huntington Entity: (i) the name of the Huntington Entity, all fictional business names, trade names, registered and unregistered trademarks, service marks and applications for same; (ii) all patents and patent applications; (iii) all copyrights in both published works and unpublished works; (iv) all rights in mask works; and (v) all know-how, trade secrets, confidential information, customer lists, software, technical information, data, process technology, plans, drawings and blueprints and other intellectual property rights owned, used or licensed by the Huntington Entity as licensee or licensor.

4.14 Insurance.

(a) Schedule 4.14 includes a list of all insurance policies (including the policy type, carrier, retention, term and claim limits) to which a Huntington Entity is a party and that provide coverage to a Huntington Entity or the business of a Huntington Entity, or any director, manager or officer of a Huntington Entity (the "***Huntington Entity Insurance Policies***"). All Huntington Entity Insurance Policies: (i) are valid, outstanding, and enforceable, subject to the

Enforceability Exceptions; (ii) are sufficient for compliance in all material respects with all applicable Contracts to which a Huntington Entity is a party; and (iii) except for workers compensation insurance maintained by a Huntington Entity, do not provide for any retrospective premium adjustment or other experienced-based liability on the part of a Huntington Entity. The consummation of the Affiliation by Huntington does not result in a default under any of the Huntington Entity Insurance Policies.

(b) Each Huntington Entity has paid all premiums due, and has otherwise performed all of its obligations in all material respects, under each Huntington Entity Insurance Policy to which the Huntington Entity is a party or that provides coverage to the business of the Huntington Entity or any officers, directors or managers thereof.

4.15 Operation of the Huntington Operations. To Huntington's Knowledge, the Huntington Assets constitute all assets, properties, goodwill and businesses necessary to conduct the Huntington Operations, in the aggregate and with respect to each Huntington Healthcare Service, in all material respects in the manner in which the Huntington Operations are currently conducted.

4.16 Membership. Huntington has no members (as defined in Section 5056 of the California Corporations Code), and Huntington is the sole member of HHP.

4.17 Due Diligence. Huntington has used good faith efforts to make available to Parent the information in a Huntington Entity's possession that is responsive to that certain Due Diligence Request list originally provided by Parent to Huntington on March 13, 2020, that certain follow-up due diligence request list dated April 16, 2020 and that certain follow-up due diligence request list dated May 15, 2020. To Huntington's Knowledge, all such information made available does not contain any untrue statement of material fact.

Article V

REPRESENTATIONS AND WARRANTIES OF TRUST

Except as otherwise set forth on the schedules prepared by the Trust, dated as of the Execution Date and updated pursuant to Section 7.2 (collectively, "***Trust Schedules***"), the Trust represents and warrants to Parent and Huntington as of the Execution Date, as follows:

5.1 Power, Absence of Conflicts.

(a) The Trust is a trust under the laws of the State and has all requisite trust power and authority to carry on its business in the State as now conducted and to own the assets and properties now owned or leased and operated by the Trust. The Trust is not licensed, qualified or admitted to do business in any jurisdiction other than the State, and there is no other jurisdiction in which the ownership, use or leasing of any asset or property owned by the Trust, or the conduct or nature of the business operated by the Trust, makes such licensing, qualification or admission necessary. The Trust has provided Parent with complete and correct copies of the Testamentary Trust under the Will of Henry E. Huntington and court orders that set forth the terms of the Trust, the Trust's powers and purposes, and the governance of the Trust.

(b) Subject to receipt of the Court Approval: the Trust has all requisite trust power and authority to conduct its business as now being conducted, to execute, deliver and enter into this Agreement, to consummate the Affiliation and to perform its obligations hereunder; the execution and delivery of this Agreement, and the consummation of the Affiliation, have been duly authorized by all necessary trust action on the part of the Trust, as required by Law; no other trust proceeding on the part of the Trust is necessary to authorize this Agreement and the Affiliation; and this Agreement has been duly executed and delivered by the Trust and (assuming that this Agreement constitutes a valid and binding agreement of the other Parties) is a legal, valid and binding obligation of the Trust, enforceable against the Trust in accordance with its terms, except to the extent of the Enforceability Exceptions.

(c) Subject to receipt of the Court Approval, the execution and delivery of this Agreement by the Trust does not, and the consummation of the Affiliation does not, (A) result in any breach or contravention of, or permit the acceleration of the maturity of, any material Encumbrances of the Trust encumbering the Huntington Hospital Land, (B) result in the creation of any material Encumbrances on any assets or properties owned by the Trust (other than Encumbrances created pursuant to the terms of this Agreement and the other agreements and documents executed in connection with the consummation of the Affiliation), (C) conflict with, or result in any violation or breach of any provision of the Governing Documents of the Trust, or (D) conflict with or result in a breach of, or give rise to a right of termination or amendment of or loss of benefit under, or accelerate the performance required by the terms of any judgment, court order or consent decree, or any material Contract or constitute a default thereunder for the Trust; except, in the case of clauses (A), (B), (C) and (D) above, for any matter which is not, individually or in the aggregate, reasonably expected to constitute a Material Adverse Change of the Trust.

5.2 Third-Party Rights. Aside from this Agreement, the Master Lease, the HMRI Lease and Permitted Liens, there are no Contracts with, or rights of, any Person to acquire, directly or indirectly, the Trust's interest in the Huntington Hospital Land, or any material interest therein.

5.3 Huntington Hospital Land.

(a) The Huntington Hospital Land comprises all of the real property owned or leased by the Trust that is currently being used by a Huntington Entity in its operations.

(b) The Trust has not received written notice within the Lookback Period of condemnation or similar proceeding relating to a government taking relating to the Huntington Hospital Land or any part thereof, other than ordinary course requirements by Governmental Entities in connection with development and construction projects or public works or infrastructure that do not have a material adverse effect on the use or value of the Huntington Hospital Land as currently being used.

(c) The Trust has leased the Huntington Hospital Land pursuant to the Master Lease and the HMRI Lease, and has no rights of possession or occupancy of the Huntington Hospital Land. To the Trust’s Knowledge, the Trust has not received any written notice of any material default or breach on the part of the landlord under the Master Lease or the HMRI Lease

which has not been cured, nor does there exist any such default or breach on the part of the landlord.

(d) The Trust is not engaged in any construction or capital projects currently in progress with respect to the Huntington Hospital Land.

5.4 Environmental Matters. With respect to the Huntington Hospital Land, to the Trust's Knowledge, (i) the Trust is not subject to any pending Action or any other material liability arising under any Environmental Laws and (ii) no circumstances exist that are reasonably expected to constitute a material violation of Environmental Laws by the Trust. During the three (3) year period prior to the Execution Date, the Trust has not received any written communication from any Person alleging that the Trust or Huntington is in violation of Environmental Laws.

5.5 Litigation. There are no material Actions pending or, to the Trust's Knowledge, threatened in writing against the Trust or, to the Trust's Knowledge, with respect to the Huntington Hospital Land. To the Trust's Knowledge, there are no material investigations pending or threatened in writing against the Trust or with respect to the Huntington Hospital Land. There is no pending or, to the Trust's Knowledge, threatened in writing, litigation, arbitration or other proceeding involving the Trust with respect to the Huntington Hospital Land before any court, arbitrator or governmental, regulatory or administrative body or authority that is reasonably expected to prevent or materially delay or adversely affect the consummation of the Affiliation or the transfer of the Huntington Hospital Land contemplated herein.

5.6 Tax and Tax Exempt Status. The Trust is recognized as exempt from federal income taxation under Code Section 501(a) as an organization described in Code Section 501(c)(3) and is recognized as exempt from State income taxation.

5.7 Certain Affiliations.

(a) The Affiliation does not confer any personal financial benefit on any officer, director, employee, doctor, medical group or other entity affiliated with the Trust or any family member of any such person as identified in California Corporations Code section 5227(b)(2).

(b) No trustee of the Trust (or any family member of such persons as identified in California Corporations Code section 5227(b)(2)) or any Affiliate of the Trust has any personal financial interest in any company, firm, partnership, or business entity (other than salary and directors/trustees' fees) currently doing business with the Trust or any Affiliate of the Trust.

Article VI

REPRESENTATIONS AND WARRANTIES OF PARENT

Except as otherwise set forth on the schedules prepared by Parent, dated as of the Execution Date and updated pursuant to Section 7.2 (collectively, "***Parent Schedules***"), Parent represents and warrants to Huntington and the Trust as of the Execution Date, as follows:

6.1 Organization, Power, Absence of Conflicts

(a) Organization and Good Standing of Parent. Parent is a nonprofit corporation duly incorporated, validly existing and in good standing under the laws of the State and has all requisite corporate power and authority to carry on its business in the State and to own or lease and operate the Parent Assets now owned or leased and operated by it. Parent is not licensed, qualified or admitted to do business in any jurisdiction other than the State as now conducted, and there is no other jurisdiction in which the ownership, use or leasing of any Parent Asset, or the conduct or nature of the Parent Operations, makes such licensing, qualification or admission necessary.

(b) Authority; No Conflict; Required Filings and Consents.

(i) Parent has all requisite corporate power and authority, to execute, deliver and enter into this Agreement, to consummate the Affiliation and to perform its obligations hereunder. The execution and delivery of this Agreement, and the consummation of the Affiliation, have been duly authorized by all necessary corporate action on the part of Parent, as required by Law. No other corporate proceeding on the part of Parent is necessary to authorize this Agreement and the Affiliation. This Agreement has been duly executed and delivered by Parent and (assuming that this Agreement constitutes the valid and binding agreement of the other Parties) is a legal, valid and binding obligation of Parent, enforceable against Parent in accordance with its terms, except to the extent of the Enforceability Exceptions.

(ii) The execution and delivery by Parent of this Agreement does not, and the consummation of the Affiliation does not, (A) result in any breach or contravention of, or permit the acceleration of the maturity of, any material Encumbrances of any Parent Entity, (B) result in the creation of any material Encumbrances on the Parent Assets (other than Encumbrances created pursuant to the terms of this Agreement and the other agreements and documents executed in connection with the consummation of the Affiliation), (C) conflict with, or result in any violation or breach of any provision of the Governing Documents of any Parent Entity, or (D) conflict with or result in a breach of, or give rise to a right of termination or amendment of or loss of benefit under, or accelerate the performance required by the terms of any judgment, court order or consent decree, or any material Contract or constitute a default thereunder for any Parent Entity; except, in the case of clauses (A), (B), (C) and (D) above, for any matter which is not, individually or in the aggregate, reasonably expected to constitute a Material Adverse Change of Parent.

(c) Organization and Good Standing of CSMC. CSMC is a nonprofit corporation duly incorporated, validly existing and in good standing under the laws of the State

and has all requisite corporate power and authority to carry on its business in the State and to own or lease and operate the Parent Assets now owned or leased and operated by it. CSMC is not licensed, qualified or admitted to do business in any jurisdiction other than the State, and there is no other jurisdiction in which the ownership, use or leasing of any Parent Asset, or the conduct or nature of the Parent Operations, makes such licensing, qualification or admission necessary.

6.2 Third-Party Rights. There are no Contracts with, or rights of, any Person to acquire, directly or indirectly, any material Parent Assets, or any interest therein.

6.3 Legal Compliance.

(a) To Parent's Knowledge, no Parent Entity is or, during the Lookback Period, has been in material violation of any Laws. To Parent's Knowledge, during the Lookback Period, each Parent Entity has timely filed all reports, data and other information required to be filed with Governmental Entities. To Parent's Knowledge, during the Lookback Period, no Parent Entity has received written notice of any proceeding or investigation by Governmental Entities against the Parent Entity alleging or based upon a material violation of any Laws that is currently pending. To Parent's Knowledge, no Parent Entity has been threatened by any Person with any proceeding or investigation by Governmental Entities against the Parent Entity alleging a violation of any Laws with respect to the Parent Operations.

(b) To Parent's Knowledge, each Parent Entity has (i) developed a compliance plan for being in compliance with the Health Information Laws, and (ii) during the Lookback Period, has used commercially reasonable efforts to implement those provisions of such compliance plan in all respects necessary to ensure that the applicable Parent Operations are not in violation of the Health Information Laws.

(c) Each Parent Entity and each Parent Healthcare Service meets all requirements of participation, claims submission and payment of the Government Payment Programs and, to Parent's Knowledge, other third-party payment programs and is a party to valid participation agreements for payment by such Government Payment Programs and, to Parent's Knowledge, other third-party payment programs, as applicable. No Parent Entity nor, to Parent's Knowledge, any of their respective officers, directors, employees, agents or contractors is currently excluded from participation in any Government Payment Program.

(d) Each Parent Entity and Parent Healthcare Service, as applicable, is qualified for participation in and has current and valid provider Contracts with, the Government Payment Programs and/or their fiscal intermediaries or paying agents and is not in material violation of the conditions of participation therein. To Parent's Knowledge, there are no material Government Payment Program recoupments or material recoupments of any third-party payor being sought, requested, claimed, or threatened against any Parent Entity. To Parent's Knowledge: (i) there is no Action or investigation pending, received or threatened against any Parent Entity which relates in any way to a violation of any Law pertaining to the Government Payment Programs or which is reasonably expected to result in the imposition of material penalties on or the exclusion of any Parent Entity or any Parent Healthcare Service from participation in any Government Payment Programs, and (ii) no Parent Entity is engaged in any activities which are cause for civil penalties or mandatory or permissive exclusion from any

Government Payment Program. No Parent Entity is a party to any corporate integrity agreements, deferred prosecution agreements, monitoring agreements, consent decrees, settlement orders, plans of correction or similar agreements imposed by any Governmental Entity.

(e) No Parent Entity, as applicable, is in material violation of any Laws regarding the selection, deselection, and credentialing of contracted providers, including verification of licensing status and eligibility for reimbursement under the Government Payment Programs. Each Parent Entity's contracted providers are properly licensed and hold appropriate clinical privileges, as applicable, for the services which they provide, and, with respect to providers that perform services eligible for reimbursement under any Government Payment Program, are not debarred or excluded from any such Government Payment Program.

(f) During the Lookback Period, all material reports, data, and information required to be filed by any Parent Entity in connection with any Government Payment Program have been timely filed and were true and complete at the time filed (or were corrected in or supplemented by a subsequent filing). There are no Actions or appeals pending (and no Parent Entity has made any filing or submission that, to Parent's Knowledge, is reasonably expected to result in any Actions or appeals) before any court, regulatory body, administrative agency, governmental body, arbitrator or other Governmental Entity (including governmental administrative contractors) with respect to any Government Payment Program reports or claims filed by any Parent Entity, during the Lookback Period, or with respect to any disallowances by any regulatory body, administrative agency, governmental body or other authority (including governmental administrative contractors) in connection with any audit taking place during the Lookback Period. No material validation review or program integrity review related to any Parent Entity or any Parent Healthcare Service has been conducted by any regulatory body, administrative agency, governmental body or other authority (including governmental administrative contractors) in connection with any Government Payment Program within the past five (5) years and, to Parent's Knowledge, no such reviews are scheduled, pending, or threatened against or affecting any Parent Entity or any Parent Healthcare Service.

(g) Each Parent Entity holds all material Licenses necessary for such Parent Entity's operations and the assets involved in such Parent Entity's operations. All such Licenses are in good standing and, to Parent's Knowledge, are not subject to meritorious challenge. To Parent's Knowledge, the Parent Operations and Parent Healthcare Services are not in material violation of such Licenses.

6.4 Parent Financial Statements. Copies of the Parent Financial Statements have been made available to Huntington. The Parent Financial Statements fairly present in all material respects the financial condition and results of operations of the Parent Operations as of the respective dates thereof and for the period therein referred to, subject to normal recurring year-end adjustments and the absence of notes; and the Parent Financial Statements reflect the consistent application of GAAP throughout the periods involved.

6.5 Absence of Material Change. Since the date of the last Parent Financial Statements, to Parent's Knowledge, there has not been any event, change, occurrence or

circumstance that has had or is reasonably expected to have a Material Adverse Change of Parent.

6.6 Real Property.

(a) The Parent Real Property comprises all of the real property owned or leased by the Parent Entities.

(b) To Parent's Knowledge, no Parent Entity has received from any Governmental Entity any written notice of condemnation relating to the Parent Real Property or any part thereof.

(c) Except for those tenants in possession of the Parent Real Property under Contracts, to Parent's Knowledge there are no Persons in possession of, or claiming any possession, adverse or not, to or other interest in, any portion of the Parent Real Property other than a Parent Entity, whether as lessees, tenants at sufferance, trespassers or otherwise. To Parent's Knowledge, during the Lookback Period no Parent Entity has received any written notice of any material default or breach on the part of the landlord under any lease of Parent Real Property which has not been cured, nor does there exist any such default or breach on the part of the landlord.

(d) Schedule 6.6(d) identifies all those construction or capital projects currently in progress with respect to the Parent Real Property for which all final approvals needed from Governmental Entities have not been obtained.

6.7 Environmental Matters.

(a) To Parent's Knowledge, (i) no Parent Entity is subject to any Action or any other material liability arising under any Environmental Laws and (ii) no circumstances exist that are reasonably expected to constitute a material violation of Environmental Laws by any Parent Entity. During the three (3) year period prior to the Execution Date, to Parent's Knowledge, no Parent Entity has received any written communication from any Person alleging that any Parent Entity is in violation of Environmental Laws.

(b) No Parent Entity is in material violation of Environmental Laws, and during the three (3) year period prior to the Execution Date, there has been no material Environmental Claim pending or, to Parent's Knowledge, threatened against any Person whose liability for any Environmental Claim has been retained or assumed either contractually or by operation of law by a Parent Entity.

6.8 Employment Matters.

(a) Employee and Employee Relations.

(i) There is no pending or, to Parent's Knowledge, threatened employee strike, work stoppage or slowdown, labor dispute or unfair labor practices in connection with the Parent Operations.

(ii) To Parent's Knowledge, no employees of any Parent Entity are represented by, or are demanding recognition of, a labor union or employee organization with respect to their work at the Parent Operations.

(iii) To Parent's Knowledge, there are no other union organizing or collective bargaining activities by or with respect to any employees of any Parent Entity with respect to such employment.

(iv) To Parent's Knowledge, Parent is not, and during the Lookback Period has not been, in material violation of any material obligations under any Plant Closure Laws as a result of the Parent Operations.

(b) Pending Proceedings. There are no active, pending or, to Parent's Knowledge, threatened material administrative or judicial proceedings under Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act, the Fair Labor Standards Act, the Occupational Safety and Health Act, the National Labor Relations Act, the Fair Employment and Housing Act, the California Labor Code, ERISA or any other foreign, federal, state or local law (including common law), ordinance or regulation relating to current employees contingent workers, or former employees or contingent workers, of any Parent Entity. No employee or independent contractor of a Parent Entity is entitled to receive any compensation, payment, or remuneration from any Party as a result of the execution and delivery of this Agreement or the occurrence of the Closing.

6.9 Employee Benefit Plans.

(a) Parent does not maintain any employee benefit program.

(b) Each Parent Employee Benefit Program that is intended to qualify under Section 401(a) of the Code has received a favorable determination or opinion letter from the IRS regarding its qualification thereunder, and, to Parent's Knowledge, no event has occurred during the Lookback Period and no condition exists that is reasonably expected to result in the loss of such tax-qualified status or the imposition of any liability, penalty or tax under ERISA, the Code or any other Laws. To Parent's Knowledge, with respect to each Parent Employee Benefit Program, all material reports, returns, notices, and other documentation that are required to have been filed with or furnished by Parent to the IRS, the DOL, the PBGC, the SEC, or any other Governmental Entity, or to the participants or beneficiaries of such Parent Employee Benefit Program, during the Lookback Period, have been filed or furnished on a timely basis.

(c) With respect to each Parent Employee Benefit Program, Parent has made available to Huntington (if applicable to such Parent Employee Benefit Program): (i) all documents embodying or governing such Parent Employee Benefit Program, including summary plan descriptions, and any funding medium for such Parent Employee Benefit Program (including plan documents, trust agreements and amendments thereto); (ii) the most recent IRS determination letter with respect to such Parent Employee Benefit Program under Code Section 401(a); (iii) Form 5500 annual reports for the last three (3) plan years for all Parent Employee Benefit Programs that require such filings; and (iv) any insurance policy related to such Parent Employee Benefit Program.

(d) Each Parent Employee Benefit Program has been established, operated, and administered in all material respects in accordance with the requirements of Law, including ERISA and the Code, and is being administered and operated in all material respects in accordance with its terms, and is being administrated in a manner that avoids the imposition of material penalties imposed by Law, including penalty taxes. No Parent Employee Benefit Program is subject to Title IV of ERISA or is a Multiemployer Plan, within the meaning of ERISA Section 3(37) and no Parent Entity or any ERISA Affiliate has within the past six (6) years sponsored, maintained, contributed to or had any liability in respect to any employee benefit plan subject to Title IV of ERISA or any Multiemployer Plan.

(e) Neither any Parent Employee Benefit Program fiduciary nor any Parent Employee Benefit Program has engaged in any transaction in violation of Section 406 of ERISA or any "prohibited transaction" (as defined in Section 4975(c)(1) of the Code), which transaction is not exempt under Section 4975(d) of the Code or Section 408 of ERISA and which is reasonably expected to result in material liability under ERISA or the Code. To Parent's Knowledge, no Parent Entity or ERISA Affiliate or any Person appointed or otherwise designated to act on behalf of such Parent Entity or such ERISA Affiliate, has engaged in any transactions in connection with any Parent Employee Benefit Program that is reasonably expected to result in the imposition of a material penalty pursuant to Section 502(i) of ERISA, material damages pursuant to Section 409 of ERISA or a material Tax pursuant to Section 4975(a) of the Code.

(f) To Parent's Knowledge, no administrative investigation, audit or other administrative proceeding by the DOL, the PBGC, the Internal Revenue Service or any other Governmental Entity is pending, with respect to any Parent Employee Benefit Program. There is no pending, or to Parent's Knowledge, threatened, legal action, proceeding, or investigation, other than routine claims for benefits, concerning any of the Parent Employee Benefit Programs, or, any fiduciary or service provider thereof. No Parent Entity has liability by virtue of its being a member of a controlled group with a person who has liability under the Code or ERISA.

(g) No Employee Welfare Benefit Plan which is a group health plan (within the meaning of Section 5000(b)(1) of the Code) is in material violation of the requirements of Section 4980B of the Code and Part 6 of Subtitle B of Title I of ERISA. As presently constituted, no Parent Employee Benefit Program provides for health or welfare benefits (other than as required pursuant to Section 4980B of the Code or pursuant to State health continuation laws) to any current or future retiree or former employee beyond the month of termination. No Parent Entity is in material violation of requirements to report to the IRS under the Affordable Care Act, and the Internal Revenue Service has not imposed any penalties or assessments as a result of such reporting obligations.

(h) The execution and delivery of this Agreement and the consummation of the Affiliation do not result in (A) any increase in severance pay otherwise due upon any termination of employment after the Execution Date; (B) the acceleration of the time of payment or vesting or result in any funding of compensation or benefits; (C) any payment, compensation or benefit becoming due, or increase in the amount of any payment, compensation or benefit due, to any current or former employee of any Parent Entity; (D) any new obligation pursuant to any Parent Employee Benefit Program; (E) payment of compensation that results in an "excess

parachute payment" within the meaning of Section 280G of the Code; or (F) any limitation or restriction on the right of any Parent Entity to merge, amend or terminate any Parent Employee Benefit Program.

(i) No Parent Employee Benefit Program that is a "nonqualified deferred compensation plan" (as defined under Section 409A of the Code) has been operated and administered in material violation of Section 409A of the Code, and no compensation is includable in the gross income of any current or former employee, officer, director or consultant of any Parent Entity or any ERISA Affiliate as a result of the operation of Section 409A of the Code with respect to any applicable arrangements or agreements in effect prior to the Closing. No agreements to provide Code Section 409A gross-ups are in place with respect to any employee or director of a Parent Entity.

6.10 Litigation. There are no material Actions pending or, to Parent's Knowledge, threatened in writing against any Parent Entity or, to Parent's Knowledge, with respect to any Parent Assets. To Parent's Knowledge, there are no material investigations pending or threatened in writing against any Parent Entity. There is no pending or, to Parent's Knowledge, threatened in writing, litigation, arbitration or other proceeding involving any Parent Entity or, to Parent's Knowledge, Parent Assets before any court, arbitrator or governmental, regulatory or administrative body or authority that is reasonably expected to prevent or materially delay or adversely affect the consummation of the Affiliation.

6.11 Tax and Tax Exempt Status.

(a) Each Parent Entity is recognized as exempt from federal income taxation under Code Section 501(a) as an organization described in Code Section 501(c)(3) and is also recognized as exempt from State income taxation.

(b) Each Parent Entity has filed or caused to be filed, on a timely basis, all Tax Returns that were required to be filed during the Lookback Period by such Parent Entity, in accordance with applicable Law. All such Tax Returns are true, correct and complete in all material respects. Each Parent Entity has paid all Taxes due and payable by such Parent Entity (whether or not shown on any Tax Return).

(c) There are no audits or administrative or judicial Tax Actions that are being conducted with respect to a Parent Entity, and, during the Lookback Period, no Parent Entity has received any written notices from any Governmental Entity that any such Tax Action is currently pending.

(d) There exists no outstanding notice of deficiency or proposed Tax assessment against a Parent Entity.

(e) All Taxes that a Parent Entity was required by applicable Law to withhold or collect during the Lookback Period have been duly withheld or collected and, to the extent required by applicable Law, have been paid to the proper Governmental Entity.

(f) No Parent Entity is a party to any Tax allocation, sharing, indemnity, or reimbursement agreement or arrangement that is primarily related to Taxes, and no Parent Entity is liable for the Taxes of any other Person as a transferee or successor.

6.12 Certain Affiliations.

(a) The Affiliation does not confer any personal financial benefit on any officer, director, employee, doctor, medical group or other entity affiliated with Parent or any family member of any such person as identified in California Corporations Code section 5227(b)(2).

(b) No officer, trustee or director of Parent (or any family member of such persons as identified in California Corporations Code section 5227(b)(2)) or any Affiliate of Parent has any personal financial interest in any company, firm, partnership, or business entity (other than salary and directors/trustees' fees) currently doing business with Parent or any Affiliate of Parent.

6.13 Intellectual Property. Each Parent Entity owns or has sufficient right to use all Parent Entity Intellectual Property Assets (as defined below) that are necessary for the operation of the business of such Parent Entity as it is currently conducted. For purposes of this Agreement, "***Parent Entity Intellectual Property Assets***" means, for each Parent Entity: (i) the name of the Parent Entity, all fictional business names, trade names, registered and unregistered trademarks, service marks and applications for same; (ii) all patents and patent applications; (iii) all copyrights in both published works and unpublished works; (iv) all rights in mask works; and (v) all know-how, trade secrets, confidential information, customer lists, software, technical information, data, process technology, plans, drawings and blueprints and other intellectual property rights owned, used or licensed by the Parent Entity as licensee or licensor.

6.14 Insurance.

(a) All insurance policies to which a Parent Entity is a party or that provide coverage to a Parent Entity or the business of a Parent Entity, or any director, manager or officer of a Parent Entity (the "***Parent Entity Insurance Policies***"): (i) are valid, outstanding, and enforceable, subject to the Enforceability Exceptions; (ii) are sufficient for compliance in all material respects with all applicable Laws and Contracts to which a Parent Entity is a party; and (iii) except for workers compensation insurance maintained by a Parent Entity, do not provide for any retrospective premium adjustment or other experienced-based liability on the part of a Parent Entity. The consummation of the Affiliation by Parent does not result in a default under any of the Parent Entity Insurance Policies.

(b) Each Parent Entity has paid all premiums due, and has otherwise performed all of its obligations in all material respects, under each Parent Entity Insurance Policy to which the Parent Entity is a party or that provides coverage to the business of the Parent Entity or any officers, directors or managers thereof.

6.15 Operation of the Parent Operations. To Parent's Knowledge, the Parent Assets constitute all assets, properties, goodwill and businesses necessary to conduct the Parent

Operations, in the aggregate and with respect to each Parent Healthcare Service, in all material respects in the manner in which the Parent Operations are currently conducted.

6.16 Membership. Parent has no members (as defined in Section 5056 of the California Corporations Code), and Parent is the sole member of CSMC and THA.

Article VII

PRE-CLOSING COVENANTS

7.1 Consents and Approvals. During the Interim Period, the Parties will use their commercially reasonable efforts and cooperate with each other and provide all necessary information to obtain at the earliest practical date all consents, waivers and approvals from, and provide all notices to, all Governmental Entities and other Persons required to consummate the Affiliation as promptly as practicable. In furtherance of the foregoing:

(a) California Attorney General.

(i) As soon as reasonably practicable following the Execution Date, Huntington shall notify the California Attorney General (the "***Attorney General***") in writing of the proposed Affiliation in accordance with Section 5920 of the California Corporations Code ("***Section 5920***"). As of the Execution Date, Parent and Huntington hereby agree that Parent has reviewed and approved Huntington's proposed written notice to the Attorney General, and that Huntington shall submit to the Attorney General the written notice in substantially the same form as reviewed and approved by Parent. Huntington shall use commercially reasonable efforts to provide such other information as the Attorney General shall request, and shall generally use its commercially reasonable efforts to obtain the Attorney General's approval of the Affiliation. Parent shall provide such information and communications to the Attorney General as Huntington or the Attorney General may reasonably request and shall otherwise cooperate with Huntington in obtaining the Attorney General's approval of the transaction.

(ii) Participation; No Consent. Each Party shall be entitled to participate, to the extent practicable, in conversations with personnel in the Office of the Attorney General in connection with the Affiliation. If the Attorney General challenges, objects to, prohibits, enjoins, places conditions upon or fails to provide any consent or approval required to complete the transaction contemplated by this Agreement, the Parties shall mutually agree on: (i) the acceptance of any conditions imposed on the transaction by the Attorney General, (ii) the decision to pursue any remedies a Party may have against the Attorney General, and/or (iii) the decision to contest or appeal the Attorney General's challenge, objection to, prohibition, enjoyment of, or failure to approve the transaction. In the event the Parties agree to take any action set forth in the foregoing sentence, each Party shall bear its own costs and expenses pertaining thereto.

(b) HSR Act.

(i) To the extent required by Law, Parent and Huntington agree to file the appropriate Notification and Report Form pursuant to the HSR Act with respect to the Affiliation as soon as reasonably practicable after the Execution Date. After filing, Parent and

Huntington agree to respond promptly to any requests for additional information by any such Governmental Entity and keep the other promptly apprised of any communications with, and inquiries or requests for information from, such Governmental Entity. Each of Parent and Huntington will take such action as required to resolve without delay any objections any such Governmental Entity may have to the Affiliation. Parent and Huntington each agree to request early termination of the waiting period under the HSR Act. In addition, Parent and Huntington each agree to promptly make any other filing that may be required under any antitrust law or by any antitrust authority and effect all other filings with and notifications to the government agencies in any other jurisdiction where such filings and notifications are required.

(ii) Parent and Huntington shall each instruct their respective counsel to cooperate with each other and use commercially reasonable efforts to facilitate and expedite the identification and resolution of any issues under any antitrust law and, consequently, expiration or termination of the applicable HSR Act waiting period at the earliest practicable date. Parent and Huntington shall supply each other with copies of all correspondence, filings or communications with antitrust authorities, with respect to the Affiliation; provided, however, that to the extent any of the documents or information are commercially or competitively sensitive, a Party may satisfy its obligations by providing such documents or information to the other Party's outside antitrust counsel, with the understanding that such antitrust counsel shall not share such documents and information with its client.

(c) Contracts. The Parties will cooperate with each another in a commercially reasonable manner to determine whether any consents, approvals and/or waivers are required to be obtained from third parties to Contracts to which a Huntington Entity is a party. Huntington, with Parent's reasonable cooperation, shall cause each Huntington Entity to use commercially reasonable efforts to seek to obtain any such consents, approvals and/or waivers; provided, that nothing in this Agreement will obligate or be construed to obligate any Party or any Huntington Entity to make or cause to be made any payment or concession to any third party in order to obtain any such action, consent, approval and/or waiver.

7.2 Schedule Updates.

(a) From time to time prior to the Closing, Huntington, Parent and the Trust will supplement or amend their respective Disclosure Schedules reasonably promptly in order to keep such information therein timely, complete and accurate. The supplements and/or amendments to the Disclosure Schedules will be arranged in sections corresponding to the numbered and lettered sections of this Agreement, but the disclosures in any section of the supplements and/or amendments to the Disclosure Schedules will qualify any other section in this Agreement to the extent such disclosure reasonably appears to be relevant to such other section, whether or not a specific cross-reference appears and whether or not a reference to the Disclosure Schedules (or the phrase "except as set forth" or any similar phrase) appears in such representations and warranties.

(b) Parent may not refuse to close as a result of any such supplement, update or correction unless an event or matter disclosed in such supplement, update or correction has had or is reasonably expected to constitute a Material Adverse Change of Huntington that causes

the condition in Section 10.2(a) (with respect to certain breaches of the representations and warranties of Huntington) not to be satisfied as of the Closing Date.

(c) Huntington may not refuse to close as a result of any such supplement, update or correction unless an event or matter disclosed in such supplement, update or correction has had or is reasonably expected to constitute a Material Adverse Change of Parent that causes the condition in Section 10.3(a) (with respect to certain breaches of the representations and warranties of Parent) not to be satisfied as of the Closing Date.

7.3 Negative Covenants of Parent. During the Interim Period, Parent shall not (and shall not agree to) take any action which would cause Huntington or the Trust to be in breach of any covenant, representation or warranty contained in this Agreement, or which would have a material adverse effect on the ability of any Party hereto to perform their respective covenants and agreements under this Agreement and the documents and agreements contemplated hereby, without the prior written consent of Huntington.

7.4 Negative Covenants of Huntington and the Trust. During the Interim Period, Huntington and the Trust shall not (and shall not agree to), and Huntington shall ensure that each Huntington Entity does not, take any action which would cause Parent to be in breach of any covenant, representation or warranty contained in this Agreement, or which would have a material adverse effect on the ability of any Party hereto to perform their respective covenants and agreements under this Agreement and the documents and agreements contemplated hereby, without the prior written consent of Parent.

7.5 Conduct of the Huntington Operations.

(a) During the Interim Period, except as expressly contemplated by this Agreement or as Parent otherwise consents to in writing, which consent shall not be unreasonably delayed, conditioned or withheld, Huntington shall conduct, and shall cause each Huntington Entity to conduct, the Huntington Operations in the ordinary course of business consistent with past practices. Without limiting the generality of the foregoing, except as expressly contemplated by this Agreement, Huntington shall, and shall cause each Huntington Entity to, in the ordinary course of business and consistent with past practices:

(i) use commercially reasonable efforts to preserve the business organization and ordinary course of operations of the Huntington Entities and Huntington Operations intact, preserve the Huntington Assets, keep available the services of each Huntington Entity's present employees involved in the Huntington Operations (other than terminations consistent with past practice and Huntington policies), and preserve the goodwill of each Huntington Entity's suppliers, patients, physicians and others with whom a Huntington Entity has business relationships relating to the Huntington Operations;

(ii) not enter into or materially change the terms of any employment agreement with any Huntington Entity employee, or increase the compensation, bonus or benefits of any Huntington Entity employee, except in the ordinary course of business; and

(iii) not terminate, amend or otherwise modify any Huntington Employee Benefit Program in any material respect, except for amendments required to comply with Laws.

(b) Notwithstanding anything Section 7.5(a) to the contrary, it is acknowledged and agreed that during the Interim Period, each Party will make such changes to its operations as such Party deems necessary or appropriate to respond to novel coronavirus and/or COVID-19 and/or any of their effects, as well as orders or advisories of the president of the United States, the governor of the State and/or other Governmental Entities, including any conduct or suspension of any of the Huntington Operations and/or Parent Operations. In no event will any such changes or any continuation of any such changes constitute a breach of Section 7.5(a).

7.6 Due Diligence. During the Interim Period, each of Huntington and Parent shall give, and shall cause each of their Related Persons to give, to the other Party and its representatives, reasonable access during normal business hours to such Party's (and such Party's Related Persons) corporate, financial, litigation, insurance and personnel files, books, accounts, records and all other relevant documents and information as representatives of the requesting Party may from time to time request for any purpose related to its due diligence review of the other Party in connection with Affiliation, all in such manner as to not unduly disrupt normal business activities and in compliance with Law and any contractual obligations relating to confidentiality. The access to and disclosure of all such books, contracts and records shall be subject to and continued to be governed by the terms and conditions of that certain Confidentiality Agreement between Parent and Huntington dated as of July 2, 2019 (the "***NDA***"). Additionally, during the Interim Period, the Trust shall give to Parent and its representatives reasonable access during normal business hours to information, documents, books and records in the Trust's custody or control with respect to the Huntington Hospital Land or other such records that Parent may from time to time request which may reasonably be necessary for Parent's evaluation of the Affiliation, which access and disclosure shall also be subject to the terms and conditions of the NDA.

7.7 No Negotiation. During the Interim Period:

(a) Huntington and its Related Persons will not directly or indirectly engage in a member substitution transaction, or a transaction that otherwise provides for one or more third parties to become the sole or controlling member of Huntington, with anyone but Parent; solicit, initiate, or encourage any proposal relating to any transaction similar to or adversely affecting the ability of Huntington to engage in the Affiliation with Parent, including any merger, sale or similar transaction; participate in any negotiations regarding or furnish to any other Person any non-public information with respect to any such proposal; encourage any effort by any Person to do any of the foregoing; approve, endorse or recommend any such proposal with any other parties; enter into any letter of intent or similar document or any contract or commitment with any other parties relating to any such proposal; or permit any of their respective directors, officers, employees, attorneys, advisors or representatives to do any of the foregoing.

(b) Parent and its Related Persons will not directly or indirectly engage in a Competing Transaction (defined below); solicit, initiate, or encourage any proposal relating to a Competing Transaction; participate in any negotiations regarding or furnish to any other Person any non-public information with respect to a Competing Transaction; encourage any effort by any Person to do any of the foregoing; approve, endorse or recommend any Competing Transaction with any other parties; enter into any letter of intent or similar document or any contract or commitment with any other parties relating to any Competing Transaction; or permit any of their respective directors, officers, employees, attorneys, advisors or representatives to do any of the foregoing. In addition, during the Interim Period, neither Parent nor any of its Related Persons will directly or indirectly solicit, initiate, or encourage any physician on the medical staff of Huntington to move the physician's practices from Huntington; or permit any of their respective directors, officers, employees or representatives to do any of the foregoing; provided that nothing in this Section 7.7 specifically shall prohibit Parent or any of its Related Persons from (a) hiring a physician who applies to an advertisement placed in the ordinary course, (b) granting or renewing any physician's medical staff membership or privileges to practice medicine at any hospital or other facility affiliated with Parent that maintains an organized medical staff, or (c) engaging any physician to provide call coverage services in such physician's medical specialty at any hospital affiliated with Parent. "***Competing Transaction***" means a transaction that is directly or indirectly related to or dependent upon the Affiliation, upon which the Affiliation would be dependent, that would make the Affiliation impractical or unfeasible or that is a Change of Control transaction with a hospital in the service area of Huntington.

7.8 Interim Financials. During the Interim Period, (a) Huntington will make available to Parent the unaudited, internal consolidated monthly balance sheet and statement of operations of the Huntington Consolidated Group reasonably promptly after they are made available to management of Huntington, and (b) Parent will make available to Huntington the unaudited, internal consolidated monthly balance sheet and statement of operations of Parent reasonably promptly after they are made available to management of Parent.

7.9 Huntington's and Trust's Efforts to Close. Huntington and the Trust shall use commercially reasonable efforts to satisfy all of the conditions precedent set forth in Article X to the Parties' obligations under this Agreement to the extent that Huntington's or the Trust's action or inaction can control or influence the satisfaction of such conditions.

7.10 Parent's Efforts to Close. Parent shall use commercially reasonable efforts to satisfy all of the conditions precedent set forth in Article X to the Parties' obligations under this Agreement to the extent that Parent's action or inaction can control or influence the satisfaction of such conditions.

Article VIII

ADDITIONAL COVENANTS AND AGREEMENTS

8.1 Government Authorizations and Court Approval. Huntington shall promptly apply for and use good faith efforts to obtain, as promptly as practicable, all material Government Authorizations that are necessary to consummate the Affiliation. The Trust shall petition the court as promptly as practicable and use good faith efforts to obtain the Court

Approval, and Huntington and Parent shall reasonably cooperate with the Trust in seeking the Court Approval.

8.2 Transfer of Huntington Hospital Land.

(a) The Trust shall use commercially reasonable efforts to obtain a lot line adjustment (as defined in Section 66412(d) of the California Government Code) isolating the Huntington Hospital Land into its own separate legally alienable parcel(s) prior to the Closing Date (the "***Lot Line Adjustment***").

(b) The Trust shall obtain, as soon as reasonably practicable after the Execution Date, current as built ALTA/NSPS Land Title surveys of the Huntington Hospital Land that are in form reasonably satisfactory to Parent and the Title Company (the "***Surveys***"), which Surveys shall be delivered to Parent and the Title Company at least sixty (60) days prior to the Closing Date. Parent shall reimburse Huntington for the direct out-of-pocket costs incurred by Huntington and/or the Trust in obtaining the Surveys provided that Parent has approved such costs in advance; provided, however, that the Trust will pay all of the costs related to any Lot Line Adjustment for the Huntington Hospital Land, including, without limitation, the costs of the surveys related to any such Lot Line Adjustment. The Surveys shall be certified to Parent, Huntington and the Title Company.

(c) The Trust shall (i) cause the satisfaction, release or reconveyance of any all liens, charges, security interests, deeds of trust, or mechanic's liens (if any) encumbering the Huntington Hospital Land, other than Permitted Liens (collectively, "***Trust Monetary Liens***") and provide Parent with copies of satisfactions, releases, reconveyances or UCC-3 Termination Statements, as applicable, evidencing the removal of all such liens, charges, security interests or other encumbrances prior to the Closing Date, and/or (ii) cause the Title Company to issue the Title Policy (as such terms are defined below) pursuant to Section 8.2(e) without exception for Trust Monetary Liens as of the Closing Date.

(d) Subject to the successful completion of the Lot Line Adjustment, prior to the Closing Date the Trust shall deliver to the National Commercial Services Office selected by Parent of First American Title Insurance Company (the "***Title Company***") a duly executed and notarized quitclaim deed, in a form reasonably satisfactory to Parent, distributing title to the Huntington Hospital Land to Huntington (the "***Huntington Hospital Land Deed***"). The Parties agree that the Huntington Hospital Land Deed will be in substantially the form of Exhibit I attached hereto and made a part hereof.

(e) The Trust shall cause the Title Company to issue prior to or at Closing (or unconditionally commit prior to or as of Closing to issue), pursuant to the terms of the Title Company's ALTA Commitment for Title Insurance File No. NCS-1012328-MIA, a copy of which is attached hereto as Exhibit J and made a part hereof (the "***Title Commitment***"), an ALTA Form 2006 Owner's Title Policy (the "***Title Policy***") in an amount satisfactory to Parent and the Title Company, with the Title Company insuring that good and marketable fee simple title to the Huntington Hospital Land is vested in Huntington as of the Closing Date, subject only to Permitted Liens. The Title Policy shall have all standard and general exceptions deleted so as to afford full "extended form coverage," shall otherwise be in a form reasonably satisfactory to Parent, including

such endorsements as Parent may reasonably require, as committed in the Title Commitment. At the Closing Parent shall reimburse Huntington and/or the Trust for the applicable title premium due the Title Company for the Title Policy.

(f) As of the Closing Date, the Trust and Huntington shall terminate the Master Lease in the form attached hereto as Exhibit K, and the Trust shall assign its rights under the HMRI Lease to Huntington in the form attached hereto as Exhibit L.

8.3 Further Assurances. Parent, Huntington and the Trust shall execute and deliver such instruments, in form and substance mutually agreeable to Parent, Huntington and the Trust (as applicable) that are reasonably required in order to carry out the terms of this Agreement or the Affiliation.

Article IX

TERMINATION OF AGREEMENT

9.1 Termination of Agreement.

(a) Mutual Agreement. This Agreement may be terminated at any time prior to the Closing by the mutual written agreement of the Parties.

(b) Breach of Covenant. By written notice to the other Parties:

(i) This Agreement may be terminated by Parent at any time prior to the Closing if Huntington or the Trust has materially breached any of their respective covenants set forth in this Agreement when performance is due and does not cure the failure within twenty (20) Business Days after receipt of written notice thereof from Parent.

(ii) This Agreement may be terminated by Huntington at any time prior to the Closing if Parent has materially breached any of its covenants set forth in this Agreement when performance is due and does not cure the failure within twenty (20) Business Days after receipt of written notice thereof from Huntington.

(c) Breach of Representation. By written notice to the other Parties:

(i) This Agreement may be terminated by Parent at any time prior to the Closing if Huntington or the Trust has materially breached any of their respective representations or warranties set forth in Article IV or Article V such that satisfaction of the condition in Section 10.2(a) by the Drop Dead Date becomes impossible.

(ii) This Agreement may be terminated by Huntington at any time prior to the Closing if Parent has materially breached any of its representations or warranties set forth in Article VI such that satisfaction of the condition in Section 10.3(a) by the Drop Dead Date becomes impossible.

(d) Failure of Condition. This Agreement may be terminated by Parent or Huntington if the Closing has not occurred on or before March 31, 2021 (the "***Drop Dead***

Date"); provided, however, that (i) Parent shall not be permitted to terminate this Agreement if the Closing is delayed beyond the Drop Dead Date by the breach of a covenant by Parent or the failure of a condition which was Parent's responsibility to fulfill; and (ii) Huntington shall not be permitted to terminate this Agreement if the Closing is delayed beyond the Drop Dead Date by the breach of a covenant by Huntington or the Trust or the failure of a condition which was Huntington's or the Trust's responsibility to fulfill.

9.2 Effect of Termination. If this Agreement is terminated as permitted by Section 9.1, such termination will be without liability of Parent, Huntington, the Trust or a Nonrecourse Person to any of the foregoing, except that the provisions of Section 1.2 (Rules of Interpretation), this Section 9.2 (Effect of Termination), Article XII (Protective Provisions), Article XV (Remedies) and Article XVI (Miscellaneous) and all provisions of the NDA will remain in full force and effect and survive any termination of this Agreement.

Article X

CONDITIONS TO CLOSING

10.1 Mutual Conditions. The respective obligations of Parent and Huntington to effect the Affiliation are subject to the satisfaction or waiver on or prior to the Closing Date of the following conditions:

(a) The waiting period pursuant to the HSR Act and any extensions thereof shall have expired or been terminated.

(b) The Attorney General shall have issued its approval of the Affiliation with terms of approval comparable to other recent nonprofit hospital acquisitions.

(c) No law that makes consummation of the Closing illegal will have been enacted, promulgated or issued by a government agency with authority to enforce such law.

(d) No order by a court or other Governmental Entity of competent jurisdiction preventing the consummation of the Affiliation will be in effect; provided that a party invoking this condition shall have used use all commercially reasonable efforts to have any such order vacated or invalidated.

(e) No Action challenging this Agreement or the Affiliation or seeking to prohibit, alter, prevent or materially delay the Affiliation will have been instituted and be pending; provided that a party invoking this condition must have used use all commercially reasonable efforts to have any such Action dismissed.

(f) All Government Authorizations that are listed in Annex 10.1(f) shall have been obtained.

(g) The consents and approvals of third parties listed in Annex 10.1(g) shall have been obtained.

10.2 Conditions Precedent to Obligations of Parent. The obligations of Parent to complete the Affiliation at the Closing shall be subject to fulfillment of all of the following conditions, except those conditions which are waived by Parent:

(a) Accuracy of Representations and Warranties.

(i) The representations and warranties of Huntington set forth in Article IV, as amended in accordance with Section 7.2, shall be true and correct as of the Closing Date, as though then made, except (i) for changes contemplated by this Agreement, (ii) to the extent a representation or warranty is made as of a specific date and (iii) where the failure of any such representations or warranties to be true and correct is not reasonably expected to constitute a Material Adverse Change of Huntington.

(ii) The representations and warranties of Trust set forth in Article V, as amended in accordance with Section 7.2, shall be true and correct as of the Closing Date, as though then made, except (i) for changes contemplated by this Agreement, (ii) to the extent a representation or warranty is made as of a specific date and (iii) where the failure of any such representations or warranties to be true and correct is not reasonably expected to constitute a Material Adverse Change of Huntington.

(b) Performance of Covenants and Agreements.

(i) Huntington shall have performed in all material respects all covenants and agreements contained in this Agreement required to be performed by Huntington before the Closing, including Huntington's obligation to supplement or amend its Disclosure Schedules, as necessary, in accordance with Section 7.2.

(ii) The Trust shall have performed in all material respects all covenants and agreements contained in this Agreement required to be performed by the Trust before the Closing, including the Trust's obligation to supplement or amend its Disclosure Schedules, as necessary, in accordance with Section 7.2.

(c) Bring-Down Certificate.

(i) Huntington shall have delivered to Parent a bring-down certificate to the effect of Sections 10.2(a)(i) and (b)(i).

(ii) The Trust shall have delivered to Parent a bring-down certificate to the effect of Sections 10.2(a)(ii) and (b)(ii).

(d) Other Certificates. The Trust shall have delivered to Parent one or more certificates as to the authority of the trustees of the Trust to execute and deliver this Agreement.

(e) Approval of Documentation. The form and substance of all certificates, documents, consents (including the Court Approval) and agreements contemplated hereby and required to be delivered to Parent at the Closing shall be reasonably satisfactory to Parent's counsel.

(f) Huntington Material Adverse Change. There shall have been no Material Adverse Change of Huntington since the Execution Date.

(g) Deliveries at Closing. All of the deliverables described in Section 11.2 shall have been provided to Parent.

(h) Transfer of Huntington Hospital Land. Each of the following shall have occurred prior to or as of the Closing Date with respect to the distribution of the Huntington Hospital Land by the Trust to Huntington:

(i) The Lot Line Adjustment shall have been completed to the reasonable satisfaction of Parent.

(ii) Parent shall have received copies of the Surveys as contemplated in Section 8.2(b).

(iii) The Title Company shall have received the Huntington Hospital Land Deed fully executed and notarized, and the Huntington Hospital Land Deed shall be duly recorded in the Official Records of Los Angeles County prior to or at Closing. The Title Company shall also have received from the Trust payment of all costs associated with the recording of the Huntington Hospital Land Deed, including, without limitation, all recording costs and documentary transfer taxes applicable to the Huntington Hospital Land Deed, if any. Upon Closing the Title Company shall deliver a certified copy of the recorded Huntington Land Deed to Huntington with copies to the Trust and Parent.

(iv) The Title Company shall have received from the Trust (1) the original satisfactions, releases or re-conveyances for each of the Trust Monetary Liens, which shall be recorded by the Title Company prior to or on the Closing Date in the Official Records of Los Angeles County, together with payment from the Trust of the costs of recording the same, or such other documentation as required by the Title Company to issue the Title Policy without exception for Trust Monetary Liens at the time the Huntington Hospital Land Deed is recorded, and (2) such affidavits, FIRPTA certificates, recording receipts, notices, and any such other documentation reasonably required by the Title Company to issue the Title Policy subject only to the Permitted Liens pursuant to the terms of the Title Commitment.

(v) The Title Company shall have issued at Closing (or unconditionally committed to issue) as of the date the Huntington Hospital Land Deed records the Title Policy contemplated in Section 8.2(e).

(vi) The Title Company shall have received at Closing the original termination of the Master Lease, effective as of the date the Huntington Hospital Land Deed records, duly executed by and notarized for Huntington and the Trust, pursuant to Section 8.2(f), and the same shall be duly recorded in the Official Records of Los Angeles County substantially concurrently with the Huntington Land Deed. Upon Closing the Title Company shall deliver a certified copy of the recorded termination of the Master Lease to Huntington with copies to the Trust and Parent.

(vii) The Title Company shall have received at Closing the original assignment of the HMRI Lease, effective as of the date the Huntington Hospital Land Deed records, duly executed by the Trust and Huntington, pursuant to Section 8.2(f). Upon Closing the Title Company shall deliver the original assignment of the HMRI Lease to Huntington with a copy to the Parent.

(i) Court Approval. The Trust will have received the Court Approval.

(j) Imaging Center JVs. The non-competition and right of first opportunity provisions in the respective operating agreements of Huntington Outpatient Imaging Centers, LLC, and Huntington Hill Imaging, LLC (collectively, the "***Imaging Center JVs***") will have been amended, waived or otherwise modified to permit Huntington, Parent and their respective Related Persons to participate in imaging services after the Closing Date within the restricted areas defined in the operating agreements resulting from a transaction in which imaging services is only an incidental part of such transaction; provided that such permission need not apply to any imaging center owned, operated, affiliated or managed by RadNet, Inc. or its Affiliates.

10.3 Conditions Precedent to Obligations of Huntington. The obligations of Huntington to complete the Affiliation at the Closing shall be subject to fulfillment of all of the following conditions, except those conditions that are waived by Huntington:

(a) Accuracy of Representations and Warranties. The representations and warranties of Parent set forth in Article VI, as amended in accordance with Section 7.2, shall be true and correct as of the Closing Date, as though then made, except (i) for changes contemplated by this Agreement, (ii) to the extent a representation or warranty is made as of a specific date and (iii) where the failure of any such representations or warranties to be true and correct is not reasonably expected to constitute a Material Adverse Change of Parent.

(b) Performance of Covenants and Agreements. Parent shall have performed in all material respects all covenants and agreements contained in this Agreement required to be performed by Parent before the Closing, including the Parent's obligation to supplement or amend its Disclosure Schedules, as necessary, in accordance with Section 7.2.

(c) Bring-Down Certificate. Parent shall have delivered to Huntington a bring-down certificate to the effect of Sections 10.3(a) and (b).

(d) Court Approval. The Trust will have received the Court Approval.

(e) Title Policy. The Title Company shall have issued (or unconditionally committed to issue) the Title Policy contemplated in Section 8.2(e).

(f) Approval of Documentation. The form and substance of all certificates, documents, consents (including the Court Approval) and agreements contemplated hereby and required to be delivered to Huntington at the Closing shall be reasonably satisfactory to Huntington's counsel.

(g) Parent Material Adverse Change. There shall have been no Material Adverse Change of Parent since the Execution Date.

(h) Deliveries at Closing. All of the deliverables described in Section 11.3 shall have been provided to Huntington.

(i) Reimbursement Agreement. As of the Execution Date, contemporaneously with the execution and delivery of this Agreement, Parent and CSMC will have delivered to the Trust that certain Reimbursement Agreement (the "***Reimbursement Agreement***"), dated and effective as of the Execution Date, by and among Parent, CSMC and the Trust, executed by duly authorized officers of CSMC and Parent; and as of the Closing Date, such Reimbursement Agreement will remain in full force without modification.

10.4 Conditions Precedent to Obligations of the Trust. The obligations of the Trust to complete the Affiliation at the Closing shall be subject to fulfillment of all of the following conditions, except those conditions that are waived by the Trust:

(a) Huntington Conditions Precedent. The conditions precedent to Huntington's obligation as set forth in Section 10.1 and Section 10.3 shall have been satisfied or waived by Huntington.

(b) Court Approval. The Trust shall have received the Court Approval.

Article XI

CLOSING

11.1 Closing and Closing Date. Completion of the Affiliation (the "***Closing***") shall take place remotely via exchange of documents and signature pages on the date (the "***Closing Date***") that is as promptly as practical (but not more than five (5) Business Days) after satisfaction or waiver of the conditions in Article X. The Affiliation shall be treated as occurring at 12:01 AM on the day immediately following the Closing (the "***Effective Time***"). All proceedings to take place at the Closing shall be deemed to have been executed and taken simultaneously.

11.2 Deliveries by Huntington. At the Closing, Huntington shall deliver to Parent the following:

(a) The Huntington Amended Articles, ready to file with the California Secretary of State.

(b) The Huntington Amended Bylaws, certified as of the Closing Date by Huntington.

(c) A certificate of Huntington, dated as of the Closing Date, as to the adoption and continued effectiveness of, and attaching a copy of, the resolutions of the Board of Directors of Huntington approving the execution, delivery and performance of this Agreement and the Transaction Documents to which Huntington is a party.

(d) A certificate of Huntington, dated as of the Closing Date, as to the incumbency and signatures of the officers of Huntington executing this Agreement and the Transaction Documents to which Huntington is a party.

(e) A Certificate of Status, or comparable status, for each Huntington Entity, issued by the California Secretary of State, dated no more than fifteen (15) Business Days prior to the scheduled Closing Date.

(f) An Entity Status Letter for each Huntington Entity from the Franchise Tax Board of California, dated no more than fifteen (15) Business Days prior to the scheduled Closing Date.

11.3 Deliveries by Parent. At the Closing, Parent shall deliver to Huntington the following:

(a) The Parent Amended Articles, ready to file with the California Secretary of State.

(b) The Parent Amended Bylaws, certified as of the Closing Date by Parent.

(c) A certificate of Parent, dated as of the Closing Date, as to the adoption and continued effectiveness of, and attaching a copy of, the resolutions of the Board of Directors of Parent approving the execution, delivery and performance of this Agreement and the Transaction Documents to which Parent is a party.

(d) A certificate of Parent, dated as of the Closing Date, as to the incumbency and signatures of the officers of Parent executing this Agreement and the Transaction Documents to which Parent is a party.

(e) A Certificate of Status, or comparable status, for each Parent Entity, issued by the California Secretary of State, dated no more than fifteen (15) Business Days prior to the scheduled Closing Date.

(f) An Entity Status Letter for each Parent Entity from the Franchise Tax Board of California, dated no more than fifteen (15) Business Days prior to the scheduled Closing Date.

Article XII

PROTECTIVE PROVISIONS

12.1 Non-Reliance.

(a) Parent acknowledges and agrees that the Parent Entities are accepting the Huntington Entities on an "as is, where is" basis, without any warranties, express or implied, and no one has made nor makes any representations or warranties, express or implied, about any of the Huntington Entities or Huntington Subsidiaries or any of their respective assets or liabilities, except for the representations and warranties made by Huntington to Parent set forth in Article

IV of this Agreement and the representations and warranties made by the Trust to Parent set forth in Article V of this Agreement. Parent acknowledges and agrees that Parent is solely responsible for its due diligence investigation relating to the Huntington Entities and their assets and liabilities; Parent and its representatives have been permitted access to books, records, facilities, equipment, contracts and other properties and assets of Huntington and have had a full opportunity to perform such due diligence investigation of the Huntington Entities and their assets, liabilities and business as they have required and to meet with representatives of Huntington to discuss these matters. Notwithstanding any such access, meetings and discussions, Parent acknowledges that none of the Parent Entities has received or is relying upon any representation or warranty, expressed or implied, by operation of law or otherwise, as to the accuracy or completeness of any information regarding the Huntington Entities or their respective assets, liabilities and business, furnished or made available to any Parent Entity or its representatives, except as to the representations and warranties made by Huntington to Parent set forth in Article IV of this Agreement and the representations and warranties made by the Trust to Parent set forth in Article V of this Agreement.

(b) Huntington and the Trust acknowledge that no Huntington Entity nor the Trust has received or is relying upon any representation or warranty, expressed or implied, by operation of law or otherwise, as to the accuracy or completeness of any information regarding the Parent Entities or their respective assets, liabilities and business, furnished or made available to any Huntington Entity, the Trust or their representatives, except as to the representations and warranties made by Parent to Huntington and the Trust set forth in Article VI of this Agreement.

12.2 AS-IS. HUNTINGTON HAS BEEN IN POSSESSION AND OCCUPANCY OF THE HUNTINGTON HOSPITAL LAND PURSUANT TO THE MASTER LEASE AND IS FULLY KNOWLEDGEABLE OF ALL ASPECTS OF THE HUNTINGTON HOSPITAL LAND. PARENT AND HUNTINGTON, EITHER INDEPENDENTLY OR THROUGH AGENTS, REPRESENTATIVES OR CONSULTANTS SELECTED BY EITHER OF THEM, MAY CONDUCT ALL INSPECTIONS, INVESTIGATIONS, TESTS, ANALYSES AND EVALUATIONS OF THE HUNTINGTON HOSPITAL LAND AS PARENT AND/OR HUNTINGTON DEEMS NECESSARY OR OTHERWISE APPROPRIATE, AT PARENT'S OR HUNTINGTON'S SOLE COST AND EXPENSE. PARENT AND HUNTINGTON EACH SPECIFICALLY ACKNOWLEDGES AND AGREES THAT THE TRUST IS TRANSFERRING AND HUNTINGTON IS ACCEPTING TITLE TO THE HUNTINGTON HOSPITAL LAND ON AN "AS IS, WHERE IS, WITH ALL FAULTS AND DEFECTS" BASIS AND THAT, EXCEPT AS SPECIFICALLY SET FORTH HEREIN OR IN ANY OTHER DOCUMENT DELIVERED BY THE TRUST TO PARENT OR HUNTINGTON PURSUANT TO THIS AGREEMENT, NEITHER PARENT NOR HUNTINGTON IS RELYING ON ANY REPRESENTATIONS OR WARRANTIES OF ANY KIND WHATSOEVER, EXPRESS OR IMPLIED, FROM THE TRUST, ITS AGENTS OR REPRESENTATIVES AS TO ANY MATTERS CONCERNING THE HUNTINGTON HOSPITAL LAND, INCLUDING WITHOUT LIMITATION: (i) the quality, nature, adequacy and physical condition and aspects of the Huntington Hospital Land and/or improvements thereon; (ii) the quality, nature, adequacy, and physical condition of soils, geology and any groundwater; (iii) the existence, quality, nature, adequacy and physical condition of utilities serving the Huntington Hospital Land; (iv) the development potential of the Huntington Hospital Land, and the Huntington Hospital Land's and/or improvements thereon use, habitability,

merchantability, or fitness, or the suitability, value or adequacy of the Huntington Hospital Land and/or improvements thereon for any particular purpose; (v) the zoning or other legal status of the Huntington Hospital Land or any other public or private restrictions on use of the Huntington Hospital Land; (vi) the compliance of the Huntington Hospital Land or improvements thereon with any applicable codes, laws, regulations, statutes, ordinances, covenants, conditions and restrictions of any governmental or quasi-governmental entity or of any other person or entity (including the Americans with Disabilities Act); (vii) the presence or release of any hazardous materials on, under or about the Huntington Hospital Land or any adjoining or neighboring property; (viii) the condition of title to the Huntington Hospital Land; (ix) the condition of the Huntington Hospital Land and/or improvements thereon; (x) the economics of the operation of the Huntington Hospital Land; or (xi) any other aspect, characteristic or feature regarding the Huntington Hospital Land and/or improvements thereon.

12.3 Natural Hazards Disclosure. Without limiting Section 12.2, the Parties acknowledge that the Disclosure Statutes (as defined below) provide that a seller of real property must make certain disclosures regarding certain natural hazards potentially affecting the property, as more particularly provided therein. As used in this Agreement, "Disclosure Statutes" means, without limitation, collectively, California Government Code Sections 8589.3, 8589.4 and 51183.5, California Public Resources Code Sections 2621.9, 2694 and 4136, and any other California statutes that require a seller to make disclosures concerning real property. The Parties acknowledge and agree that the Trust is not selling the Huntington Hospital Land and is therefore not a "seller" and not obligated to deliver to Parent or Huntington any disclosures; however, the Trust has agreed to deliver, or cause to be delivered, to Parent and Huntington a Natural Hazard Disclosure Report for the Huntington Hospital Land (the "***Report***") in accordance with California Civil Code Section 1103.2. The Report will be delivered to Parent and the Hospital as soon as the Trust can obtain the Report after the Execution Date. Parent and Huntington hereby agree as follows with respect to the Disclosure Statutes and the Report:

(a) The Trust shall not be liable for any error or inaccuracy in, or omission from, the information in the Report.

(b) The Report is being provided by the Trust for purposes of complying with the Disclosure Statutes if and to the extent applicable and shall not be deemed to constitute a representation or warranty by the Trust as to the presence or absence in, at or around of the Huntington Hospital Land of the conditions that are the subject of the Disclosure Statutes.

12.4 Release. Without limiting Sections 12.2 or 12.3 above, effective as of the Effective Time, Parent and Huntington, each on behalf of itself and its successors and assigns, waives its right to recover from, and forever releases and discharges the Trust and the Trust's Affiliates, and the partners, trustees, shareholders, directors, officers, members, managers, attorneys, employees and agents of each of them, and their respective heirs, successors, personal representatives and assigns (collectively, the "***Trust Released Parties***"), from any and all Claims and Losses, whether direct or indirect, known or unknown, foreseen or unforeseen, that may arise on account of or in any way be connected with the Huntington Hospital Land, any and all improvements thereon, and this Agreement as it relates to the foregoing. The waiver and release in the preceding sentence applies to, without limitation, the physical and structural condition of the Huntington Hospital Land, any and all improvements thereon, or any law or regulation

DocuSign Envelope ID: 296A0A88-7FAD-4308-9BBE-3515ED4A6C88

applicable thereto, as well as any information contained in any contracts, documents, agreements, records, files, surveys, reports and any other information pertaining to the foregoing. Nothing contained in this Section 12.4 shall in any way limit or restrict the right of any Party to bring a cause of action based on actual common law fraud with respect to representations and warranties of the Trust in Article V of this Agreement. With respect to the waiver and release set forth herein relating to claims unknown to or unsuspected by a Party, Parent and Huntington each hereby acknowledges that such waiver and release is being made after obtaining the advice of counsel and with full knowledge and understanding of the consequences and effects of such waiver, and that such waiver is made with the full knowledge, understanding and agreement that California Civil Code Section 1542 provides as follows, and that the protections afforded by said code section are hereby waived:

> "A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE AND THAT, IF KNOWN BY HIM OR HER, WOULD HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY."

PS PS REDACTED	REDACTED
Parent's Initials	Huntington's Initials

12.5 D&O Protections. For six (6) years after the Closing Date, Parent shall not take any action without the prior approval of Huntington that would result in Huntington failing to maintain insurance policies of the same type and nature of (and with terms that are not materially less favorable than and at coverage levels that are not lower than) the insurance policies set forth on Schedule 4.14. Additionally, for six (6) years after the Closing Date, Parent shall not take any action to amend the provisions set forth in Huntington's Governing Documents as of the Closing Date pertaining to the liability of Huntington's directors and officers or the indemnification of (and advancement of expenses to) directors, officers, employees, agents and representatives of Huntington, nor shall Parent take any action to prevent Huntington, in accordance with Huntington's Governing Documents and to the full extent permitted by law, from indemnifying, defending or holding harmless a current, former or future director, officer, employee, agent or representative of Huntington (collectively, the "***Protected Persons***) against losses in connection with any claim, based in whole or in part on or arising in whole or in part out of the fact that the Protected Person (or the person controlled by the Protected Person) is or was a director, officer, employee, agent or representative of Huntington.

Article XIII

POST-CLOSING RIGHTS AND OBLIGATIONS

13.1 Illegality. If at any time after the Closing Date, Huntington determines in good faith based on advice of qualified legal counsel that any federal, state, or local law or regulation renders the affiliation entered into pursuant to this Agreement illegal, then Huntington may give written notice thereof to Parent (***Notice of Illegality***) if such action is approved by the Huntington board of directors. If Parent disputes the conclusion set forth in the Notice of

Illegality, Parent shall notify Huntington of such dispute (the "***Illegality Dispute***") within ten (10) days after Parent's receipt of the Notice of Illegality. The Parties shall attempt to resolve such Illegality Dispute in accordance with the meet and confer process set forth in Section 16.10. If the Parties are unable to resolve the Illegality Dispute in accordance with the meet and confer process, the Parties may utilize any other available dispute resolution process (including, without limitation, binding arbitration) or seek any other available legal recourse to resolve the Illegality Dispute. In the event a final determination is made that the affiliation entered into pursuant to this Agreement is illegal, Parent and Huntington shall work together in good faith to alter their relationship to the minimum extent necessary to comply with applicable laws or regulations or otherwise resolve the legal problem. If, after diligent good faith efforts, Parent and Huntington are unable to mutually agree upon such alteration, or if such alteration is not legally possible, then Parent and Huntington shall work together in good faith to modify their organizational documents and take all other actions necessary and appropriate to terminate Parent's membership in Huntington and unwind the Affiliation between Parent and Huntington contemplated in this Agreement, the New Huntington Organizational Documents and the New Parent Organizational Documents. The Parties acknowledge and agree that in the event Parent's membership in Huntington is terminated pursuant to the terms set forth in this Section 13.1 (an "***Illegality Unwind Event***"), Huntington shall have the right to assume the assets and liabilities of Huntington and each Huntington Subsidiary pursuant to the terms set forth in Exhibit A attached hereto and incorporated herein.

13.2 Closure or Sale of Huntington Hospital.

(a) Closure or Sale of Huntington Hospital. The Parties acknowledge and agree that after the Closing Date, Parent shall, subject to the AG Consent and the terms of the New Huntington Organizational Documents, have the unilateral right to cause the closure, Change of Control (as defined below), sale, lease, transfer, exchange, disposition or change in use of all or substantially all of the assets of Huntington Hospital (including through the dissolution of Huntington) (each a "***Closure or Sale of Hospital Unwind Event***"), which shall be subject to the approval of the Board of Directors of Parent. If, after the Closing Date, Parent initiates, approves and affirmatively causes a Closure or Sale of Hospital Unwind Event, Huntington shall have the right to terminate Parent's membership in Huntington and assume the assets and liabilities of Huntington and each Huntington Subsidiary pursuant to the terms set forth on Exhibit A.

(b) For purposes of this Section 13.2, "Change of Control" means: (i) any transaction or series of related transactions (including, without limitation, merger or consolidation, sale, transfer or other disposition of equity, amendment to the articles of incorporation or bylaws or other applicable governing documents of such entity or other contract or arrangement) that results in another entity becoming the beneficial owner of more than fifty percent (50%) of the voting ownership interests of the entity that owns Huntington Hospital, (ii) the sale, lease, transfer, exchange, disposition or change in use of all or substantially all of the assets of Huntington Hospital, (iii) the substitution of a new corporate member or members that transfers the control of, responsibility for, or governance of Huntington Hospital; or (iv) a joint venture, management arrangement or similar transaction that results in another entity becoming the owner, operator or manager of all or substantially all of the assets of Huntington Hospital.

13.3 Change to Tax Exempt Status of Huntington Hospital. The Parties acknowledge and agree that if, after the Closing Date, Parent takes any action to cause a Tax Exempt Status Unwind Event (as defined below) without the prior approval of Huntington, Huntington shall have the right to terminate Parent's membership in Huntington and assume the assets and liabilities of Huntington and each Huntington Subsidiary pursuant to the terms set forth on Exhibit A. For purposes of this Section 13.3, "***Tax-Exempt Status Unwind Event***" means an action: (i) that results in the Huntington Hospital no longer being owned and operated by an organization that is tax exempt under Section 501(c)(3) of the Code that is also a public charity under Section 509(a) of the Code, or (ii) that could reasonably be expected to result in or present a material risk of revocation of the Code Section 501(c)(3) tax-exempt status of the Trust, based on the written reasoned opinion of nationally recognized Code Section 501(c)(3) tax counsel engaged by the Trust. An Illegality Unwind Event, Closure or Sale of Hospital Unwind Event, and Tax-Exempt Status Unwind Event shall be referred to herein collectively as a "***Huntington Unwind Event***".

13.4 Parent Operating Expenses. The Parties acknowledge and agree that after the Closing Date, Parent shall have the unilateral right to require all Affiliate Hospital Organizations (including Huntington, CSMC and THA) to make their share (as described below) of periodic payments to Parent to cover Parent's budgeted operating expenses ("***Parent Operating Expenses Payments***"), and Huntington shall make such Parent Operating Expenses Payments to Parent. The amount and timing of such payments shall be based on the financial need of Parent, which shall be determined by the Board of Directors of Parent from time to time. Notwithstanding the foregoing, the amount of the Parent Operating Expenses Payments made by Huntington to cover Parent's budgeted operating expenses (relative to the amounts paid by the other Affiliate Hospital Organizations) shall at all times be proportionate to the ratio of operating expenses incurred by Huntington relative to the other Affiliate Hospital Organizations (as measured by the then most recent approved operating budgets of Huntington and the other Affiliate Hospital Organizations).

13.5 Capital Contributions to Parent. Huntington shall make capital contributions to Parent from time to time after the Capital Plan Period in accordance with the terms set forth on Exhibit B, attached hereto and incorporated herein.

13.6 Gifts, Donations and Endowments. The Parties acknowledge and agree that after the Closing Date, Huntington shall have the right to approve: (i) a change in the control, management or administration of any gifts, grants, donations or endowments (collectively, the "***Restricted Assets***") received by Huntington or a Huntington Subsidiary, and/or (ii) the transfer to Parent of any Restricted Assets of Huntington or a Huntington Subsidiary that were designated by a donor after the Closing Date and only if California law and the restriction allow it to be transferred to Parent.

13.7 Identification as Affiliate. After the Closing Date, Huntington shall identify itself as an affiliate of Parent pursuant to the branding guidelines mutually agreed to by the Parties in good faith within one hundred eighty (180) days after the Closing Date.

13.8 Legacy Balance Sheets. The Parties shall memorialize the balance sheets of the Parties as of the Closing Date and the Parties acknowledge that such balance sheets shall be

referenced as needed in connection with the Parties' fulfillment of their post-Closing obligations set forth in this Agreement.

13.9 Employees and Employer Status. The Parties acknowledge and agree that employees of each Huntington Entity will, as of the Effective Time, remain employed by the Huntington Entity on the same terms as existed immediately prior to the Effective Time. Parent will not, as a condition to closing or for a period of ninety (90) days after the Closing, take or require Huntington to take any action that would subject Huntington to application of the WARN Act or any State equivalent of the WARN Act. The Parties acknowledge and agree that after the Closing, Parent shall have the right to take action causing a change to the employer (without disrupting employment status at the time such change is made) of certain groups, classes or subsets of individuals (based on job function) who are employed by Huntington or a Huntington Subsidiary as of the Closing in order to develop a shared services organization benefitting all of the Affiliate Hospital Organizations; provided, however, if Parent makes such a change with respect to a distinct group, class or subset of employees of Huntington or a Huntington Subsidiary, such change shall be implemented uniformly with respect to all Affiliate Hospital Organizations, unless otherwise mutually agreed by Parent and Huntington. Notwithstanding the foregoing, Parent will not cause any such change prior to the fifth anniversary of the Closing Date without the prior written consent of Huntington. Additionally, the Parties agree that to the extent that any Huntington Employee Benefit Program is consolidated with any Parent Employee Benefit Program after the Closing Date, employees of Huntington will, to the extent permitted by applicable Law, receive full credit for their years of service to Huntington for purposes of eligibility and vesting upon entry as a participant under any Parent Employee Benefit Program.

13.10 Trust Distributions to Huntington.

(a) On the terms and subject to the conditions of this Section 13.10, the Trust will make distributions to Huntington during each calendar year of the Capital Plan Period to be used by Huntington solely to fund the general medical education program at Huntington Hospital (the "***GME Distributions***"). The total amount of GME Distributions for calendar year 2021 will equal Five Million Three Hundred Thousand Dollars ($5,300,000). The total amount of GME Distributions for each subsequent year during the Capital Plan Period will be increased each year by two and one-half percent (2.5%) over the prior year. GME Distributions will be prorated for any partial year during the Capital Plan Period. The Trust will determine the timing and amounts of GME Distributions to make throughout each year and may consider the timing of expenditures that Huntington will incur in the operations of its general medical education program. The Trust will be entitled to, and Huntington will promptly deliver to the Trust, such records as the Trust may reasonably request to substantiate the spending of GME Distributions in accordance with this Section 13.10(a).

(b) On the terms and subject to the conditions of this Section 13.10, the Trust will make distributions to Huntington during the Capital Plan Period to be used solely to fund one or more Huntington projects designated by the Trust and approved by the Board of Directors of Huntington (the "***Project Distributions***"), including projects in the Huntington Strategic Capital Plan. The total amount of the Project Distributions for each calendar year will equal the market value of the Trust Securities Portfolio as of December 31st of the preceding calendar year, multiplied by two and one-half percent (2.5%). The Trust will reasonably determine the annual

amount of each Project Distribution based on the records of the Trust relating to the Trust Securities Portfolio. The Trust will make payment of Project Distributions no more frequently than on a monthly basis. The Trust will be entitled to receive, and Huntington will promptly deliver to the Trust, such records as the Trust may reasonably request to substantiate the spending of Project Distributions in accordance with this Section 13.10(b). For purposes of this Agreement, "***Trust Securities Portfolio***" means the cash and marketable securities owned by the Trust that have a minimum hold or exit provision of less than six (6) months. The Trust Securities Portfolio specifically excludes real estate and securities related to the Trust's real estate holdings. The Trust Securities Portfolio excludes interests in real property.

(c) Notwithstanding anything to the contrary, the Trust's obligation to make any payment of a Trust Distribution is subject to satisfaction of each of the following conditions as of the date each Trust Distribution is to be made: (i) each Huntington Entity that is exempt from federal income tax under Section 501(c)(3) of the Code as of the Closing Date must continue to be exempt under such section of the Code; (ii) Huntington must continue to operate Huntington Hospital as a general acute care hospital; (iii) Parent must continue to be the sole member of Huntington; and (iv) Parent must continue to be in compliance in all material respects with its obligations under this Agreement, including those in Article XIV (Huntington Strategic Capital Plan and EHR Project).

13.11 Quality Risk Event Notifications and Response Plans. After the Closing, Huntington shall notify Parent within three (3) calendar days of discovery by Huntington of any of the following quality or safety risk events at Huntington Hospital or any other healthcare facility operated by Huntington or any of its Subsidiaries: (i) a potential sentinel event, (ii) a "Never 28" event, (iii) a quality or patient safety event reportable to a Governmental Entity or accreditation agency, (iv) any significant quality or safety issue pertaining to a member of the Huntington Hospital medical staff or an allied health professional that provides services at Huntington Hospital, including volatile behavior, potential criminal issues, or potential substance abuse or sexual harassment accusations, or (v) any quality or safety event or series of events that may pose a reputational or brand risk to Parent or any Affiliate Hospital Organization (each, a "***Quality Risk Event***"). Huntington shall confer with Parent regarding the development and implementation of a corrective action response plan ("***CARP***") for any Quality Risk Event and shall obtain the advance approval of Parent for each CARP (except in emergent situations where obtaining such advance approval is not feasible, in which case the CARP shall be presented to Parent as soon as reasonably practicable and notice thereof shall be provided immediately to Parent); provided, however, the foregoing shall not require, with respect to a Huntington Hospital medical staff peer review CARP pertaining to events described in subsection (iv) of the preceding sentence, the approval of Parent, but shall require prompt notice to Parent so long as such notice does not require Huntington to make any disclosure that would violate or waive the protection of California Evidence Code Section 1157. The CARP for a Quality Risk Event shall include the following elements, each with defined timeframes, as appropriate: (1) immediate risk mitigation for patient care, (2) patient and family disclosure, (3) external reporting details, (4) internal action plans to mitigate future risk, and (5) media relations. Huntington shall implement the elements of each approved CARP in accordance with its terms including within the stated timeframes. The implementation and completion of all elements of each CARP in response to a Quality Risk Event shall be reported to Parent. The Parties agree that as soon as reasonably practicable after the Closing Date the Parties shall use their best reasonable efforts to cause the

medical staffs of the hospitals operated by the Affiliate Hospital Organizations to enter into appropriate peer review sharing agreements in compliance with applicable law.

13.12 Administrative Support for Trust. After the Closing Date, the Parties acknowledge and agree that Huntington shall continue to provide meeting space and administrative support to the Trust that are reasonably necessary to support the operations of the Trust after the Closing Date, consistent with Huntington's past practices.

13.13 Access to Information. After the Closing Date:

(a) Parent and Huntington shall promptly deliver to the Trust copies of the duly executed form of this Agreement, the New Huntington Organizational Documents and the New Parent Organizational Documents;

(b) Huntington shall promptly deliver to Parent and the Trust a copy of the Attorney General's letter of consent (or conditional consent) relating to the Affiliation (the "***AG Consent***");

(c) Parent, Huntington and the Trust shall each promptly deliver to the other copies of all communications made or received to or by such party with the Attorney General relating to the Affiliation, this Agreement or the AG Consent after the Closing Date; and

(d) Upon the Trust's request from time to time, the Trust shall have reasonable access during normal business hours to records and information relating to the directors, officers, employees and operations of Huntington or the subject matter of any of the terms of this Agreement for the purpose of the Trust carrying out its duties as an organization existing to support Huntington; provided, however, such access to information be in a manner as to not unduly disrupt normal business activities of Parent or Huntington and shall be in compliance with Law and any contractual obligations relating to confidentiality.

13.14 Hospital Commitments. After the Closing, for the applicable periods of time set forth in the AG Consent, Parent will comply, and will cause Huntington to comply, with the conditions of the AG Consent, including each of the following to the extent required by the AG Consent:

(a) Huntington will operate and maintain Huntington Hospital as a licensed general acute care hospital, including to the extent that Huntington is able to meet the requirements of applicable accreditation agencies, maintaining each of the following with the same types and levels of services as currently provided:

Level II Trauma Center
Level III Neonatal Intensive Care Unit
Comprehensive Stroke Center
STEMI Receiving Center
Advanced Cardiology and Cardiovascular Surgery Programs
Advanced Robotic Surgery
Orthopedic Service Line
Oncology Service Line

Neurology Service Line
GME programs
Senior Care Network
Women's Health Services
End of Life Services

(b) Huntington will continue to participate in the Medi-Cal program at Huntington Hospital.

(c) Huntington will continue to participate in the Medicare program by maintaining a Medicare provider number.

(d) Neither Parent nor any of its Related Persons will (a) sell, lease, exchange, option, convey, manage, or otherwise dispose of Huntington Hospital or (b) transfer control, responsibility, management, or governance of Huntington Hospital, or in each case allow any such transaction to occur, without the prior approval of the Attorney General.

(e) Huntington will use commercially reasonable efforts to maintain Magnet Status with substantially the same types and levels of services as currently provided.

13.15 Charity Care and Community Benefit.

(a) Parent will ensure, and Huntington will cooperate with Parent in ensuring, that Huntington continues to provide charity care at such levels as required by the Attorney General.

(b) Parent will ensure, and Huntington will cooperate with Parent in ensuring, that Huntington continues to provide community benefit programs at such levels as required by the Attorney General.

13.16 Medical Staff. From and after the Closing, Parent will permit Huntington to retain a separate, independent medical staff accountable to Huntington's board of directors and to retain separate Medical Staff Bylaws of Huntington Hospital. Parent will not require or take any action as a condition of or in connection with the Closing that, effective as of the Closing, would change any of the following: (i) the positions of all elected and appointed leaders of the medical staff of Huntington Hospital (including officers, committee chairs and vice chairs, and department chairs and vice chairs), or (ii) the membership status or clinical privileges of members of the medical staff of Huntington Hospital. The Parties agree that such status or privileges may be changed only after the Closing Date and only in accordance with the provisions of the Medical Staff Bylaws of Huntington Hospital and applicable Laws.

Article XIV

HUNTINGTON STRATEGIC CAPITAL PLAN AND EHR PROJECT

14.1 Huntington Strategic Capital Plan and Funding Commitment**.**

(a) Huntington Strategic Capital Plan. Parent hereby approves Huntington's adoption of its strategic capital plan set forth on Exhibit C, attached hereto and incorporated herein by reference (the "***Huntington Strategic Capital Plan***"), in the total amount of Five Hundred Sixty Million Dollars ($560,000,000) (the "***Total Capital Plan Costs***") for the period (the "***Capital Plan Period***") commencing on the Closing Date and ending on December 31, 2029. The Parties acknowledge and agree that the line items in the Huntington Strategic Capital Plan, the amounts identified for each line item and the year in which they are to be spent are based on estimates and projections and are subject to decisions that Huntington will make over the course of the Capital Plan Period about the needs of the Huntington Entities and the communities they serve, taking into consideration circumstances that may change over the course of the Capital Plan Period. Subject to Section 14.4 and Parent's authority to approve the strategic plans and budgets of Huntington and the Huntington Subsidiaries as set forth in the New Huntington Organizational Documents, the Parties intend for Huntington to complete the Huntington Strategic Capital Plan during the Capital Plan Period. Huntington acknowledges and agrees that if the Huntington Strategic Capital Plan is accomplished within the Capital Plan Period for an amount less than the Total Capital Plan Costs, the amount of Total Capital Plan Costs shall be reduced accordingly. The Huntington Strategic Capital Plan will be binding for all purposes of this Agreement, the New Huntington Organizational Documents and the New Parent Organizational Documents.

(b) Funding Commitment. Parent hereby commits Three Hundred Million Dollars ($300,000,000) (the "***Funding Commitment***") to Huntington during the Capital Plan Period for use in the Huntington Strategic Capital Plan. The Funding Commitment will be reduced by each distribution from Parent to Huntington made in accordance with this Section 14.1 and will be increased (to an amount not to exceed Three Hundred Million Dollars ($300,000,000)) by the amount of any cash that any Huntington Entity or the Trust delivers to Parent. Parent will deliver amounts of such funds to Huntington pursuant to the terms and conditions set forth in this Section 14.1.

(c) Funding Timing. Notwithstanding anything in this Section 14.1 to the contrary, the Parties acknowledge and agree that at all times during the Capital Plan Period Huntington shall first use the cash on hand of the Huntington Entities in excess of Sixty Days Expenses to pay for capital expenditures under the Huntington Strategic Capital Plan. During each quarter of the Capital Plan Period, Huntington will prepare a projection of the anticipated Unrestricted Cash on Hand of the Huntington Entities during the subsequent quarter. In the event Huntington reasonably anticipates at any time during the Capital Plan Period that the use of cash on hand of the Huntington Entities to pay for capital expenditures under the Huntington Strategic Capital Plan will cause the Unrestricted Cash on Hand of the Huntington Entities during the subsequent quarter to be reduced to less than Sixty Days Expenses, Huntington shall notify Parent of the amount of the anticipated shortfall of Unrestricted Cash on Hand below Sixty Days Expenses, at which point Parent shall arrange, pursuant to Section 14.1(d), the additional funding source or sources as part of the Funding Commitment, and Parent will deliver such funding to Huntington in the amount of the anticipated shortfall by the end of the quarter in which the shortfall is anticipated to arise.

(d) Source of Funds for Funding Commitment. Subject to the other provisions of this Section 14.1, the Parties acknowledge and agree that Parent shall, in its sole

and absolute discretion, determine the source of funds for any portion of the Funding Commitment, which may include debt to be incurred by Parent, Huntington or another entity, Parent's cash, or intercompany loans made by Parent to Huntington.

(e) Annual Amounts and Types of Spending. The Parties acknowledge and agree that the annual amounts and types of spending by Huntington or a Huntington Subsidiary each year towards the Huntington Strategic Capital Plan shall be approved by Parent in accordance with Parent's right to approve the annual budgets of Huntington and the Huntington Subsidiaries as set forth in the New Huntington Organizational Documents and Section 14.4 of this Agreement.

14.2 EHR Project.

(a) Pursuant to the terms and conditions set forth in this Section 14.2, Parent shall complete the following (collectively, the "***EHR Project***"): (i) establish an integrated EHR system with Epic Systems Corporation ("***Epic***") for Huntington by extending to Huntington Parent's instance of the Epic modules set forth on Exhibit D, attached hereto and incorporated herein, and (ii) extend Parent's enterprise license to use Epic software to Huntington such that Huntington has a valid sublicense of the Epic system modules set forth on Exhibit E, attached hereto and incorporated herein. Parent will commence work on the EHR project as soon as reasonably practicable after the Closing Date and will complete the EHR Project, no later than the third (3rd) anniversary of the Closing Date unless otherwise mutually agreed by Parent and Huntington. Huntington agrees that Parent's obligation and ability to complete the EHR Project is subject to Huntington making available such Huntington staff as reasonably requested by Parent and otherwise cooperating with Parent in Parent completing the EHR Project.

(b) EHR Project Committee. The EHR Project shall be overseen and directed by an EHR governance and management structure and operating model as outlined in Exhibit F, attached hereto and incorporated herein (the "***EHR Project Committee***"). Parent shall lead and oversee the EHR Project Committee and shall commit the resources reasonably necessary to do so.

(c) EHR Project Timeline and Implementation Plan. Subject to the commitments in Section 14.2(a), the EHR Project Committee shall determine the timeline and implementation plan for the EHR Project, which may be updated or amended from time to time in the reasonable discretion of the EHR Project Committee.

(d) EHR Project Capital Costs; Annual Amounts and Types of Spending. Parent shall fund the capital costs necessary to complete the EHR Project (the "***EHR Project Capital Costs***"), subject to Parent's right to determine the source of funds for the EHR Project Capital Costs as contemplated in Section 14.2(e). The Parties acknowledge and agree that, subject to the commitments in Section 14.2, the annual amounts and types of spending each year on EHR Project Capital Costs shall be approved by Parent in accordance with Parent's right to approve the annual budgets of Huntington and the Huntington Subsidiaries as set forth in the New Huntington Organizational Documents. During the EHR Project period, Parent and Huntington shall consider from time to time, as reasonably requested by Parent, the extent to which the accumulated level of surplus Unrestricted Cash on Hand could reasonably be made

available for EHR Project Capital Costs without affecting the funds available to Huntington for the Huntington Strategic Capital Plan, the Total Capital Commitment and/or the Funding Commitment.

(e) Source of Funds for EHR Project Capital Costs. Subject to the other provisions of this Section 14.2, the Parties acknowledge and agree that Parent shall, in its sole and absolute discretion, determine the source of funds for any portion of the EHR Project Capital Costs, which may include debt to be incurred by Parent, Huntington or another entity, Parent's cash, or intercompany loans made by Parent to Huntington, but may not include Huntington's cash on hand. Parent acknowledges and agrees that the Funding Commitment described in Section 14.1 of this Agreement shall be used solely to support the Huntington Strategic Capital Plan and such obligation is separate and distinct from Parent's obligations under this Section 14.2 regarding the EHR Project Capital Costs.

14.3 In-Kind Advisory Support. During the Capital Plan Period, Parent shall provide at no cost to any of the Huntington Entities the expertise and advisory support of Parent's leadership and subject matter experts to assist the Huntington Entities in executing their strategic plans and initiatives, including physician network development, ambulatory network strategy and other projects where Parent has both the scale and expertise to support such plans and initiatives.

14.4 Approval of Strategic Plans and Budgets.

(a) Strategic Plans. Huntington management periodically will develop Huntington's strategic plans and present them to the Huntington board of directors. In developing such strategic plans, Huntington management may consult with management of Parent. The Huntington board of directors will have the authority to review the strategic plans and determine whether to approve and recommend them to Parent. Parent, in its capacity as sole member of Huntington, will have the final authority to approve the strategic plans as set forth in the New Huntington Organizational Documents; provided, however, that Parent will not use its approval authority over Huntington's strategic plans to create an annual "de novo" approval process for the Huntington Strategic Capital Plan and/or the EHR Project and will not, without good cause, withhold the completion of any portion of the Huntington Strategic Capital Plan and/or the EHR Project within the Capital Plan Period. Additionally, in no event shall Parent use its approval authority over Huntington's strategic capital plans to withhold approval of the completion within the Capital Plan Period of any projects that are part of the "FMP Non-Compliance & Major Capital Projects Budget" set forth on Exhibit C as long as the completion of all such projects do not exceed the total budget of Eighty-Five Million Dollars ($85,000,000) associated with such projects as set forth on Exhibit C.

(b) Budgets. Each year Huntington management will develop Huntington's annual operating and capital budgets and present them to the Huntington board of directors. In developing budgets, Huntington management may consult with management of Parent. The Huntington board of directors will have the authority to review the annual budgets and determine whether to approve and recommend them to Parent. Parent, in its capacity as sole member of Huntington, will have the final authority to approve the annual budgets; provided, however, that Parent will not use its approval authority over Huntington's annual budgets to create an annual "de novo" approval process for the Huntington Strategic Capital Plan and/or the EHR Project

and will not, without good cause, withhold the completion of any portion of the Huntington Strategic Capital Plan and/or the EHR Project within the Capital Plan Period. Additionally, in no event shall Parent use its approval authority over Huntington's annual budgets to withhold approval of the completion within the Capital Plan Period of any projects that are part of the "FMP Non-Compliance & Major Capital Projects Budget" set forth on Exhibit C as long as the completion of all such projects do not exceed the total budget of Eighty-Five Million Dollars ($85,000,000) associated with such projects as set forth on Exhibit C.

Article XV

REMEDIES

15.1 Remedies Prior to the Closing Date. The Parties acknowledge and agree that the sole and exclusive remedy of the Parties arising out of: (i) any breach of, or any inaccuracy in, any representation or warranty made by a Party in this Agreement that occurs prior to the Closing Date; or (ii) any breach of any covenant, obligation or agreement of a Party in this Agreement that occurs on or prior to the Closing Date, shall be Parent's or Huntington's right to terminate this Agreement pursuant to Section 9.1; provided, however, nothing contained in this Section 15.1 shall in any way limit or restrict the right of any Party to bring a cause of action based on actual common law fraud in the making of another Party's representations and warranties in Article IV, Article V or Article VI of this Agreement.

15.2 Remedies After the Closing Date. The Parties shall attempt to resolve any dispute, claim or controversy arising out of or relating to any breach of any covenant, obligation or agreement of a Party in this Agreement that occurs after the Closing Date through the meet and confer process set forth in Section 16.10; provided, however, that if the Parties are unable to resolve a dispute, claim or controversy through such meet and confer process, each Party shall have the right to seek any legal or equitable recourse or remedy available to such Party.

15.3 Damages Waiver. Notwithstanding anything to the contrary, the Parties acknowledge and agree that in no event shall a Party be liable to any other Party for any punitive, incidental, consequential, special or indirect damages in connection with any breach of any covenant, obligation or agreement of a Party in this Agreement that occurs after the Closing Date.

15.4 Non-Survival. The representations, warranties, covenants and agreements in this Agreement and any certificate delivered pursuant hereto by a Party, and all rights and remedies with respect thereto, will terminate at the Closing such that no claim for breach of any representation, warranty, covenant or agreement may be brought after the Closing with respect thereto and there will be no liability in respect thereof, except that this Section 15.4 will not limit responsibility for performance of covenants and agreements of the Parties which by their terms contemplate performance in whole or in part after the Closing ("***Post-Closing Responsibilities***").

15.5 Exclusive Remedies. Notwithstanding anything to the contrary:

(a) The exclusive remedies available to the Parties (or anyone claiming by, through or on behalf of a Party or any of their respective Related Persons) in connection with this Agreement or the Affiliation will be as set forth in Section 15.1 or Section 15.2.

(b) This Agreement may only be enforced against, and any claims or causes of action that may be based upon, arise out of or relate to this Agreement or the Affiliation, or the negotiation, execution or performance of this Agreement or the Affiliation, may only be made against, the Persons that are expressly identified as parties to this Agreement in their capacities as such. No former, current or future trustee, director, officer, employee, agent or representative of any Party, any Related Person of any of the foregoing or any successor or representatives of any of the foregoing (each, a "***Nonrecourse Person***") will have any liability for any obligations or liabilities of any party to this Agreement or for any Claims and Losses based on, in respect of, or by reason of, this Agreement or the Affiliation or in respect of any representations or warranties made or alleged to be made in connection with this Agreement or the Affiliation. In no event will any Party or any of its Related Persons seek to enforce this Agreement against, make any claim based upon, arising out of or relating to this Agreement or the Affiliation, or the negotiation, execution or performance of this Agreement or the Affiliation, against, or seek to recover monetary damages from, any Nonrecourse Person. Each party hereby absolves every Nonrecourse Person from any such liability.

(c) Each Party (each on behalf of itself and anyone claiming by, through or on behalf of such Party or any of its respective Related Persons) acknowledges and agrees that the remedies in this Article XV are reasonable and adequate and covenants and agrees not to assert or pursue any damages whatsoever not authorized in this Article XV. Effective as of the Effective Time, each Party (each on behalf of itself and anyone claiming by, through or on behalf of such Party or any of its Related Persons) and each of their respective successors and assigns (collectively, the "***Releasing Parties***"), irrevocably and unconditionally releases and forever discharges each of the Nonrecourse Persons from, and forever disclaims, waives and relinquishes and will be forever precluded from asserting, any and all Claims and Losses which the Releasing Parties may have against any of the Nonrecourse Persons, now or in the future, in each case in respect of any cause, matter or thing relating to any actions taken or failed to be taken by any of the Nonrecourse Persons in connection with this Agreement occurring or arising on or prior to the Effective Time.

(d) Effective as of the Effective Time, each of the Releasing Parties irrevocably and unconditionally releases and forever discharges each of the Parties from, and forever disclaims, waives and relinquishes and will be forever precluded from asserting, any and all Claims and Losses which the Releasing Parties may have against any of the Parties, now or in the future, in each case in respect of any cause, matter or thing relating to this Agreement, other than the Post-Closing Responsibilities.

(e) The releases set forth in Section 15.5(c) or Section 15.5(d) are general releases of the Claims and Losses which are described in Section 15.5(c) or Section 15.5(d) and are intended to encompass all known and unknown, foreseen and unforeseen claims described in under Section 15.5(c) or Section 15.5(d) as of the Effective Time arising out of or in any way related to this Agreement, other than—in the case of the Parties only—the Post-Closing Responsibilities. Accordingly, the Parties hereby waive and relinquish all rights and benefits

they may have under Section 1542 of the Civil Code of the State of California (as well as under any other statutes or common law principles of similar effect) with respect to the claims being released pursuant to Section 15.5(c) or Section 15.5(d). Section 1542 reads as follows:

> "Section 1542. A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE AND THAT, IF KNOWN BY HIM OR HER, WOULD HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY."

(f) The Parties acknowledge that they may discover facts after the Effective Time that are different from or in addition to those they know or believe to be true as of the Effective Time with respect to the Claims and Losses which are the subject of the releases set forth in Section 15.5(c) or Section 15.5(d), and the Parties expressly agree to assume the risk of the possible discovery of additional or different facts and agree that this Section 15.5 shall be and remain effective in all respects regardless of such additional or different facts.

Article XVI
MISCELLANEOUS

16.1 Notices. All notices, requests, demands and other communications under this Agreement must be in writing and shall be deemed duly given, unless otherwise expressly indicated to the contrary in this Agreement, (i) when personally delivered, or (ii) one Business Day after delivery to a nationally recognized overnight courier service for next Business Day delivery, in any case addressed to the Parties or their permitted assigns at the following addresses (or at such other address as is given in writing by a Party to the other Parties):

To Parent:	Cedars-Sinai Health System 8700 Beverly Boulevard Suite 2211 Los Angeles, California 90048 Attention: President and Chief Executive Officer
With a copy to:	McDermott Will & Emery LLP 2049 Century Park East Suite 3200 Los Angeles, California 90067 Attention: James F. Owens, Esq.
To Huntington or the Trust:	Pasadena Hospital Association, Ltd. 100 West California Boulevard Pasadena, CA 91105 Attn: Chief Executive Officer
With a copy to:	Davis Wright Tremaine LLP 920 Fifth Avenue, Suite 3300

Seattle, Washington 98104
Attention: Jason A. Farber, Esq.

and a copy to: Hahn & Hahn LLP
301 E. Colorado Blvd., 9th Floor
Pasadena, California 91101
Attention: Christianne F. Kerns, Esq.

16.2 Counterparts. This Agreement may be executed in one or more counterparts and may be exchanged by email transmission, each of which shall be deemed to be an original but all of which together shall constitute one and the same document.

16.3 Captions and Section Headings. Captions and section headings are for convenience only, are not a part of this Agreement and may not be used in construing it.

16.4 Cooperation. Each of the Parties agrees to cooperate in the effectuation of the Affiliation and to execute any and all additional documents and to take such additional action as is reasonably necessary or appropriate for such purposes.

16.5 Time of Essence. The time of making payments and keeping the agreements made herein is specifically made of the essence of this Agreement.

16.6 Entire Agreement. This Agreement, including any certificate, attachment, schedule, exhibit or other document delivered pursuant to its terms, constitutes the entire agreement between the Parties, and supersedes all prior agreements and understandings between the Parties relating to the subject matter hereof. There are no verbal agreements, representations, warranties, or undertakings between the Parties other than as provided herein, and this Agreement may not be amended or modified in any respect, except by a written instrument signed by the Parties.

16.7 Governing Laws. This Agreement is to be governed by and construed in accordance with the internal laws of the State.

16.8 Assignment. This Agreement shall not be assigned or otherwise transferred by any Party without the prior written consent of the other Parties, which may be granted or withheld in the other Parties' sole and absolute discretion.

16.9 Expenses. Each Party shall be responsible for the payment of all attorney fees and costs incurred by such Party in connection with the negotiation, due diligence and completion of the final terms of this Agreement and the Affiliation.

16.10 Meet and Confer. Except as otherwise provided in this Agreement, a Party shall notify the other Parties of any dispute, claim or controversy arising out of or relating to this Agreement, or the breach, termination, enforcement, interpretation, or validity thereof (collectively, a "***Dispute***"). If, within fifteen (15) days after a Party receives written notice of a Dispute (the "***Dispute Notice***"), the Parties do not resolve such Dispute, then the Dispute shall be referred to the designated senior executives with authority to resolve the Dispute from each Party for further negotiation (the "***Meet and Confer***"). The obligation to conduct a Meet and Confer

pursuant to this Section 16.10 does not obligate any Party to agree to any compromise or resolution of the Dispute that such Party does not determine, in its sole and absolute discretion, to be a satisfactory resolution of the Dispute. The Meet and Confer shall be considered a settlement negotiation for the purpose of all applicable laws protecting statements, disclosures, or conduct in such context, and any offer in compromise or other statements or conduct made at or in connection with any Meet and Confer shall be protected under such laws, including California Evidence Code Section 1152. Additionally, nothing in this Agreement shall prevent a Party from seeking provisional measures from any court of competent jurisdiction, and any such request shall not be deemed incompatible with the agreement to Meet and Confer.

16.11 Attorneys' Fees and Costs. The prevailing Party of any Action arising out of or relating to this Agreement shall be entitled to its reasonable attorneys' fees and other costs for pertaining to such Action.

16.12 No Third-Party Beneficiaries. The terms and provisions of this Agreement (including provisions regarding employee and employee benefit matters) are intended solely for the benefit of the Parties and their respective successors and permitted assigns, and are not intended to confer third-party beneficiary rights upon any other person.

16.13 Waiver. No delay or failure to require performance of any provision of this Agreement shall constitute a waiver of the performance of such provision or any other instance. Any waiver granted by a Party must be in writing, and shall apply solely to the specific instance expressly stated.

16.14 Severability. If any provision of this Agreement is held to be unenforceable for any reason, it shall be adjusted rather than voided, if possible, in order to achieve the intent of the Parties to the greatest extent possible. All other provisions of this Agreement shall remain in full force and effect.

16.15 Successors and Assigns. The covenants and conditions contained herein, subject to the provisions as to assignment and subletting, apply to and bind the heirs, successors, executors, administrators and assigns of the Parties.

16.16 Attorney-Client Privilege and Waiver of Conflicts. Each of the Parties hereby agrees, on behalf of itself and its Affiliates, that Davis Wright Tremaine LLP, Hahn & Hahn LLP or any other internal or external legal counsel currently representing Huntington or the Trust (each, a "***Prior Counsel***") may serve as counsel to Huntington and the Trust in connection with the negotiation, preparation, execution and delivery of this Agreement and the consummation of the Affiliation. In addition, all communications between Huntington or the Trust, on the one hand, and Prior Counsel, on the other hand, related to this Agreement or the Affiliation will be deemed to be attorney-client confidences that belong solely to Huntington and the Trust (and not Parent) (the "***Pre-Closing Communications***"). Accordingly, Parent will not have access to any such Pre-Closing Communications or to the files of Prior Counsel relating to such engagement from and after the Closing, and all records and other materials of Huntington or the Trust in any medium (including electronic copies) containing or reflecting any of Pre-Closing Communications or the work product of legal counsel with respect thereto, including any related summaries, drafts or analyses, and all rights with respect to any of the foregoing, are hereby

assigned and transferred to the Trust effective as of the Closing. Such material and information will be excluded from any transfer contemplated by this Agreement and will be distributed to the Trust immediately prior to Closing with no copies thereof retained by Parent, Huntington or any of their respective representatives. From and after the Closing, Parent and the Huntington Entities will maintain the confidentiality of all such material and information. From and after the Closing, none of Parent, the Huntington Entities and their respective Related Persons and representatives will access or in any way, directly or indirectly, use or rely upon any such materials or information. To the extent that any such materials or information are not delivered to the Trust, they will be held for the benefit of the Trust, and Parent, the Huntington Entities and their respective Related Persons will deliver all such material and information to the Trust promptly upon discovery thereof, without retaining copies thereof. Without limiting the generality of the foregoing, from and after the Closing, (a) Huntington and the Trust will be the sole holders of the attorney-client privilege with respect to such Pre-Closing Communications, (b) to the extent that files of Prior Counsel contain Pre-Closing Communications, such files constitute property of the client, and only the Trust will hold such property rights and (c) Prior Counsel will have no duty whatsoever to reveal or disclose any Pre-Closing Communications to any Huntington Entity by reason of any attorney-client relationship between Prior Counsel and any Huntington Entity or otherwise. Each of Parent and Huntington hereby acknowledges and confirms that it has had the opportunity to review and obtain adequate information regarding the significance and risks of the waivers and other terms and conditions of this Section 16.16, including the opportunity to discuss with counsel such matters and reasonable alternatives to such terms. The covenants and obligations set forth in this Section 16.16 shall survive Closing, shall survive termination of this Agreement and the Trust Party End Date.

16.17 Trust Party End Date.

(a) The Parties acknowledge and agree that, notwithstanding anything in this Agreement that may be construed to the contrary, the Trust shall cease to be a party to this agreement as of the date (the "***Trust Party End Date***") that is the later of (i) the fifth (5^{th}) anniversary of the Closing Date and (ii) the date on which the projects that are part of the "FMP Non-Compliance & Major Capital Projects Budget" set forth on Exhibit C have been completed and (iii) the date on which the Trust is fully released from all of its obligations in connection with Huntington's bond indebtedness and related contractual obligations referenced in the Reimbursement Agreement. Notwithstanding anything to the contrary, any claim that is asserted by or on behalf of the Trust prior to the Trust Party End Date will survive until the resolution and satisfaction of such claim.

(b) In furtherance of the foregoing, the Parties expressly agree that as of the Trust Party End Date the Trust will have no further rights or obligations as against Parent or Huntington under this Agreement and Huntington and Parent will have no further rights or obligations as against the Trust under this Agreement; provided that the rights and obligations of the Parties pursuant to Section 1.2 (Rules of Interpretation), Article XII (Protective Provisions), Sections 13.10 (Trust Distributions), Article XV (Remedies), Article XVI (Miscellaneous) and all provisions of the NDA (collectively, the "***Surviving Trust Rights and Obligations***") will remain in full force and effect and survive the Trust Party End Date to the same extent otherwise set forth in this Agreement.

(c) Effective as of the Trust Party End Date:

(i) The Trust, on behalf of itself and its Releasing Parties, irrevocably and unconditionally releases and forever discharges each of Huntington and Parent and their respective Related Persons from, and forever disclaims, waives and relinquishes and will be forever precluded from asserting, any and all Claims and Losses which the Trust and its Releasing Parties may have against any of Huntington or Parent, now or in the future, in each case in respect of any cause, matter or thing relating to this Agreement, other than the Surviving Trust Rights and Obligations.

(ii) Each of Huntington and Parent (each on behalf of itself and their respective Releasing Parties), irrevocably and unconditionally releases and forever discharges the Trust and its Related Persons from, and forever disclaims, waives and relinquishes and will be forever precluded from asserting, any and all Claims and Losses which each of Huntington and Parent and their respective Releasing Parties may have against the Trust, now or in the future, in each case in respect of any cause, matter or thing relating to this Agreement, other than the Surviving Trust Rights and Obligations.

(d) The mutual release set forth in Section 16.17(c) is a general release of the Claims and Losses which are described in Section 16.17(c) and is intended to encompass all known and unknown, foreseen and unforeseen claims described in Section 16.17(c) as of the Trust Party End Date arising out of or in any way related to this Agreement, other than the Surviving Trust Rights and Obligations. Accordingly, the Parties hereby waive and relinquish all rights and benefits they may have under Section 1542 of the Civil Code of the State of California (as well as under any other statutes or common law principles of similar effect) with respect to the claims being released pursuant to Section 16.17(c). Section 1542 reads as follows:

> "Section 1542. A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE AND THAT, IF KNOWN BY HIM OR HER, WOULD HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY."

(e) The Parties acknowledge that they may discover facts after the Trust Party End Date that are different from or in addition to those they know or believe to be true as of the Trust Party End Date with respect to the Claims and Losses which are the subject of the release set forth in Section 16.17(c), and the Parties expressly agree to assume the risk of the possible discovery of additional or different facts and agree that this Section 16.17 shall be and remain effective in all respects regardless of such additional or different facts.

(f) This Section 16.17 shall survive the termination or expiration of this Agreement.

[Signature page follows]

DocuSign Envelope ID: 296A0A88-7FAD-4308-9BBE-3515ED4A6C88

IN WITNESS WHEREOF, the Parties have duly executed this Agreement effective as of the Execution Date.

PARENT:

CEDARS-SINAI HEALTH SYSTEM, a California nonprofit public benefit corporation

By: REDACTED

Name: Vera Guerin
Title: Chair of the Board

By: REDACTED

Name: Thomas M. Priselac
Title: President and Chief Executive Officer

HUNTINGTON:

PASADENA HOSPITAL ASSOCIATION LTD.,
a California nonprofit public benefit corporation
d/b/a Huntington Hospital

REDACTED

Name: Lori J. Morgan, M.D.
Title: President and Chief Executive Officer

TRUST:

REDACTED

By:
Jaynie Studenmund, Trustee of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

REDACTED

By:
Armando L. Gonzalez, Trustee of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

REDACTED

By:
Michelle Quinones Chino, Trustee of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

REDACTED

By:
Paul Johnson, Trustee of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

REDACTED

By:
Wayne Brandt, Trustee of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

Exhibit A

Unwind Event

1. Huntington Unwind Event. If Parent causes a Huntington Unwind Event, Parent shall promptly notify Huntington in writing of the same (the "***Huntington Unwind Event Notice***"). Upon Huntington's receipt of the Huntington Unwind Event Notice, Huntington shall have the right, but not the obligation, to terminate Parent's membership in Huntington (the "***Huntington Unwind Right***") pursuant to the following terms:

(a) Huntington shall give Parent notice of Huntington's intent to exercise the Huntington Unwind Right within thirty (30) days of Huntington's receipt of the Huntington Unwind Event Notice from Parent ("***Exercise of Unwind Notice***"), which intent to exercise the Huntington Unwind Right shall have been approved by the Board of Directors of Huntington.

(b) As soon as practical thereafter, the Parties shall meet and confer in order to mutually agree to the actions necessary to effectuate the termination of Parent's membership in Huntington and an estimated date of termination for Parent's membership in Huntington (the "***Anticipated Termination Date***"). Thereafter, Parent and Huntington shall work together in good faith to modify their organizational documents, take all actions agreed to by the Parties, and take all other actions necessary and appropriate to terminate Parent's membership in Huntington, which shall result in Huntington assuming all assets and liabilities of Huntington and each Huntington Subsidiary.

(c) In connection with the termination of Parent's membership in Huntington, and in exchange for fair market value compensation, Huntington may require Parent to provide reasonable management or other administrative services to Huntington Entities on mutually agreed upon terms for a reasonable period of time after Parent's membership in Huntington is terminated to minimize any economic or operational injury to the Huntington Entities. Parent and Huntington agree to work together in good faith to agree upon such services if requested by Huntington.

(d) Within sixty (60) days of receiving the Exercise of Unwind Notice, Parent shall provide Huntington its accounting of and anticipated payment dates (all of which shall be prior to the Anticipated Termination Date) during the unwind period of the following amounts due from/due to each other as of the Anticipated Termination Date. In the event that Huntington disagrees with Parent's accounting or payment dates, the Parties shall work in good faith to resolve such dispute prior to the Anticipated Termination Date.

(i) The "***Owed Parent Expense Payments***" to be paid by Huntington to Parent, which shall be equal to: (a) the aggregate of all Parent Operating Expenses Payments owed to Parent by Huntington and unpaid as of the Anticipated Termination Date, plus (b) the aggregate of any Contribution Deferrals (as defined below) owed by Huntington pursuant to Exhibit B, and including all Interest (as defined below) on such amounts accrued until the date of payment;

(ii) The "***Aggregate Investment in Huntington***" to be paid by Huntington to Parent, which shall be equal to: (a) the aggregate capital invested or contributed by

Parent in or to Huntington or a Huntington Subsidiary after the Closing Date (the "***Investment in Huntington***"), which would include, without limitation, all portions of the Funding Commitment and EHR Project Capital Costs paid, incurred or loaned by Parent to Huntington or any other Person, plus (b) an amount equal to the Interest accrued on the Investment in Huntington until the date of payment;

(iii) The "***Owed Huntington Expense, Asset, and Capital Contribution Payments***" to be paid by Parent to Huntington, which shall be equal to: (a) the aggregate of all Huntington Capital Contributions pursuant to Exhibit B of this Agreement plus all Interest accrued on such contributions at the time each Huntington Capital Contribution was made, plus (b) the aggregate of all Parent Operating Expenses Payments pursuant to Section 13.4 of this Agreement plus all Interest accrued on all Parent Operating Expense Payments at the time each was made.

(iv) For purposes of this Exhibit A, "***Interest***" shall be defined as the payee's applicable annual rate of interest on its investment portfolio, at the time of payment and over the period paid to the other Party.

(v) Once all actions necessary and appropriate to terminate Parent's membership in Huntington have been completed and all payments due from/due to the Parties have been made or agreed to, the Parties shall execute a final notice indicating that all actions have been completed to effectuate the termination of Parent's membership in Huntington (the "***Final Notice***"). The execution date of the Final Notice shall be the date on which Parent's membership in Huntington shall be effectively terminated.

(e) Huntington acknowledges and agrees that if Parent's membership in Huntington has not been effectively terminated within thirty (30) months after Parent receives the Exercise of Unwind Notice, then unless the Parties otherwise agree in writing, the Huntington Unwind Right shall automatically expire and terminate as to that Exercise of Unwind Notice.

2. No Restrictions. In the event Parent's membership in Huntington is terminated pursuant to the terms set forth in this Exhibit A, the Parties acknowledge and agree that after the effective date of such membership termination there shall be no restrictions on the operations or actions of any Party or its affiliated entities. Without limiting the generality of the foregoing, in the event Parent's membership in Huntington is terminated pursuant to the terms set forth in this Exhibit A, the Parties: (i) shall not be restricted from competing with each other in any way, and (ii) shall not be restricted from soliciting or recruiting each other's employees or affiliated physicians in any way. The Parties further acknowledge and agree that in the event Parent's membership in Huntington is terminated pursuant to the terms set forth in this Exhibit A, any medical practitioner providing services on behalf of Parent, Huntington or any of their respective Related Persons may elect to either: (i) continue providing services on behalf of such entity, or (ii) provide services for any other entity. The Parties agree that Huntington and Parent may solicit physicians and other providers during any unwind period.

3. Termination of Agreement. Notwithstanding anything in this Agreement that may be construed to the contrary, the Parties acknowledge and agree that in the event Parent's

membership in Huntington is terminated pursuant to the terms set forth in this Exhibit A, this Agreement shall automatically terminate upon the effective date of the termination of Parent's membership interest in Huntington.

Exhibit B

Capital Contributions to Parent

1. Capital Contributions. If Parent determines at any time after the Capital Plan Period that additional capital or other funds are required for any investments, capital initiatives, transactions or growth of Parent, Huntington or a Huntington Subsidiary, CSMC, THA or any additional Affiliate Hospital Organization (a "***Capital Need***"), Huntington shall be obligated to contribute capital to Parent (or to an entity indicated by Parent) for the purpose of funding such Capital Need pursuant to this Exhibit B.

2. Capital Call Notice. If Parent determines that a capital contribution is necessary from Huntington to fund a Capital Need pursuant to this Exhibit B, then Parent shall deliver a written notice (the "***Capital Call Notice***") to Huntington stating:

(a) the aggregate amount of the Capital Need and the intended uses therefor;

(b) the amount of the Capital Need to be provided by Huntington, which shall be proportionate to the number of individuals that Huntington has the right to nominate to the Board of Directors of Parent pursuant to the bylaws of Parent then in effect (which calculation shall not take into account any ex-officio members of the Board of Directors of Parent) ("***Huntington Capital Contribution***");

(c) the amount of the Capital Need to be provided by each Affiliate Hospital Organization (including CSMC and THA);

(d) the due date for Huntington's payment of the Huntington Capital Contribution; provided, however, Huntington shall each have at least fifteen (15) days from the date of the Capital Call Notice to make the Huntington Capital Contribution or provide a Notice of Deferral (as defined in and pursuant to Section 3 of this Exhibit B);

(e) instructions for payment of the Huntington Capital Contribution; and

(f) any other information Parent reasonably determines should be included in the Capital Call Notice.

3. Timing of Capital Contribution. All Huntington Capital Contributions shall be made by Huntington pursuant to the payment instructions set forth in the Capital Call Notice on or prior to the due date set forth in the Capital Call Notice. Provided, however, if making a Huntington Capital Contribution pursuant to this Exhibit B would cause the Huntington Entities, on a consolidated basis, to have cash on hand in an amount that is less than Sixty Days Expenses, then Huntington shall have the right to defer making the Huntington Capital Contribution (a "***Contribution Deferral***") until such time as Huntington accumulates sufficient cash on hand to make the Huntington Capital Contribution. In the event that Huntington elects to defer making the Huntington Capital Contribution, Huntington shall provide notice to Parent of such deferral instead of the Huntington Capital Contribution (the "***Notice of Deferral***").

Exhibit C

Huntington Strategic Capital Plan

Huntington Strategic Capital Plan

	2021 - 2023	Total *(rounded)*
FMP Non-Compliance & Major Capital Projects Budget	85,000	**85,000**

	2021	2022	2023	2024	2025	2026	2027	2028	2029	Total *(rounded)*
Routine Capital Budget	30,500	30,500	30,500	30,500	30,500	30,500	30,500	30,500	30,500	**275,000**

	2021 - 2025	2026 - 2029	Total *(rounded)*
Strategic Capital Budget	100,000	100,000	**200,000**

Total Proposed Capital *(rounded)*	**560,000**

($ in 000's)

Detailed FMP Non-Compliance Projects and Major Capital Projects Budget

	2021	2022	2023	2024	2025	Total
FMP Non-Compliance	**31,352**	**7,000**	**-**	**-**	**-**	**38,352**
Operating Room Build Out and Renovation	*31,352*	*7,000*	-	-	-	*38,352*
Major Capital	**23,882**	**15,594**	**6,594**	**594**	**594**	**47,258**
COU Relocation	*500*	-	-	-	-	*500*
CSPD Masterplan	*12,879*	*3,000*	-	-	-	*15,879*
Unit 35 Relocation	*4,534*	-	-	-	-	*4,534*
IT Relocation	*900*	-	-	-	-	*900*
Clinical Lab HVAC Upgrade (Regulatory)	*875*	-	-	-	-	*875*
CT Scan Upgrade	*800*	-	-	-	-	*800*
Rad Fluoroscopy 7&8	*500*	-	-	-	-	*500*
Pathology Lab Upgrade	*300*	-	-	-	-	*300*
Surgery Department Associated Services Upgrade	*2,000*	*12000*	*6000*	-	-	*20,000*
Intuitive Robotics	*594*	*594*	*594*	*594*	*594*	*2,970*
Total	**55,234**	**22,594**	**6,594**	**594**	**594**	**85,610**

($ in 000's)

Exhibit D

EHR Project – Core Modules

Inpatient
Prelude Registration/ADT
Cadence Scheduling
Health Information Management (HIM)
EpicCare Clinical System
- EMR
- Clinical Order Entry
- Decision Support
- Results Review
- Clinical Documentation
- MAR
- Rover Barcoding
- Clinical Pathways
- Care Plans & Education
- Infection Control*
- Clinical Case Management
- ICU
- Willow Inpatient Pharmacy

Specialties
Optime (OR Management)
Anesthesia
ASAP (Emergency Department)
Beaker (Clinical Lab & Pathology)*
Radiant (Radiology)*
Beacon (Oncology)*
Cupid (Cardiology)*
Stork (OB Labor/Delivery)
Bones (Orthopaedics)
Behavioral Health*
Dialysis*
EpicCare Rehab

Access & Revenue Cycle
Resolute Hospital Billing
Resolute Professional Billing
Charge Router
Eligibility
Referrals
Financial Assistance
Transfer Center

Ambulatory
Prelude Registration
Cadence Scheduling
EpicCare EHR
- Charting
- Clinical Order Entry
- e-Prescribing
- Decision Support
- Results Review
- Coding & Benefits

Welcome Patient
Check-In

Population Health & Analytics
Healthy Planet (Population Health)
Cogito Analytics
- Dashboards
- Reporting
- Analytics
- Enterprise Data Warehouse

Patient Portal
MyChart (shared EMR for patients)
MyChart Bedside (for hospital patients)

Telemedicine
Video Visits
Specialty consults

Interoperability
Care Everywhere
Share Everywhere

Clinician Mobile
Haiku (for smartphone)
Canto (for tablet)
Limerick (for watch)

**Implementation of these modules as part of the completion of the EHR Project is subject to further discussion by and approval of the EHR Project Committee.*

Exhibit E

Modules To be Provided Under Parent's Epic Enterprise License

Inpatient
Prelude Registration/ADT
Cadence Scheduling
Health Information Management (HIM)
EpicCare Clinical System
- EMR
- Clinical Order Entry
- Decision Support
- Results Review
- Clinical Documentation
- MAR
- Rover Barcoding
- Clinical Pathways
- Care Plans & Education
- Infection Control
- Clinical Case Management
- ICU
- Willow Inpatient Pharmacy

Access & Revenue Cycle
Resolute Hospital Billing
Resolute Professional Billing
Charge Router
Eligibility
Referrals
Contract Modeling
Financial Assistance
Patient Estimates
Transfer Center

Specialties
Optime (OR Management)
Anesthesia
ASAP (Emergency Department)
Urgent Care
Beaker (Clinical Lab & Pathology)
Radiant (Radiology)
Beacon (Oncology)
Cupid (Cardiology)
Stork (OB Labor/Delivery)
Kaleidoscope (Ophthalmology)
Phoenix (Transplant)
Bones (Orthopaedics)
Wisdom (Dental)
Behavioral Health
Dialysis
EpicCare Fertility
Lumens (Endoscopy)
EpicCare Rehab

Managed Care (Tapestry)
Enrollment/Eligibility
Claims/Capitation
Utilization Management
Premium Billing
PlanLink

Ambulatory
Prelude Registration
Cadence Scheduling
Call Management/CRM
EpicCare EHR
- Charting
- Clinical Order Entry
- e-Prescribing
- Decision Support
- Results Review
- Coding & Benefits

Nurse Triage
Willow Ambulatory Pharmacy
Welcome Patient Check-In

Population Health & Analytics
Healthy Planet (Population Health)
Cogito Analytics
- Dashboards
- Reporting
- Analytics
- Enterprise Data Warehouse

Clinician Mobile
Haiku (for smartphone)
Canto (for tablet)
Limerick (for watch)

Patient Portal
MyChart (shared EMR for patients)
MyChart Bedside (for hospital patients)
MyChart Virtual Care (chronic disease management)
MyChart Health Coach (promotes wellness)
Lucy (free-standing PHR)

Telemedicine
Video Visits
Specialty consults
Remote interpreters
ICU / bed monitoring
Virtual Rounds

Interoperability
Community Connect
EpicCare Link
Care Everywhere
Share Everywhere

Research
Patient Enrollment
Research Analytics
Research Billing
CTMS Interface
Genomics

Exhibit F

EHR Project Committee

The EHR Project Committee will be the steering committee responsible for the EHR Project implementation and transformation efforts, timeline, resource allocation and commitments and budget management. The EHR Project Committee will set the overall EHR Project plan, provide day to day management of the EHR Project, make key decisions regarding the EHR Project and communicate all issues, risks and/or decisions with Huntington's executive leadership.

The following are assumptions and expectations regarding the composition of the EHR Project Committee and its scope:

- Chair: Cedars-Sinai shall assign a Chair for the EHR Project committee who is an expert in EHR implementation who can provide oversight and direction for the overall EHR Project. The Chair will have ultimate decision-making authority for the EHR Project in collaboration with the EHR Project Committee members.
- EHR Project Directors/Managers: Cedars-Sinai shall provide EHR Project Directors/Managers who will also be part of the EHR Project Committee; they will be full-time dedicated to the EHR Project and lead the EHR Project management and transformation office.
- Huntington Project Leadership: Huntington shall commit the necessary administrative and clinical leadership to the EHR Project Committee who have the authority to make critical decisions and prioritize key issues regarding the EHR Project. The Huntington EHR Committee members will also serve as the key communicators with the Huntington management team and EHR key stakeholders and users and will obtain input from key stakeholders to inform decisions and directions about EHR Project implementation.
- Sub-Committees and Workgroups: The EHR Project Committee will create sub-committees and workgroups, as needed, to focus on specific elements of implementation, training and/or development of the core modules for the EHR Project. These sub-committees and workgroups will report to the EHR Project Committee and will be led by a member of the EHR Project management and transformation office.
- Huntington shall identify and commit the necessary experts and resources from clinical areas, including but not limited to Medical Staff/physicians, nursing and pharmacy to support the EHR Project Committee, sub-committees and workgroups to ensure optimal and efficient workflow design and change management. In addition, other subject matter experts from Cedars-Sinai and Huntington will participate, as needed, on the EHR Project Committee, sub-committees and/or workgroups.

Exhibit G

Huntington Hospital Land – Legal Description[1]

PARCEL 1: 5719-027-042 also known as 624 South Pasadena Avenue

LOT 4 OF LEONARD'S SUBDIVISION OF PART OF DIVISION "F" OF THE LANDS OF THE SAN GABRIEL ORANGE GROVE ASSOCIATION, IN THE CITY OF PASADENA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 14, PAGE 11 OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

PARCEL 2: 5719-027-052 also known as 47 Congress Street

LOT 14 OF MARTIN'S SUBDIVISION OF PART OF THE FRANK GREEN TRACT, IN THE CITY OF PASADENA, AS PER MAP RECORDED IN BOOK 10, PAGE 46 OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

PARCEL 3: 5719-027-061 also known as 100 Congress Street

PARCEL 2, OF PARCEL MAP NO. 18337, IN THE CITY OF PASADENA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 246, PAGES 73-75 OF MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY;

TOGETHER WITH A PORTION OF PARCEL 1, OF SAID PARCEL MAP NO. 18337, DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHEASTERLY CORNER OF SAID PARCEL 1; THENCE ALONG THE NORTHERLY LINE OF SAID PARCEL 1, NORTH 89°58’04” WEST 147.58 FEET TO THE TRUE POINT OF BEGINNING; THENCE CONTINUING ALONG THE NORTHERLY LINE OF SAID PARCEL 1, NORTH 89°58’04” WEST 210.07 FEET TO THE NORTHWESTERLY CORNER OF SAID PARCEL 1; THENCE ALONG THE WESTERLY LINE OF SAID PARCEL 1, SOUTH 0°00’03” WEST 499.23 FEET TO THE SOUTHWESTERLY CORNER OF SAID PARCEL 1; THENCE ALONG THE SOUTHERLY LINE OF SAID PARCEL 1, SOUTH 89°49’41” EAST 211.07 FEET; THENCE PARALLEL WITH THE WESTERLY LINE OF SAID PARCEL 1, NORTH 0°00’03” EAST

[1] The legal description of Parcel 3 is subject to minor variations which become necessary as a result of the lot line adjustment approval process to the end that the legal description of Parcel 3 matches the parcel as so approved when the Huntington Hospital Land is transferred to Huntington.

174.05 FEET; THENCE NORTH 89°59’57”WEST 1.00 FEET; THENCE PARALLEL WITH THE WESTERLY LINE OF SAID PARCEL 1, NORTH 0°00’03” EAST 325.70 FEET TO THE TRUE POINT OF BEGINNING.

EXCEPT THAT PORTION OF SAID PARCEL 2, DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHEAST CORNER OF SAID PARCEL 2; THENCE ALONG THE EASTERLY LINE OF SAID PARCEL 2, SOUTH 285.20 FEET TO THE EASTERLY PROLONGATION OF THAT CERTAIN COURSE ON THE EASTERLY LINE OF SAID PARCEL 2, SHOWN ON SAID PARCEL MAP NO. 18337 AS "NORTH 89°55'38" WEST 100.00 FEET", SAID INTERSECTION ALSO BEING THE NORTHWEST CORNER OF SAID LOT 7; THENCE WESTERLY ALONG SAID PROLONGED LINE NORTH 89°55'42" WEST 156.00 FEET; THENCE PARALLEL WITH THE EASTERLY LINE OF SAID PARCEL 2, NORTH 285.32 FEET TO THE NORTHERLY LINE OF SAID PARCEL 2; THENCE ALONG THE NORTHERLY LINE OF SAID PARCEL 2, SOUTH 89°52'55" EAST 156.00 FEET, TO THE POINT OF BEGINNING.

For conveyancing purposes only: APN 5719-027-042; 5719-027-052; 5719-027-061

Exhibit H

Huntington Hospital Land – Title Exceptions[2]

The following items shall be included as part of Permitted Liens:

1. Any defect, lien, encumbrance, adverse claim, or other matter that appears for the first time in the Public Records or is created, attaches, or is disclosed between the Commitment Date and the date on which all of the Schedule B, Part I-Requirements are met.

2. (a) Taxes or assessments that are not shown as existing liens by the records of any taxing authority that levies taxes or assessments on real property or by the Public Records; (b) proceedings by a public agency that may result in taxes or assessments, or notices of such proceedings, whether or not shown by the records of such agency or by the Public Records.

3. Any facts, rights, interests, or claims that are not shown by the Public Records but that could be ascertained by an inspection of the Land or that may be asserted by persons in possession of the Land.

4. Easements, liens or encumbrances, or claims thereof, not shown by the Public Records.

5. Any encroachment, encumbrance, violation, variation, or adverse circumstance affecting the Title that would be disclosed by an accurate and complete land survey of the Land and not shown by the Public Records.

6. (a) Unpatented mining claims; (b) reservations or exceptions in patents or in Acts authorizing the issuance thereof; (c) water rights, claims or title to water, whether or not the matters excepted under (a), (b), or (c) are shown by the Public Records.

7. General and special taxes and assessments for the fiscal year 2020-2021, a lien not yet due or payable.

8. The lien of supplemental taxes, if any, assessed pursuant to Chapter 3.5 commencing with Section 75 of the California Revenue and Taxation Code.

9. Water rights, claims or title to water, whether or not shown by the public records.

10. An easement for public street purposes for the widening of Fair Oaks Avenue, as shown on various maps of record.

[2] The parties agree to work together and with the Title Company and the surveyor preparing the Surveys after signing of this Agreement and prior to transferring title to the Huntington Hospital Land to Huntington to use commercially reasonable efforts to remove as exceptions from this Exhibit and the Title Commitment any items which do not affect the Huntington Hospital Land, and revise other general exceptions in this Exhibit and the Title Commitment to make them specific in light of specific facts pertaining to the Huntington Hospital Land at the time the Title Policy is issued.

11. An easement for conducting water and incidental purposes, recorded December 18, 1879 in Book 27 of Deeds, Page 229.

In Favor of:

Affects: John S. Griffin, P. Reynolds

12. Covenants, conditions, restrictions and easements in the document recorded in Book 2534 of Deeds, Page 15, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

13. Covenants, conditions, restrictions and easements in the document recorded in Book 2711 of Deeds, Page 46, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

14. Covenants, conditions, restrictions and easements in the document recorded in Book 2712 of Deeds, Page 272, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

15. Covenants, conditions, restrictions and easements in the document recorded in Book 4097 of Deeds, Page 90, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the

California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

16. Covenants, conditions, restrictions and easements in the document recorded in Book 4339 of Deeds, Page 143, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

17. Covenants, conditions, restrictions and easements in the document recorded in Book 4370 of Deeds, Page 149, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

18. Covenants, conditions, restrictions and easements in the document recorded in Book 4428 of Deeds, Page 47, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

19. Covenants, conditions, restrictions and easements in the document recorded in Book 4680 of Deeds, Page 318, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

20. Covenants, conditions, restrictions and easements in the document recorded in Book 4494 of Deeds, Page 163, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

21. Covenants, conditions, restrictions and easements in the document recorded in Book 5212 of Deeds, Page 43, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

22. Covenants, conditions, restrictions and easements in the document recorded in Book 5655 of Deeds, Page 33, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

23. An easement for pole line and incidental purposes, recorded October 18, 1933 as Book 12466, Page 34 of Official Records.

In Favor of: Western Union Telegraph Co.

Affects: as described therein

24. The right of Southern California Edison Company, Ltd., to use an existing pole line under the terms and conditions of an unrecorded License Agreement between Los Angeles & Salt Lake Railroad Company, and the Western Union Telegraph Company, Licensors and Southern California Edison Company, Ltd., Licensee, as recited in the deed recorded October 18, 1933 in Book 12466, Page 34, Official Records.

25. Covenants, conditions, restrictions and easements in the document recorded March 10, 1937 as Instrument No. 361, in Book 14686 Page 348 of Official Records, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

26. Covenants, conditions, restrictions and easements in the document recorded as in Book 18405 Page 368 of Official Records, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

27. Intentionally Omitted.

28. Covenants, conditions, restrictions and easements in the document recorded as in Book 19570 Page 353 of Official Records, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

29. The right to explore for, remove and dispose of minerals by any suitable means or methods, without entering upon or using the surface of the land as reserved by Los Angeles & Salt Lake Railroad Company recorded in Book 24171 Page 421 and by Union Pacific Railroad Company in Book 24183 Page 434, both of Official Records.

30. An easement for telephone, telegraph and signal wires and incidental purposes, recorded February 10, 1948 as Instrument No. 950, in Book 26416 Page 372 of Official Records.

In Favor of:

Affects: as described therein

31. An easement for gas, sewers and water connection and incidental purposes, recorded March 23, 1950 as Instrument No. 415, in Book 32646, Page 294 of Official Records.

In Favor of:

Affects: as described therein

32. The terms, provisions and easement(s) contained in the document entitled "Grant of Easement" recorded February 15, 1961 as Instrument No. 4965 in Book D1124, Page 686 of Official Records.

33. The rights, if any, of a city, public utility or special district, pursuant to Section 8345 et seq. of the California Streets and Highways Code, to preserve a public easement in Fairmount Avenue and/or Congress Street as the same was vacated by the document recorded October 27, 1969 as Instrument No. 2122 of Official Records.

34. An easement for public utilities and incidental purposes, recorded May 12, 1972 as Instrument No. 3831 of Official Records.

In Favor of: The City of Pasadena, a municipal corporation

Affects: as described therein

35. Terms and provisions of an unrecorded lease dated February 12, 1972, by and between Alan E. Robbins as lessor and PMP, a limited partnership as lessee, as disclosed by a Memorandum of Lease recorded June 01, 1972 as Instrument No. 2430 of Official Records.

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

36. The rights, if any, of a city, public utility or special district, pursuant to Section 8345 et seq. of the California Streets and Highways Code, to preserve a public easement in La Fuente Alley as the same was vacated by the document recorded December 31, 1979 as Instrument No. 79-1462774 of Official Records.

37. An easement for street or highway and incidental purposes, recorded July 08, 1982 as Instrument No. 82-688649 of Official Records.

In Favor of: The City of Pasadena, a municipal corporation

Affects: as described therein

38. Intentionally Omitted.

39. An easement for corner rounding and incidental purposes, recorded November 07, 1984 as Instrument No. 84-1328081 of Official Records.

In Favor of:

Affects: as described therein

Said property is more graphically described in City of Pasadena Public Works Department Drawing No. 3880, dated November 7, 1983, and attached thereto as Exhibit "A" and set forth in the deed Executed by: Richlin Company Pension Trust Recorded: May 10, 1985 as Instrument No. 85-531463, Official Records

40. The terms, provisions and easement(s) contained in the document entitled "Certificate of Correction" recorded November 09, 1984 as Instrument No. 84-1343089 of Official Records.

41. An easement for utilities and incidental purposes, recorded April 15, 1985 as Instrument No. 85- 420619 of Official Records.

In Favor of: Southern California Gas Company

Affects: as described therein

Said property is more graphically described in City of Pasadena Public Works Department Drawing No. 3880, dated November 7, 1983, and attached thereto as Exhibit "A" and set forth in the deed Executed by: Richlin Company Pension Trust Recorded: May 10, 1985 as Instrument No. 85-531463, Official Records

42. Covenants, conditions, restrictions and easements in the document recorded April 16, 1987 as Instrument No. 87-589690 of Official Records, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

43. The terms, provisions and easement(s) contained in the document entitled "License Agreement" recorded May 27, 1987 as Instrument No. 87-826037 of Official Records.

44. An easement for utilities, sanitary sewer, storm drain, ingress and egress and incidental purposes, recorded June 09, 1987 as Instrument No. 87-904741 of Official Records.

In Favor of: The City of Pasadena, a municipal corporation

Affects: as described therein

45. The terms, provisions and easement(s) contained in the document entitled "License Agreement No. 13,233" recorded September 23, 1987 as Instrument No. 87-1526087 of Official Records.

46. The rights, if any, of a city, public utility or special district, pursuant to Section 8345 et seq. of the California Streets and Highways Code, to preserve a public easement in Fairmount Avenue and/or Congress Street as the same was vacated by the document recorded May 24, 1989 as Instrument No. 89-843349 of Official Records.

47. Terms and provisions of an unrecorded lease dated September 08, 1989, by and between Collis P. and Howard Huntington Memorial Hospital Trust as lessor and Valacal Company, a California corporation as lessee, as disclosed by a Memorandum of Lease recorded September 12, 1989 as Instrument No. 89-1465512 of Official Records.

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

48. An easement for utilities and incidental purposes, recorded October 30, 1989 as Instrument No. 89- 1747231 of Official Records.

In Favor of: Southern California Company, a corporation

Affects: as described therein

49. An easement shown or dedicated on the map filed or recorded Parcel Map No. 18337 as file in Book 246, Page 73 of Parcel Maps

For: Public utilities, ingress and egress, storm drain and appurtenant structures, sanitary sewer and incidental purposes and incidental purposes.

50. An easement shown or dedicated on the map filed or recorded Parcel Map No. 18337 as file in Book 246, Page 73 of Parcel Maps

For: Future Street and incidental purposes and incidental purposes.

51. The terms, provisions and easement(s) contained in the document entitled "Reciprocal Easement Agreement" recorded September 14, 1995 as Instrument No. 95-1501801 of Official Records.

52. An easement for traffic signal and incidental purposes, recorded October 07, 1997 as Instrument No. 97-1553800 of Official Records.

In Favor of: The City of Pasadena, a municipal corporation

Affects: as described therein

53. An easement for roadway and incidental purposes, recorded July 22, 2004 as Instrument No. 04- 1877736 of Official Records.

In Favor of:

Affects: as described therein

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

54. Terms and provisions of an unrecorded lease dated July 12, 2005, by and between Pasadena Hospital Association LTD, a California non-profit organization dba Huntington Memorial Hospital as lessor and Sprint PCS Assets, L.L.C. a Delaware limited liability company as lessee, as disclosed by a Memorandum of Agreement recorded September 13, 2005 as Instrument No. 05-2200493 of Official Records.

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

55. The effect of a document entitled "Affidavit of Successor Trustees", recorded October 02, 2007 as Instrument No. 20072258902 of Official Records.

56. The terms, provisions and easement(s) contained in the document entitled "Master Covenant and Agreement Regarding On-Site BMP Maintenance" recorded June 26, 2008 as Instrument No. 20081141925 of Official Records.

57. The rights, if any, of a city, public utility or special district, pursuant to Section 8345 et seq. of the California Streets and Highways Code, to preserve a public easement in Fairmount Avenue and/or Congress Street as the same was vacated by the document recorded March 27, 2012 as Instrument No. 20120462458 of Official Records.

58. An easement for public street and incidental purposes, recorded March 27, 2012 as Instrument No. 20120462458 of Official Records.

In Favor of: The City of Pasadena, a municipal corporation

Affects: as described therein

59. An easement for public street and incidental purposes, recorded March 27, 2012 as Instrument No. 20120462840 of Official Records.

In Favor of: The City of Pasadena, a municipal corporation

Affects: as described therein

60. The terms, provisions and easement(s) contained in the document entitled "License Agreement No. 23,190" recorded July 09, 2019 as Instrument No. 20190661971 of Official Records.

61. Prior to closing, the Company must confirm whether the county recording office in which the Land is located has changed its access policies due to the COVID-19 outbreak. If recording has been restricted, specific underwriting approval is required; and, additional requirement or exceptions may be made.

NOTE: As of the date hereof, recording in this county is restricted to electronic filings.

62. Any claim that the Title is subject to a trust or lien created under The Perishable Agricultural Commodities Act, 1930 (7 U.S.C. §§499a, et seq.) or the Packers and Stockyards Act (7 U.S.C. §§181 et seq.) or under similar state laws.

63. Rights of parties in possession.

64. The description shown in this report is not to be relied upon as a legal insurable parcel. This Company has provided said description only as an accommodation for the purpose of facilitating this report. A description approved by the appropriate governing agency pursuant to the Subdivision Map Act of the State of California must be submitted to this Company for review prior to closing.

65. Any facts, rights, interests or claims which would be disclosed by a correct ALTA/NSPS survey.

66. Any lien, or right to a lien, for services, labor or material hereafter furnished, imposed by law.

67. Oil, gas or other hydrocarbons or minerals reserved in deeds recorded May 06, 1944 in Book 20888, Page 256 and November 14, 1969 as Instrument No. 366, official records, and all minerals and all mineral rights of every kind and character now known to exist or hereafter discovered, including, without limiting the generality of the foregoing, oil and gas rights thereto, together with the sole, exclusive and perpetual right to explore for, remove and dispose of said minerals by any means or methods suitable to the grantor, its successors and assigns, but without entering upon or using the surface of the lands hereby conveyed and in such manner as not to damage the surface of said lands or to interfere with the use thereof by grantee recorded March 01, 1971 as Instrument No. 2403.

Exhibit I

Form of Quitclaim Deed

RECORDING REQUESTED BY:

COLLIS P. AND HOWARD HUNTINGTON
MEMORIAL HOSPITAL TRUST

WHEN RECORDED MAIL THIS
DEED AND TAX STATEMENTS TO:

Huntington Hospital
100 W. California Blvd.
Pasadena, CA 91105
Attention: Lori J. Morgan, M.D. MBA

(Above Space for Recorder's Use Only)

APN: _____

QUITCLAIM DEED

THE UNDERSIGNED GRANTOR DECLARES:

DOCUMENTARY TRANSFER TAX is $ - 0* - CITY TAX $ - 0* -
□ Computed on full value of property conveyed, or
□ computed on full value less value of liens or encumbrances remaining at time of sale,
□ Unincorporated area:
☒ City of Pasadena, and

*Conveyance is given for no value. This is a bona fide gift and the grantor received nothing in return. Revenue and Taxation Code section 11911.

FOR VALUABLE CONSIDERATION, receipt of which is hereby acknowledged, the undersigned, Jaynie Studenmund, Armando L. Gonzalez, Wayne Brandt, Michelle Quinones Chino and Paul Johnson, as Trustees of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST, hereby remise, release and forever quitclaim to PASADENA HOSPITAL ASSOCIATION, LTD., a California nonprofit public benefit corporation, dba HUNTINGTON HOSPITAL, any and all right, title or interest in and to that certain real property in the County of Los Angeles, State of California described in Exhibit A attached hereto and incorporated herein, together with any and all right, title or interest in and to buildings and improvements located thereon (the "**Property**").

THIS DEED SERVES TO DISTRIBUTE TITLE TO THE PROPERTY FROM A TRUST TO THE SOLE BENEFICIARY OF THE TRUST.

[Signature(s) Appear on Following Page]

Dated: _____, 2020

GRANTOR:

_____
_____, Trustee of the
COLLIS P. AND HOWARD HUNTINGTON
MEMORIAL HOSPITAL TRUST

_____
_____, Trustee of the
COLLIS P. AND HOWARD HUNTINGTON
MEMORIAL HOSPITAL TRUST

_____
_____, Trustee of the
COLLIS P. AND HOWARD HUNTINGTON
MEMORIAL HOSPITAL TRUST

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

Exhibit A to

Quitclaim Deed

That certain real property located in the City of Pasadena, County of Los Angeles, State of California, more particularly described as follows:

Exhibit J

Title Commitment

[Attached.]

First American	ALTA Commitment for Title Insurance
Commitment	ISSUED BY **First American Title Insurance Company** File No: NCS-1012328-MIA

COMMITMENT FOR TITLE INSURANCE

Issued By

FIRST AMERICAN TITLE INSURANCE COMPANY

NOTICE

IMPORTANT-READ CAREFULLY: THIS COMMITMENT IS AN OFFER TO ISSUE ONE OR MORE TITLE INSURANCE POLICIES. ALL CLAIMS OR REMEDIES SOUGHT AGAINST THE COMPANY INVOLVING THE CONTENT OF THIS COMMITMENT OR THE POLICY MUST BE BASED SOLELY IN CONTRACT.

THIS COMMITMENT IS NOT AN ABSTRACT OF TITLE, REPORT OF THE CONDITION OF TITLE, LEGAL OPINION, OPINION OF TITLE, OR OTHER REPRESENTATION OF THE STATUS OF TITLE. THE PROCEDURES USED BY THE COMPANY TO DETERMINE INSURABILITY OF THE TITLE, INCLUDING ANY SEARCH AND EXAMINATION, ARE PROPRIETARY TO THE COMPANY, WERE PERFORMED SOLELY FOR THE BENEFIT OF THE COMPANY, AND CREATE NO EXTRACONTRACTUAL LIABILITY TO ANY PERSON, INCLUDING A PROPOSED INSURED.

THE COMPANY'S OBLIGATION UNDER THIS COMMITMENT IS TO ISSUE A POLICY TO A PROPOSED INSURED IDENTIFIED IN SCHEDULE A IN ACCORDANCE WITH THE TERMS AND PROVISIONS OF THIS COMMITMENT. THE COMPANY HAS NO LIABILITY OR OBLIGATION INVOLVING THE CONTENT OF THIS COMMITMENT TO ANY OTHER PERSON.

COMMITMENT TO ISSUE POLICY

Subject to the Notice; Schedule B, Part I-Requirements; Schedule B, Part II-Exceptions; and the Commitment Conditions, ***First American Title Insurance Company***, a Nebraska Corporation (the "Company"), commits to issue the Policy according to the terms and provisions of this Commitment. This Commitment is effective as of the Commitment Date shown in Schedule A for each Policy described in Schedule A, only when the Company has entered in Schedule A both the specified dollar amount as the Proposed Policy Amount and the name of the Proposed Insured.

If all of the Schedule B, Part I-Requirements have not been met within six months after the Commitment Date, this Commitment terminates and the Company's liability and obligation end.

First American Title Insurance Company

Dennis J. Gilmore, President

Greg L. Smith, Secretary

If this jacket was created electronically, it constitutes an original document.

This page is only a part of a 2016 ALTA® Commitment for Title Insurance issued by First American Title Insurance Company. This Commitment is not valid without the Notice; the Commitment to Issue Policy; the Commitment Conditions; Schedule A; Schedule B, Part I-Requirements; Schedule B, Part II-Exceptions.

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

COMMITMENT CONDITIONS

1. DEFINITIONS

(a) "Knowledge" or "Known": Actual or imputed knowledge, but not constructive notice imparted by the Public Records.
(b) "Land": The land described in Schedule A and affixed improvements that by law constitute real property. The term "Land" does not include any property beyond the lines of the area described in Schedule A, nor any right, title, interest, estate, or easement in abutting streets, roads, avenues, alleys, lanes, ways, or waterways, but this does not modify or limit the extent that a right of access to and from the Land is to be insured by the Policy.
(c) "Mortgage": A mortgage, deed of trust, or other security instrument, including one evidenced by electronic means authorized by law.
(d) "Policy": Each contract of title insurance, in a form adopted by the American Land Title Association, issued or to be issued by the Company pursuant to this Commitment.
(e) "Proposed Insured": Each person identified in Schedule A as the Proposed Insured of each Policy to be issued pursuant to this Commitment.
(f) "Proposed Policy Amount": Each dollar amount specified in Schedule A as the Proposed Policy Amount of each Policy to be issued pursuant to this Commitment.
(g) "Public Records": Records established under state statutes at the Commitment Date for the purpose of imparting constructive notice of matters relating to real property to purchasers for value and without Knowledge.
(h) "Title": The estate or interest described in Schedule A.

2. If all of the Schedule B, Part I—Requirements have not been met within the time period specified in the Commitment to Issue Policy, this Commitment terminates and the Company's liability and obligation end.

3. The Company's liability and obligation is limited by and this Commitment is not valid without:
(a) the Notice;
(b) the Commitment to Issue Policy;
(c) the Commitment Conditions;
(d) Schedule A;
(e) Schedule B, Part I—Requirements; and
(f) Schedule B, Part II—Exceptions.

4. COMPANY'S RIGHT TO AMEND

The Company may amend this Commitment at any time. If the Company amends this Commitment to add a defect, lien, encumbrance, adverse claim, or other matter recorded in the Public Records prior to the Commitment Date, any liability of the Company is limited by Commitment Condition 5. The Company shall not be liable for any other amendment to this Commitment.

5. LIMITATIONS OF LIABILITY

(a) The Company's liability under Commitment Condition 4 is limited to the Proposed Insured's actual expense incurred in the interval between the Company's delivery to the Proposed Insured of the Commitment and the delivery of the amended Commitment, resulting from the Proposed Insured's good faith reliance to:
  (i) comply with the Schedule B, Part I—Requirements;
  (ii) eliminate, with the Company's written consent, any Schedule B, Part II—Exceptions; or
  (iii) acquire the Title or create the Mortgage covered by this Commitment.
(b) The Company shall not be liable under Commitment Condition 5(a) if the Proposed Insured requested the amendment or had Knowledge of the matter and did not notify the Company about it in writing.
(c) The Company will only have liability under Commitment Condition 4 if the Proposed Insured would not have incurred the expense had the Commitment included the added matter when the Commitment was first delivered to the Proposed Insured.
(d) The Company's liability shall not exceed the lesser of the Proposed Insured's actual expense incurred in good faith and described in Commitment Conditions 5(a)(i) through 5(a)(iii) or the Proposed Policy Amount.
(e) The Company shall not be liable for the content of the Transaction Identification Data, if any.
(f) In no event shall the Company be obligated to issue the Policy referred to in this Commitment unless all of the Schedule B, Part I—Requirements have been met to the satisfaction of the Company.
(g) In any event, the Company's liability is limited by the terms and provisions of the Policy.

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

6. LIABILITY OF THE COMPANY MUST BE BASED ON THIS COMMITMENT

(a) Only a Proposed Insured identified in Schedule A, and no other person, may make a claim under this Commitment.
(b) Any claim must be based in contract and must be restricted solely to the terms and provisions of this Commitment.
(c) Until the Policy is issued, this Commitment, as last revised, is the exclusive and entire agreement between the parties with respect to the subject matter of this Commitment and supersedes all prior commitment negotiations, representations, and proposals of any kind, whether written or oral, express or implied, relating to the subject matter of this Commitment.
(d) The deletion or modification of any Schedule B, Part II—Exception does not constitute an agreement or obligation to provide coverage beyond the terms and provisions of this Commitment or the Policy.
(e) Any amendment or endorsement to this Commitment must be in writing and authenticated by a person authorized by the Company.
(f) When the Policy is issued, all liability and obligation under this Commitment will end and the Company's only liability will be under the Policy.

7. IF THIS COMMITMENT HAS BEEN ISSUED BY AN ISSUING AGENT

The issuing agent is the Company's agent only for the limited purpose of issuing title insurance commitments and policies. The issuing agent is not the Company's agent for the purpose of providing closing or settlement services.

8. PRO-FORMA POLICY

The Company may provide, at the request of a Proposed Insured, a pro-forma policy illustrating the coverage that the Company may provide. A pro-forma policy neither reflects the status of Title at the time that the pro-forma policy is delivered to a Proposed Insured, nor is it a commitment to insure.

9. ARBITRATION

Arbitration provision intentionally removed.

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

Transaction Identification Data for reference only:

Issuing Agent: First American Title Insurance Company National Commercial Services
Commitment No.: NCS-1012328-MIA
Property Address: Huntington Memorial Hospital,, Pasadena, CA

Revision No.: 7/14/2020: Amended Legal Description (Parcel 3, Deleted Parcel 4); Added Schedule B-II, Items 66 and 67; Deleted Informational Note Item 4
7/13/2020: Delete Schedule B-I- Items H, I, J, L,M,N
7/10/2020: Revised Legal Description Parcel 3 (Less and Except) and Parcel 4 (Less and Except)

Issuing Office: Southeast Financial Center, 200 South Biscayne Blvd., Ste. 2930, Miami, FL 33131
Issuing Office File No.: NCS-1012328-MIA
Escrow Officer/Assistant: Vanessa Vazquez/Mariseli Gonzalez
Phone: /(305)908-6364

Email: vvazquez@firstam.com/magonzalez@firstam.com
Title Officer/Assistant: Vanessa Abreu/Mariseli Gonzalez
Phone: (305)908-6366/(305)908-6364
Email: vabreu@firstam.com/magonzalez@firstam.com

SCHEDULE A

1. Commitment Date: April 15, 2020 at 8:00 AM

2. Policy to be issued:

   (a) ☒ 2006 ALTA® ALTA Extended Owner Policy
   Proposed Insured: A natural person or legal entity to be determined
   Proposed Policy Amount: $ 1,000.00

   (b) ☐ 2006 ALTA® Policy
   Proposed Insured:
   Proposed Policy Amount: $ 0.00

   (c) ☐ 2006 ALTA® Policy
   Proposed Insured:
   Proposed Policy Amount: $

3. The estate or interest in the Land described or referred to in this Commitment is

   A Fee Simple

4. The Title is, at the Commitment Date, vested in:

   Jaynie Studenmund, Armando L. Gonzalez, Wayne Brandt, Michelle Quinones Chino and Paul Johnson (Collectively the current Successor Trustees, of the Collis P. and Howard Huntington Memorial Hospital Trust

5. The Land is described as follows:

   See Exhibit "A" attached hereto and made a part hereof

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

Commitment No.: NCS-1012328-MIA

SCHEDULE B, PART I

Requirements

All of the following Requirements must be met:

A. The Proposed Insured must notify the Company in writing of the name of any party not referred to in this Commitment who will obtain an interest in the Land or who will make a loan on the Land. The Company may then make additional Requirements or Exceptions.

B. Pay the agreed amount for the estate or interest to be insured.

C. Pay the premiums, fees, and charges for the Policy to the Company.

D. Documents satisfactory to the Company that convey the Title or create the Mortgage to be insured, or both, must be properly authorized, executed, delivered, and recorded in the Public Records.

E. Releases(s) or Reconveyance(s) of Item(s):

F. Other: Prior to closing, the Company must confirm whether the county recording office in which the Land is located has changed its access policies due to the COVID-19 outbreak. If recording has been restricted, specific underwriting approval is required; and, additional requirement or exceptions may be made.

NOTE: As of the date hereof, recording in this county is restricted to electronic filings.

G. You must give us the following information:
   a. Any off record leases, surveys, etc.
   b. Statement(s) of Identity, all parties.
   c. Other: WITH RESPECT TO A TRUST:

1. A certification pursuant to Section 18100.5 of the California Probate Code in a form satisfactory to the Company.

2. Copies of those excerpts from the original trust documents and amendments thereto which designate the trustee and confer upon the trustee the power to act in the pending transaction.

3. Other requirements which the Company may impose following its review of the material require herein and other information which the Company may require.

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

The following additional requirements, as indicated by "X", must be met:

[X] H. Provide information regarding any off-record matters, which may include, but are not limited to: leases, recent works of improvement, or commitment statements in effect under the Environmental Responsibility Acceptance Act, Civil Code Section 850, et seq.

The Company's Owner's Affidavit form (as provided by the company) must be completed and submitted prior to close in order to satisfy this requirement. This Commitment will then be subject to such further exceptions and/or requirements as may be deemed necessary.

[] I. An ALTA/NSPS survey of recent date, which complies with the current minimum standard detail requirements for ALTA/NSPS land title surveys, must be submitted to the Company for review. This Commitment will then be subject to such further exceptions and/or requirements as may be deemed necessary.

[] J. The following LLC documentation is required from:

(i) a copy of the Articles of Organization
(ii) a copy of the Operating Agreement, if applicable
(iii) a Certificate of Good Standing and/or other evidence of current Authority to Conduct Business within the State
(iv) express Company Consent to the current transaction

[] K. The following partnership documentation is required **:**

(i) a copy of the partnership agreement, including all applicable amendments thereto
(ii) a Certificate of Good Standing and/or other evidence of current Authority to Conduct Business within the State
(iii) express Partnership Consent to the current transaction

[] L. The following corporation documentation is required:

(i) a copy of the Articles of Incorporation
(ii) a copy of the Bylaws, including all applicable Amendments thereto
(iii) a Certificate of Good Standing and/or other evidence of current Authority to Conduct Business within the State
(iv) express Corporate Resolution consenting to the current transaction

[] M. Based upon the Company's review of that certain partnership/operating agreement dated **Not disclosed** for the proposed insured herein, the following requirements must be met:
Any further amendments to said agreement must be submitted to the Company, together with an affidavit from one of the general partners or members stating that it is a true copy, that said partnership or limited liability company is in full force and effect, and that there have been no further amendments to the agreement. This Commitment will then be subject to such further requirements as may be deemed necessary.

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

[] N. A copy of the complete lease, as referenced in Schedule A, #3 herein, together with any amendments and/or assignments thereto, must be submitted to the Company for review, along with an affidavit executed by the present lessee stating that it is a true copy, that the lease is in full force and effect, and that there have been no further amendments to the lease. This Commitment will then be subject to such further requirements as may be deemed necessary.

[X] O. Approval from the Company's Underwriting Department must be obtained for issuance of the policy contemplated herein and any endorsements requested thereunder. This Commitment will then be subject to such further requirements as may be required to obtain such approval.

[] P. Potential additional requirements, if ALTA Extended coverage is contemplated hereunder, and work on the land has commenced prior to close, some or all of the following requirements, and any other requirements which may be deemed necessary, may need to be met:

[] Q. The Company's "Indemnity Agreement I" must be executed by the appropriate parties.

[] R. Financial statements from the appropriate parties must be submitted to the Company for review.

[] S. A copy of the construction contract must be submitted to the Company for review.

[] T. An inspection of the Land must be performed by the Company for verification of the phase of construction.

[] U. The Company's "Mechanic's Lien Risk Addendum" form must be completed by a Company employee, based upon information furnished by the appropriate parties involved.

H. This item has been intentionally deleted.

I. This item has been intentionally deleted.

J. This item has been intentionally deleted.

K. A recorded satisfaction, release or termination of that claim of lien recorded August 20, 2019 as Instrument No. 20190836527 of Official Records.

Lien claimant:	RMG Building, Inc.
Amount:	$818,356.97

L. This item has been intentionally deleted.

M. This item has been intentionally deleted.

N. This item has been intentionally deleted.

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

Commitment No.: NCS-1012328-MIA

SCHEDULE B, PART II

Exceptions

THIS COMMITMENT DOES NOT REPUBLISH ANY COVENANT, CONDITION, RESTRICTION, OR LIMITATION CONTAINED IN ANY DOCUMENT REFERRED TO IN THIS COMMITMENT TO THE EXTENT THAT THE SPECIFIC COVENANT, CONDITION, RESTRICTION, OR LIMITATION VIOLATES STATE OR FEDERAL LAW BASED ON RACE, COLOR, RELIGION, SEX, SEXUAL ORIENTATION, GENDER IDENTITY, HANDICAP, FAMILIAL STATUS, OR NATIONAL ORIGIN.

The Policy will not insure against loss or damage resulting from the terms and provisions of any lease or easement identified in Schedule A, and will include the following Exceptions unless cleared to the satisfaction of the Company:

1. Any defect, lien, encumbrance, adverse claim, or other matter that appears for the first time in the Public Records or is created, attaches, or is disclosed between the Commitment Date and the date on which all of the Schedule B, Part I-Requirements are met.

2. (a) Taxes or assessments that are not shown as existing liens by the records of any taxing authority that levies taxes or assessments on real property or by the Public Records; (b) proceedings by a public agency that may result in taxes or assessments, or notices of such proceedings, whether or not shown by the records of such agency or by the Public Records.

3. Any facts, rights, interests, or claims that are not shown by the Public Records but that could be ascertained by an inspection of the Land or that may be asserted by persons in possession of the Land.

4. Easements, liens or encumbrances, or claims thereof, not shown by the Public Records.

5. Any encroachment, encumbrance, violation, variation, or adverse circumstance affecting the Title that would be disclosed by an accurate and complete land survey of the Land and not shown by the Public Records.

6. (a) Unpatented mining claims; (b) reservations or exceptions in patents or in Acts authorizing the issuance thereof; (c) water rights, claims or title to water, whether or not the matters excepted under (a), (b), or (c) are shown by the Public Records.

7. General and special taxes and assessments for the fiscal year 2020-2021, a lien not yet due or payable.

8. The lien of supplemental taxes, if any, assessed pursuant to Chapter 3.5 commencing with Section 75 of the California Revenue and Taxation Code.

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

9. Water rights, claims or title to water, whether or not shown by the public records.

10. An easement for public street purposes for the widening of Fair Oaks Avenue, as shown on various maps of record.

11. An easement for conducting water and incidental purposes, recorded December 18, 1879 in Book 27 of Deeds, Page 229.
In Favor of:
Affects: John S. Griffin, P. Reynolds

12. Covenants, conditions, restrictions and easements in the document recorded in Book 2534 of Deeds, Page 15, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

13. Covenants, conditions, restrictions and easements in the document recorded in Book 2711 of Deeds, Page 46, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

14. Covenants, conditions, restrictions and easements in the document recorded in Book 2712 of Deeds, Page 272, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

15. Covenants, conditions, restrictions and easements in the document recorded in Book 4097 of Deeds, Page 90, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

16. Covenants, conditions, restrictions and easements in the document recorded in Book 4339 of Deeds, Page 143, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

17. Covenants, conditions, restrictions and easements in the document recorded in Book 4370 of Deeds, Page 149, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

18. Covenants, conditions, restrictions and easements in the document recorded in Book 4428 of Deeds, Page 47, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

19. Covenants, conditions, restrictions and easements in the document recorded in Book 4680 of Deeds, Page 318, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

20. Covenants, conditions, restrictions and easements in the document recorded in Book 4494 of Deeds, Page 163, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

21. Covenants, conditions, restrictions and easements in the document recorded in Book 5212 of Deeds, Page 43, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

22. Covenants, conditions, restrictions and easements in the document recorded in Book 5655 of Deeds, Page 33, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

23. An easement for pole line and incidental purposes, recorded October 18, 1933 as Book 12466, Page 34 of Official Records.

In Favor of:	Western Union Telegraph Co.
Affects:	as described therein

24. The right of Southern California Edison Company, Ltd., to use an existing pole line under the terms and conditions of an unrecorded License Agreement between Los Angeles & Salt Lake Railroad Company, and the Western Union Telegraph Company, Licensors and Southern California Edison Company, Ltd., Licensee, as recited in the deed recorded October 18, 1933 in Book 12466, Page 34, Official Records.

25. Covenants, conditions, restrictions and easements in the document recorded March 10, 1937 as Instrument No. 361, in Book 14686 Page 348 of Official Records, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

26. Covenants, conditions, restrictions and easements in the document recorded as in Book 18405 Page 368 of Official Records, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

27. A lease dated April 13, 1942, executed by The Trustees of the Collis P. and Howard Huntington Memorial Hospital as lessor and Pasadena Hospital Association, Ltd., a corporation as lessee, recorded May 05, 1942 as Instrument No. 1111 in Book 19264, Page 336 of Official Records.

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

28. Covenants, conditions, restrictions and easements in the document recorded as in Book 19570 Page 353 of Official Records, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

29. The right to explore for, remove and dispose of minerals by any suitable means or methods, without entering upon or using the surface of the land as reserved by Los Angeles & Salt Lake Railroad Company recorded in Book 24171 Page 421 and by Union Pacific Railroad Company in Book 24183 Page 434, both of Official Records.

30. An easement for telephone, telegraph and signal wires and incidental purposes, recorded February 10, 1948 as Instrument No. 950, in Book 26416 Page 372 of Official Records.
In Favor of:
Affects: as described therein

31. An easement for gas, sewers and water connection and incidental purposes, recorded March 23, 1950 as Instrument No. 415, in Book 32646, Page 294 of Official Records.
In Favor of:
Affects: as described therein

32. The terms, provisions and easement(s) contained in the document entitled "Grant of Easement" recorded February 15, 1961 as Instrument No. 4965 in Book D1124, Page 686 of Official Records.

33. The rights, if any, of a city, public utility or special district, pursuant to Section 8345 et seq. of the California Streets and Highways Code, to preserve a public easement in Fairmount Avenue and/or Congress Street as the same was vacated by the document recorded October 27, 1969 as Instrument No. 2122 of Official Records.

34. An easement for public utilities and incidental purposes, recorded May 12, 1972 as Instrument No. 3831 of Official Records.
In Favor of: The City of Pasadena, a municipal corporation
Affects: as described therein

35. Terms and provisions of an unrecorded lease dated February 12, 1972, by and between Alan E. Robbins as lessor and PMP, a limited partnership as lessee, as disclosed by a Memorandum of Lease recorded June 01, 1972 as Instrument No. 2430 of Official Records.

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

36. The rights, if any, of a city, public utility or special district, pursuant to Section 8345 et seq. of the California Streets and Highways Code, to preserve a public easement in La Fuente Alley as the same was vacated by the document recorded December 31, 1979 as Instrument No. 79-1462774 of Official Records.

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

37. An easement for street or highway and incidental purposes, recorded July 08, 1982 as Instrument No. 82-688649 of Official Records.
In Favor of: The City of Pasadena, a municipal corporation
Affects: as described therein

38. Terms and provisions of an unrecorded lease dated March 16, 1984, by and between Collis P. and Howard Huntington Memorial Hospital Trust, a Trust created by the Will of Henry Huntington as lessor and Huntington Medical Plaza, LTD, a California limited partnership as lessee, as disclosed by a Short Form of Ground Lease and Purchase Option recorded March 16, 1984 as Instrument No. 84-322947 of Official Records.

Document(s) declaring modifications thereof recorded November 13, 1987 as Instrument No. 87-1819247 of Official Records.

Document(s) declaring modifications thereof recorded April 04, 1990 as Instrument No. 90-648091 of Official Records.

Document(s) declaring modifications thereof recorded April 04, 1990 as Instrument No. 90-648092 of Official Records.

Document(s) declaring modifications thereof recorded July 07, 2010 as Instrument No. 2010-925345 of Official Records.

Document(s) declaring modifications thereof recorded June 15, 2012 as Instrument No. 20120896123 of Official Records.

The lessor's interest under the lease has been assigned to Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust, a testamentary charitable trust by assignment recorded September 27, 2012 as September 27, 2012 of Official Records.

Instrument No. 2012-1452712

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

39. An easement for corner rounding and incidental purposes, recorded November 07, 1984 as Instrument No. 84-1328081 of Official Records.
In Favor of:
Affects: as described therein

Said property is more graphically described in City of Pasadena Public Works Department Drawing No. 3880, dated November 7, 1983, and attached thereto as Exhibit "A" and set forth in the deed Executed by: Richlin Company Pension Trust Recorded: May 10, 1985 as Instrument No. 85-531463, Official Records

40. The terms, provisions and easement(s) contained in the document entitled "Certificate of Correction" recorded November 09, 1984 as Instrument No. 84-1343089 of Official Records.

41. An easement for utilities and incidental purposes, recorded April 15, 1985 as Instrument No. 85-420619 of Official Records.
In Favor of: Southern California Gas Company
Affects: as described therein

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

Said property is more graphically described in City of Pasadena Public Works Department Drawing No. 3880, dated November 7, 1983, and attached thereto as Exhibit "A" and set forth in the deed Executed by: Richlin Company Pension Trust Recorded: May 10, 1985 as Instrument No. 85-531463, Official Records

42. Covenants, conditions, restrictions and easements in the document recorded April 16, 1987 as Instrument No. 87-589690 of Official Records, which provide that a violation thereof shall not defeat or render invalid the lien of any first mortgage or deed of trust made in good faith and for value, but deleting any covenant, condition or restriction indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status, national origin, sexual orientation, marital status, ancestry, source of income or disability, to the extent such covenants, conditions or restrictions violate Title 42, Section 3604(c), of the United States Codes or Section 12955 of the California Government Code. Lawful restrictions under state and federal law on the age of occupants in senior housing or housing for older persons shall not be construed as restrictions based on familial status.

43. The terms, provisions and easement(s) contained in the document entitled "License Agreement" recorded May 27, 1987 as Instrument No. 87-826037 of Official Records.

44. An easement for utilities, sanitary sewer, storm drain, ingress and egress and incidental purposes, recorded June 09, 1987 as Instrument No. 87-904741 of Official Records.
In Favor of: The City of Pasadena, a municipal corporation
Affects: as described therein

45. The terms, provisions and easement(s) contained in the document entitled "License Agreement No. 13,233" recorded September 23, 1987 as Instrument No. 87-1526087 of Official Records.

46. The rights, if any, of a city, public utility or special district, pursuant to Section 8345 et seq. of the California Streets and Highways Code, to preserve a public easement in Fairmount Avenue and/or Congress Street as the same was vacated by the document recorded May 24, 1989 as Instrument No. 89-843349 of Official Records.

47. Terms and provisions of an unrecorded lease dated September 08, 1989, by and between Collis P. and Howard Huntington Memorial Hospital Trust as lessor and Valacal Company, a California corporation as lessee, as disclosed by a Memorandum of Lease recorded September 12, 1989 as Instrument No. 89-1465512 of Official Records.

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

48. An easement for utilities and incidental purposes, recorded October 30, 1989 as Instrument No. 89-1747231 of Official Records.
In Favor of: Southern California Company, a corporation
Affects: as described therein

49. An easement shown or dedicated on the map filed or recorded Parcel Map No. 18337 as file in Book 246, Page 73 of Parcel Maps
For: Public utilities, ingress and egress, storm drain and appurtenant structures, sanitary sewer and incidental purposes and incidental purposes.

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

50. An easement shown or dedicated on the map filed or recorded Parcel Map No. 18337 as file in Book 246, Page 73 of Parcel Maps
For: Future Street and incidental purposes and incidental purposes.

51. The terms, provisions and easement(s) contained in the document entitled "Reciprocal Easement Agreement" recorded September 14, 1995 as Instrument No. 95-1501801 of Official Records.

52. An easement for traffic signal and incidental purposes, recorded October 07, 1997 as Instrument No. 97-1553800 of Official Records.
In Favor of: The City of Pasadena, a municipal corporation
Affects: as described therein

53. An easement for roadway and incidental purposes, recorded July 22, 2004 as Instrument No. 04-1877736 of Official Records.
In Favor of:
Affects: as described therein

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

54. Terms and provisions of an unrecorded lease dated July 12, 2005, by and between Pasadena Hospital Association LTD, a California non-profit organization dba Huntington Memorial Hospital as lessor and Sprint PCS Assets, L.L.C. a Delaware limited liability company as lessee, as disclosed by a Memorandum of Agreement recorded September 13, 2005 as Instrument No. 05-2200493 of Official Records.

Defects, liens, encumbrances or other matters affecting the leasehold estate, whether or not shown by the public records are not shown herein.

55. The effect of a document entitled "Affidavit of Successor Trustees", recorded October 02, 2007 as Instrument No. 20072258902 of Official Records.

56. The terms, provisions and easement(s) contained in the document entitled "Master Covenant and Agreement Regarding On-Site BMP Maintenance" recorded June 26, 2008 as Instrument No. 20081141925 of Official Records.

57. The rights, if any, of a city, public utility or special district, pursuant to Section 8345 et seq. of the California Streets and Highways Code, to preserve a public easement in Fairmount Avenue and/or Congress Street as the same was vacated by the document recorded March 27, 2012 as Instrument No. 20120462458 of Official Records.

58. An easement for public street and incidental purposes, recorded March 27, 2012 as Instrument No. 20120462458 of Official Records.
In Favor of: The City of Pasadena, a municipal corporation
Affects: as described therein

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

59. An easement for public street and incidental purposes, recorded March 27, 2012 as Instrument No. 20120462840 of Official Records.
In Favor of: The City of Pasadena, a municipal corporation
Affects: as described therein

60. The terms, provisions and easement(s) contained in the document entitled "License Agreement No. 23,190" recorded July 09, 2019 as Instrument No. 20190661971 of Official Records.

61. Prior to closing, the Company must confirm whether the county recording office in which the Land is located has changed its access policies due to the COVID-19 outbreak. If recording has been restricted, specific underwriting approval is required; and, additional requirement or exceptions may be made.

NOTE: As of the date hereof, recording in this county is restricted to electronic filings.

62. Any claim that the Title is subject to a trust or lien created under The Perishable Agricultural Commodities Act, 1930 (7 U.S.C. §§499a, et seq.) or the Packers and Stockyards Act (7 U.S.C. §§181 et seq.) or under similar state laws.

63. Rights of parties in possession.

64. The description shown in this report is not to be relied upon as a legal insurable parcel. This Company has provided said description only as an accommodation for the purpose of facilitating this report. A description approved by the appropriate governing agency pursuant to the Subdivision Map Act of the State of California must be submitted to this Company for review prior to closing.

65. Any facts, rights, interests or claims which would be disclosed by a correct ALTA/NSPS survey.

66. Any lien, or right to a lien, for services, labor or material hereafter furnished, imposed by law.

67. Oil, gas or other hydrocarbons or minerals reserved in deeds recorded May 06, 1944 in Book 20888, Page 256 and November 14, 1969 as Instrument No. 366, official records, and all minerals and all mineral rights of every kind and character now known to exist or hereafter discovered, including, without limiting the generality of the foregoing, oil and gas rights thereto, together with the sole, exclusive and perpetual right to explore for, remove and dispose of said minerals by any means or methods suitable to the grantor, its successors and assigns, but without entering upon or using the surface of the lands hereby conveyed and in such manner as not to damage the surface of said lands or to interfere with the use thereof by grantee recorded March 01, 1971 as Instrument No. 2403.

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

ALERT - CA Senate Bill 2 imposes an additional fee of $75 up to $225 at the time of recording on certain transactions effective January 1, 2018. Please contact your First American Title representative for more information on how this may affect your closing.

1. Taxes for proration purposes only for the fiscal year 2019-2020.
   First Installment: $18,483.58, PAID
   Second Installment: $18,483.56, PAID
   Tax Rate Area: 07500
   APN: 5719-027-042

   (Affects Parcel 1)

2. Taxes for proration purposes only for the fiscal year 2019-2020.
   First Installment: $7,092.56, PAID
   Second Installment: $7,092.55, PAID
   Tax Rate Area: 07500
   APN: 5719-027-052

   (Affects Parcel 2)

3. Taxes for proration purposes only for the fiscal year 2019-2020.
   First Installment: $53,703.80, PAID
   Second Installment: $53,703.80, PAID
   Tax Rate Area: 07500
   APN: 5719-027-061

   (Affects Parcel 3)

4. This item has been intentionally deleted.

5. According to the latest available equalized assessment roll in the office of the county tax assessor, there is located on the land a(n) Health Care Facility known as Huntington Memorial Hospital,, Pasadena, California.

6. According to the public records, there has been no conveyance of the land within a period of twenty-four months prior to the date of this report, except as follows:

   None

7. If this preliminary report/commitment was prepared based upon an application for a policy of title insurance that identified land by street address or assessor's parcel number only, it is the responsibility of the applicant to determine whether the land referred to herein is in fact the land that is to be described in the policy or policies to be issued.

The map attached, if any, may or may not be a survey of the land depicted thereon. First American Title Insurance Company expressly disclaims any liability for loss or damage which may result from reliance on

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

this map except to the extent coverage for such loss or damage is expressly provided by the terms and provisions of this Commitment or the Policy, if any, to which the map is attached.

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

Exhibit A

File No.: NCS-1012328-MIA

The Land referred to herein below is situated in the City of Pasadena, County of Los Angeles, State of California, and is described as follows:

PARCEL 1: 5719-027-042 also known as 624 South Pasadena Avenue

LOT 4 OF LEONARD'S SUBDIVISION OF PART OF DIVISION "F" OF THE LANDS OF THE SAN GABRIEL ORANGE GROVE ASSOCIATION, IN THE CITY OF PASADENA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 14, PAGE 11 OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

PARCEL 2: 5719-027-052 also known as 47 Congress Street

LOT 14 OF MARTIN'S SUBDIVISION OF PART OF THE FRANK GREEN TRACT, IN THE CITY OF PASADENA, AS PER MAP RECORDED IN BOOK 10, PAGE 46 OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

PARCEL 3: 5719-027-061 also known as 100 Congress Street

PARCEL 2, OF PARCEL MAP NO. 18337, IN THE CITY OF PASADENA, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 246, PAGES 73-75 OF MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY;

TOGETHER WITH A PORTION OF PARCEL 1, OF SAID PARCEL MAP NO. 18337, DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHEASTERLY CORNER OF SAID PARCEL 1; THENCE ALONG THE NORTHERLY LINE OF SAID PARCEL 1, NORTH 89°58’04” WEST 147.58 FEET TO THE TRUE POINT OF BEGINNING; THENCE CONTINUING ALONG THE NORTHERLY LINE OF SAID PARCEL 1, NORTH 89°58’04” WEST 210.07 FEET TO THE NORTHWESTERLY CORNER OF SAID PARCEL 1; THENCE ALONG THE WESTERLY LINE OF SAID PARCEL 1, SOUTH 0°00’03” WEST 499.23 FEET TO THE SOUTHWESTERLY CORNER OF SAID PARCEL 1; THENCE ALONG THE SOUTHERLY LINE OF SAID PARCEL 1, SOUTH 89°49’41” EAST 211.07 FEET; THENCE PARALLEL WITH THE WESTERLY LINE OF SAID PARCEL 1, NORTH 0°00’03” EAST 174.05 FEET; THENCE NORTH 89°59’57”WEST 1.00 FEET; THENCE PARALLEL WITH THE WESTERLY LINE OF SAID PARCEL 1, NORTH 0°00’03” EAST 325.70 FEET TO THE TRUE POINT OF BEGINNING.

EXCEPT THAT PORTION OF SAID PARCEL 2, DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHEAST CORNER OF SAID PARCEL 2; THENCE ALONG THE EASTERLY LINE OF SAID PARCEL 2, SOUTH 285.20 FEET TO THE EASTERLY PROLONGATION OF THAT CERTAIN COURSE ON THE EASTERLY LINE OF SAID PARCEL 2, SHOWN ON SAID PARCEL MAP NO. 18337 AS "NORTH 89°55'38" WEST 100.00 FEET", SAID INTERSECTION ALSO BEING THE NORTHWEST CORNER OF SAID LOT 7; THENCE WESTERLY ALONG SAID PROLONGED LINE NORTH 89°55'42" WEST 156.00 FEET; THENCE PARALLEL WITH THE EASTERLY LINE OF SAID PARCEL 2, NORTH 285.32 FEET TO THE NORTHERLY LINE OF SAID PARCEL 2; THENCE ALONG THE NORTHERLY LINE OF SAID PARCEL 2, SOUTH 89°52'55" EAST 156.00 FEET, TO THE POINT OF BEGINNING.

For conveyancing purposes only: APN 5719-027-042; 5719-027-052; 5719-027-061

Copyright 2006-2016 American Land Title Association. All rights reserved.

The use of this Form (or any derivative thereof) is restricted to ALTA licensees and ALTA members in good standing as of the date of use. All other uses are prohibited. Reprinted under license from the American Land Title Association.

Exhibit K

Form of Termination of Master Lease

RECORDING REQUESTED BY:

COLLIS P. AND HOWARD HUNTINGTON
MEMORIAL HOSPITAL TRUST

WHEN RECORDED MAIL THIS DOCUMENT TO:

Huntington Hospital
100 W. California Blvd.
Pasadena, CA 91105
Attention: Lori J. Morgan, M.D. MBA

(Above Space for Recorder's Use Only)

APN: _____

LEASE TERMINATION AGREEMENT

This Lease Termination Agreement (this "Agreement") is made and entered into as of _____, 2020, by and between Jaynie Studenmund, Armando L. Gonzalez, Wayne Brandt, Michelle Quinones Chino and Paul Johnson, as Trustees of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST, a Testamentary Charitable Trust ("Lessor"), and PASADENA HOSPITAL ASSOCIATION, LTD., a California non-profit public benefit corporation, d/b/a Huntington Hospital ("Lessee"), as follows:

A. Lessor and Lessee entered into that certain Lease dated as of April 13, 1942, a copy of which was recorded on May 5, 1942, as Instrument No. 1111 in Book 19264, Page 336 of the Official Records of Los Angeles County, California, which has been amended by amendments dated June 23, 1942, February 23, 1945, June 18, 1946, December 1, 1952, January 5, 1959, September 6, 1968, December 28, 1972, July 22, 1982, November 5, 1985, September 27, 1990, November 19, 1992, August 12, 1996, September 18, 1997, April 28, 2005, May 1, 2014 and April 1 2018 (collectively, the "Lease"). Pursuant to the Lease, Lessor leased real property described in Exhibit A hereto and certain improvements thereon (the "Premises") to Lessee for the operation of the Collis P. and Howard Huntington Memorial Hospital, now known as Huntington Hospital.

B. Lessor is a charitable trust which exists for the sole benefit and support of the healthcare operations of Lessee.

C. Substantially concurrently herewith, Lessor is recording a quitclaim deed (the "Quitclaim Deed") in the Official Records of Los Angeles County, California, transferring and distributing all of its right, title and interest in and to the Premises to Lessee as a gift, for no value. The date on which such quitclaim deed is recorded shall be the "Effective Date" herein.

D. As of the Effective Date, the Lessee's interest in the fee and leasehold interests in the Premises will merge, and the Lease will terminate, on the terms and conditions set forth herein.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby expressly acknowledged, the parties hereto agree as follows:

1. Termination of the Lease. Subject to the terms hereof, as of the Effective Date, the Lease is canceled and terminated in its entirety, and the leasehold estate created by, and all rights, privileges, benefits, obligations, duties and liabilities of Lessee and Lessor, respectively, under the Lease, shall be terminated in their entirety, the Lease shall be of no further force or effect, and Lessor and Lessee each does hereby release the other from any and all obligations and liabilities under the Lease, except for obligations that expressly survive the termination of the Lease and as specifically set forth in this Agreement. Without limiting the generality of the foregoing, (a) Lessee's payment obligations under the Lease continue through the Effective Date, pro-rated as of the Effective Date if and as applicable, and any previously unpaid obligations shall be due and payable in full on the Effective Date, and (b) any indemnification obligations under the Lease shall survive termination of the Lease with respect to claims that are based on facts or conditions that first arose prior to the Effective Date.

2. Representations and Warranties. Lessee represents and warrants to Lessor that (i) Lessee is the sole owner of the leasehold interest in the Premises, and (ii) Lessee has not assigned its interests under the Lease. Lessor represents and warrants to Lessee that Lessor has not assigned its interests under the Lease. Additionally, Lessor and Lessee each warrant and represent (i) that the person executing this Agreement on its behalf is authorized to execute this Agreement, (ii) that this Agreement is a valid, binding, and enforceable against such party, except as may be limited by applicable bankruptcy, reorganization, insolvency, moratorium or other laws affecting the enforcement of creditors' rights generally and by general principles of equity regardless of whether such enforceability is considered in a proceeding at law or in equity, and (iii) that it has the authority to enter into this Agreement without the joinder of any other party.

3. Counterparts. This Agreement may be executed in counterparts, including by facsimile or electronic copies, each of which shall be an original, but all of which together shall constitute one agreement binding on all of the parties notwithstanding that all of the parties are not signatories to the same counterpart or page.

4. Governing Law; Venue. This Agreement shall be construed and interpreted in accordance with the laws of the State of California. In the event of a dispute arising under or related to this Agreement, the parties submit to the sole and exclusive jurisdiction and venue of the courts of the County of Los Angeles, State of California.

5. Miscellaneous. Except for the Quitclaim Deed, this Agreement contains the entire understanding of the parties with respect to the transactions contemplated, and any prior agreements or understandings with respect to the subject matter hereof, whether oral or written, are entirely superseded hereby. This Agreement shall extend to, shall inure to the benefit of, and shall be binding upon all of the parties and upon all of their respective successors, predecessors and assigns. Nothing contained in this Agreement is intended to confer upon any person, other than the parties and their respective heirs, successors and permitted assigns, any rights, remedies or obligations under, or by reason of, this Agreement. If any provision of this Agreement is declared invalid by a court of competent jurisdiction, the parties intend that all other provisions of this Agreement shall be valid and binding as if the invalid provision had not been included herein. Time is of the essence of this Agreement. The headings of paragraphs of this Agreement are for the convenience of the parties only and shall not be used in any way to govern, limit, modify, construe or otherwise affect the interpretation or intent of this Agreement.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first written above.

LESSOR:

_____

_____, Trustee of the

COLLIS P. and HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

_____

_____, Trustee of the

COLLIS P. and HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

_____

_____, Trustee of the

COLLIS P. and HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

LESSEE:

PASADENA HOSPITAL ASSOCIATION LTD., a California nonprofit public benefit corporation d/b/a Huntington Hospital

By: _____

Lori J. Morgan, M.D.,
President and Chief Executive Officer

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

Exhibit A to

Termination of Master Lease

LEGAL DESCRIPTION

That certain real property located in the City of Pasadena, County of Los Angeles, State of California, more particularly described as follows:

Exhibit L

ASSIGNMENT OF LEASE

THIS ASSIGNMENT OF LEASE (this "Assignment") is dated as of _____, 2020, by Jaynie Studenmund, Armando L. Gonzalez, Wayne Brandt, Michelle Quinones Chino and Paul Johnson, as the Trustees of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST, a testamentary charitable trust ("Assignor"), and PASADENA HOSPITAL ASSOCIATION LTD., a California nonprofit public benefit corporation d/b/a Huntington Hospital ("Assignee").

B. Assignor is the lessor under that certain Standard Industrial/Commercial Single-Tenant Lease – Net (including an addendum thereto), dated July 1, 2012, as amended by amendments dated June 30, 2015, [March 15, 2017, and _____, 2020] (as amended, the "Lease"), by and between Assignor, as lessor, and Huntington Medical Research Institutes, a California non-profit corporation, as lessee, for the premises located at 734 South Fairmount Ave., Pasadena, CA 91105 (the "Premises").

C. Assignor is a charitable trust which exists for the sole benefit and support of the healthcare operations of Assignee.

D. Substantially concurrently herewith, Assignor is recording a quitclaim deed in the Official Records of Los Angeles County, California, transferring and distributing, among other property, all of its right, title and interest in and to the Premises to Assignee as a gift, for no value. The date on which such quitclaim deed is recorded shall be the "Effective Date" herein.

E. As of the Effective Date, Assignor desires to assign and quitclaim to Assignee, and Assignee desires to accept from Assignor, all of Assignor's right, title and interest as lessor in and to the Lease.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby expressly acknowledged, the parties hereto agree as follows:

1. Assignment of Lease. Effective as of the Effective Date, Assignor hereby assigns and quitclaims to Assignee, except as specifically set forth in this Assignment, without representation or warranty, express or implied, all of Assignor's right, title and interest as lessor in, to and under the Lease together with any and all rights of Assignor in and to such security deposits (collectively, the "Deposits") and prepaid rents (collectively, the "Prepaid Rents"), if any, as have been paid to Assignor pursuant to the Lease and not previously applied to the lessee's obligations under the Lease.

Assignor represents to Assignee that, as of the Effective Date: (i) the amount of the Deposits held by Assignor is $_____, (ii) the amount of the Prepaid Rents held by Assignor is $_____, representing rent due under the Lease for the period of _____, (iii) rents in the amount of $_____ due under the Lease have been paid to Assignor through and including _____, 2020, and (iv) to Assignor's actual knowledge, there are no defaults by either party under the Lease.

2. Acceptance. Assignee accepts the foregoing assignment and assumes and shall perform and discharge, as and when due, all of the agreements and obligations of Assignor under the Lease first accruing or arising on or after the Effective Date and agrees to be bound by all of the terms and conditions of the lessor under the Lease first arising on or after the Effective Date.

3. Further Assurances. Assignor hereby covenants that Assignor will, at any time and from time to time upon written request by Assignee therefor, execute and deliver to Assignee such documents as Assignee may reasonably request in order to fully assign and transfer to and vest in Assignee the Lease and the Deposits.

4. Successors and Assigns. The provisions of this Assignment shall be binding upon, and shall inure to the benefit of, the successors and assigns of Assignor and Assignee, respectively.

5. Governing Law; Venue. This Assignment shall be governed by and construed in accordance with the laws of the state of California. In the event of a dispute arising under or related to this Assignment, the parties submit to the sole and exclusive jurisdiction and venue of the courts of the County of Los Angeles, State of California.

6. Costs and Expenses. In the event of any action or suit between the parties hereto for or in connection with claims arising out of this Assignment, the prevailing party shall be entitled to have and recover of and from the other party all reasonable costs and expenses of the action or suit, including reasonable attorneys' fees and costs incurred at all trial and appellate levels.

7. Representations and Warranties. Assignor and Assignee each warrant and represent (i) that the person executing this Assignment on its behalf is authorized to execute this Assignment, (ii) that this Assignment is a valid, binding, and enforceable against such party, except as may be limited by applicable bankruptcy, reorganization, insolvency, moratorium or other laws affecting the enforcement of creditors' rights generally and by general principles of equity regardless of whether such enforceability is considered in a proceeding at law or in equity, and (iii) that it has the authority to enter into this Assignment without the joinder of any other party. Additionally, Assignor represents and warrants to Assignee that Assignor is the sole owner of the lessor's interests under the Lease and that Assignor has not previously assigned its interests under the Lease, the rent thereunder, the Deposits or the Prepaid Rents.

8. Counterparts. This Assignment may be executed in counterparts, including by facsimile or electronic copies, each of which shall be an original, but all of which together shall constitute one agreement binding on all of the parties notwithstanding that all of the parties are not signatories to the same counterpart or page.

[Signatures follow on next page]

IN WITNESS WHEREOF, Assignor and Assignee have caused their duly authorized representatives to execute this Assignment as of the date first above written.

ASSIGNOR:

_____
_____, Trustee of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

_____
_____, Trustee of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

_____
_____, Trustee of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

ASSIGNEE:

PASADENA HOSPITAL ASSOCIATION LTD., a California nonprofit public benefit corporation d/b/a Huntington Hospital

By: _____
Lori J. Morgan, M.D.,
President and Chief Executive Officer

Exhibit 3-B

PHA Amended Articles of Incorporation

AMENDED AND RESTATED

ARTICLES OF INCORPORATION

OF

PASADENA HOSPITAL ASSOCIATION, LTD.

The undersigned certify as follows:

(1) They are the President and the Secretary, respectively, of PASADENA HOSPITAL ASSOCIATION, LTD., a California nonprofit public benefit corporation (the "Corporation").

(2) The Articles of Incorporation of this Corporation are amended and restated to read as follows:

I

The name of this Corporation is PASADENA HOSPITAL ASSOCIATION, LTD.

II

This Corporation is a nonprofit public benefit corporation and is not organized for the private gain of any person. It is organized under the Nonprofit Public Benefit Corporation Law for charitable purposes.

III

(1) This Corporation is organized and operated exclusively for charitable purposes within the meaning of Internal Revenue Code Section 501(c)(3). Any other provision of these Articles of Incorporation notwithstanding, this Corporation shall not carry on any activities not permitted to be carried on (i) by a corporation exempt from federal income taxation under Internal Revenue Code Section 501(c)(3) or (ii) by a corporation contributions to which are deductible pursuant to Internal Revenue Code Section 170(c)(2).

(2) No part of the net earnings or assets of this Corporation shall ever inure to the benefit of any director or officer of this Corporation or to the benefit of any private individual whatsoever (except that reasonable compensation may be paid for services rendered to or for the Corporation).

(3) No substantial part of the activities of the Corporation shall consist of carrying on propaganda or otherwise attempting to influence legislation (except to the extent that such activities can be carried on without a loss of tax-exempt status under Internal Revenue Code Section 501(h)), and the Corporation shall not participate or intervene in (including the publication or distribution or statements) any political campaign on behalf of any candidate for public office.

IV

The property of this Corporation is irrevocably dedicated to charitable purposes. Upon the winding-up or dissolution of this Corporation, after paying or adequately providing for the debts and obligations of the Corporation, any remaining

assets of this Corporation shall be distributed for use in furtherance of the purposes of this Corporation, as set forth above in these Articles of Incorporation, to one or more nonprofit funds, foundations or corporations, each of which is then in existence and each of which is organized and operated exclusively for charitable purposes and each of which is qualified as an exempt organization under Internal Revenue Code Section 501(c)(3).

V

The number of Directors of this Corporation shall be as set forth in the Bylaws of the Corporation (the "Bylaws"), and the Bylaws may provide that the number of Directors of this Corporation shall be not less than a stated minimum nor more than a stated maximum with the exact number of Directors to be fixed, within the limit specified, by approval of the Board of Directors of this Corporation in the manner provided in the Bylaws.

VI

The sole member of the Corporation (as defined in Section 5056(a) of the California Corporations Code) is Cedars-Sinai Health System, a California nonprofit public benefit corporation. The rights of Cedars-Sinai Health System as sole member of the Corporation shall be as fixed in the Bylaws.

VII

The authorization or authorizations required to amend, restate or repeal these Articles of Incorporation are set forth in the Bylaws.

VIII

In accordance with the provisions of Section 9913 of the California Corporations Code, this Corporation elects to be governed by all the provisions of the California Nonprofit Public Benefit Corporation Law not otherwise applicable to this Corporation under Sections 9910-9927, inclusive, of the California Corporations Code.

(3) As of the date of the adoption of the foregoing amendment and restatement of these Articles of Incorporation, this Corporation has no members.

(4) The foregoing amendment and restatement of these Articles of Incorporation has been duly approved by the Corporation's Board of Directors and the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST.

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this Certificate are true and correct of our own knowledge and that this Declaration was executed on [●] at Pasadena, California.

LORI J. MORGAN M.D., President

[●], Secretary

Exhibit 3-C

PHA Amended Bylaws

AMENDED AND RESTATED BYLAWS

OF

PASADENA HOSPITAL ASSOCIATION, LTD.

TABLE OF CONTENTS

Page

ARTICLE I PURPOSES 1

ARTICLE II MEMBERSHIP 1

Section 2.1 Membership 1
Section 2.2 Reserved Powers of Member. 1

ARTICLE III BOARD OF DIRECTORS 5

Section 3.1 General Powers 5
Section 3.2 Specific Powers 6
Section 3.3 Number of Directors 6
Section 3.4 Community Director Election and Term of Office 7
Section 3.5 Vacancies 8
Section 3.6 Compensation 9
Section 3.7 Resignation or Removal of a Director. 9
Section 3.8 Indemnification of Directors, Officers, Employees and Agents 9
Section 3.9 Restriction on Interested Persons as Directors 10
Section 3.10 Board Observers 10

ARTICLE IV MEETINGS OF THE BOARD OF DIRECTORS 10

Section 4.1 Annual Meeting 10
Section 4.2 Regular Meetings 11
Section 4.3 Special Meetings 11
Section 4.4 Notice of Meetings 11
Section 4.5 Quorum and Actions 11
Section 4.6 Place of Meetings 12
Section 4.7 Attendance 12
Section 4.8 Action Without Meeting 12
Section 4.9 Adjournment of Meetings 12

ARTICLE V OFFICERS 13

Section 5.1 Officers 13
Section 5.2 Election of Officers 13
Section 5.3 Term of Office 13
Section 5.4 Removal 13
Section 5.5 Vacancies 13
Section 5.6 Chair Pro Tempore 13
Section 5.7 Secretary Pro Tempore 13
Section 5.8 Treasurer Pro Tempore 13

ARTICLE VI DUTIES OF THE OFFICERS 14

Section 6.1 Duties 14
Section 6.2 Chair of the Board 14
Section 6.3 Vice Chair of the Board 14
Section 6.4 President 14
Section 6.5 Secretary 14
Section 6.6 Assistant Secretary 15
Section 6.7 Treasurer 15
Section 6.8 Assistant Treasurer 15
Section 6.9 Execution of Checks 15

ARTICLE VII COMMITTEES 16

Section 7.1 Committees 16
Section 7.2 Appointment of Committees 16
Section 7.3 Executive Committee 16
Section 7.4 Reports of Committees 17
Section 7.5 Term of Office 17
Section 7.6 Vacancies 17
Section 7.7 Meetings; Quorum 17
Section 7.8 Expenditures 17

ARTICLE VIII MEDICAL STAFF 17

Section 8.1 Organization and Appointments. 17
Section 8.2 Medical Care and Its Evaluation. 18
Section 8.3 Medical and Dental Staff Bylaws 18

ARTICLE IX AMENDMENTS 18

Section 9.1 Procedure 18
Section 9.2 Review 18

ARTICLE X AUXILIARY ORGANIZATIONS 19

ARTICLE XI CORPORATE SEAL 19

ARTICLE XII MISCELLANEOUS 19

Section 12.1 Voting Shares 19
Section 12.2 Checks, Drafts, Etc 19
Section 12.3 Execution of Contracts 19
Section 12.4 Conflict of Interest 20
Section 12.5 Confidentiality 20
Section 12.6 Records and Annual Report 20
Section 12.7 Fiscal Year 20

INDEX OF DEFINED TERMS

Affiliation Agreement 1
Board of Directors 1
Cedars-Sinai Directors 7
Change in Control 5
Community Directors 7
Corporation 1
Director 6
Emeritus Directors 7
ex officio 7
Executive Committee 16
Executive Officers 13
Five-Year Transition Period 3
Hospital 1
Incumbent President 3
Law 1
Member's Bylaws 1
Physician Directors 7
Physician Network Reorganization 3
Retirement Age 8
Special Board Approval 5
Subsidiary 5
Ten-Year Transition Period 3
Trust 1
Trust Directors 7

AMENDED AND RESTATED BYLAWS

OF

PASADENA HOSPITAL ASSOCIATION, LTD.

ARTICLE I

PURPOSES

The purposes of Pasadena Hospital Association, Ltd., a California nonprofit public benefit corporation (the "**Corporation**"), are to operate an acute care hospital and provide or participate in other healthcare services within the County of Los Angeles, State of California (the "**Hospital**") in accordance with the wishes expressed in the Will of Henry E. Huntington and the provisions of the Collis P. and Howard Huntington Memorial Hospital Trust (the "**Trust**") established by said Will and related activities, consistent with the purposes set forth in the Articles of Incorporation of the Corporation. The Corporation shall operate the Hospital as a charitable, community nonprofit general hospital.

ARTICLE II

MEMBERSHIP

Section 2.1 Membership. This Corporation shall have one member within the meaning of Section 5056 of the California Nonprofit Corporation Law (the "**Law**"), namely, Cedars-Sinai Health System, a California nonprofit public benefit corporation (the "**Member**"). Except as provided in these Bylaws and as is not inconsistent with the Law, the Member shall have and be entitled to exercise fully all rights and privileges of a member of a nonprofit public benefit corporation under the Law and under all other applicable laws. All actions of the Member with respect to this Corporation must be taken consistent and in compliance with the terms of the Amended and Restated Bylaws of Cedars-Sinai Health System, dated [●], as such are amended or restated from time to time (the "**Member's Bylaws**") and consistent with that certain Affiliation Agreement dated July 15, 2020 between the Member and this Corporation, as such is amended or restated from time to time (the "**Affiliation Agreement**").

Section 2.2 Reserved Powers of Member.

(a) Member Reserved Rights. The Member has exclusive power to take any of the following actions with respect to the Corporation or any of its Subsidiaries without the need to obtain the approval of the Board of Directors of the Corporation (the "**Board of Directors**"), and no attempted exercise of any such powers by anyone other than the Member shall be valid or of any force or effect whatsoever:

(i) Approval of the strategic plans, capital budgets and operating budgets of this Corporation and its Subsidiaries, (A) taking into account the recommendation of the Board of Directors and (B) subject to Section 14.4 of the Affiliation Agreement.

(ii) Appointment and removal, with or without cause, of the President of the Corporation, subject to Section 2.2(b)(iii).

(iii) Incurrence of indebtedness by the Corporation or any of its Subsidiaries (other than the entry into any capital lease or equipment lease valued in the aggregate under Five Million Dollars ($5,000,0000), and other than accounts payable incurred in the ordinary course of business).

(iv) Formation of an obligated group for credit purposes that includes, without limitation, the Corporation and the Member.

(v) Entrance into any settlement or consent decree with a government authority or any other third party on behalf of the Corporation or any of its Subsidiaries except for settlements with non-government authorities that are related to claims arising in the ordinary course of the business of the Corporation or any of its Subsidiaries and which are not reasonably anticipated to have an adverse effect on the reputation of the Member, the Corporation or any of the Corporation's Subsidiaries.

(vi) Any change of the legal form of the Corporation or any of its Subsidiaries if such change is part of a Change in Control.

(vii) Any transaction or series of related transactions involving a Change in Control of the Corporation or any of its Subsidiaries.

(viii) The closure, sale, lease, transfer, exchange, disposition or change in use of all or substantially all of the assets of the Hospital.

(ix) Dissolution of the Corporation or any of its Subsidiaries if such dissolution is part of a Change in Control.

(x) Election of individuals to serve as Community Directors in accordance with the nomination and election process set forth in these Bylaws.

(xi) Removal of individuals who serve as Community Directors from the Board of Directors either with or without cause.

(xii) Sale of any real property owned by the Corporation or any of its Subsidiaries, subject to Section 2.2(c)(i).

(xiii) Sale, transfer or other disposition of all or substantially all of the assets owned by the Corporation or any of its Subsidiaries that are used exclusively for the operation of the Corporation's affiliated physician network if such sale, transfer or other disposition constitutes an entirely internal reorganization by the Member of the Member's entire affiliated physician enterprise within the Southern California region in which all such assets remain owned by controlled affiliates of the Member (a "**Physician Network Reorganization**").

(xiv) Sale, transfer, or other disposition of assets of the Corporation or any of its Subsidiaries that have an aggregate value exceeding two percent (2%) of the net

revenue of the selling, transferring or disposing entity for the entity's immediately preceding fiscal year if such sale, transfer or other disposition is part of a Change in Control.

(xv) Select the independent auditor that will serve as auditor for the Member, the Corporation and its Subsidiaries.

(b) Five-Year Qualified Member Reserved Rights. Except as otherwise set forth in this Section 2.2, the Member has exclusive power to take any of the following actions without the need to obtain the approval of the Board of Directors, and no attempted exercise of any such powers by anyone other than the Member shall be valid or of any force or effect whatsoever; *provided that*, during the period from the effective date of these Bylaws through [●] (the "**Five-Year Transition Period**"), the following actions shall also require Special Board Approval (as defined in Section 2.2(h)(i)):

(i) Adoption, repeal, amendment, modification or restatement of the articles of incorporation, bylaws or other governing documents, as applicable, of the Corporation or any of its Subsidiaries.

(ii) Any action or decision that would change the size or composition of the Board of Directors, including the number of Cedars-Sinai Directors, Trust Directors, Physician Directors or Community Directors.

(iii) Approval of the successor to the person serving as the President of the Corporation as of the effective date of these Bylaws (the "**Incumbent President**") if the Incumbent President for any reason ceases to occupy the office of President of the Corporation during the Five-Year Transition Period.

(c) 10-Year Qualified Member Reserved Rights. Except as otherwise set forth in this Section 2.2, the Member has exclusive power to take any of the following actions without the need to obtain the approval of the Board of Directors, and no attempted exercise of any such powers by anyone other than the Member shall be valid or of any force or effect whatsoever; *provided that*, during the period from the effective date of these Bylaws through [●] (the "**Ten-Year Transition Period**"), the following actions shall also require Special Board Approval:

(i) Sale of any real property owned by the Corporation or any of its Subsidiaries if such sale is not part of a Change in Control.

(d) Approvals by Member and Board. Each of the following actions or decisions with respect to the Corporation or any of its Subsidiaries requires both the approval of the Member and the approval of the Board of Directors:

(i) Approval of an expenditure by the Corporation or any of its Subsidiaries that is not set forth in an approved budget and exceeds Five Million Dollars ($5,000,000).

(ii) Approval of the community benefit plan of the Corporation or any of its Subsidiaries.

(iii) Lending of money by the Corporation or any of its Subsidiaries in amounts that exceed two percent (2%) of the lending entity's net assets, except for intercompany transfers made by Huntington to its Subsidiaries in the ordinary course of business.

(e) Approval by Member and Special Board Approval. Each of the following actions or decisions with respect to the Corporation or any of its Subsidiaries requires both the approval of the Member and Special Board Approval:

(i) Any change to the mission, vision or values of the Corporation or any of its Subsidiaries.

(ii) Any change to the name of the Corporation or the Hospital.

(iii) Any change of the legal form of the Corporation or any of its Subsidiaries if such change is not part of a Change in Control.

(iv) Dissolution of the Corporation if such dissolution is not part of a Change in Control.

(v) Any action that results in the Corporation or the Hospital not being owned and operated by a tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code of 1986 (as amended, the "**Code**") which is also a public charity under Section 509(a) of the Code or which otherwise jeopardizes the tax exempt status of the Trust.

(vi) Sale, transfer or other disposition of all or substantially all of the assets owned by the Corporation or any of its Subsidiaries that are used exclusively for the operation of the Corporation's affiliated physician network, *provided that* such sale, transfer or disposition is not part of a Physician Network Reorganization.

(vii) The sale, transfer or other disposition of assets of the Corporation or any of its Subsidiaries that have an aggregate value exceeding two percent (2%) of the net revenue of the selling, transferring or disposing entity for the entity's immediately preceding fiscal year if such sale, transfer or other disposition is not part of a Change in Control.

(f) Approval Rights of the Trust. Notwithstanding anything to the contrary, approval of the Trust (acting by majority of its trustees then in office) shall be required for any action or decision that would change the requirement that at least a majority of the Trust Directors vote in favor of any Special Board Approval, as described in Section 2.2(h)(ii).

(g) Scope of the Member's Rights and Approvals over Subsidiaries. Notwithstanding anything in this Section 2.2 that may be construed to the contrary, any right of the Member to take action with respect to, or approve an action taken by or with respect to, a Subsidiary of the Corporation as set forth in this Section 2.2 may only be exercised by the Member if the Corporation possesses the right to take or approve such action, pursuant to the Subsidiary's organizational documents, at the time the Member desires to exercise its right over the Subsidiary. Additionally, the Member shall consider the recommendation of the Corporation prior to the Member taking any action described in this Section 2.2 with respect to, or approving

any action described in this Section 2.2 taken by or with respect to, a Subsidiary of the Corporation.

(h) Definitions. For the purposes of these Bylaws:

(i) "**Change in Control**" means the following with respect to the Corporation or any of its Subsidiaries: (A) any transaction or series of related transactions of an entity (including, without limitation, merger or consolidation, sale, transfer or other disposition of equity, amendment to the articles of incorporation or bylaws or other applicable governing documents of such entity or other contract or arrangement) that results in another entity becoming the beneficial owner of more than fifty percent (50%) of the voting ownership interests of such entity, (B) the sale, lease, transfer, exchange, disposition or change in use of all or substantially all of the property and assets of an entity, (C) the substitution of a new corporate member or members that transfers the control of, responsibility for, or governance of the entity; or (D) a joint venture, management arrangement or similar transaction by an entity with another entity that results in the other entity becoming the owner, operator or manager of all or substantially all of the assets of the entity.

(ii) "**Special Board Approval**" means either (A) the affirmative vote of a majority of the Directors who are present at a duly held meeting of the Board of Directors, provided that such affirmative vote must include a majority of the Trust Directors in office, or (B) the unanimous written consent of the Board of Directors in accordance with Section 4.8.

(iii) "**Subsidiary**" means an entity that, directly or indirectly through one or more intermediaries, is controlled by the Corporation. For purposes of this definition, "control" means the power or possession of the power, direct or indirect, to direct or cause the direction of the management and policies of an entity, whether through the ownership of securities, election or appointment of directors, by contract or otherwise. Without limiting the generality of the foregoing, "Subsidiary" includes those entities of which the Corporation is a corporate member and those entities in which the Corporation owns at least fifty-one percent (51%) of the voting securities.

ARTICLE III

BOARD OF DIRECTORS

Section 3.1 General Powers. Subject to the provisions of Sections 5110 – 6910 of the California Corporations Code and the provisions in the Affiliation Agreement and these Bylaws relating to action that may be taken by, or that require the approval of, the Member, the activities and affairs of the Corporation shall be conducted and all the corporate powers shall be exercised by or under the direction of the Board of Directors. The Board of Directors may delegate the management of the Corporation to any person or persons, management company or committee however composed, *provided that* the affairs of the Corporation shall be managed and all corporate powers shall be exercised under the ultimate direction of the Board of Directors and the Member to the extent provided in Sections 5110 – 6910 of the California Corporations Code, the Affiliation Agreement or these Bylaws. The powers and responsibilities of the Board of Directors shall include:

(a) To nominate individuals to be appointed by the Member to the Board of Directors in accordance with the nomination process set forth in these Bylaws.

(b) To nominate and recommend to the Member representatives of this Corporation to be appointed to the board of directors of the Member.

(c) To recommend to the Member for approval, the strategic plans, capital budgets and operating budgets of this Corporation and its Subsidiaries, taking into account the recommendation of the President of the Corporation.

(d) To prescribe such duties for the officers, agents and employees of this Corporation as are not inconsistent with these Bylaws or applicable laws, and to require from them security for faithful performance.

(e) To provide input on the addition of a new entity as an "Affiliated Hospital Organization" as such term is defined in the Member's Bylaws.

(f) To provide input to the Member on any proposed action to establish or consummate a transaction that results in a Change in Control of the Member.

(g) To provide input on any proposed change in the name of the Member.

(h) To do and perform every act whatsoever not inconsistent with these Bylaws that may pertain to the office of director, or that may legally or properly be done by a board of directors.

Section 3.2 Specific Powers. Subject to the terms of the Affiliation Agreement, and notwithstanding the Member reserved rights set forth in Section 2.2, the Board of Directors shall have the right to terminate the membership of the Member in the event that any of the following events occur, each as defined in the Affiliation Agreement: (i) a Closure or Sale of Hospital Unwind Event; (ii) a Tax-Exempt Status Unwind Event; or (iii) an Illegality Unwind Event. Any such termination of the Member shall be subject to full compliance with Section 5341 of the California Corporations Code and the terms of the Affiliation Agreement.

Section 3.3 Number of Directors. Unless changed by an amendment to these Bylaws, the authorized range for the number of individuals on the Board of Directors (each a "**Director**") is not less than thirteen (13) and not more than twenty-eight (28). The authorized number of Directors at the effective time of these Bylaws is twenty-eight (28). At all times, the Board of Directors will be constituted as follows (except that a position described below may remain vacant until the vacancy is filled under Section 3.5):

(a) Cedars-Sinai Directors. Two (2) of the Directors are the Member's Chief Executive Officer and the Member's Chief Financial Officer (the "**Cedars-Sinai Directors**"), who will serve ex officio with vote pursuant to Section 5220(f) of the California Corporations Code ("**ex officio**").

(b) Trust Directors. Five (5) of the Directors are the trustees of the Trust (the "**Trust Directors**"), who will serve ex officio.

(c) Physician Directors. Three (3) of the Directors are the president of the medical staff of the Hospital, the immediate past president of the medical staff of the Hospital and the predecessor of the immediate past president of the medical staff of the Hospital (the "**Physician Directors**"), who will serve ex officio.

(d) Community Directors. Eighteen (18) of the Directors (the "**Community Directors**") will consist of the following:

(i) the President of the Corporation, who will serve ex officio;

(ii) each Emeritus Director so long as such Emeritus Director remains in office; and

(iii) the remainder of the Community Directors shall be individuals nominated by the Board of Directors subject to election by the Member, as further set forth in Section 3.4(a).

(e) Emeritus Directors. At the effective time of these Bylaws, three of the Community Directors are individuals who were elected as Directors in recognition of their years of service to the Corporation (each, an "**Emeritus Director**"). Each Emeritus Director has a six (6) year term and may be reelected for additional six (6) year terms. A vacancy in the position of an Emeritus Director will not be filled by an Emeritus Director described in Section 3.3(d)(ii), but will be filled by a Community Director described in Section 3.3(d)(iii) pursuant to the process for filling vacancies for Community Directors described in Section 3.5(d).

Section 3.4 Community Director Election and Term of Office.

(a) Election of Community Directors. At each annual meeting of the Board of Directors (or at a special meeting of the Board of Directors if an annual meeting is not held) the Board of Directors shall select a list of nominees to fill offices of Community Directors (including Emeritus Directors) whose terms will expire as of the end of the applicable year and such other vacancies which have not been previously filled, subject to the discretion of the Member to retain vacancies for Community Directors. Each Director shall be afforded a reasonable means to present candidates for nomination by the Board of Directors. The nominees receiving a majority vote at such meeting of the Board of Directors shall be declared officially nominated by the Corporation, and the Secretary of the Corporation shall immediately send notice of the list of nominees to the Member for election at the next annual meeting of the Member. If, at such annual meeting of the Member, the Member fails to elect any of the individuals nominated by the Corporation, the Corporation shall promptly propose alternative nominees for election by the Member. The process set forth in the foregoing sentence shall continue until such time as the Member has elected individuals to fill the offices of all Community Directors with expiring terms.

(b) Community Director Terms. Except for Emeritus Directors, each Community Director will hold a specific numbered position. Each position will have a term of four (4) years. The terms shall be staggered so that the terms of approximately one-third (1/3) of the authorized number of Community Directors expire each year. Community Directors may be elected to serve for no more than three (3) successive four (4) year terms; *provided that*

exceptions to the three-term limitation may be granted by resolution duly adopted by the Board of Directors.

(c) Community Director Age Limit. No person eighty (80) years of age or older shall be eligible for election, reelection, appointment or reappointment as a Community Director.

Section 3.5 Vacancies.

(a) A vacancy in the position of a Cedars-Sinai Director shall be filled by the person occupying the position of Chief Executive Officer or Chief Financial Officer, as applicable, of the Member.

(b) A vacancy in the position of a Physician Director shall be filled, in the case of the ex officio position reserved for the President of the Medical Staff, by the person who is appointed the new President of the Medical Staff; in the case of the ex officio position reserved for the immediate past President of the Medical Staff, by the person who was the immediate past President of the Medical Staff; and in the case of the ex officio position reserved for the predecessor to the immediate past President of the Medical Staff, by the person who was the predecessor to the immediate past President of the Medical Staff.

(c) A vacancy in the position of a Trust Director shall be filled by the successor trustee appointed by the Trust.

(d) A vacancy in the position of a Community Director who is the President of the Corporation shall be filled by the person who is appointed the new President of the Corporation. Subject to the Member's right to leave vacancies for Community Directors unfilled as set forth in Section 3.4(a), all other vacancies in the position of a Community Director, including vacancies in the position of an Emeritus Director, shall be filled as follows:

(i) The Board of Directors shall nominate a Community Director to fill any such vacancy, and the nominee shall then be nominated for election to the Board of Directors by the Member. Each Community Director so elected shall hold office for the balance of the term of the vacated position.

(ii) A Community Director vacancy shall be deemed to exist (1) in case of the death, resignation or removal of any Community Director, (2) if the authorized number of Community Directors is increased, (3) if the Member's board of directors fails, at any meeting at which any Community Director is elected, to elect the full authorized number of Community Directors to be elected at that meeting, (4) if no nomination is made pursuant to these Bylaws to fill any Community Director position to be elected at that meeting, or (5) when a Community Director who was a compensated officer of this Corporation at the beginning of such Community Director's initial or re-election term, as applicable, is no longer a compensated officer of this corporation.

(iii) In the event that Community Director vacancies are created by an increase in the authorized number of Community Directors, the new Community Directors shall be appointed for staggered terms so that the terms of approximately one-third (1/3) of the

authorized number of Community Directors expire each year. No reduction of the authorized number of Community Directors shall have the effect of removing any Community Director prior to the expiration of such Director's term; *provided that* the foregoing shall not in any way limit the Member's right to remove a Community Director with or without cause pursuant to Section 2.2(a)(xi).

Section 3.6 Compensation. Directors shall not receive any compensation for their services as Directors; *provided that* Directors may be reimbursed for any expenses actually incurred in connection with the performance of their duties as Directors if the same be authorized by the Board of Directors. Except as otherwise precluded by law, nothing herein shall be construed to preclude any Director from serving the Corporation in any other capacity as an officer, agent, employee or otherwise, and receiving compensation therefor.

Section 3.7 Resignation or Removal of a Director.

(a) Any Director may resign as a Director by a writing delivered to the Board of Directors. Such resignation will be deemed effective upon delivery unless the notice specifies a later time of effectiveness. Notwithstanding the foregoing, no Director may resign without providing proper notice to the Attorney General, if such resignation would leave the Corporation without a duly elected Director in charge of its affairs.

(b) The Board of Directors may declare vacant the office of a Community Director who has been declared of unsound mind by a final order of court, or convicted of a felony, or been found by a final order or judgment of any court to have breached any duty under Article 3 (Sections 5230 – 5239) of the Law.

(c) A Community Director may be removed from office by the Member for any reason in accordance with the Member's Bylaws, taking into consideration any input of the Board of Directors.

Section 3.8 Indemnification of Directors, Officers, Employees and Agents.

(a) As to the Board of Directors, Executive Officers (as defined in Section 5.1) and the members of any committee of the Board of Directors, the Corporation shall, and as to all other agents the Corporation may, to the maximum extent permitted by the Law, indemnify each of its agents against expenses, judgments, fines, settlements and other amounts actually and reasonably incurred in connection with any proceeding arising by reason of the fact that any such person is or was an agent of the Corporation. For purposes of this Section 3.8, an "agent" of the Corporation includes any person who is or was a director, officer, employee or other agent of the Corporation or is or was serving at the request of the corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise; or was a director, officer, employee or agent of the predecessor corporation, of the Corporation, or of another enterprise at the request of such predecessor corporation.

(b) As to the Board of Directors, Executive Officers and the members of any committee of the Board of Directors, the Corporation shall, and as to all other agents the Corporation may, to the extent permitted by law, advance expenses incurred or to be incurred by an agent in connection with any proceeding arising by reason of the fact that such person was or

is an agent of the Corporation, provided such advance is authorized by the Board of Directors and permitted by law.

(c) The Board of Directors may adopt a resolution authorizing the purchase and maintenance of insurance on behalf of any agent of the Corporation against any liability which may be asserted against or incurred by the agent in such capacity or arising out of the agent's status as such, whether or not this Corporation would have the power to indemnify the agent against that liability under the provisions of this Section 3.8.

(d) This Section 3.8 does not apply to any proceeding against any trustee, investment manager or other fiduciary of an employee benefit plan in such person's capacity as such, even though such person may also be an agent of the Corporation as defined in subsection (a) of this Section 3.8. The Corporation shall have power to indemnify such trustee, investment manager or other fiduciary to the extent permitted by subsection (f) of Section 5140 of the Law.

(e) The indemnification provided by this Section 3.8 shall not be deemed exclusive of any rights to which those seeking indemnification may be entitled under any agreement, vote of disinterested directors, or otherwise, both as to action in their official capacity while holding such office, and shall continue as to a person who has ceased to be a director, officer or employee and agent, and shall inure to the benefit of the heirs, executors and administrators of such person.

Section 3.9 Restriction on Interested Persons as Directors. No more than forty-nine percent (49%) of the persons serving on the Board of Directors may be interested persons. An interested person is (a) any person compensated by the Corporation for services rendered to it within the previous twelve (12) months, whether as a full-time or part-time employee, independent contractor, or otherwise, excluding any reasonable compensation paid to a Director as Director; and (b) any brother, sister, ancestor, descendant, spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, or father-in-law of such person. However, any violation of the provisions of this section shall not affect the validity or enforceability or any transaction entered into by the Corporation.

Section 3.10 Board Observers. Each of the President-elect of the Medical Staff of the Hospital and (subject to approval by the Board of Directors) an individual nominated by Huntington Medical Research Institutes may be an invited guest at each meeting of the Board of Directors but shall have no vote, shall not be a Director and shall leave the meeting when requested by the Chair of the Board or the President.

ARTICLE IV

MEETINGS OF THE BOARD OF DIRECTORS

Section 4.1 Annual Meeting. The annual meeting of the Board of Directors shall be held in conjunction with the regular monthly meeting in December of each year or as otherwise determined by the Board of Directors. The Executive Officers of the Board of Directors for the coming year shall be elected at the annual meeting.

Section 4.2 Regular Meetings. The Board of Directors shall hold a regular meeting on the fourth Thursday of each month at 4:00 p.m., or on such other day and time as may be fixed by resolution of the Board of Directors, at the Huntington Hospital, 300 West California Boulevard, Pasadena, California.

Section 4.3 Special Meetings. Special meetings may be called by the Chair of the Board or Secretary at any time, and must be called at the written request of three (3) Directors. In the absence of the Chair of the Board, the Vice Chair of the Board may call special meetings.

Section 4.4 Notice of Meetings.

(a) The Secretary shall give notice of the time and place of the annual meeting and special meetings to each Director upon at least four (4) calendar days' notice given by first-class mail or at least forty-eight (48) hours' notice delivered personally or by telephone, including a voice messaging system or other system or technology designed to record and communicate messages, or by "electronic transmission by the Corporation" (as defined below).

(b) Any such notice shall be addressed or delivered to each Director at such Director's address as is shown upon the records of the Corporation or as may have been given to the Corporation by the Director for purposes of notice, or if such address is not shown on such records or is not readily ascertainable, at the place in which the meetings of the Directors are regularly held. Notice by mail shall be deemed to have been given at the time a written notice is deposited in the United States mail, postage prepaid. Any other written notice shall be deemed to have been given at the time it is personally delivered to the recipient or is delivered to a common carrier for transmission or actually transmitted by the person giving the notice by electronic means, to the recipient. Oral notice shall be deemed to have been given at the time it is communicated, in person or by telephone, including a voice messaging system or other system or technology designed to record and communicate messages, telegraph, facsimile, electronic mail, or other electronic means, to the recipient or to a person at the office of the recipient who the person giving notice has reason to believe will promptly communicate it to the recipient. The recital by the Secretary in the minutes that due notice was given shall be sufficient evidence of that fact. No notice of the regular monthly meetings shall be required.

(c) For purposes of these Bylaws, "electronic transmission by the Corporation" means a communication (a) delivered by facsimile telecommunication or electronic mail when directed to the facsimile number or electronic mail address, respectively, for that recipient on record with the Corporation, (b) to a recipient who has provided an unrevoked consent to the use of those means of transmission for communications under or pursuant to the California Corporations Code, and (c) that creates a record that is capable of retention, retrieval, and review, and that may thereafter be rendered into clearly legible tangible form.

Section 4.5 Quorum and Actions.

(a) At all meetings of the Board of Directors, ten (10) Directors shall constitute a quorum; *provided that* a quorum shall not be less than two-fifths (2/5) of the total number of Directors then in office, or less than two, whichever is larger, unless the number of Directors authorized in these Bylaws is one, in which case one Director constitutes a quorum.

(b) An act or decision done or made by a majority of the Directors present at a meeting duly held at which a quorum is present is the act of the Board of Directors, except for those acts or decisions that also require Member approval or Special Board Approval under Section 2.2.

(c) Members of the Board of Directors may participate in a meeting through use of a conference telephone, electronic video screen communication or similar communications equipment so long as all Directors participating in the meeting are able to hear one another. Participation in a meeting as permitted in the preceding sentence constitutes presence in person at such meeting of the person or persons so participating if the following apply:

(d) Each member participating in the meeting can communicate with all of the other members concurrently.

(e) Each member is provided the means of participating in all matters before the Board, including the capacity to propose, or to interpose an objection, to a specific action to be taken by the Corporation.

Section 4.6 Place of Meetings. All meetings of Directors shall be held in the County of Los Angeles, California, unless the Directors shall otherwise designate or approve.

Section 4.7 Attendance. All Directors shall be expected to attend all duly called meetings of the Board of Directors. Attendance at no less than fifty percent (50%) of all duly called meetings shall be necessary for a non-ex officio Director to remain a Director; *provided, however, that*, for purposes of computing a Director's percentage of attendance, there shall be excluded (both from the numerator and from the denominator) any meeting which such Director fails to attend for good cause, as determined by the affirmative vote of the Board of Directors.

Section 4.8 Action Without Meeting. Any action required or permitted to be taken by the Board of Directors may be taken without a meeting if all members of the Board of Directors shall individually or collectively consent in writing to such action, *provided, however, that* the consent of any Director who has a material financial interest in a transaction to which the corporation is a party and who is an "interested director" as defined in section 5233 of the California Corporations Code, or who is a "common director" as described in Section 5234 of the California Corporations Code, shall not be required for approval of that transaction where the facts giving rise to the exception are established in advance of the execution of, and are set forth in, the written consent or consents. Such consent or consents shall be filed with the minutes of the proceedings of the Board of Directors and shall have the same force and effect as a unanimous vote of such Directors.

Section 4.9 Adjournment of Meetings. A majority of the Board of Directors present, whether or not a quorum is present, may adjourn any meeting to another time and place. If the meeting is adjourned for more than twenty-four (24) hours, notice of any adjournment to another time and place shall be given prior to the time of the adjourned meeting to the Directors who are not present at the time of the adjournment.

ARTICLE V

OFFICERS

Section 5.1 Officers. The officers of the Corporation shall consist of a Chair of the Board, a Vice Chair of the Board, a President, one or more additional Vice Presidents, a Secretary, one or more Assistant Secretaries, a Treasurer, and one or more Assistant Treasurers, one of whom serves as the Chief Financial Officer for the Corporation (collectively, the "**Executive Officers**"). Neither the Secretary, Treasurer nor the Assistant Treasurer who serves as the Chief Financial Officer may serve concurrently as President or Chair of the Board.

Section 5.2 Election of Officers. The officers of the Corporation, except for the President, shall be elected by the Board of Directors at the annual meeting. The President shall be appointed by the Member, subject to Section 2.2(b)(iii).

Section 5.3 Term of Office. The officers of the Corporation shall hold office for one (1) year until their successors are chosen and qualified or until such officer is removed or resigns. The term of office of an officer shall begin immediately after such officer's election.

Section 5.4 Removal. The officers of the Corporation, except for the President, may be removed with or without cause by the Board of Directors at any meeting of the Board of Directors. The President may be removed with or without cause by the Member.

Section 5.5 Vacancies.

(a) Should a vacancy occur in any office except for the office of President, the Board of Directors may fill the vacancy for the unexpired term at any meeting of the Board of Directors, and the Board of Directors may delegate the powers and duties of such office to any officer or to any Director until such time as a successor for such office has been elected.

(b) Should a vacancy occur in the office of President, the Member shall fill the vacancy for the unexpired term (subject to Section 2.2(b)(iii)), and the Member may delegate the powers and duties of the President to any officer or to any Director until such time as a successor President has been appointed by the Member.

Section 5.6 Chair Pro Tempore. In the absence of the Chair and Vice Chair of the Board, or in the event of their inability to act, the Board of Directors may elect a Chair Pro Tempore who shall act as such Chair of the Board during such absence or inability to act.

Section 5.7 Secretary Pro Tempore. In the absence of the Secretary and Assistant Secretary, or in the event of their inability to act, the Board of Directors may elect a Secretary Pro Tempore who shall act as such Secretary during such absence or inability to act.

Section 5.8 Treasurer Pro Tempore. In the absence of the Treasurer and Assistant Treasurer, or in the event of their inability to act, the Board of Directors may elect a Treasurer Pro Tempore who shall act as such Treasurer during such absence or inability to act.

ARTICLE VI

DUTIES OF THE OFFICERS

Section 6.1 Duties. The Executive Officers shall exercise the usual functions of such officers, together with such powers and duties as may from time to time be designated or assigned to them.

Section 6.2 Chair of the Board. The Chair of the Board shall be a member of the Board of Directors and shall:

(a) have general direction of the affairs of the Board of Directors and shall preside at all meetings of the Directors;

(b) sign all corporate instruments in writing, required by law to be signed by such officer and not others, except as directed by resolution of the Board of Directors;

(c) perform such other duties from time to time as directed or authorized by the Board of Directors; and

(d) act as the representative of the Board of Directors in relationships with the President regarding administration of the Hospital.

Section 6.3 Vice Chair of the Board. There shall be a Vice Chair of the Board who is a Director. If at any time the Chair of the Board shall for any reason be unable to perform the duties of such office, or any of them, the Vice Chair of the Board shall perform such duties, and when so acting shall have the power and authority of the Chair of the Board.

Section 6.4 President. The President shall be the Chief Executive Officer of the Corporation. In accordance with the objectives and policies of the Corporation as established by the Board of Directors, the President shall have full authority and responsibility for the management and operation of Hospital and shall report regularly to the Board of Directors concerning the performance of Hospital. The President shall provide leadership and administrative staff support for the development and execution of objectives, policies, plans and programs adopted by the Board of Directors; coordinate and direct the administration and management of the Hospital through the delegation of authority and management to such one or more other Vice Presidents as the President may designate; ensure competency of the staff; coordinate the continuing planning and long-range development of the Hospital; and provide appropriate continuing administrative support to the Board of Directors, its committees and officers and to the medical staff of the Hospital and its committees and officers to ensure appropriate policy and program development and control. In the temporary absence of the President, one of the Vice Presidents will be designated by the President to act on behalf of the President.

Section 6.5 Secretary. The Secretary:

(a) shall notify or cause the notification of the Directors of all meetings of the Board of Directors as required by these Bylaws and shall keep or cause to be kept the minutes of all meetings of Directors;

(b) shall sign, as Secretary, all corporate instruments in writing required by law to be signed by such officer and no others, except as directed by resolution of the Board of Directors; and

(c) shall perform such other duties from time to time as directed or authorized by resolution of the Board of Directors.

Section 6.6 Assistant Secretary. The Assistant Secretary shall assist the Secretary in the Secretary's general duties, and in the absence of the Secretary shall perform all the duties of said office.

Section 6.7 Treasurer. The Treasurer shall perform such duties from time to time as directed or authorized by the Board of Directors.

Section 6.8 Assistant Treasurer. The Assistant Treasurer who serves as the Chief Financial Officer, excepting such functions that are by these Bylaws or by the Board of Directors assigned to another, shall exercise the usual functions of that office and any other duties that are from time to time prescribed by the Board of Directors. In this regard, and not in any way limiting the description of functions in the preceding sentence, the Chief Financial Officer shall:

(a) keep and maintain, or cause to be kept and maintained, adequate and correct accounts of the properties and business transactions of the Corporation, including accounts of its assets, liabilities, receipts, disbursements, gains and losses;

(b) cause to be deposited all moneys and other valuables in the name and to the credit of the Corporation in such depositories as may be designated by the Board of Directors;

(c) disburse or cause to be disbursed the funds of the Corporation as shall be ordered by the Board of Directors;

(d) render or cause to be rendered to the Chair of the Board and the Board of Directors, whenever they shall request it, an accounting of all transactions as Chief Financial Officer and of the financial condition of the Corporation;

(e) submit an annual report as required by Section 12.6 hereof; and

(f) have such other powers and perform such other duties as may be prescribed by the Board of Directors or these Bylaws.

Section 6.9 Execution of Checks. All checks, warrants, bills, notes and/or contracts of the Corporation shall be executed for and on behalf of the Corporation as provided from time to time by resolution of the Board of Directors.

ARTICLE VII

COMMITTEES

Section 7.1 Committees. The Board of Directors shall determine the number of its committees and their functions, including any standing committees. A committee that consists exclusively of Directors shall, to the extent provided in a resolution of the Board of Directors or in these Bylaws, have the authority of the Board of Directors, except with respect to powers reserved to the Board of Directors pursuant to Section 5212(c) of the Law. In furtherance of the foregoing, a committee that does not consist exclusively of Directors shall not have any delegated authority of, or ability to make decisions on behalf of, the Board of Directors.

Section 7.2 Appointment of Committees. The chair and the members of each committee shall be appointed by the Chair of the Board at the annual meeting, and shall be confirmed by the Board of Directors. Removals or replacements of committee members may be made in the same manner as original appointments at any regular meeting of the Board of Directors.

Section 7.3 Executive Committee. There shall be an executive committee of the Board of Directors (the "**Executive Committee**") consisting only of Directors and consisting of a proportionate number of Cedars-Sinai Directors, Community Directors and Trust Directors. An Executive Committee consisting of one (1) Cedars-Sinai Director, three (3) Trust Directors, one (1) Physician Director, the President of the Corporation and four (4) Community Directors is considered proportionate. Except as otherwise prohibited by law, the Board of Directors, by written resolution, may delegate to the Executive Committee any of the powers and authority of the Board of Directors in the management of the business and affairs of this Corporation, *provided that* the designation of the Executive Committee and the delegation of authority to it shall not operate to relieve the Board of Directors or any Director of any responsibility imposed by law, by the Corporation's Articles of Incorporation or by these Bylaws. The Executive Committee shall have only those powers specifically delegated to it by written resolution of the Board of Directors. The Executive Committee shall establish rules and regulations for its meetings and meet at such times and places as shall be fixed by the Chair of the Board; *provided that* a reasonable notice as required by law shall be given of all meetings of the Executive Committee, and no act of the Executive Committee shall be valid unless approved by the vote of a majority of the members of the Executive Committee present at a meeting at which a quorum is then present; *provided further that* the dissenting opinion of any member of the Executive Committee may be reported to the Board of Directors. The Executive Committee shall keep regular minutes of its proceedings and report the same to the Board of Directors from time to time as the Board of Directors may require. A quorum of the members of the Executive Committee may adjourn any meeting thereof to meet again at a stated day and hour; *provided that* in the absence of a quorum a majority of the Executive Committee members present at any meeting of the Executive Committee may adjourn until the time fixed for the next meeting of the Executive Committee. The Executive Committee shall oversee the preparation and modification of long-term strategic and development plans and an annual implementation plan for the Corporation and its Subsidiaries. The Executive Committee may establish such subcommittees as it deems appropriate, which subcommittees shall have such duties and responsibilities as are delegated to them by written resolution of the Executive Committee.

Section 7.4 Reports of Committees. Whenever requested by the Board of Directors, each committee shall make a report, oral or written.

Section 7.5 Term of Office. The chair, vice chair and each member of each standing committee shall serve until the next annual election of committee members by the Board of Directors and until such person's successor is appointed or until such committee is sooner terminated, or until such person is removed, resigns, or otherwise ceases to qualify as a chair or member, as the case may be, of the committee. Chairs, vice chairs and members of special committees shall serve for the life of the committee unless they resign or are sooner removed, replaced or cease to qualify as a chair or member, as the case may be, of such committee.

Section 7.6 Vacancies. Vacancies on any committee may be filled for the unexpired portion of the term in the same manner as provided in the case of original appointment.

Section 7.7 Meetings; Quorum. Each committee shall meet as often as necessary to perform its duties, at such times and places as directed by its chair or by the Board of Directors. A majority of the members of a committee shall constitute a quorum of such committee. The chair of each committee shall preside at such committee's meetings; in the absence of the chair, the vice chair will preside at such meetings. Each committee shall keep accurate minutes of its meetings, the chair designating a secretary of the committee for this purpose, and shall, make periodic reports and recommendations to the Board of Directors. Except as otherwise provided in this Article VII, meetings of committees shall be governed by, and held and taken in accordance with the following provisions of Article VI, with such changes in the context therein as are necessary to substitute the committee and its members for the Board of Directors and its members: Section 4.2 (Regular Meetings), Section 4.3 (Special Meetings), Section 4.4 (Notice of Meetings), Section 4.5 (Quorum and Actions), Section 4.6 (Place of Meetings), Section 4.8 (Action Without Meeting), and Section 4.9 (Adjournment of Meetings).

Section 7.8 Expenditures. Any expenditure of corporation funds by a committee shall require prior approval of the Board of Directors.

ARTICLE VIII

MEDICAL STAFF

Section 8.1 Organization and Appointments.

(a) The Board of Directors shall require the physicians, dentists and podiatrists granted practice privileges in the Hospital to organize into a medical and dental staff under Medical and Dental Staff Bylaws approved by the Board of Directors. The Board of Directors shall consider recommendations of the Medical and Dental Staff and appoint to the Medical and Dental Staff physicians, dentists and podiatrists who meet the qualifications for membership as set forth in the Bylaws of the Medical and Dental Staff. Each member of the Medical and Dental Staff shall have appropriate authority and responsibility for the care of their patients subject to such limitations as are contained in these Bylaws and in the Bylaws, rules and regulations for the Medical and Dental Staff and subject, further, to any limitations attached to their appointment.

(b) Rules regarding applications for appointment, term of appointment, renewal of privileges, reduction, suspension or termination of staff membership, or other appropriate rules for the governing of the Medical Staff, shall be contained in Medical Staff Bylaws as approved from time to time by the Board of Directors, which approval shall not be unreasonably withheld.

(c) A physician or dentist in a medical-administrative position, who holds a concurrent appointment on the Medical and Dental Staff, shall not have such physician or dentist's Medical Staff privileges terminated without the same due process provisions as are available to any other member of the Medical and Dental Staff, unless otherwise provided in the terms of a formal agreement covering the individual's engagement.

Section 8.2 Medical Care and Its Evaluation.

(a) The Medical and Dental Staff shall conduct a continuing review and appraisal of the quality of professional care rendered in the Hospital and shall report such activities and their results to the Board of Directors.

(b) The Medical and Dental Staff shall make recommendations to the Board of Directors concerning (1) appointments, reappointments, and alterations of staff status, (2) granting of clinical privileges, (3) disciplinary actions, (4) all matters relating to professional competency, and (5) such specific matters as may be referred to it by the Board of Directors.

Section 8.3 Medical and Dental Staff Bylaws. There shall be bylaws, rules and regulations for the Medical and Dental Staff setting forth its organization and government and which shall include a mechanism for review of decisions affecting the privileges of members which provides for the exercise of due process. Proposed bylaws, rules and regulations may be recommended by the Medical and Dental Staff, but only those approved by the Board of Directors shall become effective, which approval shall not be unreasonably withheld. Neither the Medical Staff nor the Board of Directors may unilaterally amend the Medical Staff Bylaws or Rules and Regulations.

ARTICLE IX

AMENDMENTS

Section 9.1 Procedure. Any amendment, restatement, repeal or replacement of these Bylaws must be adopted in accordance with Section 2.2.

Section 9.2 Review. These Bylaws shall be reviewed periodically by a committee appointed by the Chair of the Board of Directors with the observations and results of the review reported to the Board of Directors at a regular meeting.

ARTICLE X

AUXILIARY ORGANIZATIONS

There may be established from time to time auxiliary volunteer organizations such as guilds, leagues and women's auxiliaries whose purpose is to assist the Hospital in obtaining its goals through volunteer service, fund raising, public relations and public information programs. All auxiliary organizations associated with the Hospital shall have bylaws which delineate the purpose and functions of the auxiliary organization and such bylaws shall be approved by the Board of Directors and the Member. These Bylaws and the Articles of Incorporation of the Corporation shall prevail and govern over the documents and actions of such auxiliary organizations. To the extent required by the Board of Directors or the President of the Corporation, auxiliary and associated organizations shall provide periodic financial reports to the Corporation and be carried under a fidelity bond if they handle any funds.

ARTICLE XI

CORPORATE SEAL

The corporate seal of the corporation shall be the impression of a circular disc, with the following inscription upon the circumference thereof, to wit: "PASADENA HOSPITAL ASSN., LTD., a corporation" and within the last mentioned inscription, the word "SEAL".

ARTICLE XII

MISCELLANEOUS

Section 12.1 Voting Shares. The Corporation may vote any and all shares held by it in any other corporation by such officer, agent or proxy as the Board of Directors or President of the Corporation may appoint, or in default of any such appointment, by the Chair of the Board or by the Vice Chair of the Board, and, in such case, such officers, or any of them, may likewise appoint a proxy to vote said shares.

Section 12.2 Checks, Drafts, Etc. All checks, drafts or other orders for payment of money, notes or other evidence of indebtedness issued in the name of or payable to the Corporation, and any and all securities owned or held by the Corporation requiring signature for the transfer, shall be signed or endorsed by such person or persons and in such manner as, from time to time, shall be determined by a resolution of the Board of Directors.

Section 12.3 Execution of Contracts. Except as otherwise provided in these Bylaws, the Board of Directors or the President of the Corporation may authorize any officer or officers, agent or agents, to enter into any contract or execute any instrument in the name of and on behalf of the Corporation, and such authority may be general or confined to specific instances and unless so authorized by the Board of Directors or the President of the Corporation, no officer, agent or employee shall have any power or authority to bind the Corporation by any contract or engagement or to pledge its credit or to render it liable for any purpose or in any amount.

Section 12.4 Conflict of Interest. The Board of Directors shall enforce a policy on conflicts of interest and self-dealing that requires a disclosure by all Directors and officers of the Corporation and other persons in a position to influence corporate decisions of actual and potential conflicts of interest and that will assure that no person holding such a position will be permitted to vote on any issue, motion or resolution that directly or indirectly inures to such individual's benefit financially or with respect to which such individual shall have any other conflict of interest, except that such individual may be counted in order to qualify a quorum, and, except as the Board of Directors may otherwise direct, may participate in a discussion of such an issue, motion, or resolution if such individual first discloses the nature of the individual's own interest.

Section 12.5 Confidentiality. Each Director or officer of the Corporation with access to confidential information regarding the Corporation or the Corporation's business is expected to hold such information in confidence and to refrain from either using such information for personal gain or disclosing it unnecessarily outside the scope of the Director's or officer's duty with respect to the Corporation or the Member.

Section 12.6 Records and Annual Report. The Corporation shall keep adequate and correct books and records of account and minutes of the proceedings of its Board of Directors and committees of the Board of Directors. The Board of Directors shall cause an annual report to be sent to all Directors of the Corporation not later than one hundred twenty (120) days after the close of the Corporation's fiscal year. Such report shall contain in appropriate detail the following:

(a) The assets and liabilities, including the trust funds, of the Corporation as of the end of the fiscal year.

(b) The principal changes in assets and liabilities, including trust funds, during the fiscal year.

(c) The revenue or receipts of the Corporation, both unrestricted and restricted to particular purposes, for the fiscal year.

(d) The expenses or disbursements of the Corporation, for both general and restricted purposes, during the fiscal year.

(e) Any information required by Section 6322 of the California Corporations Code.

Any financial statements presented as part of the above-described report shall be prepared in accordance with generally accepted accounting principles and be audited by an independent certified public accountant in conformity with generally accepted auditing standards.

Section 12.7 Fiscal Year. The fiscal or business year of the Corporation shall be as determined by approval of the Board of Directors.

CERTIFICATE

I, _____, the Secretary of Pasadena Hospital Association, Ltd., a California nonprofit public benefit corporation, do hereby certify that the Bylaws attached hereto constitute the Bylaws of said corporation as adopted by its Board of Directors on the ____ day of _____, ____.

By: _____

Exhibit 3-D

Cedars-Sinai Amended Articles of Incorporation

AMENDED AND RESTATED ARTICLES OF INCORPORATION

OF

CEDARS-SINAI HEALTH SYSTEM

THE UNDERSIGNED CERTIFY THAT:

1. They are the President and Secretary, respectively, of Cedars-Sinai Health System, a California nonprofit public benefit corporation (this "Corporation").

2. The Articles of Incorporation of this Corporation are amended and restated to read as follows:

ARTICLE I

The name of this corporation is CEDARS-SINAI HEALTH SYSTEM.

ARTICLE II

A. This corporation is a nonprofit public benefit corporation and is not organized for the private gain of any person. It is organized under the Nonprofit Public Benefit Corporation Law for charitable purposes.

B. This corporation is organized and operated exclusively for charitable, scientific and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended , or the corresponding provision of any future United States internal revenue law (the "Code"). Specifically, this corporation shall be organized, and at all times operated, exclusively for the benefit of, to perform the functions of, or to carry out the purposes of, and to support: (i) Cedars-Sinai Medical Center, a California nonprofit public benefit corporation; (ii) Torrance Memorial Medical Center, a California nonprofit public benefit corporation; and (iii) Pasadena Hospital Association, Ltd., a California nonprofit public benefit corporation doing business as Huntington Hospital (collectively, the "Named Affiliate Hospital Organizations"), which are nonprofit health care organizations organized for the purpose of establishing, maintaining, sponsoring and promoting activities relating to the improvement of human health and well-being, though only as long as that Named Affiliate Hospital Organization is exempt from Federal income taxation under Section 501(c)(3) of the Code and classified as other

than a private foundation pursuant to Section 509(a)(1) or 509(a)(2) of the Code. In support and in furtherance of the charitable purposes of the Named Affiliate Hospital Organizations, the corporation may: (i) establish, maintain, sponsor and promote activities relating to the improvement of human health and the provision of care to the sick, injured or disabled; (ii) establish, maintain, sponsor and promote educational and research programs relating to the promotion of health and the provision of care to the sick, injured or disabled; (iii) coordinate, sponsor, promote and advance programs and activities designed and carried on to improve the physical, psychological and emotional health and welfare of persons living in and around the territory which it serves; (iv) provide management support and direction to those specified nonprofit corporations that this corporation was organized to support; (v) evaluate, develop and implement long-range health care objectives, strategies, plans, and alternative health care delivery systems, in furtherance of the purposes of this corporation and the purposes of those nonprofit health care organizations that this corporation was organized to support; (vi) otherwise function as a functionally integrated parent organization of the Named Affiliate Hospital Organizations, within the meaning of the applicable regulations promulgated under the Code; and (vii) carry out such other acts and undertake such other activities as may be necessary, appropriate or desirable in furtherance of or in connection with the conduct, promotion or attainment of the foregoing purposes, provided that none of such activities shall be undertaken that would cause this corporation to lose its status as an organization described in Section 501(c)(3) of the Code, or as a supporting organization within the meaning of Section 509(a)(3) of the Code.

ARTICLE III

A. No substantial part of the activities of this corporation shall consist of carrying on propaganda, or otherwise attempting to influence legislation, and this corporation shall not participate or intervene in any political campaign (including the publishing or distribution of statements) on behalf of or in opposition to any candidate for public office.

B. Notwithstanding any other provision of these articles, this corporation shall not, except to an insubstantial degree, engage in any activities or exercise any powers that are not in furtherance of the purposes of this corporation as stated herein, and this corporation shall not carry on any other activities not permitted to be carried on: (i) by a corporation exempt from federal

income tax under Section 501(c)(3) of the Code, or (ii) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

ARTICLE IV

A. This corporation shall not have members.

B. The powers of this corporation shall be exercised, its properties controlled, and its affairs conducted by the corporation's board of directors as provided in the bylaws of this corporation.

ARTICLE V

A. The property of this corporation is irrevocably dedicated to charitable purposes. No part of the net income or assets of this corporation shall ever inure to the benefit of any director or officer thereof, or to the benefit of any other private person.

B. Upon the dissolution or winding up of this corporation, its assets remaining after payment, or provision for payment, of all debts and liabilities of this corporation shall be distributed to the Named Affiliate Hospital Organizations. If, at the time of the dissolution or winding up of this corporation, the Named Affiliate Hospital Organizations are not organizations which are organized and operated exclusively for charitable purposes which at such time have established their tax-exempt status under Section 501(c)(3) of the Code, then upon the dissolution or winding up of this corporation, its assets remaining after payment, or provision for payment, of all debts and liabilities of this corporation shall be distributed to an organization which is organized and operated exclusively for charitable purposes which at such time has established its tax-exempt status under Section 501(c)(3) of the Code.

ARTICLE VI

These Amended and Restated Articles of Incorporation may only be amended or restated as provided in the Bylaws of this corporation.

3. The foregoing Amended and Restated Articles of Incorporation of this Corporation have been duly approved by the required vote of the board of directors of this Corporation.

4. The Corporation has no members.

5. The foregoing Amended and Restated Articles of Incorporation of this Corporation shall be effective as of [_____ ___, 20__].

[Remainder of page intentionally left blank]

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this certificate are true and correct of our knowledge:

Dated: [_____ ___, 20__]

_____
Thomas M. Priselac, President

_____
Greg Geiger, Secretary

Exhibit 3-E

Cedars-Sinai Amended Bylaws

AMENDED AND RESTATED BYLAWS

OF

CEDARS-SINAI HEALTH SYSTEM

TABLE OF CONTENTS

Page

ARTICLE I HEALTH SYSTEM PARENT ENTITY 1

Section 1.1 Corporate Name; Preamble 1
Section 1.2 Purposes 1
Section 1.3 Location 1
Section 1.4 Members 1

ARTICLE II BOARD OF DIRECTORS 2

Section 2.1 Powers 2
Section 2.2 Numbers 4
Section 2.3 Qualifications of Directors 5
Section 2.4 Term of Office 5
Section 2.5 Election of Directors 5
Section 2.6 Vacancies 6
Section 2.7 Board Orientation 6
Section 2.8 Quorum of Board of Directors; Adjournment 6
Section 2.9 Annual Meeting of the Board 7
Section 2.10 Regular Meetings of the Board 7
Section 2.11 Special Meetings of the Board 7
Section 2.12 Written Notice of Meetings 7
Section 2.13 Failure to Attend Meetings 8
Section 2.14 Telephonic Meetings 8
Section 2.15 Action by Written Consent 8
Section 2.16 Retirement from Board Membership 8
Section 2.17 Conflict of Interest Policies 8
Section 2.18 Emergency Powers 9

ARTICLE III MEETINGS OF THE BOARD 10

Section 3.1 Annual Meetings of the Board 10
Section 3.2 Vote 10

ARTICLE IV OFFICERS OF HEALTH SYSTEM PARENT ENTITY 10

Section 4.1 Enumeration of Officers 10
Section 4.2 Election of Officers 10
Section 4.3 Removal, Appointment and Term 11
Section 4.4 Powers and Duties of Officers 11
Section 4.5 Compensation of Employees 14

ARTICLE V BOARD COMMITTEES 14

Section 5.1 Creation of Committees; Function 14
Section 5.2 Board Committees 14
Section 5.3 Vacancies in Board Committees; Removal 14
Section 5.4 Written Consent 14

TABLE OF CONTENTS
(continued)

Page

ARTICLE VI FISCAL PROVISIONS 15

Section 6.1 Fiscal Year 15
Section 6.2 Withdrawal of Funds 15
Section 6.3 Deposit of Securities 15
Section 6.4 Transfer of Securities 15
Section 6.5 Financial Records 15
Section 6.6 Inspection 15
Section 6.7 No Proprietary Interest 15

ARTICLE VII INDEMNIFICATION 15

Section 7.1 Indemnity of Officers and Directors 16
Section 7.2 Employees and Agents 16
Section 7.3 Insurance 16

ARTICLE VIII AMENDMENT AND REPEAL OF BYLAWS 16

Section 8.1 General Provisions 16

CERTIFICATE OF SECRETARY 18

AMENDED AND RESTATED BYLAWS

OF

CEDARS-SINAI HEALTH SYSTEM

ARTICLE I
Health System Parent Entity

Section 1.1 Corporate Name; Preamble. The name of the corporation shall be Cedars-Sinai Health System (the "Health System Parent Entity"). The Health System Parent Entity is a nonprofit public benefit corporation organized and existing under the laws of the State of California. These Amended and Restated Bylaws of the Health System Parent Entity ("Bylaws") are adopted as of [_____ ___, 20__] (the "Effective Date") for the purpose of providing for the governance of the Health System Parent Entity.

Section 1.2 Purposes. The Health System Parent Entity's purposes shall at all times be as set forth in the Articles of Incorporation of the Health System Parent Entity (the "Articles of Incorporation"), which provide that the Health System Parent Entity shall be organized, and at all times operated, exclusively for the benefit of, to perform the functions of, or to carry out the purposes of, and to support certain specified nonprofit health care organizations organized for the purpose of establishing, maintaining, sponsoring and promoting activities relating to the improvement of human health and well-being including the provision of clinical health care services, engaging in community benefit activities and undertaking health care research and professional education, which organizations are exempt from Federal income taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or the corresponding provision of any future United States Internal Revenue law (the "Code") and which are exempt from classification as a private foundation pursuant to Section 509(a)(1) or 509(a)(2) of the Code. The named organizations set forth in the Articles of Incorporation as of the Effective Date are: (i) Cedars-Sinai Medical Center, a California nonprofit public benefit corporation ("CSMC"), (ii) Torrance Memorial Medical Center, a California nonprofit public benefit corporation ("TMMC"), and (iii) Pasadena Hospital Association, Ltd., a California nonprofit public benefit corporation doing business as Huntington Hospital ("Huntington"). Torrance Health Association, Inc., a California nonprofit public benefit corporation ("THA"), is the sole corporate member of TMMC. CSMC, THA and Huntington shall be referred to herein as the "Affiliate Hospital Organizations".

Section 1.3 Location. The principal office of the Health System Parent Entity shall be located at 8700 Beverly Boulevard, Suite #2622, Los Angeles, CA 90048. The Health System Parent Entity may also have offices at such other locations both within and without of the State of California as the Board of Directors may from time to time determine or as the business of the Health System Parent Entity may require.

Section 1.4 Members. The Health System Parent Entity shall have no members.

ARTICLE II
Board of Directors

Section 2.1 Powers.

(a) General Powers of the Board. The powers of the Health System Parent Entity shall be exercised, its property controlled, and its affairs conducted by the Board of Directors. Additionally, the Board of Directors shall exercise those powers reserved to the Health System Parent Entity as identified in the governing documents of the Affiliate Hospital Organizations.

(b) Approval of Certain Actions by Board. The following actions shall only be taken by the Health System Parent Entity upon affirmative vote of a majority of the Board of Directors:

(i) Establish or consummate a transaction that results in a Change of Control (as defined below) of the Health System Parent Entity;

(ii) Adopt, repeal, modify, amend or restate the Health System Parent Entity's Articles of Incorporation or Bylaws;

(iii) Remove individuals from the Board of Directors of the Health System Parent Entity with or without cause;

(iv) Elect to voluntarily dissolve the Health System Parent Entity;

(v) Change the name of the Health System Parent Entity;

(vi) Establish the mission, vision and values of the Health System Parent Entity, or make any change thereto;

(vii) Change the corporate structure of the Health System Parent Entity if such change would affect the Health System Parent Entity's status as an exempt organization under Section 501(c)(3) of the Code;

(viii) Add a new entity as an Affiliate Hospital Organization;

(ix) Elect individuals to the Board of Directors who are nominated in accordance with Section 2.5;

(x) Elect, renew or remove the Health System Parent Entity CEO;

(xi) Approve the Health System Parent Entity's strategic plans, capital budgets and operating budgets;

(xii) Adopt a charity care policy for the Health System Parent Entity or make any change or modification thereto;

(xiii) Select the independent auditor that will serve as auditor for the Health System Parent Entity and the Affiliate Hospital Organizations and their Affiliates; and

(xiv) Form an obligated group amongst the Health System Parent Entity and the Affiliate Hospital Organizations.

For the purposes of these Bylaws, "Change of Control" means: (a) any transaction or series of related transactions of an entity (including, without limitation, merger or consolidation, sale, transfer or other disposition of equity, amendment to the articles of incorporation or bylaws or other applicable governing documents of such entity or other contract or arrangement) that results in another entity becoming the beneficial owner of more than fifty percent (50%) of the voting ownership interests of such entity, (b) the sale, lease, transfer, exchange, disposition or change in use of all or substantially all of the property and assets of an entity, (c) the substitution of a new corporate member or members that transfers the control of, responsibility for, or governance of the entity; or (d) a joint venture, management arrangement or similar transaction by an entity with another entity that results in the other entity becoming the owner, operator or manager of all or substantially all of the assets of the entity.

For purposes of these Bylaws, an "Affiliate" of an Affiliate Hospital Organization means an entity that, directly or indirectly through one or more intermediaries, is controlled by the Affiliate Hospital Organization. For purposes of this definition, "control" means the power or possession of the power, direct or indirect, to direct or cause the direction of the management and policies of an entity, whether through the ownership of securities, election or appointment of directors, by contract or otherwise. Without limiting the generality of the foregoing, "Affiliate" shall include those entities of which an Affiliate Hospital Organization is a corporate member and those entities in which an Affiliate Hospital Organization own at least fifty-one percent (51%) of the voting securities.

(c) Approval of Certain Actions of an Affiliate Hospital Organization. The following actions shall only be taken by the Health System Parent Entity with respect to an Affiliate Hospital Organization upon affirmative vote of a majority of the Board of Directors, subject to the approval rights set forth in an Affiliate Hospital Organization's organizational documents:

(i) Adopt, repeal, modify, amend or restate the articles of incorporation, bylaws or other governing documents, as applicable, of an Affiliate Hospital Organization or any of its Affiliates;

(ii) Elect individuals to the Board of Directors of an Affiliate Hospital Organization in accordance with the nomination and election process set forth in the Affiliate Hospital Organization's Bylaws;

(iii) Transfer non-cash assets from an Affiliate Hospital Organization or any of its Affiliates to the Health System Parent Entity;

(iv) Remove individuals from the Board of Directors of the Affiliate Hospital Organization with or without cause;

(v) Establish or consummate a transaction that results in a Change of Control of an Affiliate Hospital Organization or any of its Affiliates;

(vi) Change the mission, vision and values of the Affiliate Hospital Organization or any of its Affiliates;

(vii) Change the corporate structure of the Affiliate Hospital Organization or any of its Affiliates if such change would affect the Affiliate Hospital Organization's or its Affiliate's status as an exempt organization under Section 501(c)(3) of the Code;

(viii) Elect to voluntarily dissolve the Affiliate Hospital Organization or any of its Affiliates;

(ix) Change the name of the Affiliate Hospital Organization or a licensed hospital owned and operated by the Affiliate Hospital Organization or any of its Affiliates;

(x) Sell any real property owned by an Affiliate Hospital Organization or any of its Affiliates;

(xi) Approve an Affiliate Hospital Organization's strategic plans, capital budgets and operating budgets; and

(xii) Approve the incurrence of debt or lending of money in material amounts by the Affiliate Hospital Organization or any of its Affiliates.

Section 2.2 Numbers. The Board of Directors shall consist of not less than twelve (12) persons and no more than eighteen (18) persons. The exact number of authorized Directors shall be fixed from time to time, within said range, by resolution of the Board of Directors. As of the Effective Date, the Board shall consist of fifteen (15) Directors, including President/Chief Executive Officer ("CEO"), who shall serve as an ex-officio voting member, and fourteen (14) additional Directors, eight (8) of whom shall be nominated by CSMC (the "CSMC Directors"), three (3) of whom shall be nominated by THA (the "THA Directors"), and three (3) of whom shall be nominated by Huntington (the "Huntington Directors").

(a) CSMC, THA and Huntington Representatives. At all times: (i) at least one (1) member of the Board of Directors shall be a director or officer of CSMC, (ii) at least one (1) member of the Board of Directors shall be a director or officer of THA, and (iii) at least one (1) member of the Board of Directors shall be a director or officer of Huntington.

(b) Notwithstanding any change that may occur in the future to the number of Directors and/or composition of the Board, CSMC shall at all times have the right to nominate at least a majority of the total number of Directors serving on the Board at any given time.

(c) Notwithstanding any increase that may occur in the future to the number of Directors and/or composition of the Board, THA shall at all times have the right to: (i) nominate at least ten percent (10%) of the total number of Directors serving on the Board at

any given time, and (ii) approve any change to these Bylaws that results in CSMC and THA, in the aggregate, not having the right to nominate at least a majority of the total number of Directors serving on the Board at any given time.

(d) Notwithstanding any increase that may occur in the future to the number of Directors and/or composition of the Board, Huntington shall at all times have the right to nominate at least ten percent (10%) of the total number of Directors serving on the Board at any given time.

Section 2.3 Qualifications of Directors. Members of the Board of Directors ("Directors") shall be individuals who have demonstrated leadership, civic interest and community involvement; have exhibited an awareness of and interest in the provision of health care services, educational or research activities; and have the ability to contribute to the appropriate governance of the Health System Parent Entity. Additionally, the individual Directors should at all times have complementary and diverse skill sets, backgrounds and experiences to contribute to Board effectiveness.

Section 2.4 Term of Office. At each annual meeting of the Board, Directors shall be elected to fill the expiring terms of office and any other vacancies on the Board which have not been previously filled. Vacancies on the Board may remain unfilled at the discretion of the Board; provided, however, the Board shall not leave a vacancy unfilled if doing so would result in the Board being comprised of fewer Directors than as of the Effective Date. Except as expressly set forth herein, persons elected as Directors at each annual meeting of the Board may be elected to serve for a one (1) or two (2) year term. As used in these Bylaws, the expression "year" means the period from the annual meeting of the Board at which a Director is elected to the next succeeding annual meeting of the Board. The exceptions to this provision relate to the CEO, who shall serve as a member of the Board of Directors as long as he or she holds office.

Section 2.5 Election of Directors. At least fifteen (15) days before each annual meeting of the Board of the Health System Parent Entity: (i) CSMC shall select a list of nominees to fill the offices of the CSMC Directors whose terms will expire and such other vacancies of CSMC Directors which have not been previously filled, subject to the discretion of the Board to retain vacancies, (ii) THA shall select a list of nominees to fill the offices of the THA Directors whose terms will expire and such other vacancies of THA Directors which have not been previously filled, subject to the discretion of the Board to retain vacancies, and (iii) Huntington shall select a list of nominees to fill the offices of the Huntington Directors whose terms will expire and such other vacancies of Huntington Directors which have not been previously filled, subject to the discretion of the Board to retain vacancies. Notwithstanding the foregoing, the Board may not: (i) retain a vacancy of a THA Director without the approval of THA, (ii) retain a vacancy of a CSMC Director without the approval of CSMC, or (iii) retain a vacancy of a Huntington Director without the approval of Huntington. CSMC, THA and Huntington shall file with the Secretary of the Health System Parent Entity a written list of such nominees. At least three (3) business days before the date of such meeting, the Secretary shall send notice of the names of the nominees to each member of the Board of Directors. The term "business days" means Monday through Friday, unless one of those days is a legal holiday as defined under California law.

(a) Nomination a Prerequisite to Election. No person shall be eligible for election as a Director at an annual meeting of the Board unless he or she has been nominated by CSMC, THA or Huntington, as applicable, in the manner provided for in this Section 2.5, except that at any time before the annual meeting of the Board, if by reason of the death, declination or incapacity of any nominee, the number of nominees remaining is less than the number of Directors to be elected, nominations to supply such deficiency may be made by CSMC, THA or Huntington, as applicable, at, or any time before, the annual meeting.

(b) Vote Required for Election. The nominees receiving a majority vote at such annual meeting of the Board shall be declared elected. If, at the annual meeting of the Board, the Board fails to elect any of the individuals nominated by CSMC, then the Health System Parent Entity shall promptly notify CSMC, CSMC shall promptly propose alternative nominees for election by the Board, and thereafter a special meeting of the Board shall promptly be called for the purpose of voting on the election of such alternative nominees. If, at the annual meeting of the Board, the Board fails to elect any of the individuals nominated by THA, then the Health System Parent Entity shall promptly notify THA, THA shall promptly propose alternative nominees for election by the Board, and thereafter a special meeting of the Board shall promptly be called for the purpose of voting on the election of such alternative nominees. If, at the annual meeting of the Board, the Board fails to elect any of the individuals nominated by Huntington, then the Health System Parent Entity shall promptly notify Huntington, Huntington shall promptly propose alternative nominees for election by the Board, and thereafter a special meeting of the Board shall promptly be called for the purpose of voting on the election of such alternative nominees. The process set forth in the foregoing sentence shall continue until such time as the Board has elected individuals to fill the offices of all Directors with expiring terms.

Section 2.6 Vacancies. Vacancies occurring in the Board of Directors from time to time shall be filled in accordance with Section 2.5. Each Director elected to fill a vacancy shall hold office for the unexpired term of such Director's predecessor.

Section 2.7 Board Orientation. The Board will require each newly elected member of the Board of Directors to participate in an orientation program designed to enhance that Director's understanding of the Director's new responsibilities.

Section 2.8 Quorum of Board of Directors; Adjournment.

(a) A majority of the actual number of Directors shall constitute a quorum for any meeting of the Board, provided that at least seven (7) CSMC Directors are in attendance at such meeting.

(b) If a quorum is not present at any meeting of the Board, such meeting may be adjourned from time to time until a quorum shall be obtained. Each such adjournment, and the reason therefore, shall be recorded in the minutes of the Health System Parent Entity.

(c) Every act or decision done or made by a majority of the Directors present at a meeting duly held at which a quorum is present shall be regarded as the act of the Board of Directors, unless a greater or different number be required by law, by the Articles of Incorporation, or by another provision of these Bylaws.

(d) A majority of the Directors present, whether or not a quorum is present, may adjourn any meeting to another time and place. If the meeting is adjourned to a different calendar date, notice of an adjournment to another time and place shall be given prior to the time of the adjourned meeting to the Directors who were not present at the time of the adjournment in accordance with the notice procedure set forth in Section 2.12.

Section 2.9 Annual Meeting of the Board. An annual meeting of the incumbent Board of Directors shall be held as provided by Section 3.1 for the election of Directors for the succeeding year. At this meeting, in addition to any other business of the Health System Parent Entity, the officers of the Health System Parent Entity shall be elected.

Section 2.10 Regular Meetings of the Board. In addition to the annual meeting of the Board of Directors, the Board of Directors shall hold at least three (3) regular meetings of the Board of Directors per year at the time and place fixed by the Board of Directors.

Section 2.11 Special Meetings of the Board. On call of either the Chairperson of the Board of Directors or two-thirds (2/3) of the members of the Board of Directors then in office, a special meeting of the Board may be held at a time and place designated in the call.

Section 2.12 Written Notice of Meetings. The Secretary shall give notice of each regular or special meeting to each member of the Board of Directors by any of the following means:

(a) In person at least forty-eight (48) hours prior to the time designated for the holding of the meeting;

(b) Electronically directed to the electronic address of a Director as set forth in the books and records of the Health System Parent Entity, sent at least forty-eight (48) hours prior to the time designated for the holding of the meeting; or

(c) By written notice directed to the address of the Director as it appears on the books and records of the Health System Parent Entity and deposited in the United States mail in the County of Los Angeles at least four (4) calendar days prior to the time designated for the holding of the meeting.

(d) Any notice of a special meeting of the Board of Directors shall specify the primary purpose therefor.

(e) Any Director shall be deemed to have waived the requirement of a formal notice of a meeting of the Board of Directors when he or she:

(i) Does so in writing either before, at or after the meeting;

(ii) Participates in or attends such meeting; or

(iii) Ratifies or approves in writing such action (and such assent is recorded in the minutes).

Section 2.13 Failure to Attend Meetings. The Board of Directors may declare vacant the office of a Director who does not attend annually at least fifty percent (50%) of the regular meetings of the Board or any committee of the Board to which such individual has been duly elected or appointed, held in the respective calendar year, or grant any Director a leave of absence for any period of time upon the affirmative vote of a majority of the remaining Directors.

Section 2.14 Telephonic Meetings. Directors are encouraged to attend meetings in person. In certain circumstances, with the approval of the Chairperson of the Board and, if applicable, the Chairperson of the relevant Board Committee, members of the Board or members of any such Board Committee may participate in meetings through the use of conference telephone or similar communications equipment, so long as all members participating in such meeting can hear one another. Participation in a meeting by these means constitutes presence in person at such meeting.

Section 2.15 Action by Written Consent. Except as otherwise provided in these Bylaws, any action required or permitted to be taken by the Board of Directors under any provision of law or by these Bylaws may be taken without a meeting if all members of the Board shall individually or collectively consent in writing to such action. Such written consent shall be filed with the Board minutes. Such action by written consent shall have the same force and effect as a unanimous vote of the Board of Directors. Any certificate or other document filed under this Section which relates to an action so taken shall state that the action was taken by unanimous written consent of the Board of Directors without a meeting, and that the Bylaws authorize the Directors to so act, and such statement shall be prima facie evidence of such authority.

Section 2.16 Retirement from Board Membership. Except as otherwise provided in this Article II, individuals shall be eligible to serve as members of the Board of Directors until the annual meeting of the Board next succeeding such individual's seventy-second (72nd) birthday. For purposes of these Bylaws, the retirement age for Board members shall be as set forth in this Section 2.16. Members of the Board of Directors who reach retirement age during the first year of election to a two (2) year term shall serve as a member of the Board only until the annual Board meeting next succeeding such individual's retirement age and not beyond that date.

Section 2.17 Conflict of Interest Policies. The Board shall establish and adopt for the Health System Parent Entity policies and procedures for determining when an actual or potential conflict of interest exists, addressing all such conflicts of interest, and ensuring appropriate remedies for failure to comply with said policies. All members of the Board shall annually complete an accurate Conflict of Interest Questionnaire consistent with the Health System Parent Entity's Conflict of Interest Policy from time to time in effect. Any Board member who fails to return the required Conflict of Interest Questionnaire within sixty (60) days of the date it is sent to such Board member may be removed from Board membership. Individuals who are not members of the Board but who are otherwise required to return a complete and accurate Conflict of Interest Questionnaire as "Covered Individuals" under the Board-approved Conflict of Interest policies shall be removed by the Board of Directors from Board Committees, research responsibilities or key administrative positions (as the case may be) for failure to return the Conflict of Interest Questionnaire within sixty (60) days of the date it is sent to such Covered

Individual, subject to the provisions of the relevant policies. Nothing contained herein shall alter the requirement that conflicts of interest be disclosed in writing more frequently than annually should one arise between the dates that the annual Conflict of Interest Questionnaire is required to be completed.

Section 2.18 Emergency Powers.

(a) "Emergency" is defined as any of the following events or circumstances as a result of which, and only so long as, a quorum of the Board of Directors cannot be readily convened for action:

(i) A natural catastrophe, including, but not limited to, a hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought, or regardless of cause, any fire, flood, or explosion;

(ii) An attack on the State of California or the nation by an enemy of the United States of America, or upon receipt by the State of California of a warning from the federal government indicating that an enemy attack is probable or imminent;

(iii) An act of terrorism or other man-made disaster that results in extraordinary levels of casualties or damage or disruption severely affecting the infrastructure, environment, economy, government functions, or population, including, but not limited to, mass evacuations.

(iv) A state of emergency proclaimed by the Governor of the State of California or by the President of the United States of America which impacts the Cedars-Sinai Health System, its property, officers or activities or its surroundings.

(b) In anticipation of or during an Emergency, the Board of Directors may take either or both of the following actions necessary to conduct the Health System Parent Entity's ordinary business operations and affairs:

(i) Modify lines of succession to accommodate the incapacity of any director, officer, employee, or agent resulting from the Emergency.

(ii) Relocate the principal office, designate alternative principal offices or regional offices, or authorize the officers to do so.

(c) During an Emergency, the Board of Directors may give notice to a Director in any practicable manner under the circumstances, including but not limited to, by publication and radio, when notice of a meeting of the Board of Directors cannot be given to that Director in the manner otherwise prescribed by these Bylaws.

(d) In the event of an Emergency, a quorum of the Board shall be reduced to a minimum number of seven (7) Directors, provided that at least four (4) CSMC Directors are in attendance at such meeting. Notwithstanding Section 2.8(c), every act or decision done or made

by the Board at a Board meeting that is held during an Emergency shall require the affirmative vote of all of the CSMC Directors in attendance at such Board meeting.

(e) Notwithstanding anything in these Bylaws to the contrary, the Board of Directors may not, in anticipation of or during an Emergency, take any action that is not in the Health System Parent Entity's ordinary course of business, unless the required vote of the Board of Directors was obtained prior to the Emergency.

(f) Those Directors representing a quorum of the Board during an Emergency shall use their best efforts to report what actions they have taken during the Emergency to the full Board within a reasonable time period after the Emergency has ended.

(g) Any actions taken in good faith in anticipation of or during an Emergency under this Section 2.18 shall bind the Health System Parent Entity and may not be used to impose liability on a director, officer, employee or agent of the Health System Parent Entity.

(h) All other provisions of these Bylaws consistent with the provisions in this Section 2.18 shall remain in full force and effect during the Emergency. The provisions of this Section 2.18 shall cease to apply once the Emergency has been reasonably deemed ended.

ARTICLE III
Meetings of the Board

Section 3.1 Annual Meetings of the Board. The annual meeting of the Board of Directors shall be held at such place and time as may be determined by the Board.

Section 3.2 Vote. Each member of the Board of Directors shall have one (1) vote in any action voted upon by the Board or a Board Committee to which such member is appointed. Votes may be cast only by members in attendance at a meeting except as provided in Sections 2.14 and 2.15. Votes may not be cast by proxy.

ARTICLE IV
Officers of Health System Parent Entity

Section 4.1 Enumeration of Officers. The officers of the Health System Parent Entity shall be: Chairperson of the Board of Directors (the "Chairperson"), Vice-Chairperson of the Board of Directors (the "Vice Chairperson"), the CEO, Treasurer, Secretary, and such other officers as may be elected or appointed in accordance with Sections 4.2 and 4.3, as the case may be.

Section 4.2 Election of Officers.

(a) Election to these offices of the Chairperson, Vice-Chairperson, CEO, Treasurer and Secretary shall occur at the annual meeting of the Board by a majority vote of the total number of Directors then in office. A vacancy in the offices of the Chairperson, Vice-Chairperson, CEO, Treasurer and Secretary may be filled prior to the next annual meeting of the Health System Parent Entity by majority vote of the total number of Directors then in office at the next succeeding regular meeting of the Board of the Health System Parent Entity.

(b) The term of office for all persons elected at the annual meeting shall commence at the conclusion of such meeting.

Section 4.3 Removal, Appointment and Term.

(a) The Board of Directors shall have the authority to remove officers and to promote persons to officer positions from time to time during the year; provided, however, the CEO shall have the authority to appoint an individual to any office except those offices specifically referred to in Section 4.2.

(b) The CEO shall be elected to serve for a term of three (3) years. There shall be no restriction on the number of terms that the CEO may serve.

(c) The Chairperson shall be elected to serve for a term of three (3) years. No person shall serve as Chairperson for more than one (1) term.

(d) The Vice-Chairperson shall be elected to serve for a term of one (1) year. No person shall serve as Vice-Chairperson for more than three (3) consecutive terms

(e) The Secretary shall be elected to serve for a term of one (1) year. No person shall serve as Secretary for more than three (3) consecutive terms.

(f) The Treasurer shall be elected to serve for a term of one (1) year. There shall be no restriction on the number of terms that the Treasurer may serve.

(g) Notwithstanding the limitations of Section 2.4, each of the officers referenced in this Section 4.1 may complete the term of that office, even if completion of the term results in Board membership extending beyond such individual's Board retirement age as set forth in Section 2.16 (provided that all individuals must be elected prior to reaching their Section 2.16 retirement age). The respective limitations on the term of office set forth in Sections 4.3(b), 4.3(c), 4.3(d), 4.3(e) and 4.3(f) shall not include that part of an officer's tenure to the extent that such officer was elected to fill the unexpired term of office for his or her predecessor.

(h) It is not the intention of the Health System Parent Entity to provide that election to any officer position necessarily presumes that such officer is then in line to succeed to any other officer position, including, but not limited to, Chairperson of the Board of Directors.

Section 4.4 Powers and Duties of Officers.

(a) The Chairperson shall:

(i) preside at all meetings of the Board of Directors;

(ii) periodically review and evaluate the performance of the CEO in the discharge of that office's responsibilities, and have the authority to direct the CEO in the execution of the policies and programs established from time to time by the Board of Directors;

(iii) exercise the powers and duties accorded to the Chairperson pursuant to these Bylaws;

(iv) exercise such other powers and duties requested from time to time by the Board of Directors;

(v) be an ex officio member of all Board Committees; and

(vi) serve as the liaison between the Board of Directors and all of the Board Committees, and in this regard the Chairpersons of all such Board Committees periodically and promptly shall report to the Chairperson all decisions, recommendations and proposed actions of their respective Board Committees.

(b) The Vice Chairperson of the Board of Directors shall:

(i) assist the Chairperson in carrying out the duties and responsibilities of the Chairperson;

(ii) act in place of the Chairperson when requested by the Chairperson;

(iii) serve as the Chairperson of the Board of Directors in the event the Chairperson retires, resigns or is otherwise incapable, unable or unwilling to complete the elected term until a new Chairperson is elected by the Board of Directors; and

(iv) perform such other duties as the Board of Directors may from time to time designate.

In the event the Vice Chairperson of the Board of Directors becomes the Chairperson under circumstances set forth in subsection (b)(iii), such individual shall serve as the Chairperson of the Board of Directors until the next annual meeting of the Board. At such meeting, the individual who has completed the year as Chairperson of the Board shall be eligible for nomination and election to a new three (3) year term as Chairperson of the Board in a manner consistent with these Bylaws. Notwithstanding anything else to the contrary set forth in the Bylaws, a Vice Chairperson who succeeds to the office of Chairperson of the Board shall serve as the Chairperson regardless of such individual's age upon the date of succession provided that an individual who has reached the Section 2.16 retirement age shall not be eligible for election to a subsequent term.

(c) The CEO shall:

(i) be the chief executive officer of the Health System Parent Entity and by reason of that office be deemed to be an elected member of the Board of Directors and be counted as a member of the Board for all purposes;

(ii) act as the representative of the Board of Directors in all matters pertaining to the administration of the business and the affairs of the Health System Parent Entity;

(iii) execute the policies of the Board of Directors in managing the Health System Parent Entity's business and affairs;

(iv) participate in the formulation of policies and the development, coordination and execution of corporate programs; and

(v) be responsible to the Board of Directors;

(d) The Treasurer shall be the Chief Financial Officer of the Health System Parent Entity (unless otherwise determined by vote of the Board) and shall:

(i) supervise the collecting, receipt, deposit and distribution of all funds of the Health System Parent Entity as directed by the Board of Directors;

(ii) cause to be kept regular books of account financial records of the Health System Parent Entity and account for the Treasurer's actions and of the financial condition of the Health System Parent Entity as the Board of Directors requires from time to time; and

(iii) perform such other duties as are assigned the Treasurer from time to time by the Board of Directors.

(e) The Secretary shall, or shall cause the appropriate officers to:

(i) keep full and complete minutes of the meetings of the Board of Directors and Board Committees, and when notice of a meeting is required by law or by these Bylaws give notice of each such meeting;

(ii) keep at the principal office of the Health System Parent Entity records containing the name and address of each member of the Board of Directors and the Board Committee members and record the date of election of such member, the duration of that membership, and the date on which the membership ceased;

(iii) keep the seal of the Health System Parent Entity and affix it to all instruments executed by the Health System Parent Entity when required;

(iv) keep at the principal office of the Health System Parent Entity a book in which the Secretary shall record all Bylaws of the Health System Parent Entity as amended to date which Bylaws and amendments shall be reviewed annually, revised as necessary, and dated to indicate the time of last review;

(v) maintain custody of and keep the books of account and other records of the Health System Parent Entity except such books or records which are in the custody of the Treasurer; and

(vi) generally perform such other duties as are assigned to the Secretary from time to time by the Board of Directors.

Section 4.5 Compensation of Employees. Compensation may be paid by the Health System Parent Entity to officers who are also employees of the Health System Parent Entity in such amounts as are determined from time to time by the Board of Directors.

ARTICLE V
Board Committees

Section 5.1 Creation of Committees; Function. The Chairperson of the Board of Directors shall appoint the members and the Chairpersons of the standing committees duly constituted by the Board (the "Board Committees"). Except for Board Committees delegated to act on behalf of the Board by specific Board resolutions, Board Committees of the Board shall act by making recommendations to the Board. Each Board Committee with delegated authority shall be comprised solely of persons who are members of the Board provided that individuals serving as non-voting advisors may also be asked to routinely attend such meetings. Each Board Committee shall be chaired and co-chaired solely by members of the Board. Board Committees shall not otherwise establish policy for the Health System Parent Entity or act on behalf of the Board except pursuant to a specific resolution adopted by the Board.

Section 5.2 Board Committees. The Health System Parent Entity, by approval of the Board of Directors, may from time to time establish standing Board Committees, including an Executive Committee, Audit and Finance Committee, Quality Committee and/or such other committees as the Board of Directors shall approve. The term of each standing Board Committee shall terminate at the discretion of the Board. If after the Effective Date the Health System Parent Entity establishes an Executive Committee, such Executive Committee shall at all times include at least one (1) THA Director and at least one (1) Huntington Director.

Section 5.3 Vacancies in Board Committees; Removal. Vacancies in any Board Committee shall be filled by appointment by the Chairperson of the Board of Directors. Board Committee members may be removed from a standing Board Committee by the Chairperson of the Board of Directors.

Section 5.4 Written Consent. Except as otherwise provided in these Bylaws, any action required or permitted to be taken by any Board Committee under any provision of law or by these Bylaws may be taken without a meeting if all members of the Board Committee shall individually or collectively consent in writing to such action. Such written consent or consents shall be filed with the minutes of the proceedings of the applicable committee. Such action by written consent shall have the same force and effect as a unanimous vote of the Board Committee. Any certificate or other document filed under this Section which relates to an action so taken shall state that the action was taken by unanimous written consent of the Board

Committee without a meeting, and that the Bylaws authorize the Board Committees to so act, and such statement shall be prima facie evidence of such authority.

ARTICLE VI
Fiscal Provisions

Section 6.1 Fiscal Year. The fiscal year of the Health System Parent Entity shall be fixed by the Board of Directors.

Section 6.2 Withdrawal of Funds. Funds of the Health System Parent Entity on deposit with any bank or other financial institution shall be subject to withdrawal on the signatures of such persons as are determined from time to time by resolution of the Board of Directors.

Section 6.3 Deposit of Securities. Securities of the Health System Parent Entity held by any custodian approved by the Board shall be subject to withdrawal by such persons (not less than two) as are determined from time to time by resolution of the Board of Directors.

Section 6.4 Transfer of Securities. Any two (2) or more persons designated by the Board of Directors by appropriate resolution shall have authority to execute such forms of transfer and assignment as are customary to effect transfer of shares or other securities in the name of the Health System Parent Entity.

Section 6.5 Financial Records. The books and accounts of the Health System Parent Entity shall be kept in accordance with approved accounting procedures and shall be audited annually by independent auditors selected by the Board of Directors.

Section 6.6 Inspection. Subject to applicable law, every member of the Board of Directors shall have the absolute right at any reasonable time to inspect the books, records, documents of every kind, and physical properties of the Health System Parent Entity, provided reasonable advance notice of such inspection is given to the Chairperson of the Board or the CEO. Upon receipt, the Chairperson and the CEO shall then consult regarding the nature of the particular request and to make suitable arrangements. Subject to applicable law, the right of inspection includes the right to copy and make extracts of documents.

Section 6.7 No Proprietary Interest. By virtue of being a member of the Board, no individual shall have any proprietary interest whatsoever in or to the assets of the Health System Parent Entity; there shall be no distribution of gains, profits or dividends to any members of the Board; and no income, increments or other pecuniary or proprietary gain, benefit or advance of any kind arising from or growing out of the assets of the Health System Parent Entity or its operations and activities shall in any way inure to, go to or vest in any member of the Board. Nothing herein contained shall prevent payment of compensation, by affirmative vote of the Board, to any director or officer for services rendered to the Health System Parent Entity provided any such payment is not prohibited by law.

ARTICLE VII
Indemnification

Section 7.1 Indemnity of Officers and Directors. Every person who serves, or has in the past served, as a director or officer of the Health System Parent Entity, and every person who serves, or has in the past served, at the written request of the Health System Parent Entity (or at its oral request subsequently confirmed in writing) as a director or officer of the Health System Parent Entity, except as otherwise provided by law, shall be indemnified to the full extent permitted by law and held harmless by the Health System Parent Entity from and against any loss, cost, liability or expense that may be imposed on or incurred by such individual in connection with or resulting from any claim, action, suit or proceeding, civil or criminal, in which he or she may become a party or otherwise involved because of his or her being or having been a director or officer of the Health System Parent Entity, whether or not he has this relationship when the loss, cost, liability or expense was imposed or incurred. The phrase "loss, cost, liability or expense" shall include all expenses incurred in defense of the claim, action, suit or proceeding and the amounts of judgments, fines or penalties levied or rendered against the indemnified person, provided that, except as otherwise provided by law, no person shall be entitled to indemnity under this section unless he or she was acting in good faith and within the scope of his or her employment or authority and for a purpose that he or she reasonably believed to be in the Health System Parent Entity's best interests. Payments authorized under this Section shall include amounts paid and expenses incurred in settling the claim, action, suit or proceeding, whether actually begun or only threatened. Expenses incurred with respect to a claim, action, suit or proceeding indemnified against under this section may be advanced by the Health System Parent Entity before final disposition of the matter on receipt of an undertaking by or on behalf of the recipient to repay this amount if it is ultimately determined that he or she is not entitled to indemnification. This undertaking shall be satisfactory in form and amount to the Board of Directors. This right of indemnification shall not affect any other rights to which any person may otherwise be entitled by law or contract.

Section 7.2 Employees and Agents. The Health System Parent Entity may indemnify any employee or agent of the Health System Parent Entity to the maximum extent permitted by law as approved by majority vote of the total number of Directors then in office.

Section 7.3 Insurance. Except as prohibited by law, the Board of Directors may (but shall not be required to) adopt a resolution authorizing the purchase and maintenance of insurance on behalf of the Health System Parent Entity and any Director, officer, employee or other agent of the Health System Parent Entity, against any liability asserted against or incurred by such person in such capacity or arising out of such person's status as such, whether or not the Health System Parent Entity would have the power to indemnify such person against the liability under the provisions of this Article VII. The Directors shall receive advance notice of any action by the Health System Parent Entity to eliminate or substantially reduce Directors and officers insurance coverage.

ARTICLE VIII
Amendment and Repeal of Bylaws

Section 8.1 General Provisions. These Bylaws or any of them may be repealed or amended or new or additional Bylaws may be adopted at a duly held meeting by the affirmative vote of a majority of the total number of Directors then in office, or by unanimous written consent in accordance with Section 2.15. Notwithstanding the foregoing: (i) any change to the

rights, preferences, privileges, powers or restrictions provided for the benefit of THA (by amendment, restatement or repeal of these Bylaws or the Articles of Incorporation or by merger, consolidation, conversion or otherwise) set forth in Section 2.2(c), Section 2.5, Section 5.2 or Section 8.1 of these Bylaws shall require the prior written approval of THA, and (ii) any change to the rights, preferences, privileges, powers or restrictions provided for the benefit of Huntington (by amendment, restatement or repeal of these Bylaws or the Articles of Incorporation or by merger, consolidation, conversion or otherwise) set forth in Section 2.2(d), Section 2.5, Section 5.2 or Section 8.1 of these Bylaws shall require the prior written approval of Huntington. Notice of the proposed repeal, amendment, or adoption of new or additional Bylaws must be included in the notice calling the meeting to consider such proposal.

CERTIFICATE OF SECRETARY

I, the undersigned, do hereby certify:

(1) That I am the duly elected and acting Secretary of Cedars-Sinai Health System, a California nonprofit public benefit corporation; and

(2) That the foregoing Bylaws constitute true and accurate Bylaws adopted by the action of the Board of Directors on [_____ ___, 20__].

CEDARS-SINAI HEALTH SYSTEM,
a California nonprofit public benefit corporation

_____ By: _____
Date Greg Geiger
Secretary

(SEAL)

Exhibit 3-F

Form of Deed for Hospital Land

Exhibit I

Form of Quitclaim Deed

RECORDING REQUESTED BY:

COLLIS P. AND HOWARD HUNTINGTON
MEMORIAL HOSPITAL TRUST

WHEN RECORDED MAIL THIS
DEED AND TAX STATEMENTS TO:

Huntington Hospital
100 W. California Blvd.
Pasadena, CA 91105
Attention: Lori J. Morgan, M.D. MBA

(Above Space for Recorder's Use Only)

APN: _____

QUITCLAIM DEED

THE UNDERSIGNED GRANTOR DECLARES:

DOCUMENTARY TRANSFER TAX is $ - 0* - CITY TAX $ - 0* -
□ Computed on full value of property conveyed, or
□ computed on full value less value of liens or encumbrances remaining at time of sale,
□ Unincorporated area:
☒ City of Pasadena, and

*Conveyance is given for no value. This is a bona fide gift and the grantor received nothing in return. Revenue and Taxation Code section 11911.

FOR VALUABLE CONSIDERATION, receipt of which is hereby acknowledged, the undersigned, Jaynie Studenmund, Armando L. Gonzalez, Wayne Brandt, Michelle Quinones Chino and Paul Johnson, as Trustees of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST, hereby remise, release and forever quitclaim to PASADENA HOSPITAL ASSOCIATION, LTD., a California nonprofit public benefit corporation, dba HUNTINGTON HOSPITAL, any and all right, title or interest in and to that certain real property in the County of Los Angeles, State of California described in Exhibit A attached hereto and incorporated herein, together with any and all right, title or interest in and to buildings and improvements located thereon (the "**Property**").

THIS DEED SERVES TO DISTRIBUTE TITLE TO THE PROPERTY FROM A TRUST TO THE SOLE BENEFICIARY OF THE TRUST.

[Signature(s) Appear on Following Page]

Dated: _____, 2020

GRANTOR:

_____
_____, Trustee of the
COLLIS P. AND HOWARD HUNTINGTON
MEMORIAL HOSPITAL TRUST

_____
_____, Trustee of the
COLLIS P. AND HOWARD HUNTINGTON
MEMORIAL HOSPITAL TRUST

_____
_____, Trustee of the
COLLIS P. AND HOWARD HUNTINGTON
MEMORIAL HOSPITAL TRUST

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Los Angeles)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

Exhibit A to

Quitclaim Deed

That certain real property located in the City of Pasadena, County of Los Angeles, State of California, more particularly described as follows:

Exhibit 3-G

Reimbursement Agreement

REIMBURSEMENT AGREEMENT

This Reimbursement Agreement ("Agreement") is entered into as of July 15, 2020 (the "Effective Date") among Cedars-Sinai Medical Center, a California nonprofit public benefit corporation ("CSMC"), Cedars-Sinai Health System, a California nonprofit public benefit corporation ("CSHS" and collectively with CSMC, the "Cedars-Sinai Parties"), and the Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust, a testamentary charitable trust (the "Trust"), with reference to the following:

Recitals

A. CSHS is the sole member of CSMC, which owns and operates acute care hospitals located in Los Angeles and, Marina Del Rey, California. CSMC is a part of CSHS's integrated healthcare delivery system (the "CS Health System") and derives substantial benefit from the CS Health System and the operation thereof.

B. The Trust is a charitable trust which exists for the sole benefit and support of the healthcare operations of Pasadena Hospital Association, Ltd., a California nonprofit public benefit corporation doing business as Huntington Hospital ("Huntington"). The support of the Trust for Huntington includes its role as a Member of the Obligated Group under the Huntington Master Indenture.

C. On and subject to the terms and conditions of that certain Affiliation Agreement dated as of the Effective Date (the "Affiliation Agreement") among Huntington, CSHS and the Trust, it is contemplated that, among other things, Huntington will become part of the CS Health System (the "Affiliation"). CSMC will derive substantial benefit as a result of Huntington becoming part of the CS Health System.

D. As part of the Affiliation, the Trust has requested that (1) the Cedars-Sinai Parties cause the Trust to be fully released and discharged from all of the Obligations and (2) CSMC agree to provide reasonable protections to the Trust Persons from the payment obligations arising under the Obligations, in each case, on the terms and conditions set forth in this Agreement.

E. In consideration of and as a condition to the Cedars-Sinai Parties executing and delivering this Agreement, the Trust has agreed that it will not be released as a Member of the Obligated Group under the Huntington Master Indenture until after Closing, subject to the terms and conditions of this Agreement.

In consideration for the mutual undertakings of the parties stated herein and other good and valuable consideration, the receipt and sufficiency of this are hereby acknowledged, the parties agree as follows:

Agreement

1. Interpretation and Defined Terms. The foregoing recitals are true and correct, and the parties expressly so acknowledge. All capitalized terms not otherwise defined

herein shall have the meanings given such terms in Exhibit A attached hereto and incorporated herein. All capitalized terms not otherwise defined herein or in Exhibit A shall have the meanings given such terms in the Affiliation Agreement. The rules of interpretation in the Affiliation Agreement apply in this Agreement.

2. Discharge and Release of the Trust. The Cedars-Sinai Parties will cause the Trust to be fully discharged and released from the Obligations and removed as a Member of the Obligated Group as follows:

(a) By July 1, 2024, the Cedars-Sinai Parties will cause the Trust to be fully discharged and released from all Obligations related to:

(i) the Series 2014A Bonds, Obligation No. 3 and that certain supplemental master indenture, dated as of April 1, 2014, between Huntington and the Master Trustee, relating to the Series 2014A Bonds, and

(ii) the Series 2014B Bonds, Obligation No. 4 and that certain supplemental master indenture, dated as of November 1, 2014, between Huntington and the Master Trustee, relating to the Series 2014B Bonds.

(b) By July 1, 2028, the Cedars-Sinai Parties will cause the Trust to be fully discharged and released from all other Obligations and removed as a Member of the Obligated Group.

(c) As soon as reasonably practicable after the Cedars-Sinai Parties have satisfied their obligations under Sections 2(a) and (b), the Cedars-Sinai Parties will provide the Trust with documentation to demonstrate that either (1) the Huntington Master Indenture has been discharged and terminated in accordance with its terms or (2) the Trust has withdrawn from and is no longer a part of the Obligated Group in accordance with the terms of the Huntington Master Indenture, together with in either case a UCC-3 Termination Statement terminating the UCC-1 Financing Statement(s) of the Trust relating to the Huntington Master Indenture (the "Trust Substitution/ Release"). The Trust acknowledges and agrees that the complete redemption and/or defeasance of the Series 2014A Bonds and the Series 2014B Bonds in accordance with their terms, so that the Trust has no further liability under any of the Obligations, will qualify as a Trust Substitution /Release with respect to, and will satisfy the requirements of, Section 2(a) as it relates to the Series 2014A Bonds and the Series 2014B Bonds.

(d) The Cedars-Sinai Parties will from time to time advise the Trust of its intentions for fulfillment of its obligations under this Section 2, which will not require formal written notice pursuant to Section 9 of this Agreement, and which may take the form of information provided to the Huntington board of directors at ,or as part of the materials for, any meeting of that board or of any committee of that board. The Cedars-Sinai Parties will provide the Trust sufficient notice of any Trust Substitution/Release Transaction to allow the Trust to approve (which approval may not be unreasonably withheld, conditioned or delayed) all documentation necessary to release the Trust and remove the Trust as a Member of the Obligated Group. The Cedars-Sinai Parties will promptly provide information pertaining to its obligations under this Section 2 in response to reasonable requests from the Trust.

3. Trust Obligations and Commitments.

(a) Until Closing. Until the Closing or earlier termination of this Agreement, the Trust will: (i) comply in all respects with each and every reporting and disclosure provision applicable to it under the Huntington Master Indenture and the Obligations, including providing annual audited financial statements of the Trust in accordance with Section 3.06 of the Huntington Master Indenture and providing quarterly financial information of the Trust as necessary for Huntington to comply with its obligations under the continuing disclosure agreements related to the Obligations, (ii) not take any action that causes the Trust or Huntington to be in breach of any their respective obligations under the Huntington Master Indenture or the Obligations, (iii) comply with all applicable laws to the extent violation of the same constitutes a default under the Huntington Master Indenture or the Obligations, or gives rise to a claim by any Bondholder with respect to the applicable Obligation, and (iv) notify the Cedars-Sinai Parties of all communications received by the Trust from the Master Trustee, any rating agency, or any Bondholder in connection with or related to the Huntington Master Indenture or the Obligations, and to the extent that such communications require or request a response, provide the Cedars-Sinai Parties with a reasonable opportunity to approve such response in advance, which approval may not be unreasonably withheld, conditioned or delayed.

(b) From and After Closing. From and after the Closing until the Trust Substitution/Release of all Obligations, the Trust will: (i) comply in all respects with each and every reporting and disclosure provision applicable to it under the Huntington Master Indenture and the Obligations, including providing annual audited financial statements of the Trust in accordance with Section 3.06 of the Huntington Master Indenture and providing quarterly financial information of the Trust as necessary for Huntington to comply with its obligations under the continuing disclosure agreements related to the Obligations, (ii) not take any action that causes the Trust or Huntington to be in breach of any their respective obligations under the Huntington Master Indenture or the Obligations, except to the extent that the obligation is a payment obligation of CSMC under Section 4, (iii) comply with all applicable laws to the extent violation of the same constitutes a default under the Huntington Master Indenture or the Obligations, or gives rise to a claim by any Bondholder with respect to the applicable Obligation, and (iv) notify the Cedars-Sinai Parties of all communications received by the Trust from the Master Trustee, any rating agency, or any Bondholder in connection with or related to the Huntington Master Indenture or the Obligations, and to the extent that such communications require or request a response, provide the Cedars-Sinai Parties with a reasonable opportunity to approve such response in advance, which approval may not be unreasonably withheld, conditioned or delayed. In the event that the Trust is in breach of a reporting or disclosure obligation under Section 3(b)(i) or breach of a covenant of the Trust under the Huntington Master Indenture or the Obligations, and such breach is reasonably subject to cure without risking immediate acceleration of any Obligation, the Trust shall have a reasonable opportunity to cure such breach.

4. Payment of Trust Obligations. From and after the Closing, except upon the occurrence and during the continuance of an uncured breach by the Trust of its obligations under Section 3(b), provided that the Trust has first given no less than five (5) Business Days' notice to CSMC, CSMC will, upon such notice from the Trust (a) at the Trust's option, pay or cause to be paid all of the Obligations as and when due on the terms and conditions of the Obligations to the extent that Huntington has failed (or has notified the Cedars-Sinai Parties that Huntington will fail)

to make such payment, or reimburse the Trust for the Obligations to the extent the Trust has paid the same, and (b) pay or reimburse the Trust Persons for all Losses incurred in connection with any of the Obligations. For example, and without limiting the foregoing, CSMC will, within five (5) Business Days after receipt of (i) a copy of a request from the Bond Trustee and directed to the Trust to make a payment under any of the Obligations, make the requested payment directly to the Bond Trustee in lieu of the Trust making such payment, without offset, defense or reduction (provided, however, that so long as CSMC continues to be obligated and pays any amount due by the Trust and Losses associated therewith when any dispute in connection therewith is finally resolved, CSMC may offset or reduce any such payment to the extent that the Trust has the right of offset, defense or reduction under the Huntington Master Indenture or applicable Obligation(s)), or (ii) a request by the Trust for reimbursement, reimburse the Trust if it has made such payment to the Bond Trustee. Notwithstanding the foregoing, nothing in this Section 4 will serve to release Huntington of its payment obligations under the Obligations.

5. Hold Harmless. If a Trust Person is made a party or is threatened to be made a party to or is otherwise involved (including as a witness) in a Proceeding, CSMC will reimburse, defend and hold the Trust Person harmless from and against the Obligations and any and all Losses in connection with, related to or arising out of such Proceeding, including without limitation investigating, defending, being a witness in, participating in or otherwise being involved in such Proceeding or preparing to defend, be a witness in, participate in or otherwise be involved in such Proceeding, except to the extent of Losses arising from (a) the Trust's breach of its obligations under Section 3, or (b) the actions of such Trust Person in violation of the Trust's obligations under Section 3, in violation of law constituting a violation of the Huntington Master Indenture or any Obligation or giving rise to any claim by a Bondholder with respect to the applicable Obligation, or with intentional willful misconduct with respect to the obligations of the Trust under the Huntington Master Indenture or the Obligations or to any Bondholder, or a Trust Person having made any misrepresentations of fact to the Master Trustee, any rating agency, or any Bondholder in connection with the Huntington Master Indenture or the Obligations.

(a) If a Proceeding arises for which CSMC is required to reimburse, defend and/or hold harmless a Trust Person pursuant to this Section 5, the Trust shall give CSMC reasonably prompt written notice thereof, but in any event not later than ten (10) Business Days after the Trust becomes aware of such Proceeding. As soon as reasonably practicable thereafter, the Trust shall provide additional notice to CSMC describing the Proceeding in reasonable detail, and shall include copies of all material written evidence thereof and shall indicate the estimated amount, if reasonably practicable, of the Loss that has been or may be sustained by a Trust Person in connection with the Proceeding.

(b) CSMC shall have the right to participate in or completely assume the defense of any Proceeding at CSMC's expense and by CSMC's own counsel, and all Trust Persons involved in the Proceeding shall cooperate in good faith in such defense. In the event that CSMC assumes the defense of any Proceeding, it shall have the right to take such action as it deems necessary or appropriate to avoid, dispute, defend, settle, appeal or make counterclaims pertaining to any such Proceeding in the name and on behalf of the Trust Persons; provided, however, that any settlement or other agreement pursuant to which any Trust Person will have liability shall be subject to the prior written consent of such Trust Person, which consent shall be given or withheld in such Trust Person's sole and absolute discretion.

(c) If CSMC exercises its right to assume the defense of any Proceeding pursuant to paragraph (b) above, a Trust Person shall have the right to participate in the defense of any Proceeding with counsel selected by such Trust Person subject to CSMC's right to control the defense thereof and provided that the fees and costs of such Trust Person's counsel shall, at the Trust's option, be at the Trust's or such Trust Person's sole cost and expense. If CSMC elects not to compromise or defend a Proceeding, a Trust Person may pay, compromise or defend such Proceeding and seek indemnification from CSMC for any Losses incurred by the Trust Person related to such Proceeding, subject to the terms and conditions set forth in this Section 5.

6. Limitation on Trust Liability. The Cedars-Sinai Parties agree that no Trust Person will have any liability (whether direct or indirect, in contract or tort or otherwise) to any Cedars-Sinai Party or any of their respective affiliates (including, after Closing, Huntington) or any of their respective creditors or security holders for or in connection with any of the Obligations or any Losses in connection with the Obligations or any Proceeding, except to the extent of liabilities arising as a direct result of a Trust Person acting in violation of the Trust's obligations under Section 3, in violation of law constituting a violation of the Huntington Master Indenture or the Obligations or which violation otherwise gives rise to any claim by a Bondholder with regard to the applicable Obligation or with intentional disregard or willful misconduct with respect to the obligations of the Trust under the Huntington Master Indenture or the Obligations, or a Trust Person having made any misrepresentations of fact to the Master Trustee, any rating agency, or any Bondholder in connection with the Huntington Master Indenture or the Obligations.

7. Additional Commitments. The Cedars-Sinai Parties agree that (except upon termination of this Agreement in accordance with Section 10(a)), the obligations of the Cedars-Sinai Parties under this Agreement are irrevocable, absolute, independent and unconditional irrespective of any amendment, extension or waiver of or any consent to any departure from the Obligations or the Affiliation Agreement. The Cedars-Sinai Parties hereby waive any rights to require the Trust to proceed against any other obligor, or to pursue any remedy the Trust may have at any time in connection with the Huntington Master Indenture and/or the Obligations, provided that the Trust hereby irrevocably assigns to the Cedars-Sinai Parties each and every right the Trust may have with respect thereto. The Trust's rights hereunder shall be reinstated and revived, and the obligations and liability of each Cedars-Sinai Party hereunder shall continue, with respect to any amount at any time paid on account of the obligations hereunder which thereafter shall be required to be restored or returned by the Trust upon the bankruptcy, insolvency or reorganization of any Cedars-Sinai Party or Huntington, all as though such amount had not been paid. The Cedars-Sinai Parties each agrees that notwithstanding any payments made by any Cedars-Sinai Party, no Cedars-Sinai Party shall have a right of subrogation, reimbursement, exoneration, indemnity, contribution with respect to the Trust or any Trust Person or any other rights against the Trust or any Trust Person that would result in any Cedars-Sinai Party being deemed a creditor of any other obligor of the Trust or any Trust Person under the Obligations under the federal Bankruptcy Code or any other law or for any other purpose, and hereby irrevocably waives any benefit of and any right to participate in, any security now or hereafter held by the Trust, whether any of the foregoing rights arise in equity, at law or by contract.

8. Representations and Warranties.

(a) Each Cedars-Sinai Party represents and warrants to the Trust that it will use its best reasonable efforts to obtain from Huntington, on a continuing basis, financial and other information pertaining to the businesses, operations and condition (financial and otherwise) of Huntington and its properties.

(b) Each Cedars-Sinai Party hereby expressly waives and relinquishes any duty on the part of the Trust (should any such duty exist) to disclose to the other Cedars-Sinai Party any matter, fact or thing related to the businesses, operations or condition (financial or otherwise) of Huntington or its properties, whether now known or hereafter known by the Trust. The Trust represents and warrants that it will, upon request of any Cedars-Sinai Party, provide for so long as this Agreement remains in effect, such financial and other information pertaining to the business, operations and condition (financial and otherwise) of the Trust and its properties as may be required for purposes of reporting and disclosure obligations under the terms of the Huntington Master Indenture, the Obligations, and any related documents to which the Trust is a party.

(c) Each Cedars-Sinai Party represents and warrants to the Trust that (i) it is a nonprofit corporation duly incorporated, validly existing and in good standing under the laws of the State of California and has all requisite corporate power and authority to carry on its business and to own or lease and operate its assets; (ii) it has all requisite corporate power and authority to execute, deliver and enter into this Agreement and perform its obligations hereunder; (iii) the execution, delivery and performance of this Agreement by the Cedars-Sinai Parties have been duly authorized by all necessary corporate action on the part of the Cedars-Sinai Parties; (iv) no other corporate proceeding on the part of any Cedars-Sinai Party is necessary to authorize this Agreement and the transactions contemplated hereunder; and (v) this Agreement has been duly executed and delivered by each Cedars-Sinai Party and (assuming that this Agreement constitutes the valid and binding agreement of the Trust) is a legal, valid and binding obligation of each Cedars-Sinai Party, enforceable against each Cedars-Sinai Party in accordance with its terms, except to the extent of the Enforceability Exceptions (as that term is defined in the Affiliation Agreement).

(d) Each Cedars-Sinai Party represents and warrants to the Trust that the execution, delivery and performance of this Agreement by each Cedars-Sinai Party will not (i) conflict with or result in a violation or breach of any material provision of the Governing Documents of any Cedars-Sinai Party, (ii) violate any order, writ, injunction, ruling or law applicable to any Cedars-Sinai Party, or cause the suspension or revocation of any governmental license or authorization applicable to or binding upon or affecting any Cedars-Sinai Party or any of their respective assets, (iii) require any consent, approval or authorization of, or notice to, or declaration, filing or registration with, any governmental or regulatory authority or other person, (iv) result in the creation or imposition of any lien on any of the assets of any Cedars-Sinai Party, or (v) conflict with, result in any breach or contravention of, or permit the acceleration of the maturity of any portion of, any liability of any Cedars-Sinai Party.

(e) The Trust represents and warrants to the Cedars-Sinai Parties that (i) it is a nonprofit testamentary charitable trust existing under the laws of the State of California and has all requisite trust power and authority to carry on its business and to own or lease and operate its assets; (ii) it has all requisite trust power and authority to execute, deliver and enter into this

Agreement and perform its obligations hereunder; (iii) the execution, delivery and performance of this Agreement by the Trust have been duly authorized by all necessary action on the part of the Trust; (iv) no other trust proceeding is necessary to authorize this Agreement and the transactions contemplated hereunder; and (v) this Agreement has been duly executed and delivered by the Trust and (assuming this Agreement constitutes the valid and binding agreement of the Cedars-Sinai Parties) is a legal, valid and binding obligation of the Trust, enforceable against the Trust in accordance with its terms, except to the extent of the Enforceability Exceptions.

(f) The Trust represents and warrants to the Cedars-Sinai Parties that the execution, delivery and performance of this Agreement by the Trust will not (i) conflict with or result in a violation or breach of any material provision of the Governing Documents of the Trust, (ii) violate any order, writ, injunction, ruling or law applicable to the Trust, or cause the suspension or revocation of any governmental license or authorization applicable to or binding upon or affecting the Trust or any of its assets, (iii) require any consent, approval or authorization of, or notice to, or declaration, filing or registration with, any governmental or regulatory authority or other person, (iv) result in the creation or imposition of any lien on any of the assets of the Trust, or (v) conflict with, result in any breach or contravention of, or permit the acceleration of the maturity of any portion of, any liability of the Trust.

9. Notices. All notices, requests and other communications under this Agreement must be in writing and shall be deemed duly given (i) when personally delivered, (ii) when delivered by electronic mail to the attention of a party's representative as identified below, but only if such representative acknowledges receipt within two (2) Business Days; or (iii) one Business Day after delivery to a nationally recognized overnight courier service for next Business Day delivery, in any case addressed to the parties at the following addresses (or at such other address as is given in writing by a party to the other party):

To CSHS or CSMC:	Cedars-Sinai Health System or Cedars-Sinai Medical Center 8700 Beverly Boulevard Suite 2211 Los Angeles, California 90048 Attn: Chief Financial Officer
To the Trust:	Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust c/o Huntington Memorial Hospital 100 W. California Blvd Pasadena, California 91105 Attention: President and CEO
With a copy to:	Hahn & Hahn LLP 301 E. Colorado Boulevard, 9th Floor Pasadena, California 91101 Attention: Christianne F. Kerns, Esq.

10. Termination. This Agreement shall become effective on the Effective Date and may only be terminated as follows:

(a) Prior to the Closing, solely by written notice to the Trust upon termination of the Affiliation Agreement in accordance with Section 9.1 of the Affiliation Agreement; or

(b) After the Closing, solely upon satisfaction of the Cedars-Sinai Parties' obligations under Section 2, including the Trust's receipt of documentation that the Trust Substitution/Release described in Section 2(c) has occurred for all Obligations. Notwithstanding termination of this Agreement, the obligations under Sections 4, 5 and 6 above shall survive termination.

11. Entire Agreement. This Agreement constitutes the entire agreement between the parties and supersedes all prior agreements and understandings between the parties relating to the subject matter hereof.

12. Amendment. This Agreement may be amended from time to time only in writing executed by each of the parties.

13. Governing Law. This Agreement shall be governed by and construed in accordance with the internal laws of the State of California.

14. Waivers. To the maximum extent permitted by applicable law, (a) no claim or right arising out of this Agreement or any of the documents referred to in this Agreement can be discharged by one party, in whole or in part, by a waiver or renunciation of the claim or right unless in writing signed by the other party; (b) no waiver that may be given by a party will be applicable except in the specific instance for which it is given; and (c) no notice to or demand on one party will be deemed to be a waiver of any obligation of that party or of the right of the party giving such notice or demand to take further action without notice or demand as provided in this Agreement or the documents referred to in this Agreement. Failure or delay on the part of either party in exercising any rights, power or privileges under this Agreement will not waive any right, power or privilege.

15. Jury Trial. WAIVER OF JURY TRIAL. EACH OF THE PARTIES HERETO KNOWINGLY AND VOLUNTARILY WAIVES, TO THE FULLEST EXTENT PERMITTED BY LAW, ALL RIGHTS TO TRIAL BY JURY WITH RESPECT TO ANY DISPUTE, WHETHER IN CONTRACT, TORT, OR OTHERWISE, BETWEEN CEDARS-SINAI PARTIES AND ANY TRUST PERSON ARISING OUT OF, IN CONNECTION WITH, RELATED TO, OR INCIDENTAL TO THE RELATIONSHIP ESTABLISHED IN CONNECTION WITH THIS AGREEMENT OR MADE PURSUANT TO ANY OTHER INSTRUMENT, DOCUMENT, OR AGREEMENT EXECUTED OR DELIVERED BY A CEDARS-SINAI PARTY OR ANY TRUST PERSON IN CONNECTION WITH THIS AGREEMENT.

16. Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original. The parties agree that electronic signatures shall be deemed originals for all purposes.

[Signature page follows]

DocuSign Envelope ID: 296A0A88-7FAD-4308-9BBE-3515ED4A6C88

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their authorized representatives as of the effective date stated above.

CEDARS-SINAI MEDICAL CENTER

By REDACTED _____

Thomas M. Priselac,
President and Chief Executive Officer

CEDARS-SINAI HEALTH SYSTEM

By REDACTED _____

Thomas M. Priselac,
President and Chief Executive Officer

TRUSTEES OF THE COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

REDACTED

Jayme Studenmund, TRUSTEE OF THE COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

REDACTED

Armando L. Gonzalez, TRUSTEE OF THE COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

REDACTED

Michelle Quinones Chino, TRUSTEE OF THE COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

REDACTED

Paul Johnson, TRUSTEE OF THE COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

REDACTED

Wayne Brandt, TRUSTEE OF THE COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

Exhibit A

DEFINITIONS

"Bondholder" means any holder or beneficial owner of the Series 2014A Bonds, the Series 2014B Bonds or the Series 2018 Bonds.

"Bond Trustee" means U.S. Bank National Association, a national banking association duly organized and existing under the laws of the United States of America, or its successor, as bond trustee relating to the Series 2014A Bonds, Series 2014B Bonds and/or Series 2018 Bonds.

"Business Day" means a day other than a Saturday, Sunday or other day on which banks located in California are authorized or required by law to close.

"Huntington Master Indenture" means the Amended and Restated Master Indenture of Trust, dated as of November 1, 2014, among Huntington, the Trust, and the Master Trustee, as now modified, supplemented and amended, and as it may hereafter be supplemented, modified and amended from time to time, and includes, for purposes of this agreement, any continuing disclosure agreement(s), whether or not contained in one or more documents separate from the Huntington Master Indenture, which are required of the Trust as a member of the Huntington obligated group with respect to the Obligations.

"Losses" means any and all damages, losses, amounts paid in settlement, judgments, fines, interest, assessments, penalties, costs or burdens associated with performing injunctive relief, liabilities, obligations, costs and expenses of any kind or nature whatsoever, whether any of the foregoing is known or unknown, contingent or vested, matured or unmatured, and whether or not resulting from third-party claims, and any taxes imposed on a Trust Person as a result of the actual or deemed receipt of any payments pursuant to this Agreement, including attorneys' fees, costs of accountants and other professional advisors and expert witnesses.

"Master Trustee" means U.S. Bank National Association, a national banking association organized and existing under the laws of United States of America, or its successor, as master trustee under the Huntington Master Indenture.

"Member" has the meaning given such term in the Huntington Master Indenture. As of the Effective Date, Huntington and the Trust are each a Member.

"Obligated Group" means all Members.

"Obligation No. 3" means the obligation issued under the Huntington Master Indenture and that certain supplemental master indenture, dated as of April 1, 2014, between Huntington and the Master Trustee, relating to the Series 2014A Bonds.

"Obligation No. 4" means the obligation issued under the Huntington Master Indenture and that certain supplemental master indenture, dated as of November 1, 2014, between Huntington and the Master Trustee, relating to the Series 2014B Bonds.

"Obligation No. 6" means the obligation issued under the Huntington Master Indenture and that certain supplemental master indenture, dated as of May 1, 2018, between Huntington and the Master Trustee, relating to the Series 2018 Bonds.

"Obligations" means all liabilities and payment obligations of the Trust in connection with, related to or arising out of (a) the Series 2014A Bonds, Obligation No. 3 and/or that certain supplemental master indenture, dated as of April 1, 2014, between Huntington and the Master Trustee, relating to the Series 2014A Bonds; the Series 2014B Bonds, Obligation No. 4 and/or that certain supplemental master indenture, dated as of November 1, 2014, between Huntington and the Master Trustee, relating to the Series 2014B Bonds; and/or the Series 2018 Bonds, Obligation No. 6 and/or that certain supplemental master indenture, dated as of May 1, 2018, between Huntington and the Master Trustee, relating to the Series 2018 Bonds; (b) the Huntington Master Indenture; (c) being a Member of the Obligated Group; and/or (d) any and all modifications, amendments, supplements, extensions and replacements of any of the foregoing.

"Proceeding" means any actual, pending, threatened or completed action, suit, claim, investigation, hearing or proceeding (whether civil, criminal, administrative or investigative and whether formal or informal), and appeals of any of the foregoing, in which a Trust Person is, has been or becomes involved based in whole or in part on or arising out of any of the Losses and/or Obligations, whether or not the basis of such action, suit, claim, investigation, hearing or proceeding is alleged action or omission by a Trust Person in any capacity.

"Series 2014A Bonds" means the California Statewide Communities Development Authority Revenue Bonds (Huntington Memorial Hospital), Series 2014.

"Series 2014B Bonds" means the California Statewide Communities Development Authority Refunding Revenue Bonds (Huntington Memorial Hospital), Series 2014B.

"Series 2018 Bonds" means the California Statewide Communities Development Authority Revenue Bonds (Huntington Memorial Hospital), Series 2018.

"Trust Persons" means the Trust and each of its past, present and future trustees.

#4

Title 11, California Code of Regulations, § 999.5(d)(1)(C)

A statement of all of the reasons the board of directors of applicant believes that the proposed agreement or transaction is either necessary or desirable

PHA has been engaged in its charitable mission of delivering healthcare services to communities in Pasadena and the San Gabriel Valley for over 125 years, with the support of the Trust. The current operations of PHA include operating Huntington Hospital as a 619-licensd bed general accurate care hospital on a 28-acre campus in Pasadena, California.

In late 2018, in recognition of its long history and its desire to secure PHA's future in an increasingly competitive healthcare industry landscape, the PHA Board began a process of exploring potential strategic transactions that would both: (i) preserve and strengthen the quality and scope of healthcare services that PHA and its affiliates provide to their communities, including charity care and community benefit services; and (ii) provide PHA with access to additional resources to support its current and anticipated capital needs. The PHA Board authorized the formation of a committee (the "Rose Committee") to explore alternatives for PHA to consider.

The Rose Committee engaged in a months-long process to explore alternatives, with the advice of legal counsel and assistance of an independent strategic advisor. The Rose Committee identified and refined PHA's priorities, which it determined included mission, culture, clinical programs and services, physician alignment, ambulatory strategies, value-based care capabilities, IT resources, financial resources, and strategic alignment, as well as effects on the community governance of PHA and its relationship with the Trust.

At the conclusion of this process in April 2019, the Rose Committee presented the findings of the Rose Committee to the PHA Board. After deliberations, the PHA Board determined that it would be in the best interests of PHA and in furtherance of its charitable purposes to pursue a process designed to generate interest in an affiliation transaction in which PHA could join a health system that best met PHA's priorities. The Board authorized the reconstitution of the Rose Committee as the "Partnership Committee," adjusted the membership of the Partnership Committee to consist solely of volunteer directors, including directors who are also trustees of the Trust, and granted broad authority to the Partnership Committee to explore strategic alternatives for PHA and Huntington Hospital. The PHA Board made clear that these strategic alternatives could include the possibility of PHA becoming affiliated with a charitable health system with a mission and values consistent with those of PHA (the "Potential Transaction") and charged the Partnership Committee with reporting and making recommendations to the PHA Board concerning its findings.

PHA's President and Chief Executive Officer resigned from the PHA Board, and the Partnership Committee adopted and implemented protocols concerning compliance with California Health and Safety Code 1260.1, including prohibiting communications concerning the Potential Transaction from members of management who may receive compensation from an acquiring party in a transaction with PHA to members of the Partnership Committee or other directors of PHA.

After April 2019, the Partnership Committee explored strategic alternatives for PHA, including identifying charitable health systems (the "Interested Parties") whose missions, values and operations provided a reasonable basis to believe that an affiliation with one of the systems could help PHA meet its objectives; entering into nondisclosure agreements with the Interested Parties; engaging in confidential discussions with the Interested Parties; soliciting and receiving nonbinding initial indications of interest

from multiple Interested Parties; evaluating the initial indications for the PHA Board; narrowing the field of Interested Parties based on their initial indications, after input and direction from the PHA Board; two-way due diligence with the Interested Parties, including visiting each other's facilities; soliciting and receiving letters of intent from multiple Interested Parties; and negotiating the terms of the letters of intent with each Interested Party.

At a meeting of the PHA Board in February 2020 with no members of management participating, the Partnership Committee presented its qualitative assessment of each Interested Party based on campus tours and confidential meetings with directors and executives of each Interested Party measured against the criteria developed by the Rose Committee. The Partnership Committee did not reach conclusions or make recommendations at that meeting, as it wished to consider the outcome of negotiations concerning the letters of intent. After the February 2020 PHA Board meeting, negotiations of the letters of intent continued, and one of the Interested Parties withdrew from the process.

At a meeting of the PHA Board duly held in March 2020 with no members of management participating, the PHA Board, after presentations by the financial and legal advisers to PHA and due deliberation, determined that the Potential Transaction in which Cedars-Sinai would become the sole member of PHA, commit to install a new electronic health record system, support the 9-year strategic capital plan of PHA and preserve key community healthcare programs, among other things, on substantially the terms in the letter of intent negotiated with Cedars-Sinai and presented to the PHA Board (collectively, the "Cedars Affiliation"), was in the best interests of PHA and in furtherance of its charitable purposes. The PHA Board's decision in this regard was informed by its determination that the Cedars Affiliation will enhance PHA's ability to fulfill its mission and vision and position PHA to be a leader in a value-based care environment. The PHA Board authorized the Partnership Committee to negotiate agreements to implement the Cedars Affiliation.

The letter of intent (the "Letter of Intent") was signed by PHA and Cedars-Sinai as of March 6, 2020, and a public announcement was issued on March 9, 2020. The Letter of Intent specifically noted the following goals of PHA in pursuing the Cedars Affiliation:

- Enhance PHA's ability to fulfill its mission and vision.
- Develop a compatible culture with Cedars-Sinai, with a focus on collaboration and a commitment to quality and community.
- Recognize PHA's commitment to and relationship with its community as key foundational assets to be maintained and built upon.
- Develop the leading clinically integrated healthcare delivery platform in PHA's service area.
- Enhance the relationship with PHA's medical provider community.
- Commit to the wellness of PHA's service area.
- Balance the current economic realities of the greater Los Angeles area.
- Enable PHA to continue and enhance its ambulatory growth strategy.
- Support investment in the ambulatory resources necessary to provide value-based care.
- Position PHA to be a leader in a value-based care environment with specific competencies, including the ability to enter into risk-based payment arrangements, coordinate care effectively, perform sophisticated data analytics and provide broad access to care.

- Implement an enterprise-wide information technology strategy, including electronic health records, ambulatory population health management and wellness, and revenue cycle management.

- Provide the resources necessary to support the development of a full service management services organization and offer competitive employment and quasi-employment options to our medical community.

- Consider strategic and economic realities, balancing the possible effects on PHA's current partnerships and relationships.

- Support the full spectrum of the clinical services PHA offers to the community, particularly in areas of cardiology and oncology.

- Commit to clinical quality.

- Demonstrate alignment with PHA's focus upon excellence in nursing and its medical staff.

- Continue PHA's existing commitment to research and education.

- Provide financial strength and stability to support the combined capital needs of PHA and Cedars-Sinai.

- Ensure ongoing commitment to PHA's relationship with the community as well as its existing mission, including a meaningful role in governance for the PHA Board and the Trust.

- Demonstrate that the affiliation with PHA is a strategic priority for Cedars-Sinai.

- Successfully execute an affiliation strategy.

In short, the parties believe the Affiliation will improve the quality of and access to healthcare in their communities, strengthening PHA and its affiliates with the resources and support of Cedars-Sinai and enabling PHA and its affiliates to lead the development and execution of the strategy for ongoing operations to deliver clinical excellence and value-based care in the San Gabriel Valley.

Title 11, California Code of Regulations, § 999.5(d)(2)

FAIR MARKET VALUE

#5

Title 11, California Code of Regulations, § 999.5(d)(2)(A)

The estimated market value of all cash, property, stock, notes, assumption or forgiveness of debt, and any other thing of value that the applicant would receive for each health facility covered by the proposed transaction

The Affiliation will result in Cedars-Sinai becoming the sole member of PHA and does not involve the sale, transfer, merger or other disposition of any assets of PHA. Immediately after the Affiliation, PHA will continue to own and operate Huntington Hospital. The Affiliation is a mission-driven affiliation, which PHA believes will provide substantial benefits to PHA and the communities it serves through important commitments made in the Affiliation Agreement, including:

- Cedars-Sinai's agreement, within three years after Closing, to install Epic software for an integrated electronic health record system at PHA. Cedars-Sinai agrees to fund the capital costs of this project from sources other than cash of PHA (*e.g.*, borrowings or intercompany loans).

- Cedars-Sinai's approval of PHA's $560 million capital plan through December 31, 2029. If PHA's days cash on hand falls below 60 days, then Cedars-Sinai will fund up to $300 million of the capital plan from sources other than cash of PHA. Annual capital spending is subject to budget approval processes, except that a current $85 million capital project is pre-approved.

- Cedars-Sinai's and CSMC's agreement to cause the Trust to be released from its obligations under the master indenture of trust and related agreements involving the approximately $290 million of bond indebtedness of PHA by 2028, and CSMC agreeing to hold the Trust and trustees harmless from those obligations. More information about the Reimbursement Agreement is in Exhibit 3-G to Section 999.5(d)(1)(B).

#6

Title 11, California Code of Regulations, § 999.5(d)(2)(B)

The estimated market value of each health facility or other asset to be sold or transferred by the applicant under the proposed transaction

The Affiliation does not involve a sale, transfer, merger or other disposition of any of PHA's assets. Instead, pursuant to the Affiliation Agreement, Cedars-Sinai will become the sole member of PHA, with PHA retaining its assets and liabilities. The Affiliation will, however, help strengthen PHA and its affiliates as further described in response to Section 999.5(d)(2)(A).

For information regarding PHA's assets, liabilities, and other financial matters, see the response to Section 999.5(d)(11)(F) and related exhibits.

#7

Title 11, California Code of Regulations, § 999.5(d)(2)(C)

A description of the methods used by the applicant to determine the market value of any assets involved in the proposed transaction, including a description of the efforts made by the applicant to sell or transfer each health facility that is the subject of the proposed agreement or transaction

The Affiliation provides for Cedars-Sinai becoming the sole member of PHA, and does not involve a sale, transfer merger or other disposition of any of PHA's assets. Therefore, the parties did not obtain an appraisal in connection with the proposed Affiliation.

For information regarding PHA's assets, liabilities, and other financial matters, see the response to Section 999.5(d)(11)(F) and related exhibits.

For a description of the deliberate and extensive process that PHA engaged in to determine that this Affiliation with Cedars-Sinai is the best course of action for PHA, and the reports, analyses, requests for proposals, and other documents that informed this deliberative process, see the responses to Section 999.5(d)(1)(C) and Section 999.5(d)(2)(D), respectively.

#8

Title 11, California Code of Regulations, § 999.5(d)(2)(D)

Reports, analysis, Requests for Proposal, and any other documents that refer or relate to the valuation of any asset involved in the agreement or transaction

Because the Affiliation provides that Cedars-Sinai will become the sole member of PHA, and does not involve a sale, transfer, merger or other disposition of any of PHA's assets, the parties did not obtain an appraisal in connection with the proposed Affiliation. PHA did, however, engage in a deliberate and extensive process in exploring potential transactions that could help preserve and strengthen the quality and scope of healthcare services that PHA and its affiliates provide and provide PHA with access to additional resources to support its current and anticipated capital needs. After considering the multiple proposals it received, the PHA Board ultimately chose the affiliation partner it felt would maximize these objectives going forward.

For more information regarding PHA's deliberative process in selecting Cedars-Sinai as an affiliation partner, see the response to Section 999.5(d)(1)(C) and the following materials:

- Attached to this Section 999.5(d)(2)(D) as **Exhibit 8-A** is a copy of the Project Rose Meeting 1 Discussion Materials dated February 5, 2019.
- Attached to this Section 999.5(d)(2)(D) as **Exhibit 8-B** is a copy of the Confidential Information Presentation prepared by PHA and its advisers in July of 2019.
- Attached to this Section 999.5(d)(2)(D) as **Exhibit 8-C** is a copy of the request for proposal issued by PHA on July 8, 2019.
- Attached to this Section 999.5(d)(2)(D) as **Exhibit 8-D** is a copy of the Cedars-Sinai indication of interest dated September 12, 2019.
- Attached to this Section 999.5(d)(2)(D) as **Exhibit 8-E** is a copy of follow-up questions sent by PHA to Cedars-Sinai dated October 1, 2019.
- Attached to this Section 999.5(d)(2)(D) as **Exhibit 8-F** is a copy of Cedars-Sinai's responses to the follow-up questions dated October 23, 2019.
- Attached to this Section 999.5(d)(2)(D) as **Exhibit 8-G** is a copy of Project Rose: Workstreams Overview dated November 15, 2019.
- Attached to this Section 999.5(d)(2)(D) as **Exhibit 8-H** is a copy of presentation materials from a site visit to Cedars-Sinai in February of 2020.
- Attached to this Section 999.5(d)(2)(D) as **Exhibit 8-I** is a copy of the letter of intent between PHA and Cedars-Sinai dated March 6, 2020.
- Attached to this Section 999.5(d)(2)(D) as **Exhibit 8-J** is a copy of presentation materials from a Project Rose Funding Commitment Discussion in April of 2020.

- Attached to this Section 999.5(d)(2)(D) as **Exhibit 8-K** is a copy of presentation materials from a Project Rose Debt Consolidation discussion in May of 2020.

- Attached to this Section 999.5(d)(2)(D) as **Exhibit 8-L** is a copy of Project Rose presentation materials comparing Affiliation Agreement terms to the letter of intent dated June 19, 2020.

- Attached to this Section 999.5(d)(2)(D) as **Exhibit 8-M** is a copy of Project Rose: Board Meeting Pre-Read Summary dated July 14, 2020.

- Attached to this Section 999.5(d)(2)(D) as **Exhibit 8-N** is a copy of Project Rose: Board Meeting materials dated July 14, 2020.

- Attached to this Section 999.5(d)(2)(D) as **Exhibit 8-O** is a copy of the resolutions of the PHA Board approving the Affiliation on July 14, 2020.

Exhibit 8-A

Project Rose Meeting 1 Discussion Materials

Huntington Hospital

KaufmanHall

Exceptional Partners. Exceptional Performance.

Project Rose

Meeting 1 Discussion Materials

Pasadena, California | February 5, 2019

CONFIDENTIAL

CONFIDENTIAL – ©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Today's Agenda

1. Introductions
2. Kickoff and Process Overview
3. Environmental Overview
4. Illustrative Partnership Goals and Objectives
5. Next Steps and Discussion

CONFIDENTIAL
©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

1. Introductions
2. Kickoff and Process Overview
3. Environmental Overview
4. Illustrative Partnership Goals and Objectives
5. Next Steps and Discussion

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Introductions

"Rose Committee" Members

Trustees	Huntington Board Members	Management Team	Advisors

• Paul Ouyang
• Jaynie Studenmund
• Michelle Chino
• Armando Gonzalez
• Wayne Brandt
	• Scott Jenkins
	• Paul Johnson
	• Chris Hedley, MD
	• Chris Mitchell
		• Lori Morgan, MD
		• Paula Verrette, MD
		• Raj Takhar
		• Rick Ellingsen
		• John Goeders
		• Steve Mohr
			• Kaufman Hall
			  • Steve Hollis
			  • Kris Blohm
			  • Sam DiSalvo
			  • Omar Farris
			• Counsel as appropriate

CONFIDENTIAL

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

1. Introductions
2. Kickoff and Process Overview
3. Environmental Overview
4. Illustrative Partnership Goals and Objectives
5. Next Steps and Discussion

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Process Objectives

- We are embarking on a process of education and information gathering with Huntington and the Trust to evaluate options in a structured and informed manner

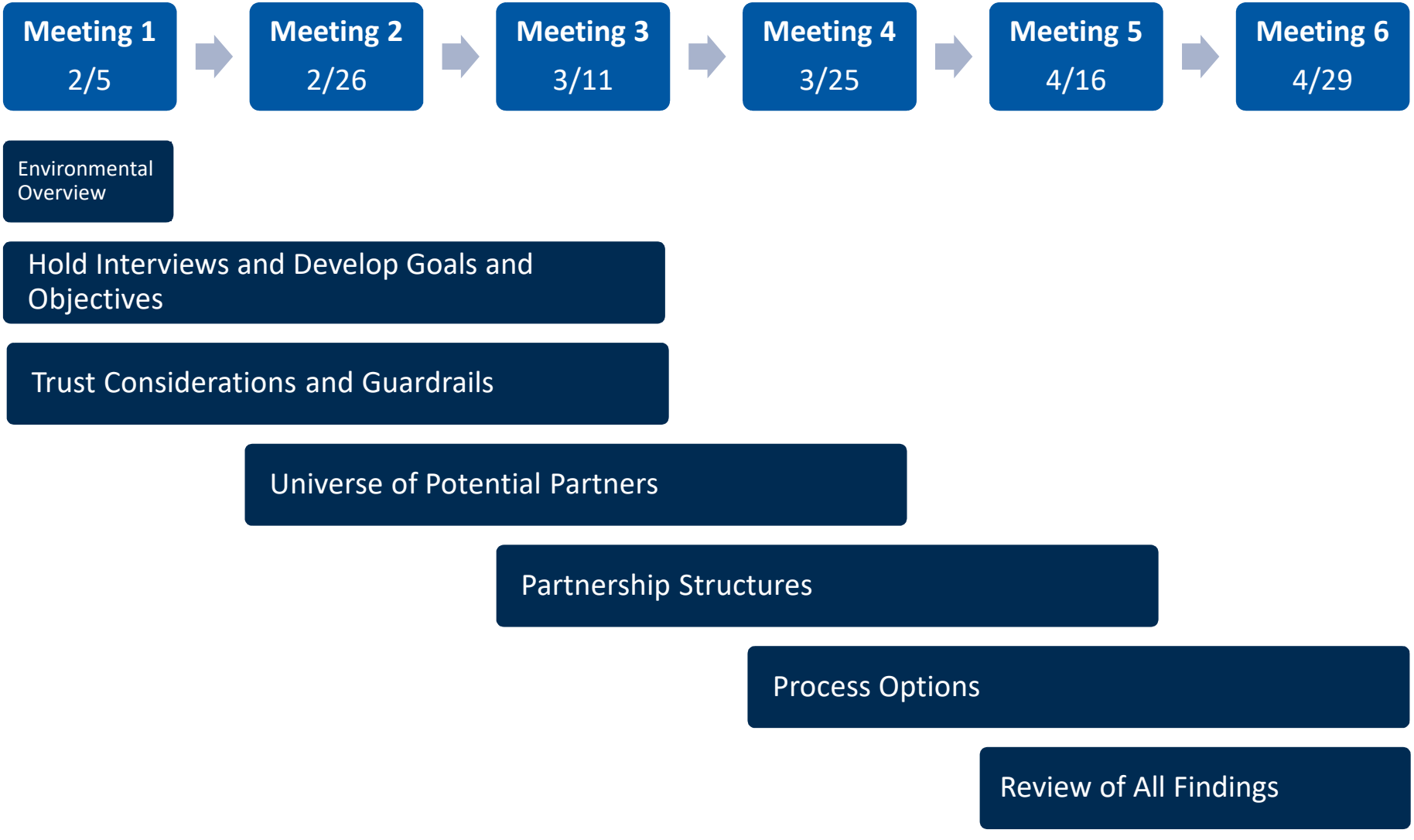
Primary Questions to Be Explored in this Process			
What are our goals in seeking an affiliation?	Who are the potential candidates and their relative merits?	What form could such an affiliation take?	What is the role of the Trust within an affiliation?

- Should the Boards decide to proceed, a structured outreach process would be put in place to identify target partner(s) that have an interest in an affiliation (and on what terms)

CONFIDENTIAL
©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Meeting Agendas and Sequencing

- We intend to address these questions over the course of six meetings between now and the end of April



CONFIDENTIAL
©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

1 Introductions

2 Kickoff and Process Overview

3 Environmental Overview

4 Illustrative Partnership Goals and Objectives

5 Next Steps and Discussion

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

National Trends

CONFIDENTIAL

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Legacy Healthcare Is Under Immense and Multiple Pressures

Insurers/ Risk Managers	Will change the high and often inconsistent costs of legacy care models
Clinicians/ Caregivers	Are likely to resist payment changes until new models are proven
Patients/ Users	Losing tolerance for lack of accessible transparency about cost and quality
Disruptive Entrants	Show intense cross-vertical interest in key segments of care delivery
Government Agencies	Continue their regulatory scrutiny as transformation marches ahead

CONFIDENTIAL
©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

The Largest Provider(s) Are Dwarfed by Entrants/Disruptors



©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

New Competitors Are Attacking Where Traditional Providers Are Most Vulnerable

VULNERABILITY	STRATEGY	EXAMPLES
Limited hours and locations; high prices	Retail clinics, urgent care, telemedicine, diagnostic centers	minute clinic, Concentra, Dr DOCTOR ON DEMAND, RadNet
Limited availability of information	Transparency tools	CASTLIGHT HEALTH, HealthAdvocate
Long wait times, challenges in caregiver communication, and other shortcomings of patient experience	New primary care models	MDVIP, one MEDICAL GROUP
Lack of coordination, consistency, and assistance in coping with varied patient situations	Care management tools and practices	DaVita, HealthSmart
High clinical costs and inflexible traditional diagnostic and treatment methods	Precision medicine	Roche, illumina

CONFIDENTIAL
©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

The Implementation of Digitized Care Is Still in its Infancy

- 33% of ambulatory care visits are addressable through telehealth
- 80% of behavioral health visits are addressable through telehealth
- The country's largest telehealth company says it has only reached 1% of its total addressable market

"The digital world has been in a separate orbit from our medical cocoon, and it's time the boundaries be taken down."
– Eric Topol, M.D.

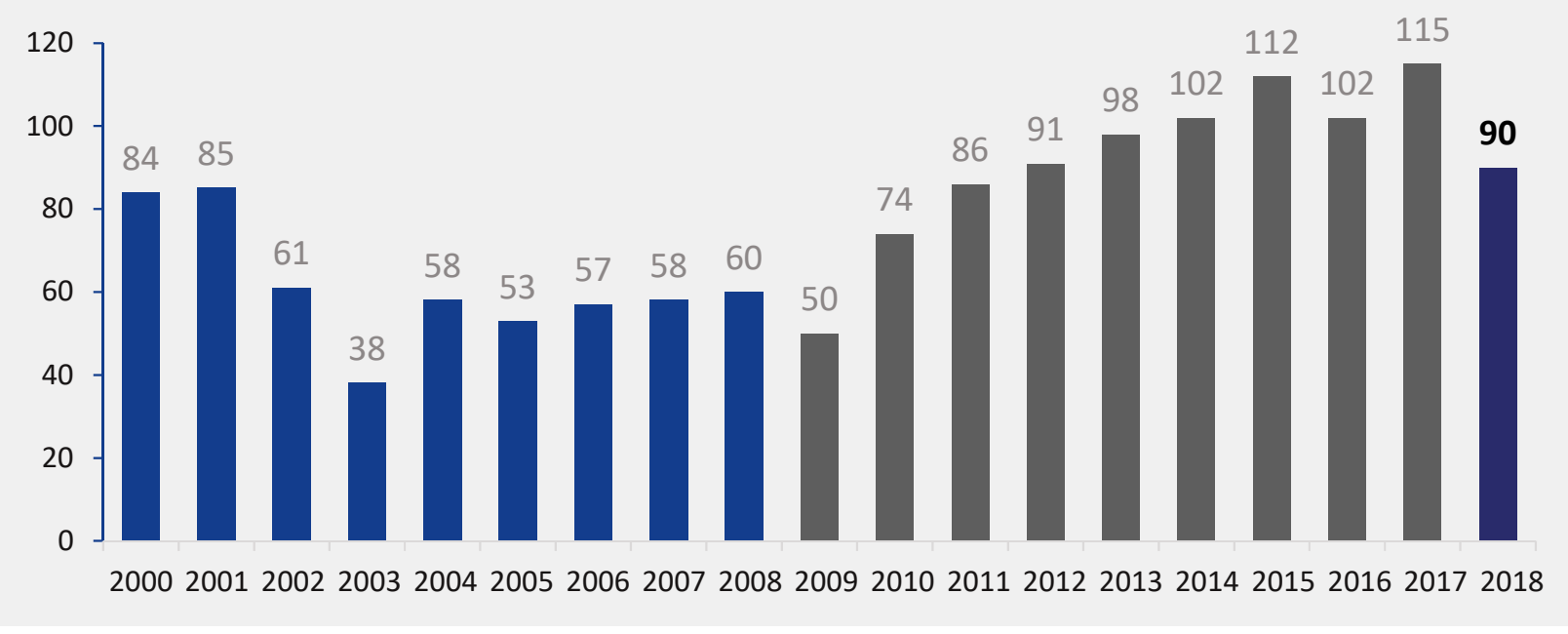


Sources: Teladoc: J.P. Morgan Healthcare Conference, Jan. 8, 2018; Winslow, R.: "The Wireless Revolution Hits Medicine." *The Wall Street Journal,* Feb. 14, 2013.

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Consolidation Among Hospitals and Health Systems Continues

Hospital and Health System M&A Transactions, 2000-2018



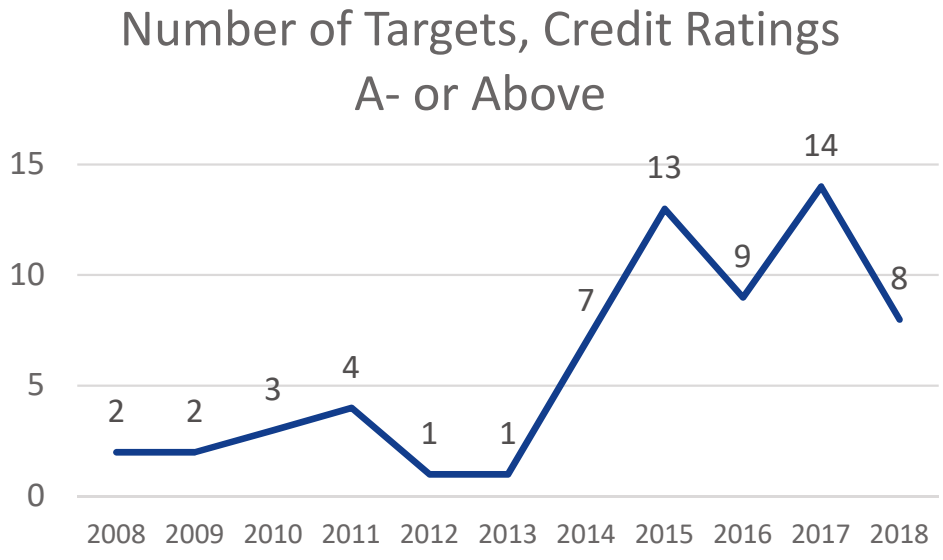
The number of transactions nearly doubled in the last decade

Sources: Kaufman Hall Transactions Data, S&P Median Credit Rating Reports, Moody's Median Credit Rating Reports, Moody's Credit Rating Changes Reports.

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

The Participants Are Increasingly Including Market Leaders

Year	Transacted Revenue ($B)	Number of Transactions
2018	$36,360	90
2017	$63,186	115
2016	$31,288	102
2015	$32,028	112
2014	$23,098	102
2013	$31,328	98



Note: For cases in which two parties merged, smaller party labeled as "Target"; Size determined based on target revenue.
Sources: Kaufman Hall Transactions Data, S&P Median Credit Rating Reports, Moody's Median Credit Rating Reports, Moody's Credit Rating Changes Reports.

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Large For-Profits Are Exiting Markets and Regions

(activity Since 1/1/17)

CHS Community Health Systems

21 transactions involving
41 hospitals

QUORUM HEALTH

9 transactions involving
11 hospitals

tenet HEALTH

9 transactions involving
15 hospitals

Note: Copyrights of images belong to their respective owners.

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

The Emerging Success Model Will Likely Require…

- A contemporary point of view around industry and market transformation linked to an achievable and **integrated strategic and financial planning road map**
- Requisite supporting financial, clinical, infrastructure and leadership resources to **succeed in a value-based environment**, and eventually assume population health management and contractual risk directly or in partnership with payor(s) and/or employer(s)
- A solid **competitive position** in the geographies served (market relevance, coverage, durability, and diversification)
- A durable, integrated, and highly **aligned physician platform**
- A **care, cost, and quality management culture**
- A comprehensive **consumer understanding**, segmentation and retail strategy
- Sophisticated, integrated, and distributed **information technology**
- Acute attention to operations and business **portfolio management**
- **Scale and size** to leverage fixed costs and maintain market relevance
- A **well managed balance sheet** to support investments and weather volatility

CONFIDENTIAL
©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

California Market Context

CONFIDENTIAL
©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

California Providers Face Unique Challenges



Seismic Investment Requirements are Significant

- Systems stretching capital positions to comply



California Provider Fee Winners, Losers and Inherent Risk

- Many hospitals depend on Provider Fee income to be viable
- Long term future uncertain in current environment

KAISER PERMANENTE®

Prevalence of Kaiser Limits Available Commercial Business

- Restricts the competitive position and options of many regional systems and hospitals



Attorney General in California Is Active

- AG is interested and asserting its authority

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Noteworthy Transaction Activity in California

Adventist Health *A+ (Fitch)*	• Highly active in expanding footprint through acquiring community hospitals (Delano, Rideout, Lodi) • Joint operating agreement with Providence St. Joseph Health in Northern California (Sacred Trust) – currently under FTC review
Providence St. Joseph Health *Aa3 (Moody's)* *AA- (S&P)*	• Joint operating agreement with Adventist Health in Northern California (Sacred Trust) – currently under FTC review
Dignity Health. *A3 (Moody's)* *A (S&P)*	• Merger with CHI Health (Baa1 Moody's; BBB+ S&P) approved in 2018, completed in 2019 • Combined organization to be known as CommonSpirit Health and will have 142 hospitals in total, 30 of which in California
Verity Health	• Bankruptcy filing in 2018 • 2 Northern California hospitals in process of sale to Santa Clara County • 4 Southern California hospitals in process of sale to KPC Group • Formerly Daughters of Charity Health System
DaVita Medical Group OPTUM	• Optum/ UnitedHealth Group acquires Davita Medical Group

CONFIDENTIAL
©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Regional and Local Market Context

CONFIDENTIAL
©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Affiliation / Network Development Discussions Are Ramping Up, but Still No Catalyst for Consolidation in LA County

- Cedars-Sinai (Aa3 Moody's) has been active in expanding its hospital presence through Torrance Memorial and Marina Del Rey Hospital transactions, as well as through ambulatory growth (particularly in South Bay)
- UCLA (Aa3 Moody's; AA- S&P and rated together with other UC entities) pursuing growth through ambulatory / physician strategy throughout LA County and beyond
- City of Hope (A1 Moody's; AA- Fitch) expanding outpatient footprint in region through radiation oncology joint venture with Vantage/ McKesson
- Dignity's combination with CHI Health not anticipated to affect operation or market presence in Southern California
- Providence and St. Joseph Hoag Health merger further consolidates Orange County
- Individual community hospitals are looking for a non-traditional network solution

CONFIDENTIAL
©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

1 Introductions

2 Kickoff and Process Overview

3 Environmental Overview

4 Illustrative Partnership Goals and Objectives

5 Next Steps and Discussion

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Introduction to Illustrative Partnership Goals and Objectives

- To stimulate thinking and discussion, the following slides present a number of illustrative potential goals and objectives within the following categories

Mission, Vision and Values	Governance and Role of Trust	Strategic Fit and Existing Partnerships
Clinical Programs and Services	Physician Enterprise	Corporate Infrastructure
Capital and Facilities	Value Based and Population Health Capabilities	Other Considerations

CONFIDENTIAL
©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Introduction to Interviews

- In the coming days/weeks, Kaufman Hall will be holding 30-45 minute individual discussions with members of the Project Rose Committee
- The purpose of these discussions is to gather individual perspectives on the considerations most important to Huntington and the Trust in the assessment of a potential partnership
- Feedback will be summarized by Kaufman Hall on an **ANONYMOUS** basis, and will be used to further develop the organization's strawman goals and objectives
- These guiding principles will ultimately be agreed to and formalized by the Project Rose Committee, and will serve as a "true north" throughout the partnership process as Huntington and the Trust weighs various matters and makes decisions

CONFIDENTIAL
©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Example Interview Discussion Questions

- Introductions (for contextual purposes)
- What is your long-term vision for Huntington locally, regionally, or nationally?
- What competitive threats or other challenges does Huntington face today and into the future?
- What are the most important considerations and/or concerns for you as Huntington assesses a potential partnership?
- Discussion of Huntington's preliminary strawman goals and objectives (as displayed on previous pages in this section)
- Are there any additional guiding principles, goals, objectives, and/or constraints for a potential partnership that we have not discussed that you would like to raise?
- Others TBD

CONFIDENTIAL
©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Long-term Mission, Vision and Values Alignment

Illustrative "Straw Man" Position	Questions and Comments
Common Vision and Values: A partner should exhibit common values and a compelling vision for healthcare delivery in the region	• What are views regarding a for-profit partner?
Cultural Compatibility: Partner organization should demonstrate cultural compatibility across key stakeholder groups (i.e., Boards, management, physicians) and embody a culture of collaboration	• What are our views regarding a religiously sponsored or aligned partner? • Difficult to evaluate, especially early in process

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Governance and Role of the Trust

Illustrative "Straw Man" Position	Questions and Comments
Continued Role in Governance: Huntington seeks to maintain a meaningful role in governance and management at Huntington, and ability to influence decisions of an overall partnership	• What are our governance expectations, including the desired degree of continuing involvement?
Role of the Trust: The Trust desires to maintain and enhance its direct support of and economic relationship with Huntington through a partnership	• What role does the Trust seek within a partnership?

CONFIDENTIAL

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Strategic Fit and Existing Partnerships

Illustrative "Straw Man" Position	Questions and Comments
Similar Strategic Plans/Goals: The strategic plans and goals of the partner should be congruent, complementary and philosophically consistent those of Huntington	• Are there any defensive considerations to be mindful of?
Huntington "Essentiality": Partner should demonstrate that Huntington's operations will be an integral part of a combined organization's overall business strategy	• What role does Huntington see itself playing within a partnership?
Existing Partnerships: Existing partnerships developed by Huntington must be maintained and enhanced.	• Are there any partnerships that must be preserved and maintained?

CONFIDENTIAL

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Clinical Programs, Services and Capabilities

Illustrative "Straw Man" Position	Questions and Comments
Commitment to Primary Care: Partner should demonstrate commitment to continuing and enhancing Huntington primary care capabilities (recently enhanced through DHCP affiliation)	• How important is maintaining DHCP relationship?
Enhancing Specialty Service Lines: Partner should demonstrate commitment to enhancing key Huntington service lines	• What are our goals in the development or enhancement of services?
Care Coordination: Partner should possess the ability and necessary resources to effectively coordinate the provision of services across a system to ensure seamless access to high quality, cost-effective health care	• What resources do we want the partner to offer?
Leading Edge Technology: Partner should demonstrate commitment to investing in leading edge clinical technology	
Academic Teaching and Research: Partner should demonstrate commitment to academic research and teaching programs	• What current relationships are in place that should be considered, or enhanced?
Quality Excellence: Partner should have a demonstrated track record of providing the highest possible quality of health care services to its community	• Why do patients and contracting entities select Huntington and how do we maintain and advance these characteristics within a partnership?

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Physician Enterprise

Illustrative "Straw Man" Position	Questions and Comments
Physician Alignment: Partner should seek to leverage its existing physician infrastructure capabilities to improve integration in Huntington's physician communities and improve alignment across system	• Are there any specific needs or gaps (e.g., primary care)?
Ability to Recruit and Retain Physicians: Partner should demonstrate its ability to recruit and attract qualified physicians to Huntington	
Administration Expertise: Partner should have the medical administration expertise and resources to enhance local medical staff leadership	

CONFIDENTIAL

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Corporate Infrastructure

Illustrative "Straw Man" Position	Questions and Comments
Corporate Services: Partnership should provide meaningful opportunities to leverage economies of scale to create operational efficiencies in corporate management and back-office functions	• What tools and capabilities does Huntington seek from a partner?

CONFIDENTIAL

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Capital and Facilities

Illustrative "Straw Man" Position	Questions and Comments
Access to Capital: Partner must demonstrate adequate access to capital and Huntington must in turn have access to such capital	
Continued Investment in Huntington: Huntington will require the partner's commitment to continue to make capital investments to maintain, enhance, renovate and expand Huntington facilities for community benefit	• Are there specific commitments we are seeking?
Debt and Liabilities: Partner must commit to either assuming Huntington's current debt and liabilities or providing proceeds sufficient to fully satisfy debt and liabilities	• Is addressing current debt at Huntington a consideration in a partnership?
Information Technology: Partner should demonstrate a sophisticated information technology infrastructure to support clinical integration, population health management and enable connectivity	• How important is having a partner with an interconnected enterprise-wide EHR?

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Value-based / Population Health Management Infrastructure

Illustrative "Straw Man" Position	Questions and Comments
Focus on Population Health: Partner should be focused around the purposeful development of a care management/ population health model	
Innovative Payment Arrangements: Partner should support advancement of population health management locally through quality incentive and risk-bearing payment arrangements, among other appropriate mechanisms	• How might a partner further existing Medicare Advantage strategic initiatives?
Process Improvement: Partner should demonstrate proficiency in developing, implementing and managing processes and protocols to redesign care, reduce variation, and systematically improve outcomes while lowering cost	• Are there any specific needs or gaps that a partner might fill here?
Data Analytics Expertise: Partner should provide the necessary expertise and tools in predictive modeling and population-based analytics to effectively segment the patient population, link financial and clinical information, and create a platform for patient interventions	• Are there any specific needs or gaps that a partner might fill here?
Improving Access: Partner should demonstrate desire and ability to expand access to managed populations with anticipated healthcare needs and activity levels to support a robust set of subspecialty practices	

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Other Considerations

Illustrative "Straw Man" Position	Questions and Comments
Commitment to Employees: Existing employees of the system should be retained at the same, or better, level of compensation and benefits and the current tenure of employees is maintained post-transaction for benefit eligibility and other purposes	• Are there any union considerations?
Recruitment and Retention: Combined organization should be well positioned to attract and retain qualified talent serving Huntington's communities	• Are there any specific gaps or needs identified here?
Branding and Identity: The Huntington brand must be maintained and enhanced through a partnership	
Philanthropic Foundation: A partnership should enhance the current philanthropic foundation's ability to support the hospital and community	

CONFIDENTIAL

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

1 Introductions

2 Kickoff and Process Overview

3 Environmental Overview

4 Illustrative Partnership Goals and Objectives

5 Next Steps and Discussion

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Next Steps

Next meeting is Tuesday, February 26

- Kaufman Hall to schedule and hold interviews with Rose Committee members
- Kaufman Hall to summarize and condense major interview themes and findings
- Kaufman Hall to review work of Trust counsel to date regarding affiliation considerations and guardrails, and discuss directly as appropriate
- Kaufman Hall to continue to review background data provided relating to the hospital and the Trust
- Kaufman Hall to work with Huntington management to continue to understand operational, financial and strategic positions to further inform process

Meeting 2 Agenda

- Discuss summary interview findings
- Review first draft of partnership goals and objectives
- Present Trust considerations and guardrails
- Summary of current Huntington strategic partnerships
- Introduce universe of potential affiliation partners

CONFIDENTIAL

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Qualifications, Assumptions and Limiting Conditions (v.12.08.06):

This Report is not intended for general circulation or publication, nor is it to be used, reproduced, quoted or distributed for any purpose other than those that may be set forth herein without the prior written consent of Kaufman, Hall & Associates, LLC. ("Kaufman Hall").

All information, analysis and conclusions contained in this Report are provided "as-is/where-is" and "with all faults and defects". Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified by Kaufman Hall. No warranty is given as to the accuracy of such information. Public information and industry and statistical data, including without limitation, data are from sources Kaufman Hall deems to be reliable; however, neither Kaufman Hall nor any third party sourced, make any representation or warranty to you, whether express or implied, or arising by trade usage, course of dealing, or otherwise. This disclaimer includes, without limitation, any implied warranties of merchantability or fitness for a particular purpose (whether in respect of the data or the accuracy, timeliness or completeness of any information or conclusions contained in or obtained from, through, or in connection with this report), any warranties of non-infringement or any implied indemnities.

The findings contained in this report may contain predictions based on current data and historical trends. Any such predictions are subject to inherent risks and uncertainties. In particular, actual results could be impacted by future events which cannot be predicted or controlled, including, without limitation, changes in business strategies, the development of future products and services, changes in market and industry conditions, the outcome of contingencies, changes in management, changes in law or regulations. Kaufman Hall accepts no responsibility for actual results or future events.

The opinions expressed in this report are valid only for the purpose stated herein and as of the date of this report.

All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the client.

In no event will Kaufman Hall or any third party sourced by Kaufman Hall be liable to you for damages of any type arising out of the delivery or use of this Report or any of the data contained herein, whether known or unknown, foreseeable or unforeseeable.

©2018 Kaufman, Hall & Associates, LLC. All rights reserved.

Exhibit 8-B

Confidential Information Presentation

Huntington Hospital

PROJECT ROSE

CONFIDENTIAL INFORMATION PRESENTATION

July 2019

KaufmanHall

HIGHLY CONFIDENTIAL

Table of Contents

No.	Topic	Pg. #
1.	Executive Summary	4
2.	Organizational Overview	11
3.	Operational Highlights	21
4.	Service Area and Market	36
5.	Medical Staff	42
6.	Governance, Management, and Employees	47
7.	Financial Summary	60
8.	Strategic & Financial Initiatives	73

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Disclosures

This Confidential Information Presentation (the "CIP" or "Presentation") contains confidential information and trade secrets regarding Huntington Hospital ("Huntington"), located in Pasadena, California. This Presentation has been prepared for informational purposes only, and is being furnished through Kaufman, Hall & Associates, LLC. ("Kaufman Hall"), the financial consultant of Huntington with respect to this Presentation, solely for use by the recipient in evaluating a specific potential business combination transaction with Huntington.

Kaufman Hall has relied upon information provided by Huntington and other sources, and has not independently verified the accuracy or completeness of any such information contained in this CIP. Any estimates, projections or forward-looking information contained in this CIP or communicated otherwise are based on information available to Huntington as of this date. Such estimates, projections and forward-looking statements involve known and unknown risks, uncertainties, assumptions and other factors that may cause actual results, performance or achievements to be materially different. Huntington and Kaufman Hall do not make any representation or warranty, expressed or implied, as to the accuracy or completeness of the CIP or any of the information contained herein, or otherwise delivered to you, or with respect to any other matter. Only those representations and warranties made in a written definitive agreement to a business combination, when and if executed and delivered by the parties to the agreement, and subject to any limitations and restrictions as may be specified in such written definitive agreement, shall have any legal effect. In addition, neither Huntington, Kaufman Hall and any of their representatives shall have any liability to the recipient for the accuracy of any materials contained in, or for any materials omitted from, this CIP or any other documents or information or written or oral communications transmitted to the recipient in the course of its evaluation of Huntington. The CIP does not purport to contain all of the information that may be required for the recipient to evaluate all of the factors that would be relevant to a recipient considering a strategic business combination transaction with Huntington. If a recipient pursues such a transaction, the recipient will be responsible for conducting its own, more detailed due diligence investigation of Huntington.

The recipient acknowledges that it has previously executed and delivered a Non-Disclosure Agreement (the "NDA") and that the existence of this CIP and the information contained herein are subject to the terms and conditions of the NDA.

By accepting delivery of this CIP, the recipient acknowledges and agrees to all of the terms, conditions and disclaimers set forth herein, and that: (1) all of the information contained herein is confidential; (2) the recipient will not reproduce this CIP, in whole or in part; (3) if the recipient does not wish to pursue this matter, it will return this CIP to Kaufman Hall as soon as possible, together with any other materials relating to Huntington, which the recipient may have received from Kaufman Hall, Huntington or any of their representatives; and (4) any proposed actions by the recipient inconsistent in any manner with the foregoing agreement will require the prior written consent of Huntington. This CIP (and all copies thereof) shall at all times remain the exclusive property of Huntington, who reserve the right to request the return of this CIP (and all copies thereof) at any time, and you agree to comply with any such request. The delivery of this CIP or anything contained herein in no way alters or qualifies the recipient's obligations under the NDA.

Huntington reserves the right to terminate, at any time, the process and to modify the request for information and other procedures without assigning any reason therefore. Huntington intends to conduct its business in the ordinary course during the evaluation period; however, it reserves the right to take any actions, in or out of the ordinary course of business, which Huntington deems necessary or prudent in the course of its business.

Except where otherwise specifically indicated herein, this CIP only presents information known as of the date hereof. The delivery of this Presentation shall not under any circumstances create any implication that there has been no change in the affairs or business of Huntington since the date hereof. Huntington and Kaufman Hall undertake no obligation to update any information contained in this CIP.

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Contact Information

Huntington Hospital requests you direct inquiries regarding this CIP to the following individuals at Kaufman Hall, the Partnership Advisor:

Steve Hollis
Senior Vice President
SHollis@kaufmanhall.com

Kristofer Blohm
Senior Vice President
KBlohm@kaufmanhall.com

Nick Gialessas
Assistant Vice President
NGialessas@kaufmanhall.com

Omar Farris
Associate
OFarris@kaufmanhall.com

Kaufman, Hall & Associates, LLC.
10 S. Wacker Drive, Suite 3375
Chicago, Illinois 60606
Telephone: 847.441.8780

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Executive Summary

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Key Partnership Considerations

- Leading market position – essential hospital in San Gabriel Valley
- Strong reputation for clinical quality – U.S. News #10 best hospital in California
- Comprehensive service offerings – multiple tertiary services and Level II Trauma
- Well established culture – history of collaboration among the hospital and community
- Consistent philanthropic support with a remarkably loyal and generous donor base
- Strategically developed differentiating partnerships to enhance patient care
- History of meaningful support from the Collis P. and Howard Huntington Memorial Trust
- Enhanced financial performance – pursuing $25 million in operating improvements
- Multiple access points across the enterprise including 28-acre campus in the heart of Pasadena in addition to other real estate holdings

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Key Partnership Considerations – Detail

Leading Hospital in San Gabriel Valley	✓ Essential healthcare provider in the San Gabriel Valley ✓ Leading market share in its primary service area (~40%) ✓ Long history of collaboration among the providers, management, board, affiliate partners, and an engaged and supportive community ✓ Pasadena and San Gabriel Valley also benefits from a vibrant economic base, supporting strong commercial payor mix and a diverse population ✓ Largest non-profit employer in San Gabriel Valley
Strong Clinical Quality and Reputation	✓ Embedded in Huntington's culture and associated with its brand ✓ Fostered by a deep commitment by all providers, as well as the broader organization to deliver on that quality ✓ Recognized by national awards including Leapfrog A and Newsweek top 100 hospitals among additional award recognition ✓ Recognized by U.S. News and World Report as #5 Best Hospital in LA Metro area and #10 Best Hospital in California ✓ Received Four and Five Star Ratings in Quality of Care by CMS
Broad Array of Clinical Services Offered	✓ Offers many tertiary services, including cancer, neurology, orthopedics and cardiac care ✓ Level II trauma designation ✓ Level III neonatal intensive care center ✓ Teaching hospital with independent ACGME residency programs in internal medicine and general surgery

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Key Partnership Considerations – Detail *(continued)*

Strong Philanthropic/ Community Support	✓ A tradition of strong community support with average total philanthropy in excess of $16M per year over the past 15 years, $19M per year over the past 5 years, and $29M in 2018 as part of the ongoing $140M 5-year philanthropic campaign ✓ Over 1,500 volunteers serve Huntington Hospital donating over 100,000 hours per year ✓ More non-profit organizations in Pasadena than any other city ✓ Huntington Hospital provided over $120M in community benefit in 2018
Differentiating Partnerships	✓ Strategic partner with DaVita Healthcare Partners (now part of Optum Care) with ties to ~600 primary care physicians in the San Gabriel Valley ✓ Meaningful relationships with City of Hope, Keck Medicine of USC, Vivity, Providence St. Joseph Health, Shriners, The Hill Medical Corporation, and Exer Urgent Care, among others
Key Strategies Being Pursued	✓ Risk bearing organizations for exclusive physician relationships, control of critical product lines, and support for independent physicians ✓ Growth of The Huntington Foundation Model (physician aligned strategy) ✓ Large health systems for direct to employer and innovative contracting strategies ✓ National ambulatory organizations to enhance profitability and growth of ASC business line ✓ Best of breed radiologists to build on strong imaging business line enabling growth in outpatient revenues to diversify business ✓ Comprehensive IT platform development ✓ Population health management and community wellness

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Key Partnership Considerations – Detail *(continued)*

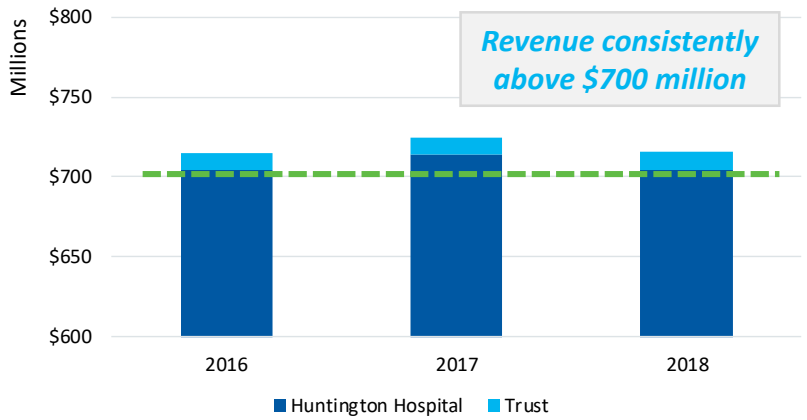
Meaningful Support from the Trust	✓ Significant Trust held cash, investments and real estate assets support foundational stability for Huntington ✓ Trust serves as co-obligor for Huntington bonds
Enhanced Financial Performance	✓ Focus by management on efficiency, productivity and re-contracting to significantly enhance margins with dramatic improvement in 2018 ✓ Management has developed a continued EBIDA enhancement plan that has identified over $25M in annual margin enhancement opportunities in 2019 focused on: – Labor (productivity, overtime and contract labor) – Pharmacy and Supply Chain – Revenue Cycle
Large and Diverse Fixed Asset Base	✓ 28-acre campus including 15 structures totaling 1.5 million sq. ft. ✓ Average age of plant of 12 years ✓ Trust owns buildings and real estate adjacent/near to Huntington Hospital campus, totaling over 600,000 square feet (land only) ✓ Close access to Gold Line (LA Metro public transit), located in nexus of 210, 110, 134, and 710 freeways

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

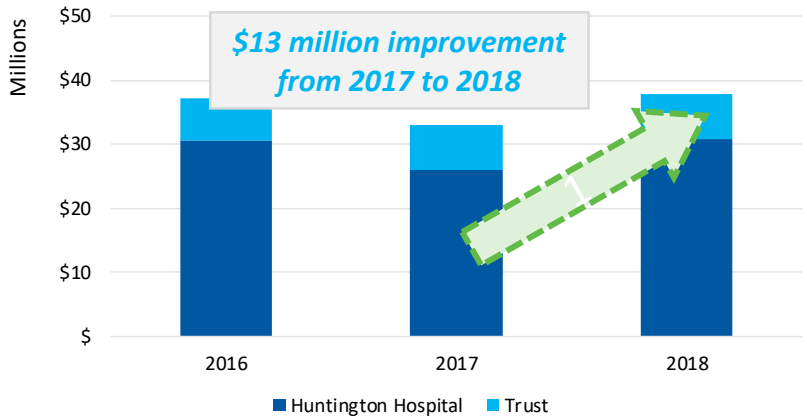
Huntington Hospital

Total Revenue

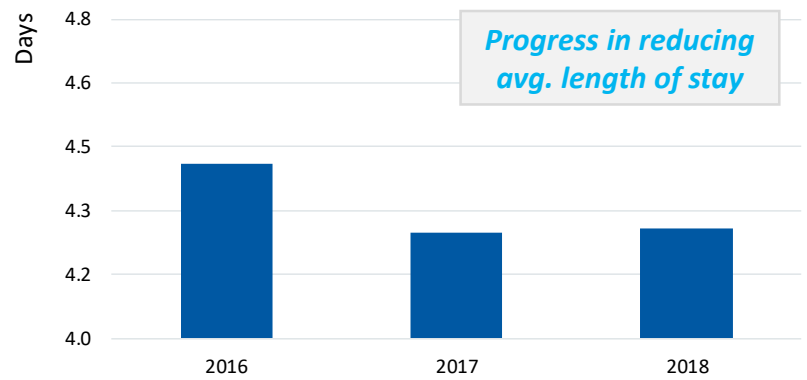


Note: Includes other revenue

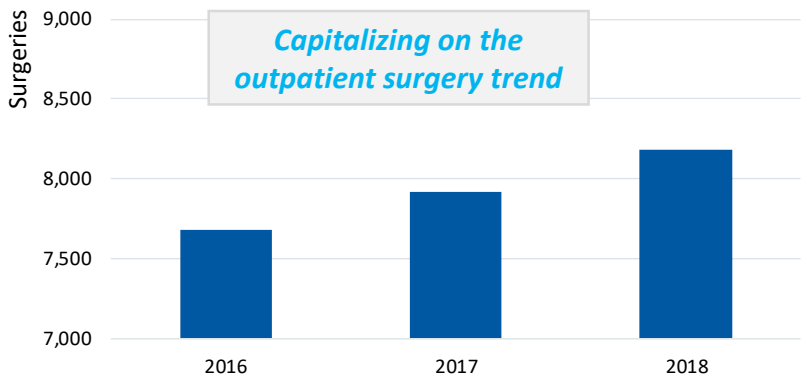
Operating EBIDA



Average Length of Stay



Outpatient Surgeries



Source: Huntington Hospital FY2018 and FY2017 Audited Financial Statements, FY2018 and FY2017 Annual Operating Reports. Huntington Hospital includes the Foundation.

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Recent Initiatives

- Huntington's strategic plan consists of the following strategic priorities:
  - Physician Collaboration
  - Value-based Emphasis
  - Community Connections
  - Patient-focused Care
  - People
  - World Class Quality
- Enabling strategies to achieve these strategic priorities include the following:
  - Partnering with primary care and specialists, with clinical outcomes focus, to ensure viability of highest quality partners
  - Seeking efforts to align financial return with highest quality outcomes for patients
  - Emphasizing access to right care, at right place, at right time
  - Positioning the Hospital as a national quality leader, compassionate care for all, with patient experience driving design
  - Working to attract, develop and retain a best-in-class workforce
  - Focusing on leading edge quality outcomes across the delivery system
  - Over 30 year history of Senior Care Network for aging in place
  - Investments in case management for decreased LOS and decreased re-admissions

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Organizational Overview

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Huntington Mission, Vision and Values

MISSION

Our mission is to provide excellent health care and compassionate service to each person by bringing together outstanding physicians, caring nurses, professional staff and advanced technologies

VISION

To be the leader in creating community well-being through world-class health care delivered with kindness and dignity

VALUES: Huntington Hospital

- Respect
- Integrity
- Stewardship
- Excellence
- Collaboration

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Huntington History

1892: Pasadena Hospital formed and 16-bed temporary hospital opens



1932: Henry E. Huntington endowed the hospital with a $2 million gift and established the Huntington Trust & Huntington Memorial Hospital

1975: NICU opens at Huntington Memorial Hospital

1983: ACS verified Level II trauma center in the San Gabriel Valley



1998: 5 story Carmen and Charles Hale East Tower opens

2005: Acquires first da Vinci Robot





2010: First hospital in Southern California to acquire the Ekso exoskeleton



2007: West Tower opens, a ground + 5 story patient care tower



2011: Named 1 of only 6% of hospitals to achieve Magnet designation



2014: The Nan and Howard Schow Emergency & Trauma Center Project debuts, doubling capacity to provide emergency care

2018: Ranked 5th best hospital in Los Angeles and 10th best in California



1892 — 1983 — Present

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Collis P. and Howard Huntington Memorial Hospital Trust ("the Trust")

- The Trust is a 501(c)(3) organization created by court order pursuant to the will of Henry E. Huntington in 1932 solely for the benefit and support of Huntington Hospital(1)
- A fundamental purpose is to hold the income and profit from Trust investments as an endowment for the maintenance and operation of the Hospital
- Pursuant to the guidance of Trust legal counsel, funds allocated by the Trust are earmarked to particular programs and not available for general use
- There are five Trustees who hold lifetime appointments. The Trustees are automatically members of the Hospital Board (and, as a practical matter, chair many of the committees)
- The affirmative vote of a majority of the Trustees is necessary for the transaction of any business of the Hospital, i.e. the Trust can block but not compel action (this includes changes to the Hospital Bylaws)
- For the Trust to support activities beyond the maintenance and operation of the Hospital, court approval may be necessary
- A change in Trustee involvement in corporate governance would likely require court approval
- Trust assets currently include an investment portfolio of $240M and ownership of hospital or related property of $146M(2), comprised of the Huntington Hospital campus as well as other developable land and (over 600,000 sq. ft.) and buildings (over 400,000 sq. ft.) adjacent or near to the Hospital campus

Source: Huntington Hospital Management

(1) There is a current court petition requesting that the "hospital" be defined as encompassing all of the healthcare related activities of the Pasadena Hospital Association

(2) Estimated based on recent market values of properties in the vicinity

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

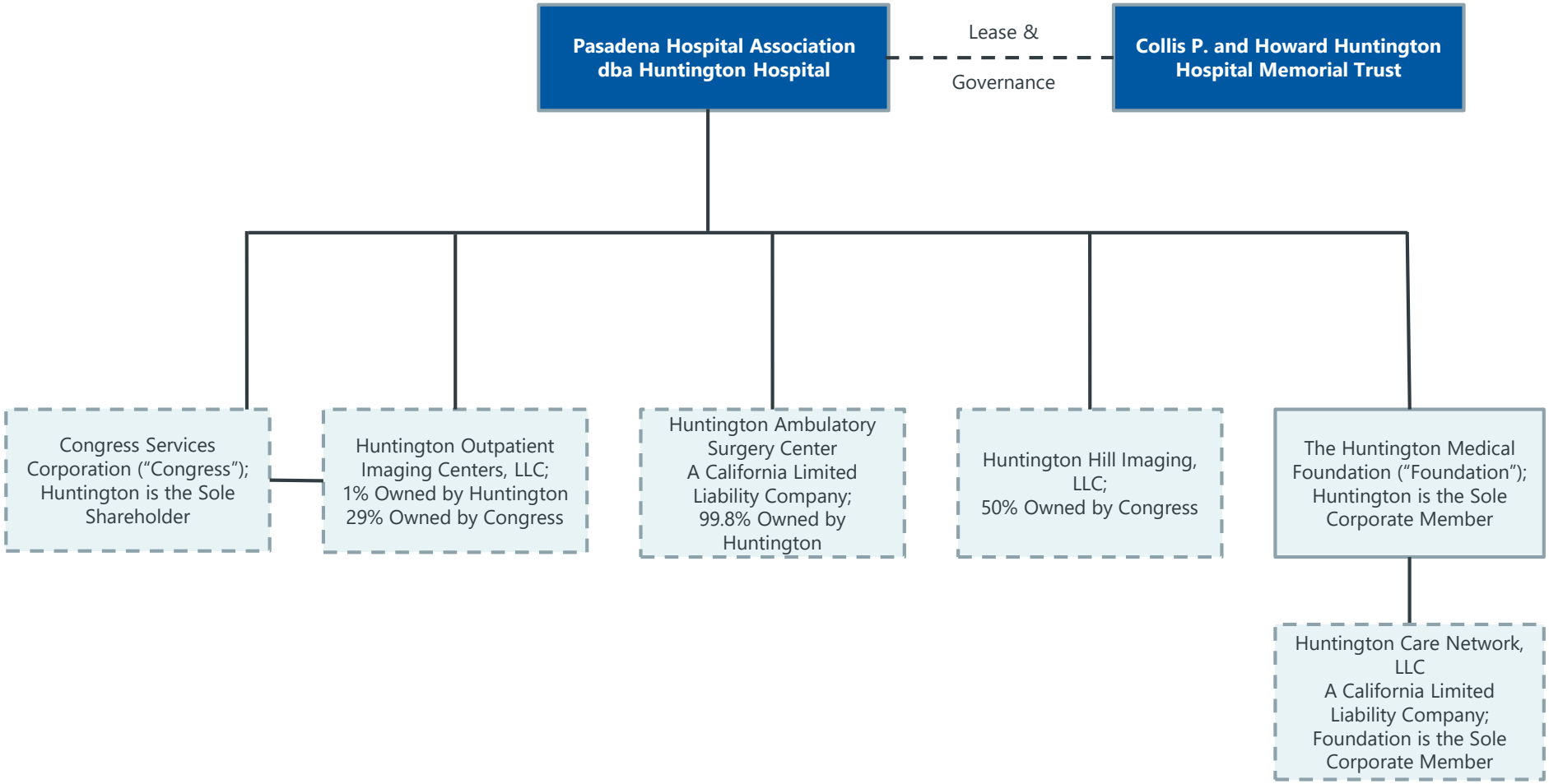
Collis P. & Howard Huntington Memorial Trust *(continued)*

- The Trust owns the land on which the Hospital is located as well as a portion of the hospital facilities and improvements operated by Huntington Hospital
- The Trust entered into a Master Lease between the Trust and Huntington Hospital
  - The land and buildings owned by the Trust on the hospital campus are leased to Huntington
  - The current lease term runs through 2050

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Organization Structure



Solid borders indicate non-profit organizations
Dotted borders indicate for profit organizations

Source: Huntington Hospital Management; Series 2018 Appendix A

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Description of Legal Entities

Pasadena Hospital Association, Ltd. dba Huntington Memorial Hospital ("Huntington Hospital"): a California nonprofit public benefit corporation with tax-exempt status as a 501(c)(3) organization. Formed in 1892, Huntington operates a 619-licensed bed general acute care hospital. Huntington Hospital has several key affiliates that currently maintain active operations as described below.

Congress Services Corporation ("Congress"): incorporated in 1985 as a California for-profit corporation and is a wholly owned subsidiary of Huntington Hospital. Congress oversees the Huntington Hospital's interest in several joint ventures

Huntington Ambulatory Surgery Center ("HASC"): organized in 2010 and is a California limited liability company which is owned 99.8% by Huntington Hospital and the balance by one physician group

The Huntington Medical Foundation ("Foundation"): organized in 1993 as a California nonprofit public benefit corporation exempt from state licensure under California Health & Safety Code Section 1206(l). The Foundation conducts medical research and health education and provides health care to its patients in settings or place(s) of service being private practice offices, outpatient imaging centers, and Hospital through integrated group of providers which are affiliated through three (3) Professional Services Agreements.

Source: Huntington Hospital Management; Series 2018 Appendix A

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Description of Legal Entities *(continued)*

Huntington Hill Imaging ("HHI"): organized in 2019 as a California limited liability company. HHI is a joint venture owned 50% by Congress and 50% by Hill Radiology. HHI provides outpatient imaging services to its patients

Huntington Outpatient Imaging Centers LLC ("HOPIC"): a California limited liability company formed in 1997, which operates an outpatient imaging center. HOPIC is owned by: The Hill Medical Corporation (42%) a California professional corporation which is a medical group specializing in radiology; Huntington Medical Research Institute ("HMRI") (28%), an independent, tax-exempt research organization; Congress (29%) and Huntington Hospital (1%). Since 1985, HMRI has had an affiliation agreement with Huntington Hospital focused on sharing of resources, including recruiting physicians to enhance HMRI's research activities and Huntington Hospital's patient care activities, conferring graduate medical education opportunities and a commitment to use the same Institutional Review Board.

Huntington Care Network ACO, LLC ("Huntington ACO"): a California limited liability company formed in 2013 to participate in the Medicare Shared Savings Program as an enrolled accountable care organization ("ACO") and to participate in shared savings and similar programs offered by commercial payers. The sole member of Huntington ACO is the Foundation. Huntington Hospital provides certain administrative services to Huntington ACO pursuant to an administrative services agreement. The Medicare Shared Savings contract was terminated January 2019. There are approximately 110 participating providers in the Huntington ACO, of which 90 are primary care physicians.

Source: Huntington Hospital Management; Series 2018 Appendix A

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

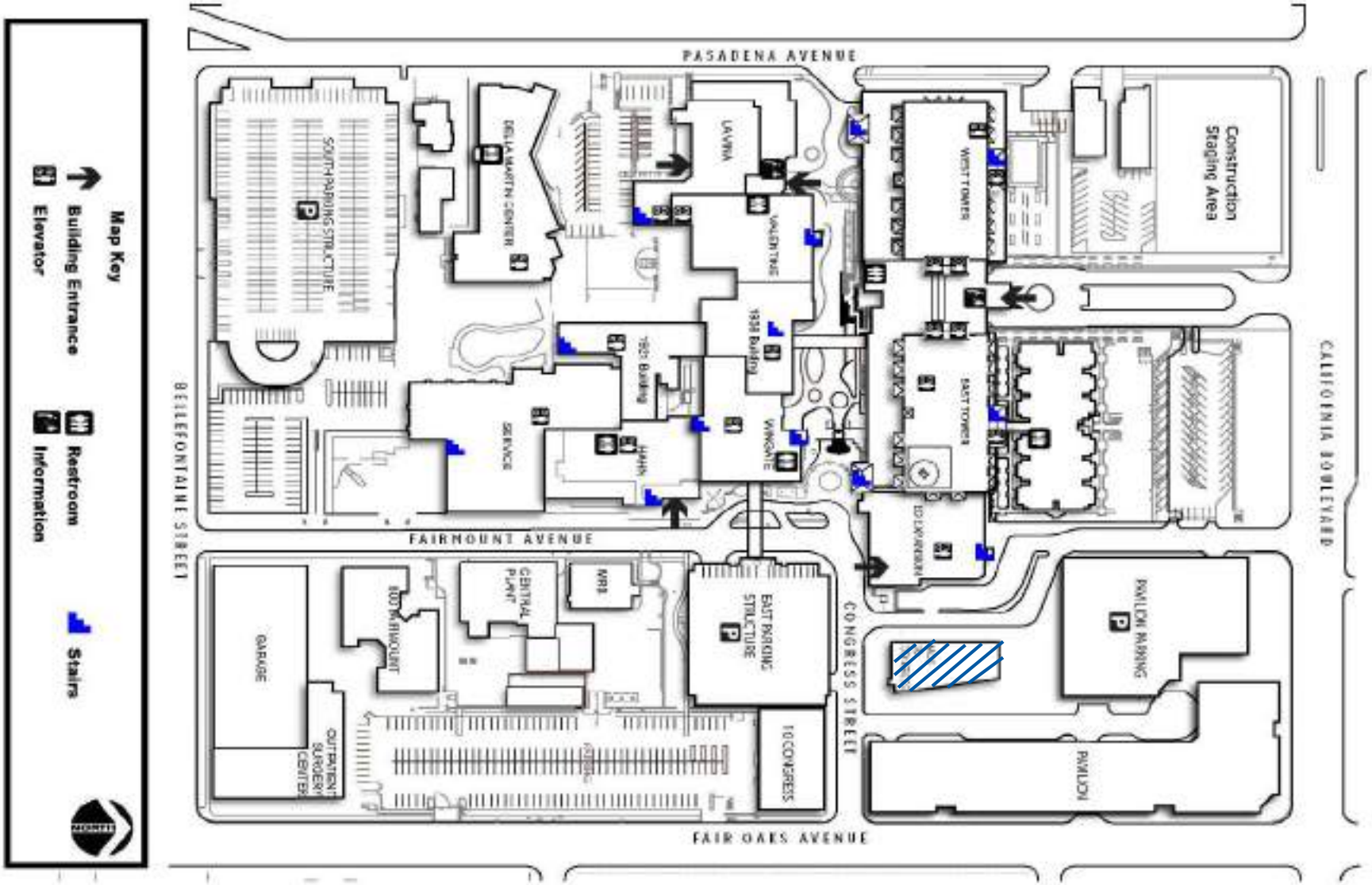
Campus Facilities Overview

Facility Name	Year Constructed	Sq. Ft.	Uses
Huntington Memorial Hospital	-	-	The main campus is located on a ~28 acre site in Pasadena and consists of 15 structures (described below), many of which are interconnected
La Vina Building	1984	97,000	Houses inpatient and outpatient acute care services and limited administrative services
Valentine Building	1968	99,000	Houses administrative services In 2020, this building will no longer meet the seismic requirement for inpatient care. After January 1, 2020, this building will house outpatient services and/or administrative services
1938 Building	1938	69,000	Houses administrative services and a small portion of the Hospital's pediatric services. In 2020, this building will no longer meet the seismic requirement for inpatient care. After January 1, 2020, this building will house outpatient services and/or administrative services
1921 Building	1921	62,000	Houses administrative services
Wingate Building	1961	93,087	Houses inpatient and outpatient acute care services and limited administrative services
Hahn Building	1971	112,000	Houses inpatient and outpatient acute care services and limited administrative services
Service Building	1969	93,000	Houses the Hospital's loading docks to the south end of the ground-floor level
Della Martin Center	1956	42,000	Houses the acute psychiatric facility
Ambassador/Gilbert Building	1957	8,500	Houses Construction Management
East Tower and East Tower Annex	1990/1997	348,000	Houses inpatient and outpatient acute care services and limited administrative services
West Tower	2007	235,000	Houses inpatient and outpatient acute care services, support services, and limited administrative services
Emergency Department and Vertical Expansion	2012	66,000	Houses the Emergency Department. Second and third levels are currently shelled space that the Corporation expects may be improved to accommodate additional operating and cath lab suites
Senior Care Network Buildings	1958	8,000	Houses Senior Care at two addresses
Huntington Pavilion*	2004	190,000	Houses Operations of a breast center and a cancer center on the first floor and subleases about 1/3 of its first floor space to its affiliate, HOPIC; operation of an outpatient laboratory, an education center and certain ancillary facilities on the third floor and subleases 60% of the third floor to its affiliate, HASC
Total		**1,522,587**	

Source: Huntington Hospital Management
Note: The Trust owns all the grounds while Huntington owns all the buildings
*The Huntington Pavilion is owned by Pacific Medical Buildings/Ventas. Huntington Hospital is the master lessee and the ground lease is held by the Trust. The ground lease has a term of 50 years with three 10-year options to extend

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Facilities Footprint



Source: Huntington Hospital Management

Not owned by Huntington Hospital and/or the Trust

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Operational Highlights

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Key Service Lines

Cancer	✓ Accredited by the American College of Surgeons Committee on Cancer and the National Accreditation Program on Breast Cancer ✓ Staffed by nationally known specialists from UCLA, City of Hope and Norris (Keck/USC) cancer centers ✓ Full range of services, including robotic assisted surgery, advanced imaging and radiation therapy ✓ Multi-disciplinary tumor boards that review cases ✓ Access to clinical trials ✓ Supportive services, including certified nurse navigators, social workers and dieticians ✓ Integrative oncology, including acupuncture, support groups, massage therapy, mind-body stress management
Neurology	✓ Nationally recognized by US News and World Report ✓ Advanced technology, including whole-organ imaging, multi-modal MRI, state-of-the-art bi-plane angiography suites and computer assisted neurosurgical navigation technology ✓ Continuous ICU EEG monitoring ✓ Physicians specializing in spine surgery, brain tumors, epilepsy, Parkinson's Disease
Comprehensive Stroke Center	✓ Stroke program with Advanced Certification by Joint Commission ✓ Get With The Guidelines® – Stroke Gold Plus Quality Achievement Award from the American Heart Association/American Stroke Association ✓ Dedicated inpatient stroke unit ✓ Acute inpatient rehabilitation unit

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Key Service Lines *(continued)*

Cardiac Care	✓ U.S. News & World Report ranked as a Best Regional Hospital, including High Performing designations for aortic valve surgery, heart bypass and heart failure ✓ Cardiac Services Center of Distinction through Blue Cross/Blue Shield national program ✓ Most advanced technology, included electrophysiology suite, minimally invasive transcatheter aortic valve replacement (TAVR) and WATCHMAN™ Left Atrial Appendage Closure (LAAC) device for patients with atrial fibrillation (AFib) ✓ Cardiac rehabilitation program ✓ Open-heart and robotic assisted cardiac surgery ✓ Full spectrum of screening and diagnostic tests ✓ Dedicated cardiac catheterization suites for diagnostic and interventional procedures
Level II Trauma Center	✓ Verified by the American College of Surgeons ✓ Only Level II Trauma Center in the San Gabriel Valley and largest Trauma Center in the region ✓ Dedicated Trauma wing within the emergency department
Level III Neonatal ICU	✓ In-house neonatologists 24/7 ✓ Neonatal physician specialists, including surgeons, cardiologists and pulmonologists ✓ One of the few hospitals in the area to offer extracorporeal membrane oxygenation (ECMO), a life-saving surgical treatment for pulmonary hypertension or respiratory failure in infants ✓ Dedicated small baby unit providing specialized care for infants under 32 weeks and 1,500 grams ✓ Technologically advanced treatments such as nitric oxide for treating respiratory issues and Total Body Cooling to minimize brain injury

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Key Service Lines *(continued)*

Orthopedics	✓ Nationally recognized by US News and World Report ✓ Joint Replacement Center of Distinction through Blue Cross/Blue Shield national program ✓ Highest volume joint replacement facility in the San Gabriel Valley ✓ Patient-focused joint replacement, including pre-surgery class, patient guide and in-house videos through hospital-issued tablet ✓ Physicians specializing in joint replacement, hand surgery, sports medicine, foot and ankle surgery, trauma and upper extremity ✓ Successfully offers profitable bundled payment joint replacement program through CMS
STEMI Receiving Center	✓ Designation by County for improving diagnosis and treatment of heart attack ✓ Meet 90-minute goal of “door to cath lab” to remove blockage and restore blood flow ✓ EKG reading from paramedics in the field are transmitted to the hospital emergency department to mobilize specialty care team and ensure best outcomes

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Comprehensive Service Line Offering

Huntington Hospital Service Line Offerings

- Ambulatory Care
- Blood Donor Center
- Breast Center
- Cancer Center
  - Oncology Services
  - Radiation Therapy
- Community Outreach
  - Health Resource Center
  - Senior Care Network
- Critical Care
- DOU (Definitive Observation Unit)
- Endoscopy
- Emergency Services
- Heart Center
  - Invasive & Non-Invasive Cardiology
  - Cardiac Electrophysiology
  - Cardiac Rehabilitation
  - Cardiothoracic Unit
  - Transcatheter Aortic Valve
  - Replacement (TAVR)
- Internal Medicine
- Medical Education / Residency Program
- Neurological Services
  - Epilepsy and Brain Mapping
  - Neurology
  - Neurodiagnostic Testing (EEG)
- Nutritional Services
- Pathology Services / Tissue Registry
  - Clinical Laboratories
- Pharmacy Services
- Psychiatry (Della Martin Center)
  - Inpatient Acute / General Psychiatry
  - Gero-ECT-Pysch Services
  - Outpatient Services
  - Chemical Dependency
- Radiology
  - Ultrasound
  - Computed Tomography (CT Scan)
  - Magnetic Resonance Imaging
  - Nuclear Medicine
  - Radiation Therapy
- Rehabilitation Services
  - Inpatient
  - Physical Therapy
  - Occupational Therapy
  - Speech Pathology / Audiology
- Respiratory Care
  - Pulmonary Lab
  - Respiratory Therapy
- Social Services
- Surgical Services
  - Anesthesiology
  - Bariatrics
  - Cardio Thoracic
  - Dental / Oral
  - Fetal
  - General Surgery
  - Minimally Invasive
  - Neurosurgery
  - Opthalmology
  - Orthopedic
  - Otorhinolaryngology
  - Outpatient Surgery Center
  - Plastic Surgery
  - Urology
  - Vascular
- Trauma
- Vascular Services
  - Vascular Lab
- Women's / Children's Health Services
  - Extracorporeal Membrane Oxygenation
  - Fetal Treatment (In-Utero) Surgery
  - Hearing Screens (Newborn & Infant)
  - Labor & Delivery
  - Neonatology
  - Newborn Nursery
  - Obstetrics / Gynecology
  - Pediatric Intensive Care
  - Pediatrics
  - Perinatal Health Education
  - Perinatal High Risk
  - Perinatology
  - Postpartum Care
  - SCAN Team (Child Abuse)
  - Sweet Success (Gestational Diabetes)

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Huntington's Residency and Nursing Programs

Residency Programs

- Huntington is an active teaching hospital with independent ACGME residency programs in internal medicine and general surgery training 43 residents per year
- Huntington hosts 15 other residents and fellows affiliated with the USC Keck School of Medicine in specialties including OB, Cardiac Surgery, Maternal Fetal Medicine and Vascular Surgery

2017 Residency and Educational Programs

Specialty Residency	**# of Residents**
General Surgery	18
Internal Medicine	25
Total Specialty Residency	43
Graduate/Undergrad Programs	**# of Students**
Clerkship	105
Rotating Resident/Fellow	35
Total Graduate/Undergrad Programs	140

Nursing Programs

- Huntington employs ~1,220 nurses
- RN residency programs are available in the following areas:
  - Critical Care
  - Definitive Observation Unit
  - Neonatal ICU
  - Maternity
  - Med-Surg Telemetry
  - Med-Surg
  - Operating Room
  - New Grad Float Pool
- This approximately 22-week program helps new graduate nurses develop effective decision-making abilities in clinical judgment and performance
- Huntington Hospital is a Magnet recognized hospital

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Select Huntington Awards and Designations

Magnet hospital – represents the highest level of national recognition to health care organizations that demonstrate sustained excellence in nursing care in a collaborative and professional work environment

CMS 4 star overall rating

Recognized by U.S. News and World Report as Best Hospital:

- ✓ #5 in LA Metro area
- ✓ #10 in California
- ✓ Nationally ranked in specialties: Gynecology and Urology
- ✓ High Performing in seven specialties and seven common adult conditions

Leapfrog "A" rating

- ✓ One of 832 awarded for its commitment to keeping patients safe meeting the highest safety standards in the U.S.

Healthgrades "Outstanding Patient Experience Award – 2019"; "America's 50 Best Hospitals – 2017"

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Additional Community Offerings

Vulnerable Populations

- Dedicated Senior Care Network Services including a free 50+ Health Connection Membership Program with 9,300 members – dedicated to aging in place for over 32 years
- Ambulatory Care Clinic provides care for uninsured and underinsured residents providing 5,800 visits in 2018
- Offers services for interpretation in 22 languages and sign language serving over 9,000 persons
- Provided 24-hour transportation assistance to help patients overcome transportation-related barriers to care
- Hospital & community (PUSD) teaching on Trauma Informed Care in collaboration with Young & Healthy
- Asthma education and management classes

Broader Community

- Offers programs to obtain health insurance or services
- Conducts free two-hour health screenings and counseling at 17 different screening clinics
- Huntington Cancer Center participates in health fairs, offers open houses and support groups, partners with Pasadena Fire Department to support awareness, and offers Look Better, Feel Better classes with licensed cosmetologists
- Administered 1,862 free flu shots on 19 different occasions
- Conducted “Stop the Bleed” training services for PUSD and for other local businesses
- Staff “pop-up” clinics in underserved areas to increase access to medical care

Research, Education, Training

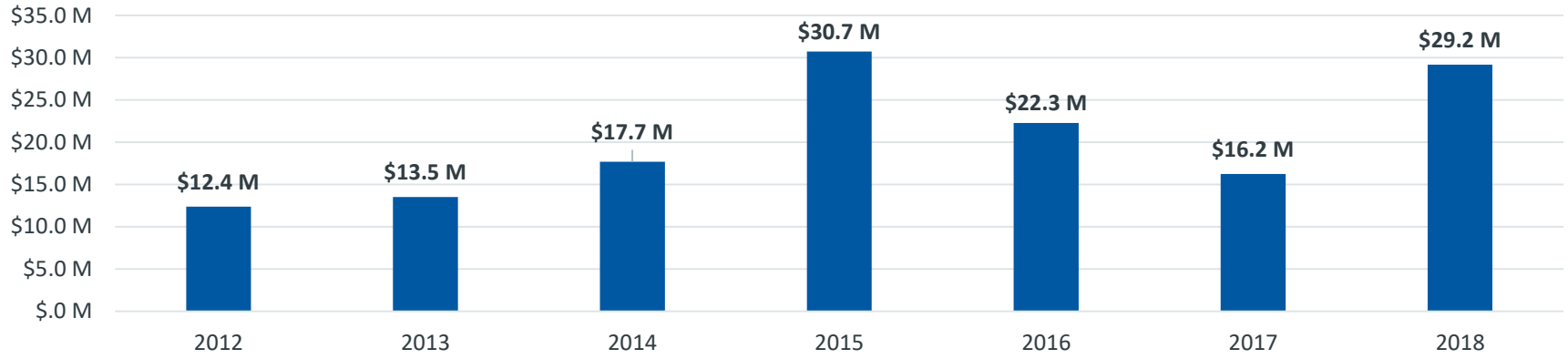
- Continued collaboration in the education and training of general surgery and internal medicine residents, pharmacy interns and residents, nurses, technicians, physical and occupational therapists, respiratory therapy practitioners, and social workers
- Recently established Huntington Hospital Evidence-based Practice/Nursing Research Council sponsored an inaugural Annual Nursing Research Conference
- Programs with Blair Health Careers Academy and Pasadena Unified School District prepare students for advanced health-related careers
- Robust clinical research program supporting industry sponsored studies (pharma, med devices), and national consortium studies
- Collaborative relationships with HMRI & CalTech

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Philanthropy & Fundraising Efforts

Total Pledged Philanthropic Support by Year



- On average, Huntington has received $16 million per year from an average of 3,500 donors since 2005, and since 2012 philanthropic support has increased to over $20 million per year on average
- Philanthropic funds are raised by Huntington Hospital directly rather than through a separate fundraising foundation and are generally used to fund near-term capital expenditures and support operations determined to be in the best interest of the community
- In 2018, 3,472 individual donors made gifts totaling $29.2M
- **Strong History of Giving**: $150 million for West Tower (2008) and $80 million for ER Expansion (2013)
- **Current Campaign**: $140 million over 5 years (capital $110 million, endowments $15 million and unrestricted use $15 million)

Source: Huntington Hospital Management

Recently received the pledge of portion of donor's estate at time of their death, estimated at $80M
(currently unrecorded in the financial statements)

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Huntington's Existing Strategic Relationships

HealthCare Partners. A DaVita Medical Group

City of Hope

Keck Medicine of USC

Davita HealthCare Partners (now part of Optum Care)

- Multi-year Hospital Services / Affiliation Agreement which includes value-based sharing incentives (including membership growth, Medicare Advantage, quality and cost savings)
- Designated as the Preferred Tertiary Provider for DHCP's (Optum Care) Greater San Gabriel Valley Region
- Represents ~$125 million of annual Hospital generated revenue in 2018
- In 2018, DHCP (Optum Care) represented approximately $14.6 million annual generated revenue through its Provider Agreement with The Foundation

City of Hope

- Professional Services Agreement whereby COH Medical Foundation provides professional services for Radiation Oncology to the Huntington Cancer Center
- Represents ~$16 million of Huntington revenue in 2018
- COH performed 829 inpatient cases, mostly surgical, at Huntington in 2018
- Academic affiliation, whereby Huntington residents rotate to COH and leverage the affiliation to gain ACGME approval for an academic fellowship program

Keck Medicine of USC

- Academic affiliation with USC Keck School of Medicine as well as professional service agreements for Cardiac Care and Maternal Care and a clinical program for Fetal Surgery
- Call contracts with USC Keck School of Medicine Perinatologists
- Program Directors for Medicine and Surgery Residencies are USC faculty
- USC performed 978 inpatient cases at Huntington in 2018
- Represents ~$26 million of Huntington revenue in 2018

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Huntington's Existing Strategic Relationships *(continued)*







Providence St. Joseph Health

- Network Affiliation Agreement: Huntington is the preferred provider for PSJH's Greater Regional contracting strategies (including Direct to Employer) in the San Gabriel Valley
- Participating provider with Oscar, with generated revenue of $0.57M and 400 attributed enrollees in 2018

Vivity

- Joint Venture LLC with Anthem Blue Cross and seven health systems to create a high performing regional narrow network in the Greater Southern California region
- Anthem has developed an Exclusive Licensed HMO product known as Vivity which is only marketed, promoted, attribution of enrollment to the seven systems
- ~43,000 enrollees, of which ~2,500 are attributed to the Huntington/Vivity Network through the DHCP (Optum Care) San Gabriel Valley Network, inclusive of Magan Medical Group
- In addition, Founder Member Eligible Distributions (since inception 2015-2018) is approximately $2.2M
- Represents ~$1.2 million of Huntington revenue in 2018

Exer

- Trademark License Agreement (TLA) for Exer to use the Huntington brand for community marketing of Pasadena Community Urgent Center in exchange for 10% of distributions generated from the former Pasadena Community Urgent Care Center (PCUC)
- Second urgent care center opened in La Canada, California in May 2019
- Both Urgent Care Centers are staffed by Huntington ER Group
- Year-over-year growth in use of Huntington ER and Paramedic transports

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Huntington's Existing Strategic Relationships *(continued)*

THE HILL MEDICAL CORPORATION

Huntington Ambulatory Surgery Center

Hill Radiology Medical Group (aka Hill Medical Corporation)	Huntington Ambulatory Surgery Center
• Joint Venture Partner in the Huntington Outpatient Imaging Center • Joint Venture Partner in Huntington Hill Imaging, LLC • Represents ~$13.8 million of Huntington revenue in 2018	• Huntington Hospital is 99% Member of the LLC • Represents ~$11.4 million of Huntington revenue in 2018

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Value-Based Arrangements

- **DaVita HealthCare Partners ("DHCP") (now part of Optum Care)**
  - Partnership to share operational responsibilities for the delivery of care for the San Gabriel Valley (total lives: ~180,000 including ~47,000 Medicare Advantage, primary care physicians in the market: ~600)
  - $33M fixed payment for access to Huntington's quality, along with shared incentive to drive enrollment to DHCP (Optum Care). Quality payments tied to outcome, in addition to FFS payments
  - Virtual integration, unique collaboration that seeks to lower the costs of administration
  - Critical component of MACRA strategy through well established, highly profitable (to Huntington) Medicare Advantage plan expansion
- **Providence St. Joseph Health**
  - Formal affiliation agreement to participate with large system in regional contracting strategy including exclusive agreement with Oscar Health Plan and direct to employer products
- **Vivity**
  - Partnership between Anthem Blue Cross and 7 Metro LA Care Providers: Huntington Memorial Hospital, UCLA, Cedars-Sinai, MemorialCare, Presbyterian Intercommunity, Torrance Memorial, and Good Samaritan for a high quality narrow network insurance product
  - Approximate HMO enrollment of ~43,000
- **Comprehensive Care for Joint Replacement**
  - A CMS bundled payment program collaborating with independent orthopedic surgeons, streamlining care delivery and ensuring high quality throughout the program
  - Generated savings of $154k, $427k, and $604k in the first three years of the program, respectively

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

IT – Current State

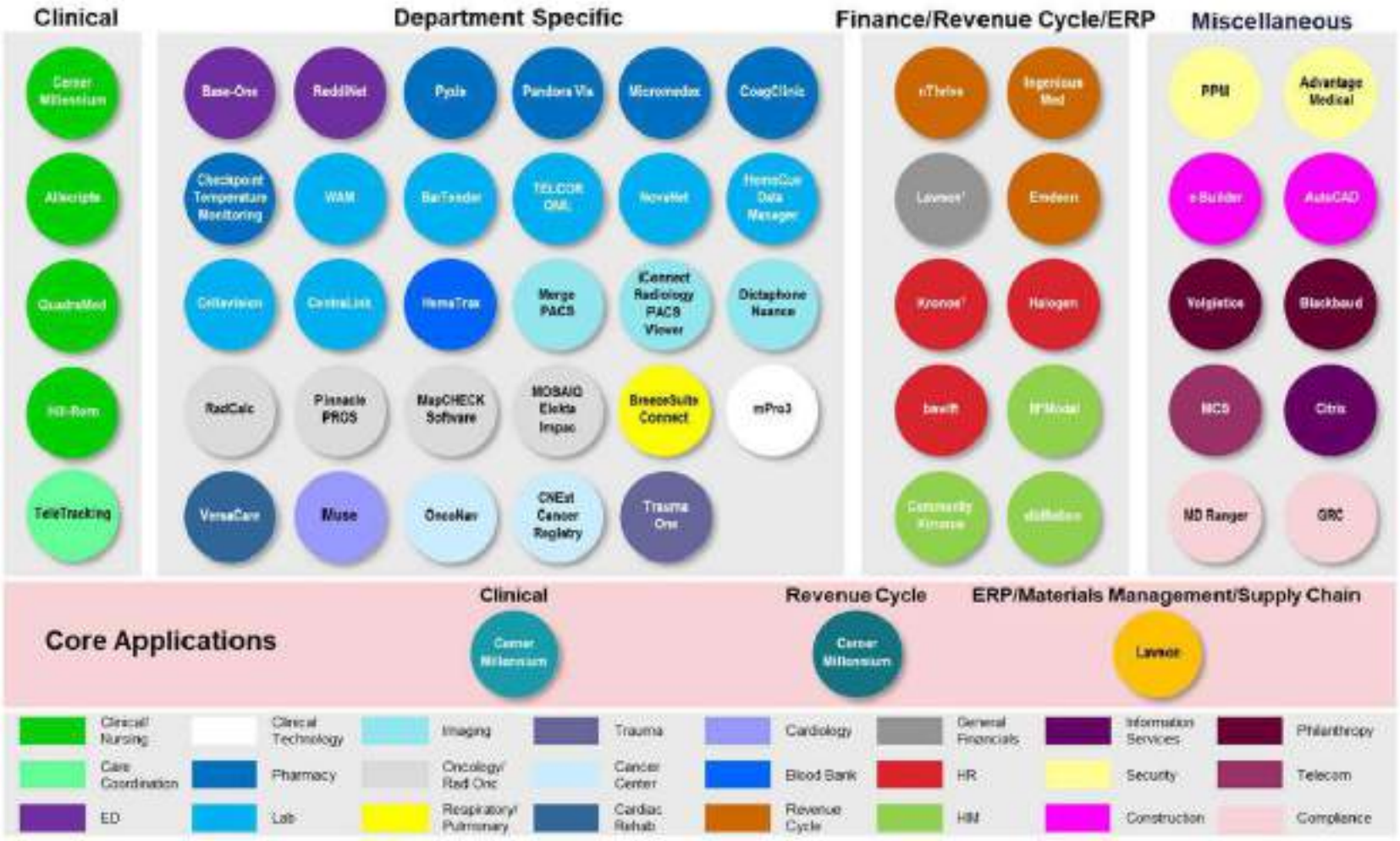
- Huntington is focused on providing services and information technology that enhance the patient experience and improve operational efficiency while meeting regulatory standards
- Huntington continues to optimize the electronic record to improve patient safety and the quality of care
  - **2016**: completed year six of Meaningful Use Stage 2 CMS requirements
  - **2016**: completed an upgrade of the Cerner Millennium electronic record as well as the patient portal to prepare for Meaningful Use Stage 3
  - **2017**: achieved Healthcare Information and Management Systems Society - Stage 6

Function	System
Acute Care EHR Systems	Cerner
Ambulatory Care System	Allscripts (Foundation Model)
Accounting	Lawson
Clinical & Patient Accounting	Cerner
HR and Timekeeping	Kronos (transitioning to Workday)

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

IT – Infrastructure



Source: Huntington Hospital Management
Notes: Cerner IP only; not enterprise; Workday HRIS project in underway with future planned phases

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Service Area and Market

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

San Gabriel Valley Market

Pasadena Highlights

- Pasadena has high household value, $906k, and household income, $91k, compared to Los Angeles County with $652k and $70k, respectively
- Rated “2018 Top 100 Best Places to Live” by Liveability
- Unemployment rate in Pasadena is 3.5% as of May 31st as compared to the broader LA County at 4.5%
- Home to major employers Jet Propulsion Laboratories and CalTech
- Vibrant arts and culture including the Rose Bowl Game and Pasadena Symphony
- Conveniently located relative to downtown Los Angeles
- $7,549 total per capita spending on personal health care
- Primary care physicians in Pasadena see 1,281 patients per year on average
- Second largest industry in Pasadena is Health Care and Social Assistance

Sources: U.S. census data (www.census.gov); City of Pasadena Economic Development website

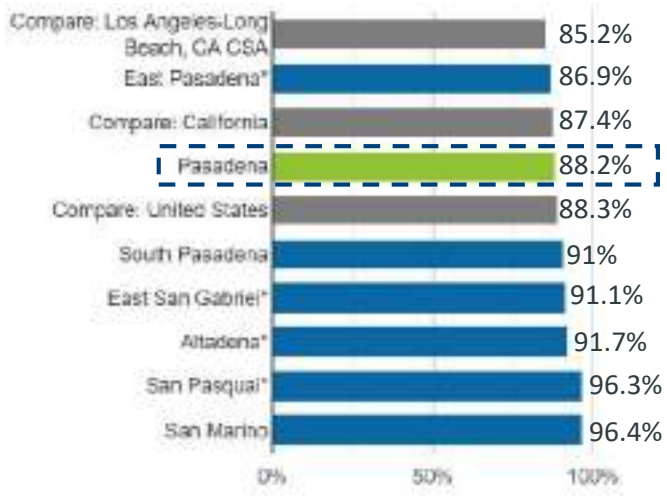
CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

San Gabriel Valley Market

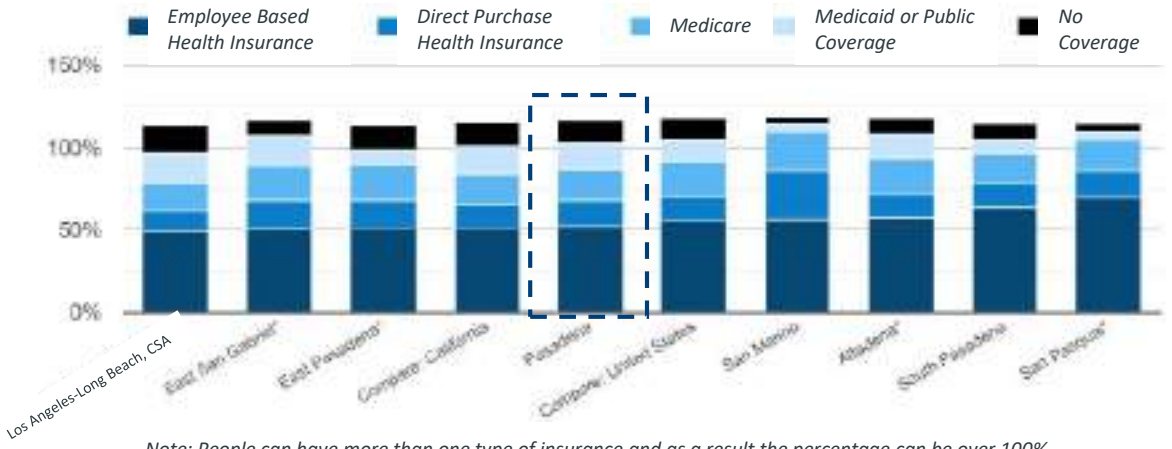
Pasadena Demographic Overview

- Well-educated with 51% of persons age 25+ having a Bachelor's Degree or better (compared to 28% across U.S. overall)
- 88.2% of the Pasadena population have health insurance with the largest portion coming from employer based health insurance at 52% followed by Medicare at 19%

% of People with Health Insurance



Types of Health Insurance Coverage



Note: People can have more than one type of insurance and as a result the percentage can be over 100%

Note: (*) These places should be recognizable by the local community but their boundaries have no legal status and without their own government (i.e., Mayor)
Sources: U.S. census data (www.census.gov); American Community Survey 2017

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

San Gabriel Valley Market

Pasadena Demographic Overview

Huntington Hospital

Pasadena Demographics

Age Group	FY 2019	% of Total	FY 2024	% of Total	CAGR
Age < 18	33,087	19%	33,741	19%	0.4%
Age 18 - 34	39,184	23%	36,999	21%	-1.1%
Age 35 - 54	48,279	28%	49,540	28%	0.5%
Age 55 - 64	22,354	13%	23,474	13%	1.0%
Age 65+	29,920	17%	34,062	19%	2.6%
Total Population	172,824		177,816		0.6%
Median Household Value	$ 906,020				
Median Household Income	$ 91,577				
Los Angeles County					
Total Population	10,246,644		10,556,321		0.6%
Median Household Value	$ 652,783				
Median Household Income	$ 70,069				
California State					
Total Population	41,335,584		42,954,313		0.8%
Median Household Value	$ 589,879				
Median Household Income	$ 78,967				
National					
Total Population	329,236,175				
Median household value	$ 285,518				
Median household income	$ 65,753				

Commentary

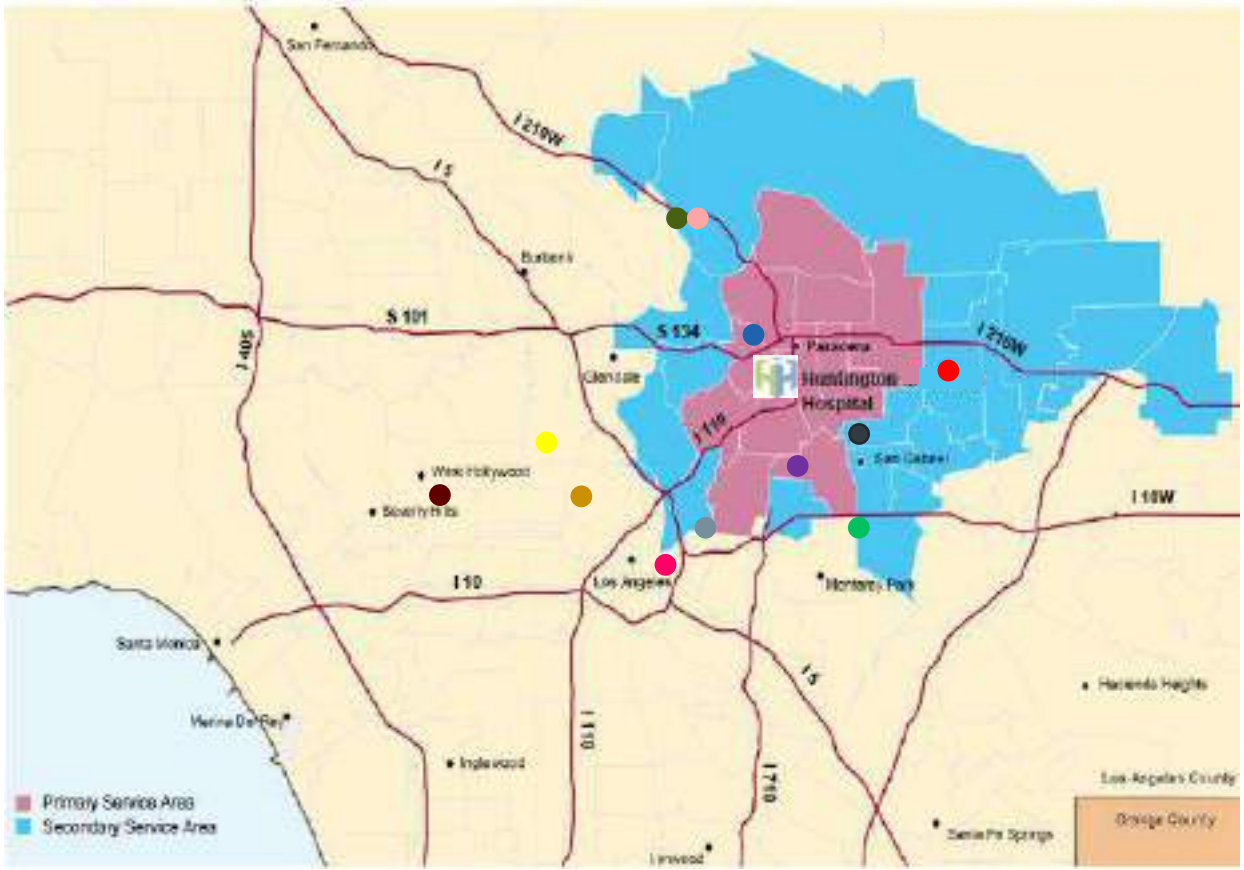
- Pasadena is expected to grow in line with Los Angeles County at a CAGR of 0.6%
- Pasadena has high household value and household income compared to Los Angeles County, the state of California, and national averages
- Household value and income are 28% and 23% higher than Los Angeles County, respectively
- Younger demographic that is gradually maturing with declines seen over the next 5 years in the 18-34 age cohort
- Medicare Age category expected to grow at a CAGR of 2.6% over the same timeframe

Source: 2019 Claritas population data

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

San Gabriel Valley Market

Service Area Competitive Landscape



Huntington Hospital:

Huntington Hospital

Other Hospitals:

- Glendale Adventist Medical Center
- Kaiser Fnd Hosp – Los Angeles
- Methodist Hospital of Sothern California
- San Gabriel Valley Medical Center
- Alhambra Hospital Medical Center
- Garfield Medical Center
- Lac+USC Medical Center
- White Memorial Medical Center
- USC Verdugo Hills Hospital
- Cedars Sinai Medical Center
- Keck Hospital of USC
- Children's Hospital of Los Angeles

Source: Huntington Hospital Series 2018 Official Statement Appendix A

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Leading Hospital by Inpatient Market Share in San Gabriel Valley

Inpatient Market Share by Hospital - Huntington Hospital Service Area

Up from 21.2% in prior year

Up from 38.0% in prior year

Hospital	Total Service Area		Primary Service Area		Secondary Service Area	
	Discharges	Percent	Discharges	Percent	Discharges	Percent
Huntington Memorial Hospital	**25,977**	**22.0%**	**18,905**	**38.4%**	**7,072**	**10.1%**
Methodist Hospital Of Southern California	13,974	11.9%	2,426	5.1%	11,549	16.5%
Glendale Adventist Medical Center	8,333	7.1%	2,728	5.7%	5,605	8.0%
Garfield Medical Center	7,878	6.7%	1,635	3.4%	6,243	8.9%
San Gabriel Valley Medical Center	7,640	6.5%	1,979	4.1%	5,661	8.1%
Kaiser Fnd Hosp - Los Angeles	4,897	4.2%	2,563	5.3%	2,334	3.3%
Lac+usc Medical Center	3,999	3.4%	1,569	3.3%	2,431	3.5%
Kaiser Fnd Hosp - Baldwin Park	3,614	3.1%	881	1.8%	2,733	3.9%
Alhambra Hospital Medical Center	3,450	2.9%	1,716	3.6%	1,735	2.5%
Glendale Memorial Hospital And Health Center	2,803	2.4%	810	1.7%	1,994	2.9%
White Memorial Medical Center	2,518	2.1%	1,165	2.4%	1,352	1.9%
Usc Verdugo Hills Hospital	2,503	2.1%	674	1.4%	1,829	2.6%
Citrus Valley Medical Center - Qv Campus	1,653	1.4%	87	0.2%	1,566	2.2%
Foothill Presbyterian Hospital-Johnston Memorial	1,599	1.4%	38	0.1%	1,561	2.2%
Children's Hospital Of Los Angeles	1,499	1.3%	568	1.2%	931	1.3%
Keck Hospital Of Usc	1,497	1.3%	586	1.2%	911	1.3%
Cedars Sinai Medical Center	1,440	1.2%	652	1.4%	787	1.1%
All Others	22,596	19.2%	8,997	18.8%	13,599	19.5%
Total Discharges	117,872	100.0%	47,979	100.0%	69,893	100.0%

Huntington is the leading hospital provider in its service area, competing with Methodist to the East and Glendale Adventist to the West.

Source: OSHPD 2018 – 2017 year end numbers

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Medical Staff

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Medical Staff Overview

- Appointments to the Hospital's Medical Staff are made by the Board upon recommendation of the Medical Executive Committee
- As of June 2019, there were over 949 physicians on the Hospital's Medical Staff across 64 specialties including Affiliate, Consulting, Provisional, Active, Courtesy and Associate staff

Huntington Hospital
Medical Staff Specialties

Specialty	# of Physicians	Specialty	# of Physicians
Addiction Medicine	1	Ophthalmology	45
Allergy and Immunology	3	Oral/Maxillo Facial Surgery	5
Anesthesiology	45	Orthopedic Surgery	28
Cardiothoracic Surgery	2	Otolaryngology	13
Cardiovascular Disease	20	Pain Management	4
Clinical Neurophysiology	1	Pathology	5
Colorectal Surgery	4	Pediatric Cardiology	12
Critical Care Medicine	1	Pediatric Critical Care	4
Dermatology	12	Pediatric Endocrinology	1
Diagnostic Radiology	16	Pediatric Gastroenterology	4
Electrophysiology	6	Pediatric Hematology/Oncology	1
Emergency Medicine	38	Pediatric Infectious Disease	4
Endocrinology	6	Pediatric Neurology	3
Family Medicine	10	Pediatric Neurosurgery	1
Gastroenterology	15	Pediatric Ophthalmology	1
General Surgery	38	Pediatric Orthopedics	5
Geriatrics	3	Pediatric Pulmonary	1
Gynecologic Oncology	12	Pediatric Radiology	1
Gynecology	1	Pediatric Surgery	10
Gynecology/Urogynecology	2	Pediatric Urology	2
Hand Surgery	1	Pediatrics	82
Hematology	2	Physical Med & Rehab	6
Hematology/Medical Oncology	4	Plastic Surgery	30
Hematology/Oncology	31	Podiatry	6
Hepatobiliary	1	Psychiatry	8
Hepatology	1	Pulmonary Disease	22
Hospice & Palliative Medicine	3	Radiation Oncology	5
Infectious Disease	8	Reproductive Endocrinology & Infertili	4
Internal Medicine	108	Rheumatology	7
Interventional Cardiology	15	Sports Medicine	1
Maternal & Fetal Medicine	13	Surgical Critical Care	8
Medical Oncology	8	Surgical Oncology	5
Medical Toxicology	2	Teleradiology	17
Neonatology	12	Thoracic Surgery	12
Nephrology	13	Urogynecology	1
Neurology	16	Urology	22
Neuroradiology	2	Vascular and Interventional Radiology	4
Neurosurgery	13	Vascular Neurology	1
Obstetrics & Gynecology	58	Vascular Surgery	11
		Total	**949**

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Physician Recruitment

During the past 4 years, Huntington has recruited over 50 physicians with approximately 30% of the recruits being Hospitalists

Huntington Hospital

FY16 to FY19 Physician Recruitment

Specialty	2016	2017	2018	2019	Total
Endocrinology	1	1	-	-	**2**
Family Medicine	2	-	-	-	**2**
GME	-	2	2	2	**6**
Hospitalist	-	10	2	3	**15**
Internal Medicine	2	2	1	1	**6**
Neurosurgery	-	-	-	1	**1**
Nocturnist	-	1	-	-	**1**
Palliative Care	-	1	1	-	**2**
Pathology	-	-	-	5	**5**
Pediatric Endocrinology	1	-	-	-	**1**
Pediatrics	1	3	2	-	**6**
Physical Medicine & Rehab	-	-	1	1	**2**
Pulmonology Critical Care	1	1	-	-	**2**
Rheumatology	-	2	-	-	**2**
Total	**8**	**23**	**9**	**13**	**53**

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

1206(l) Foundation

- In 1993, Huntington Hospital organized a 1206(l) foundation, The Huntington Medical Foundation ("Foundation") which is also known as Huntington Health Physicians ("HHP")
- Currently, HHP has three operating Professional Services Agreements ("PSAs") with three Professional Groups:
  - Huntington Foundation Medical Group (considered the Primary Group and Medical Specialties)
  - The Hill Medical Group for Radiology Services to support the Jim & Eleanor Randall Breast Center
  - Huntington Aligned Medical Group (Hospital Based Physicians, including Hospitalists, Palliative Care, Pathology, Physical Medicine, GME)
- Through its Affiliates and/or PSAs, the Foundation has:
  - Over 78 physicians, including Advanced Practice Providers
  - 65 of which are on a full-time basis
- Contracted with DaVita Healthcare Partners (now part of Optum Care) as exclusive primary care physician provider. Approximately 23,800 commercial equivalence enrollees
- Newly hired executive medical director, Dr. Timothy Albert, will provide clinical and operational leadership for the the Foundation
- In 2018, physicians affiliated with the Foundation account for 156,000 outpatient visits/encounters
- The Foundation has the necessary board certified specialties to qualify as a 1206(l) Medical Foundation
- In addition, the Foundation conducts medical research and health education
- Huntington Hospital is the sole corporate member of the Foundation

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

1206(l) Foundation Income Statement

Foundation
Statement of Operations
($ in 000's)

	2016	2017	2018
Visits	207,757	236,518	249,539
Revenues			
Net Patient Service Revenue	$ 30,278	$ 38,301	$ 37,213
DHCP Capitation	1,458	1,571	1,644
Other Revenues	211	118	25
Total Operating Revenues	**31,947**	**39,990**	**38,883**
Expenses			
Salaries and Benefits	9,009	11,432	10,976
Medical Supplies and Drugs	6,094	6,183	5,918
Provider Fee Expense	13,546	14,925	16,467
Other	7,347	11,469	9,454
Total Operating Expenses (before deprec. & int.)	**35,996**	**44,009**	**42,816**
Operating EBIDA	**(4,050)**	**(4,018)**	**(3,934)**
Operating EBIDA Margin	*-13%*	*-10%*	*-10%*
Depreciation and Amortization	425	1,014	999
Interest	-	-	-
Total Operating Expenses	**36,421**	**45,022**	**43,815**
Operating Income (loss)	**(4,475)**	**(5,032)**	**(4,932)**
Total Other Income	**373**	**18**	**91**
Revenues in Excess of Expenses	**(4,101)**	**(5,014)**	**(4,841)**
Increase in Unrestricted Assets	**(2,324)**	**(4,444)**	**(4,282)**

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Governance, Management, and Employees

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Huntington Hospital Board of Directors

- Huntington Hospital is governed by a highly engaged Board of Directors (the "Hospital Board") who are local, regional and national leaders in their respective industries
- The Hospital Board is vested with the responsibility for overseeing the management and financial needs of Huntington Hospital
- The Hospital Board consists of not less than 13 nor more than 30 members and currently has 26 members
- The Bylaws provide that the Hospital Board meets 9-10 times per year
- The Hospital Board is a working board with much work done in board committees, listed below, and establishes Ad Hoc committees as necessary:
  - Audit & Compliance (meets 4x)
  - Building & Facilities (meets 6x)
  - Community Benefits (meets 3x)
  - Compensation (meets 6x)
  - Finance and Investment (meets 6x)
  - Governance (meets 4x)
  - Information Technology (meets 4x)
  - Quality (meets 5x)
  - Strategy (meets 4x)
  - Philanthropy (meets 4x)
  - Partnership (adhoc committee)
- There is a separate Board of Trustees, appointed for life, and each of the five Trustees serves on the Hospital Board so long as he/she is a Trustee
  - The approval of a majority of the Trustees is required for any action to be taken by the Hospital Board (see Trust intro on slide 14)

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Huntington Hospital & Trust Board of Directors

Huntington Hospital
Board of Directors

	Member	Occupation	Membership
	Akila Gibbs	Executive Director, Pasadena Senior Center	Elected
	Allen Mathies, Jr., M.D.	President Emeritus, Huntington Hospital; Dean Emeritus, USC School of Medicine	President Emeritus, Ex-officio
	Armando Gonzalez	Founder and Principal, Gonzalez/Goodale Architects	Trustee, Ex-officio
	Brandon Lew, DO	Emergency Room Physician, Huntington Hospital, Medical Director of the Emergency Room	President Elect of the Medical Staff, Ex-officio non-voting
*	M. Christian Mitchell	Corporate Board Member, Parsons PPBI and Western Asset Mortgage; Retired Senior Partner, Deloitte	Elected
	Christopher (Chris) Hedley, MD	Huntington Hospital, Department of Radiology	President of the Medical Staff; Ex-officio
*	David Kirchheimer	Retired Chief Financial Officer, Oaktree Capital Management	Elected
	Elizabeth (Liz) Graham Olson	Attorney	Elected
	Ellen Lee	Retired Real Estate Professional	Elected
	Harry Bowles, M.D.	Anesthesiologist, Huntington Hospital	President Elect of the Medical Staff, Ex-officio non-voting
	James Shankwiler, MD	Congress Medical Group, Orthopedic Surgeon	Past President of Medical Staff; Ex-officio
*	Jaynie M. Studenmund	Retired COO, Overture Services; public corporate board member: Core Logic, EXL Services, and Western Asset Funds	Trustee, Ex-officio
	John Mothershead	Board Member, HMRI	HMRI representative, Ex-officio, non-voting
	Kathleen (Kathy) Good Podley	Retired Real Estate Professional	Elected
	Lori J. Morgan, MD, MBA	President and Chief Executive Officer, Huntington Hospital	President, Ex-officio

* ***Member of Partnership Committee***

Indicates Trustee on the Trust Board as well

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Huntington Hospital & Trust Board of Directors *(continued)*

Huntington Hospital
Board of Directors

	Member	Occupation	Membership
	Louise Bryson	Retired Television Executive	Elected
	Michelle Quinones Chino	Marketing Consultant Past Advisor to Yahoo!, POM Wonderful and Nestle USA	Trustee, Ex-officio
*	Paul Johnson	Management Company Consultant; Past President and Chief Executive Officer, Kelley Blue Book	Trustee, Ex-officio
	R. Scott Jenkins	Partner, Hahn & Hahn	Elected
	Reed Gardiner	Retired Partner, Price WaterhouseCoopers LLP	Elected
	Renee Ying	Chair, I/O Controls	Elected
	Robert Yu	Chief Executive Officer, Real Estate Development	Elected
*	Ronald (Ron) L. Havner, Jr.	Retired CEO of Public Storage and Current Chair	Elected
	Rosemary B. Simmons	Retired - Mayor, City of San Marino, California (1986-1988)	Director Emeritus, Ex-officio
	Sharon Arthofer	Entrepreneur and Franchisee, Wetzel's Pretzels	Elected
	Simon Li	Retired Assitant Managing Editor, Los Angeles Times	Elected
	Stephen Ralph	President Emeritus, Huntington Hospital	President Emeritus, Ex-officio
	Wayne Brandt	Managing Director & Western Regional Head of Real Estate Capital Markets, Wells Fargo	Trustee, Ex-officio
	William J. Bogaard	Former Mayor, City of Pasadena	Elected

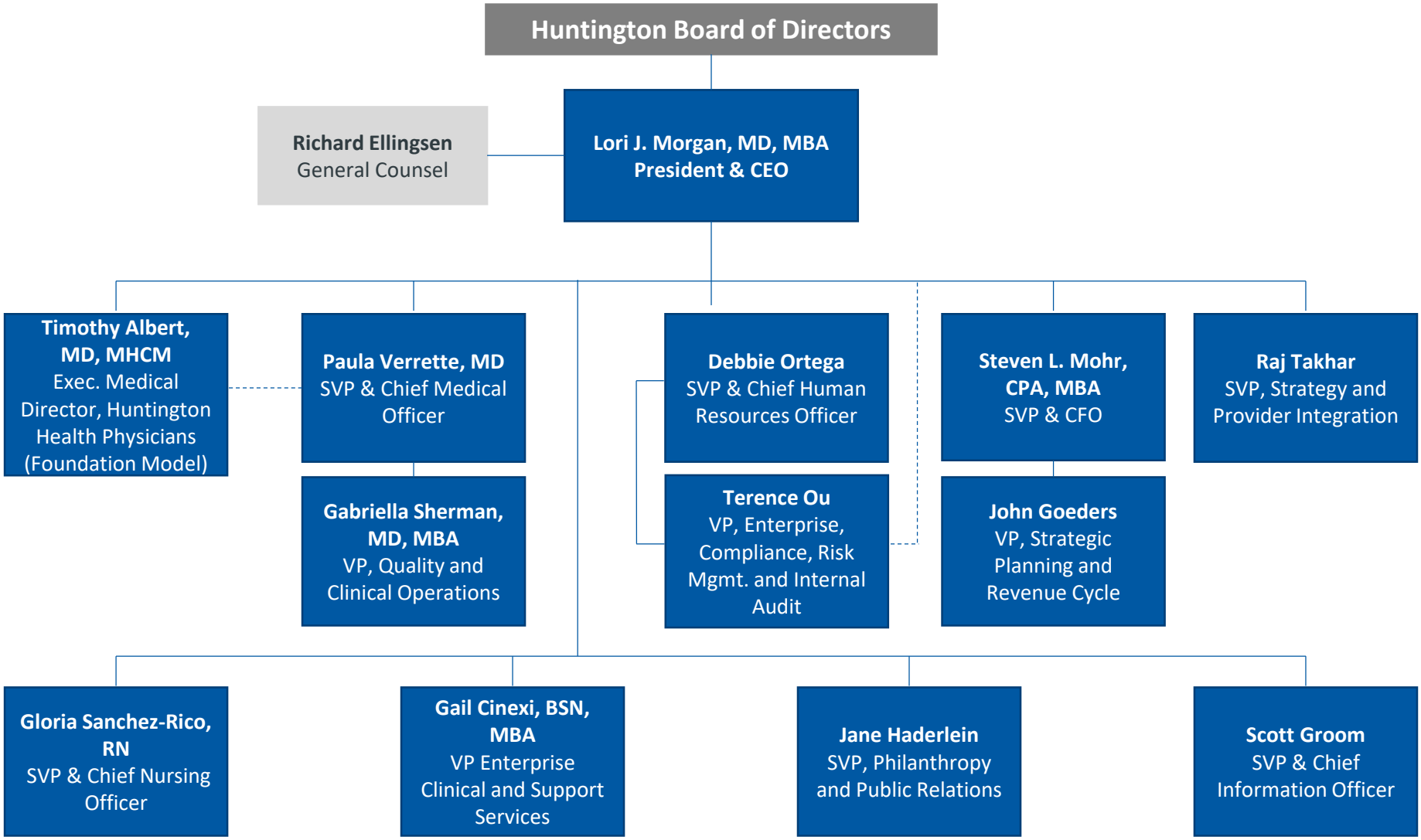
Indicates Trustee on the Trust Board as well

* ***Member of Partnership Committee***

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Senior Management Overview



Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Senior Management Team Bios



Lori J. Morgan, MD, MBA
President and Chief Executive Officer

Lori J. Morgan, MD, MBA, joined the Huntington as President and Chief Executive Officer in September 2017. Dr. Morgan most recently served as corporate vice president of Legacy Health, Portland's largest local health system, and as president of Legacy Emanuel Medical Center, the system's largest hospital.

Prior to those positions, Dr. Morgan spent 20 years as a trauma surgeon and intensivist while overseeing multiple trauma programs. Dr. Morgan currently serves or has served on the boards of the Oregon EMS & Trauma Advisory Board, Urban League of Portland, Emanuel Foundation, Legacy Institute for Surgical Education & Innovation, Life Flight and Legacy Health Partners.

Dr. Morgan received her medical degree from the University of Washington School of Medicine, then completed her surgical residency at Stanford University Medical Center, and her trauma/critical care fellowship at the University of Pennsylvania Medical Center. She received her Master of Business Administration degree from Pacific Lutheran University where she concentrated on technology and innovation management.



Steven L. Mohr, CPA, MBA
Senior Vice President & Chief Financial Officer

Steven Mohr joins Huntington Hospital from Providence St. Joseph Health Los Angeles, where he served as chief financial officer since 2014. He was a key member of the executive leadership team, managing, developing and implementing strategic direction for a $2.7 billion region of a large, multi-state, nonprofit health system. Mohr held direct oversite and accountability for all regional financial operations and was a key partner on strategy and business development.

Prior to Providence St. Joseph, Mohr served as chief financial officer for Loma Linda University Medical Center. In these roles he oversaw financial services, health information management, decision support, supply chain management, property management, engineering, clinical engineering and construction for the medical center and six hospital facilities. Mohr began his career at Ernst & Young.

Mohr earned his masters in business administration from the University of Southern California, Marshall School of Business and received his bachelor of business administration from Loma Linda University.

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Senior Management Team Bios



Raj Takhar
Senior Vice President, Strategy and Provider Integration

Mr. Takhar joined the Corporation in 2013 as Vice President, Business/Provider Strategy. Prior to joining the Corporation, Mr. Takhar had over 20 years of experience in healthcare management in a variety of leadership roles, including executive vice president of regional network operations and strategy for Heritage Provider Network; chief executive officer for Gateway Medical Group/Pinnacle Health Resources; and chief operations officer for HMO California. He has extensive experience with managed care and medical group operations.

He holds a Bachelor of Science in behavioral health sciences from the University of Utah, and master's degrees in public health administration and healthcare administration from Loma Linda University.

Mr. Takhar is a fellow of the Healthcare Financial Management Association and a member of the American Medical Group Association.



Paula M. Verrette, M.D
Senior Vice President & Chief Medical Officer

Dr. Verrette joined the Corporation in 2007. Prior to joining the Corporation, Dr. Verrette had a private pediatric medical practice and served in a variety of leadership roles on the Hospital's medical staff, including chair of the department of pediatrics, chair of quality management and chief of staff.

Dr. Verrette also served as a pediatric consultant to the Pasadena Unified School District, Pediatric Medical Director of the Community Health Alliance of Pasadena (CHAP) Clinic, and Project Director of the Healthy Eating Lifestyle Program, a collaboration with three area hospitals to address the growing epidemic in childhood obesity.

Dr. Verrette received her Bachelor of Science degree from Xavier University and her medical degree from Tulane University School of Medicine.

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Senior Management Team Bios



Debbie Ortega
Senior Vice President & Chief Human Resources

Ms. Ortega returned to the Corporation in 2011, after previously serving as Vice President, Human Resources from 2003 to 2008. Ms. Ortega has over 25 years' experience in the human resources and healthcare industry, and most recently was employed as vice president of human resources at St. Joseph Health System in Orange.

Ms. Ortega served as the division director of human resources and employee development for Catholic Healthcare West – Southern California, and was director of human resources for St. Francis Medical Center, a Catholic Healthcare West facility. Ms. Ortega was part-time faculty and sat on the advisory board for the healthcare administration for California State University, Long Beach. She currently serves on the Union Station - Pasadena Human Resources Committee.

Ms. Ortega holds a bachelor's degree in business administration from California State University, Pomona, with an emphasis in human resource management.



Gloria Sanchez-Rico, RN
Senior Vice President & Chief Nurse Executive

Ms. Sanchez-Rico was promoted to Vice President and Chief Nurse Executive in 2014. Ms. Sanchez-Rico joined the Corporation in 1999 as clinical manager of the neonatal intensive care unit and respiratory/pulmonary services and, throughout her career at the Corporation, has served in various leadership roles, including clinical director for medical and support services and executive director for medical and children's services. Most recently, she served as executive director for children's and support services.

She holds bachelor's degrees in both health sciences and nursing from California State University, Los Angeles, as well as a Master of Business Administration degree from the University of Phoenix.

Ms. Sanchez-Rico serves on the board of trustees of the Ronald McDonald House of Pasadena.

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Senior Management Team Bios



John Goeders
Vice President, Strategic Planning/Revenue Cycle

Mr. Goeders serves as the Corporation's Vice President, Strategic Planning and Revenue Cycle. He first joined the Corporation as Reimbursement Manager in 1999, with his leadership responsibilities and influence progressively broadening ever since. Additional positions held by Mr. Goeders leading up to his current executive role include Executive Director of Strategic and Financial Planning, and Director of Strategic Planning & Reimbursement. He joined the Corporation with a reimbursement consulting background from EY Healthcare Advisory Services, and a previous position with Aetna as a government reimbursement auditor.

Mr. Goeders earned a Bachelor of Arts degree in Business Economics with an emphasis in accounting from the University of California at Santa Barbara, and holds a Master of Business Administration degree with an emphasis in Finance from the University of Redlands.



Gabriella Sherman, MD, MBA
Vice President, Quality and Clinical Operations

Dr. Sherman was appointed to her current position in 2016. Dr. Sherman is a board certified internal medicine physician and has worked as a hospitalist and as an Associate Program Director with the internal medicine residency.

She graduated summa cum laude from Virginia Commonwealth University and received her medical degree at the Medical College of Virginia. Dr. Sherman completed her internship and residency at Huntington Hospital, where she served as the Chief Resident in internal medicine. She received her Master of Business Administration degree from The Wharton School at the University of Pennsylvania.

Dr. Sherman is a fellow of the American College of Physicians and an assistant professor of clinical medicine at the University of Southern California. She has presented numerous research presentations at The Society of Hospital Medicine and The Institute for Healthcare Improvement that focus on quality improvement and clinical innovation.

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Senior Management Team Bios



Scott Groom
Senior Vice President & Chief Information Officer

Mr. Groom was appointed Chief Information Officer in February 2018 and brings 20 years of experience in advanced technology, clinical integration, management of physician and outpatient operations, strategic planning/marketing, business development and consulting across multiple healthcare and Fortune 500 corporations. Most recently, Mr. Groom served as Network Vice President and Chief Information Officer for New York-based Bassett Healthcare, a top 50 integrated delivery network.

Mr. Groom earned his Master of Health Services Administration degree from The George Washington University's School of Business and received a Bachelor of Arts from Virginia Polytechnic Institute and State University. He completed a post-graduate residency at the University of Virginia Medical Center.



Jane Haderlein
Senior Vice President, Philanthropy & Public Relations

Ms. Haderlein was appointed vice president in March 1995 and was promoted to senior vice president in 2012. Previously, she was the hospital's director of development, a position she assumed in 1992. From 1988 to 1992, Ms. Haderlein was senior managing associate with Phillips & Associates, a management consulting firm that provides fundraising counsel to nonprofit institutions throughout the United States. Prior to that, Ms. Haderlein worked with United Way of Los Angeles, where she directed the campaign for major law and accounting firms in Los Angeles.

Ms. Haderlein is a member of the Association for Healthcare Philanthropy and the Southern California Association for Healthcare Development. She serves on the program board for Young & Healthy and is a participant in PUSD's Reading Partners program. Jane has attended executive education programs at Harvard Business School and Stanford Graduate School of Business. She received her bachelor's degree from the University of California, Los Angeles.

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Senior Management Team Bios



Gail Cinexi
Vice President, Clinical and Support Services

Ms. Cinexi was promoted to Vice President in June 2018 and oversees cardiovascular, imaging, endoscopy, radiation oncology, respiratory/pulmonary and cancer center programs as well as Environmental Services, linen, transport and food services. She has been with Huntington Hospital since 1986 first serving as an RN in the surgical intensive care unit and most recently as Director of Imaging, Cardiology, and GI Services.

Ms. Cinexi received her BS in Nursing from Fairleigh Dickinson University. Ms. Cinexi developed the Cardiac Rehabilitation Program which started in 1988 with four patients, to present, with over 300 patients. She assisted in establishing H.E.A.R.T. Fund which has raised over $1.5 million and provided education and rehabilitation services to cardiac patients at Huntington Hospital.

Ms. Cinexi serves on the executive leadership team with the American Heart Association and is a member of the STEMI Advisory Board for Los Angeles County that develops strategies for improvement of myocardial infarction care.



Timothy Albert, MD, MHCM
Executive Medical Director, Huntington Health Physicians

Dr. Albert, a board-certified cardiologist, is an experienced leader in community-based medical groups, as well as a proven leader in the use and development of medical technology in community-hospital settings.

Dr. Albert received his medical degree from the University of California, San Francisco School of Medicine, completed post-graduate training in internal medicine at the University of Washington, and completed his cardiology fellowship at Duke University. Dr. Albert subsequently obtained a master's in health care management degree from the Harvard University School of Public Health.

In his role as Executive Medical Director, Dr. Albert provides clinical leadership as well as overall strategic, clinical and operational planning of Huntington Health Physicians, a medical foundation model of organized physician delivery. With offices throughout the San Gabriel Valley, Huntington Health Physicians offers adult and pediatric primary and specialty care, as well as hospital-based care.

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Senior Management Team Bios



Terence Ou
Vice President, Enterprise/Compliance/Risk Mgmt./Internal Audit

Terence Ou is the Vice President of Enterprise Compliance, Risk Management, and Internal Audit at Huntington Hospital in Pasadena, CA, and leads the risk management, internal audit, compliance, patient privacy, and contracts management programs. Before working at Huntington Hospital for the last six years, he was with Deloitte for twelve years providing regulatory compliance, audit, and information security risk services to healthcare systems, community hospitals, physician groups, and health plans. Terence received his Bachelor of Arts (BA) degree from Middlebury College and a Masters in Business Administration (MBA) from the University of Southern California. His professional certifications include the Certified in Healthcare Compliance (CHC), Certified in Healthcare Privacy Compliance (CHPC), Certified Information Systems Security Professional (CISSP), Certified Healthcare Internal Audit Professional (CHIAP), and Certified Information Systems Auditor (CISA).

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Huntington Employee Overview

Huntington Hospital

FTEs by Function

Employee Classification	FY2016 Total FTEs	FY2016 Productive FTEs	FY2017 Total FTEs	FY2017 Productive FTEs	FY2018 Total FTEs	FY2018 Productive FTEs	Current Total FTEs	Current Productive FTEs
Huntington Memorial Hospital								
Nursing	1,048.3	928.7	1,074.9	932.5	1,026.3	858.7	1,028.2	859.4
Ancillary	932.5	830.9	954.6	844.0	928.5	807.7	939.7	823.6
Support	1,151.2	1,036.8	1,198.8	1,069.4	1,161.7	1,028.7	1,150.4	1,025.0
Total Huntington Hospital	**3,132.0**	**2,796.4**	**3,228.3**	**2,845.9**	**3,116.5**	**2,695.1**	**3,118.3**	**2,708.0**
Non-Huntington Memorial Hospital								
Ancillary	9.8	8.7	10.1	8.4	9.5	8.3	9.6	8.4
Support	77.7	71.7	78.0	70.4	77.6	69.7	76.3	68.4
Total Non-Huntington Memorial Hosptial	**87.5**	**80.4**	**88.1**	**78.8**	**87.1**	**78.0**	**85.9**	**76.8**
Total Huntington	**3,219.5**	**2,876.8**	**3,316.4**	**2,924.7**	**3,203.6**	**2,773.1**	**3,204.2**	**2,784.8**

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Financial Summary

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Utilization Overview

Huntington Hospital

Key Utilization Summary

	Fiscal Year Ended December 31,			Year-to-Date	Year-to-Date
	2016	2017	2018	Mar 31, 2018	Mar 31, 2019
Licensed and Available Beds	578	578	578	578	578
Average Daily Census	356	346	334	368	347
Observation Visits	2,578	3,079	4,567	816	1,667
% Growth		*19.4%*	*48.3%*		*104.3%*
Discharges	29,561	29,712	28,635	7,431	7,106
% Growth		*0.5%*	*-3.6%*		*-4.4%*
Births	3,429	3,580	3,475	842	881
% Growth		*4.4%*	*-2.9%*		*4.6%*
Patient Days	130,259	126,305	121,897	33,163	31,235
% Growth		*-3.0%*	*-3.5%*		*-5.8%*
Occupancy	62%	60%	58%	64%	60%
% Growth		*-3.2%*	*-3.3%*		*-6.3%*
Average Length of Stay (Days)	4.41	4.25	4.26	4.46	4.40
% Growth		*-3.6%*	*0.2%*		*-1.3%*
Inpatient Surgical Procedures	9,275	8,591	8,182	1,962	1,934
% Growth		*-7.4%*	*-4.8%*		*-1.4%*
Outpatient Surgeries	7,682	7,919	8,185	817	2,090
% Growth		*3.1%*	*3.4%*		*155.8%*

Source: Huntington Hospital Management; Fy2018 and FY2017 Operating Reports

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Utilization Commentary

- Huntington Hospital experienced a notable increase in observations days over the past two years increasing 19.4% from 2016 to 2017 and 48.3% from 2017 to 2018
- Discharges have remained relatively flat over the prior three fiscal years with a small decrease of 3.6% from 2017 to 2018
- Outpatient surgeries have demonstrated consistent year-over-year increases of 3.1% from 2016 to 2017 and 3.4% from 2017 to 2018. Outpatient surgery volumes were also strong through Q1 2019 with 2,090 surgeries in the quarter
- Huntington has reduced average length of stay from 4.41 in 2016 to 4.26 in 2018, but has experienced a modest increase to 4.40 for Q1 2019

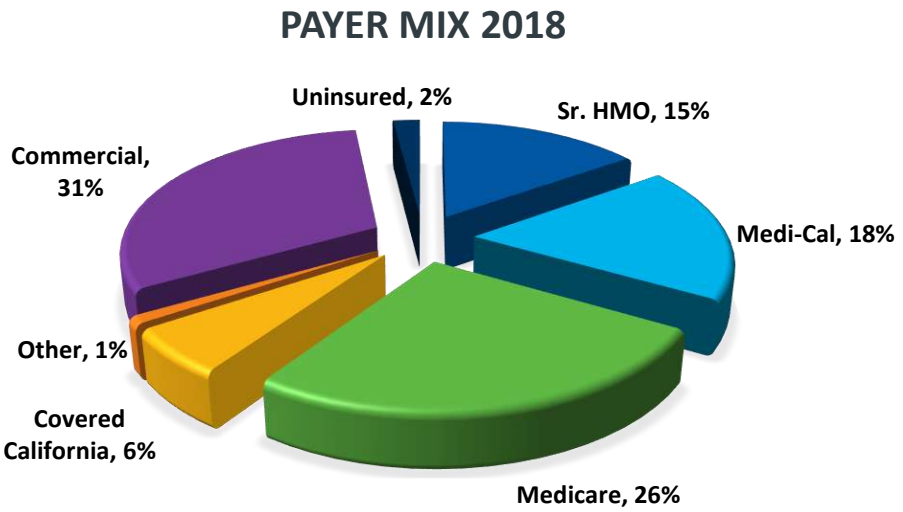
Through collaborative efforts between clinicians and a robust case management program, Huntington has seen the above positive trends in utilization in the past three years

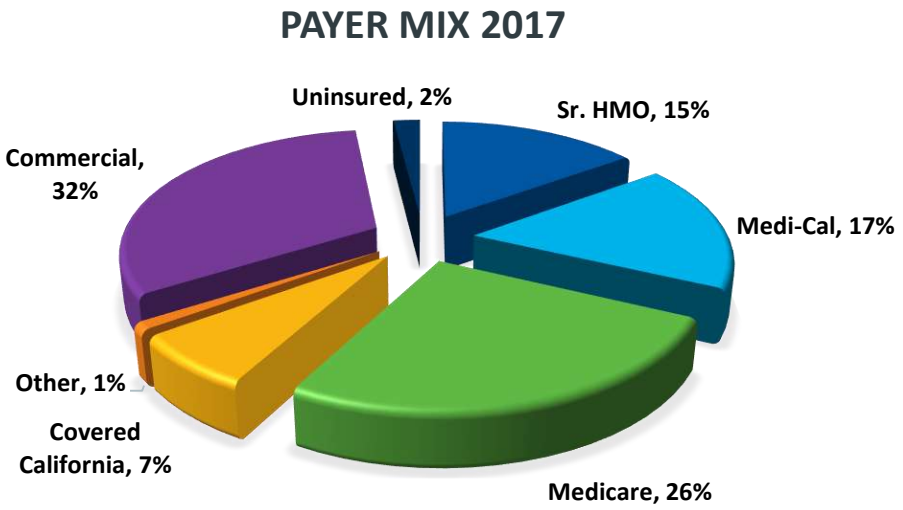
Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Payer Mix Shifts

- Commercial generally continues to incrementally transition to Medicare due to population aging and Covered California plans
- Traditional Medicare continues transition to Medicare Advantage at an incremental pace
- Uninsured continues to be stabilized at 2%, down from 4% prior to the ACA
- Covered California has seen trended growth reversing slightly in 2018
- Medi-Cal continues to see growth due to Medi-Cal Managed Care initiatives



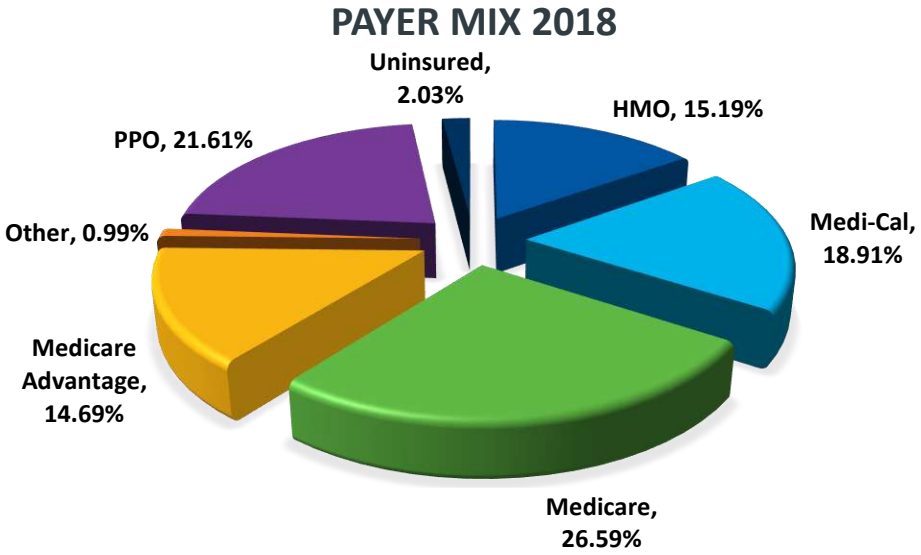


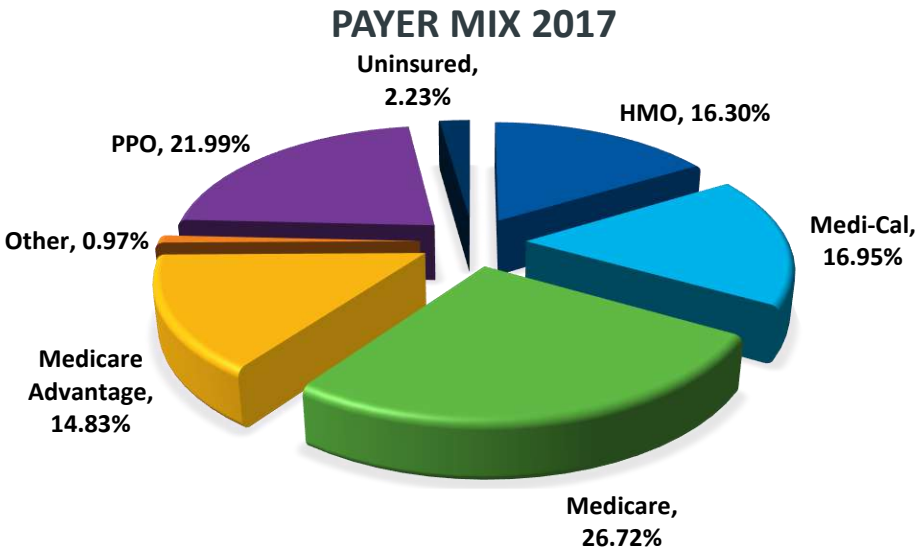
Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Total Admissions by Payer

- Medicare (26%), Medi-Cal (19%) and PPO (21%) represent the largest source of hospital admissions
- Medicare Advantage represents approximately 28,000 enrollees as attributed to DHCP (Optum Care) IPA and staff model networks utilizing Huntington as the primary hospital. Other value-based participation includes Vivity and Oscar
- The remaining source of Huntington's admissions is primarily commercial insurance patients



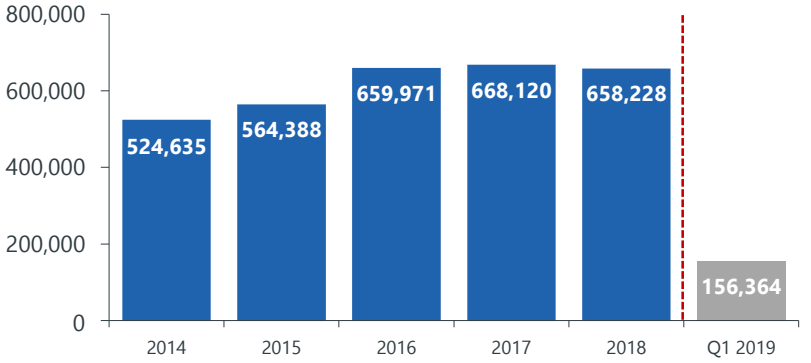


Source: Huntington Hospital Management

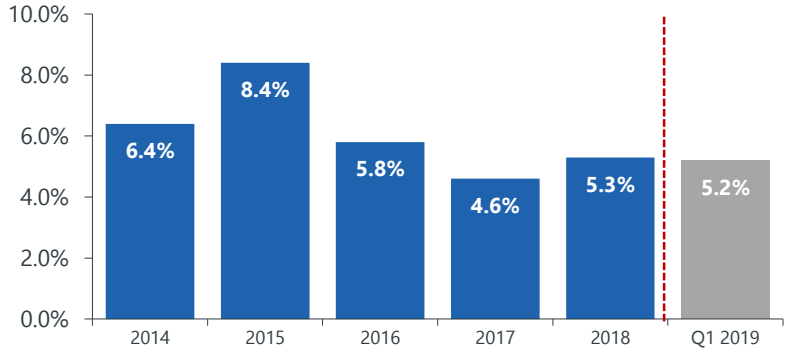
CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Historical Operating Results

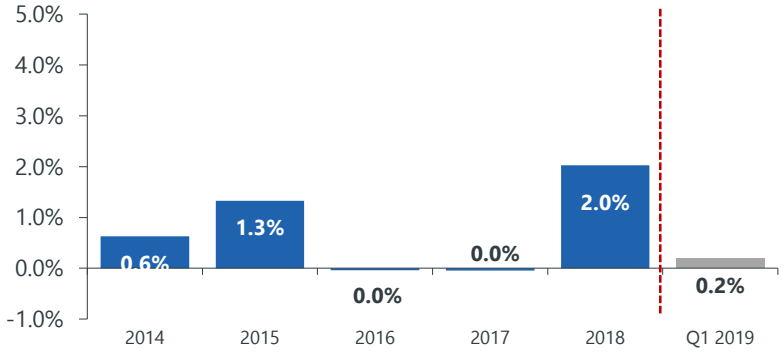
Net Patient Revenue ($000)



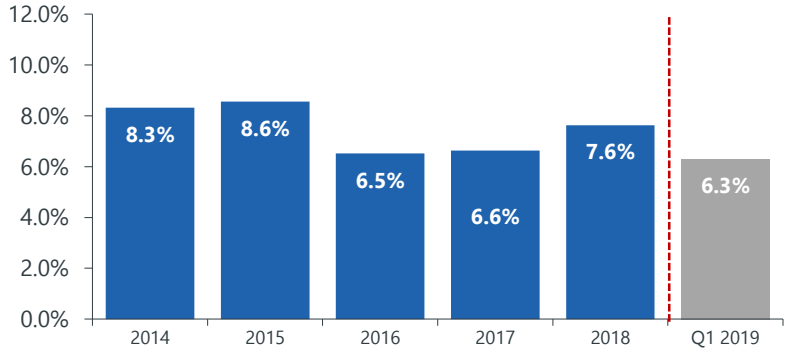
Operating Cash Flow Margin



Excess Margin



EBIDA Margin

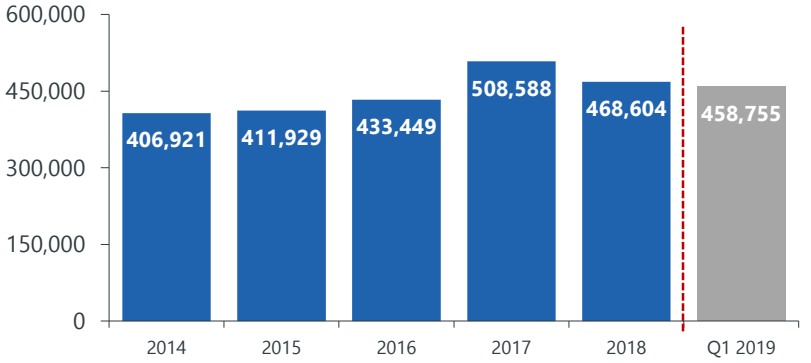


Source: Audited Financial Statements (blue bar) and Unaudited Q1 2019 Financials (grey bar).
Notes: Includes contributions revenue part of operating revenue.

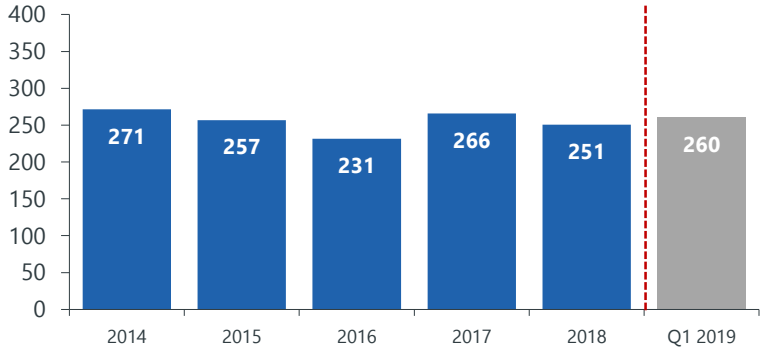
CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Key Balance Sheet Metrics

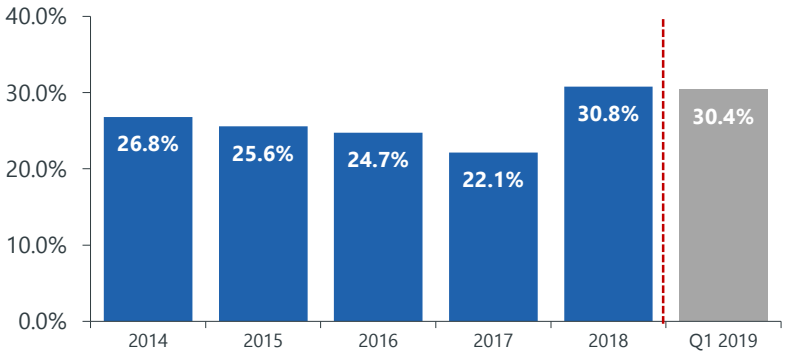
Unrestricted Cash ($000)



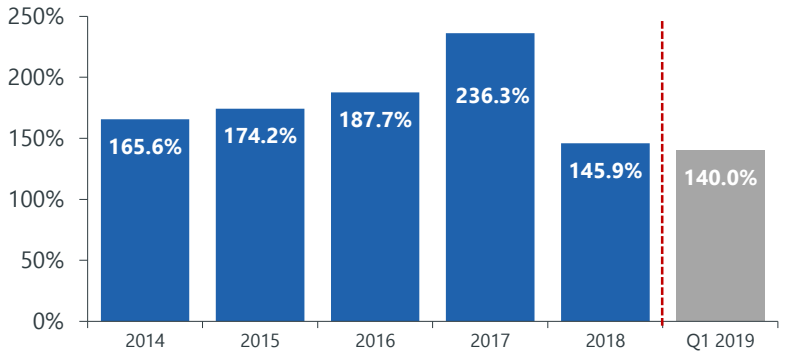
Days Cash on Hand



Debt to Capitalization



Cash to Debt



Source: Audited Financial Statements (blue bar) and Unaudited Q1 2019 Financials (grey bar).
Notes: Includes contributions revenue part of operating revenue. Adjusted days cash on hand based on adjusted operating expense.

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Balance Sheet: Assets

Huntington Hospital
Balance Sheet

($ in 000's)	Fiscal Year Ended December 31,									March 31,
	2016			2017			2018			2019
	Trust	Huntington Hospital	Consolidated	Trust	Huntington Hospital	Consolidated	Trust	Huntington Hospital	Consolidated	Consolidated
Assets										
Cash and Cash Equivalents	$3,466	$14,530	$17,996	$5,153	$14,417	$19,570	$2,969	$18,289	$21,258	$7,326
Short-term Investments	201,625	145,640	347,265	238,708	181,825	420,533	221,458	151,098	372,556	388,382
Patient Accounts Receivable	-	93,372	93,372	-	98,656	98,656	-	108,187	108,187	115,073
Other Receivables	-	37,929	37,929	-	63,377	63,377	-	48,980	48,980	43,130
Inventories	-	13,050	13,050	-	13,660	13,660	-	15,237	15,237	15,526
Prepaid Expenses and Other Current Assets	1,428	48,191	31,525	1,640	52,984	30,167	1,158	58,918	35,330	25,684
Current Assets	**206,519**	**352,712**	**541,137**	**245,501**	**424,919**	**645,963**	**225,585**	**400,709**	**601,548**	**595,121**
Assets Limited as to Use, net	2,034	172,499	174,533	2,034	163,418	165,452	2,034	244,290	246,324	242,117
Property, Plant and Equipment, net	52,830	434,716	487,546	50,421	433,176	483,597	50,068	458,660	508,728	519,735
Right of Use Assets	-	-	-	-	-	-	-	-	-	61,574
Other Assets:										
Goodwill	-	10,126	10,126	-	10,006	10,006	-	10,006	10,006	10,006
Other Noncurrent Assets	9,641	13,531	13,534	9,093	10,405	10,408	7,269	12,308	12,311	12,619
Other Assets	9,641	23,657	23,660	9,093	20,411	20,414	7,269	22,314	22,317	22,625
Total Assets	**271,024**	**983,584**	**1,226,876**	**307,049**	**1,041,924**	**1,315,426**	**284,956**	**1,125,973**	**1,378,917**	**1,441,172**

Source: Audited Annual Financial Statements and Unaudited Quarterly Financial Statements. Huntington Hospital includes the Foundation.

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Balance Sheet: Liabilities & Net Assets

Huntington Hospital
Balance Sheet

($ in 000's)	Fiscal Year Ended December 31,									March 31,
	2016			2017			2018			2019
	Trust	Huntington Hospital	Consolidated	Trust	Huntington Hospital	Consolidated	Trust	Huntington Hospital	Consolidated	Consolidated
Liabilities and Net Assets										
Current Maturities of Long-Term Debt	-	5,349	4,161	-	4,629	3,441	-	5,247	4,734	5,638
Accounts Payable	661	42,022	40,551	762	31,297	29,327	671	43,017	39,907	32,702
Accrued Payroll and Employee Benefits	-	32,876	32,876	-	32,982	32,982	-	35,364	35,364	32,517
Revolving Credit Line	-	-	-	-	9,664	9,664	-	-	-	-
Accrued Provier Fee	-	9,746	9,746	-	45,826	45,826	-	31,675	31,675	11,987
Other Current Liabilities	6,185	23,990	15,253	6,104	35,739	21,612	1,050	44,969	26,552	20,814
Current Liabilities	**6,846**	**113,983**	**102,587**	**6,866**	**160,137**	**142,852**	**1,721**	**160,272**	**138,232**	**103,658**
Other Liabilities:										
Long-Term Debt, net	-	226,758	226,758	-	211,827	211,827	-	316,537	316,537	322,001
Accrued Pension Liabilities	-	66,067	66,067	-	66,841	66,841	-	66,022	66,022	65,343
Accrued Self-Insurance Claims, Less Current Pc	-	18,799	18,799	-	19,605	19,605	-	18,474	18,474	18,474
Long-Term Lease Liability	-	-	-	-	-	-	-	-	-	57,466
Other Long-Term Liabilities	4,820	8,229	5,059	4,434	9,349	5,887	4,080	7,701	5,030	4,295
Total Other Liabilities	**4,820**	**319,853**	**316,683**	**4,434**	**307,622**	**304,160**	**4,080**	**408,734**	**406,063**	**467,579**
Total Liabilities	**11,666**	**433,836**	**419,270**	**11,300**	**467,759**	**447,012**	**5,801**	**569,006**	**544,295**	**571,237**
Total Net Assets	**259,358**	**549,748**	**807,606**	**295,749**	**574,165**	**868,414**	**279,155**	**556,967**	**834,622**	**869,935**
Total Liabilities and Net Assets	**$271,024**	**$983,584**	**$1,226,876**	**$307,049**	**$1,041,924**	**$1,315,426**	**$284,956**	**$1,125,973**	**$1,378,917**	**$1,441,172**

Source: Audited Annual Financial Statements and Unaudited Quarterly Financial Statements. Huntington Hospital includes the Foundation.

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Statement of Operations

Huntington Hospital
Statement of Operations

($ in 000's)	Fiscal Year Ended December 31,									Quarter Ended March 31,	
	2016			2017			2018			2018	2019
	Trust	Huntington Hospital	Consolidated	Trust	Huntington Hospital	Consolidated	Trust	Huntington Hospital	Consolidated	Consolidated	Consolidated
Revenues											
Net Patient Service Revenue	$-	$659,971	$659,971	$-	$668,120	$668,120	$-	$658,228	$658,228	$154,912	$156,364
Other Revenues	10,760	43,982	53,109	10,846	46,003	55,290	11,067	46,135	55,653	12,375	11,672
Total Operating Revenues	**10,760**	**703,953**	**713,080**	**10,846**	**714,123**	**723,410**	**11,067**	**704,363**	**713,881**	**167,287**	**168,036**
Expenses											
Salaries and Benefits	-	377,319	377,319	-	388,902	388,902	-	381,865	381,865	96,724	96,053
Medical Supplies and Drugs	-	213,553	213,553	2,619	207,350	209,969	3,236	206,417	209,653	51,533	54,047
Provider Fee Expense	-	47,188	47,188	-	55,656	55,656	-	43,701	43,701	-	-
Other	4,065	35,305	37,737	1,052	36,278	35,771	832	41,521	40,804	8,437	9,142
Total Operating Expenses (before deprec. & int.)	**4,065**	**673,365**	**675,797**	**3,671**	**688,186**	**690,298**	**4,068**	**673,504**	**676,023**	**156,694**	**159,242**
Operating EBIDA	**6,695**	**30,588**	**37,283**	**7,175**	**25,937**	**33,112**	**6,999**	**30,859**	**37,858**	**10,593**	**8,794**
Operating EBIDA Margin	*62%*	*4%*	*5%*	*66%*	*4%*	*5%*	*63%*	*4%*	*5%*	*6%*	*5%*
Depreciation and Amortization	3,336	36,094	39,430	3,743	38,086	41,829	1,925	32,347	34,272	10,418	8,704
Interest	(535)	8,521	7,986	(523)	8,109	7,586	(452)	7,210	6,758	1,769	1,690
Total Operating Expenses	**6,866**	**717,980**	**723,213**	**6,891**	**734,381**	**739,713**	**5,541**	**713,061**	**717,053**	**168,881**	**169,636**
Operating Income (loss)	**3,894**	**(14,027)**	**(10,133)**	**3,955**	**(20,258)**	**(16,303)**	**5,526**	**(8,698)**	**(3,172)**	**(1,594)**	**(1,600)**
Total Other Income	**15,074**	**16,153**	**31,227**	**36,724**	**30,472**	**67,196**	**(16,714)**	**(13,589)**	**(30,303)**	**(2,815)**	**31,186**
Revenues in Excess of Expenses	**18,968**	**2,126**	**21,094**	**40,679**	**10,214**	**50,893**	**(11,188)**	**(22,287)**	**(33,475)**	**(4,409)**	**29,586**
Increase in Unrestricted Assets	**15,404**	**(951)**	**14,453**	**36,100**	**18,464**	**54,564**	**(16,161)**	**(18,699)**	**(34,860)**	**(4,409)**	**29,586**

Source: Audited Annual Financial Statements and Unaudited Quarterly Financial Statements. Huntington Hospital includes the Foundation.

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Management Discussion & Analysis

- In 2018, consolidated total revenue was $713.9 million compared to $723.4 million in 2017. After a 7.8% decrease in inpatient surgical volume in 2017, the inpatient surgeries settled at a two-year total of 11.8% decrease from 2016 levels. The migration to outpatient surgeries from inpatient surgeries experienced nationally is a contributing factor to the decline in inpatient surgical volume.
- Total operating expenses were $717.1 million for fiscal year ended December 31, 2018 as compared to $739.7 million in fiscal year 2017, a decrease of 3.6%. Operating expenses reduced by 1.6% (exclusive of expense related to California's provider fee program, which does not materially impact the Obligated Group and Affiliates), as labor costs decreased to $381.9 million in fiscal year 2018 from $388.9 million in fiscal year 2017. Not including the decline in provider fee expenses, operating expenses decreased by $10.7 million, with management initiatives in supplies and purchased services and also decreased depreciation resulting from an asset lifing study performed in 2018.
- The Investment loss for 2018 was $27.9 million compared to a gain of $68.2 million in fiscal year 2017, consistent with the global market performance. The Obligated Group, through philanthropic efforts[1], raised approximately $20.4 million in fiscal year 2018 compared to $11.3 million for the same period in 2017. Donation income was $8.8 million through December 31, 2018 compared to $5.6 million through December 31, 2017. Total Unrestricted Cash and Investments were $466.3 million at December 31, 2018 as compared to $508.6 million at December 31, 2017, representing 249 and 266 Days Cash on Hand, respectively.

Source: Huntington Hospital Management

1. Philanthropic support numbers are indicative of revenue recognized in the respective fiscal year

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Historical Capital Spend

Huntington Hospital
Historical Capital Expenditures

($ in 000)	Fiscal Year Ended December 31,		
	2016	**2017**	**2018**
Capital Expenditures	$51,800	$35,947	$50,830
Depreciation	$39,430	$41,829	$34,272
Capital Expenditures as % of Depreciation	131%	86%	148%
Major Projects (>$1 million)			
Orbiter Camera Replacement	$1,452	--	--
Facility Master Plan	$3,729	$11,519	$26,500
Hank One - Phase I	$3,054	--	--
Renovation of Unit 45	$2,710	--	--
Automation Line Upgrade	--	--	$1,127
SPC2 Seismic Upgrade - Wingate / Hahn	--	--	$6,807

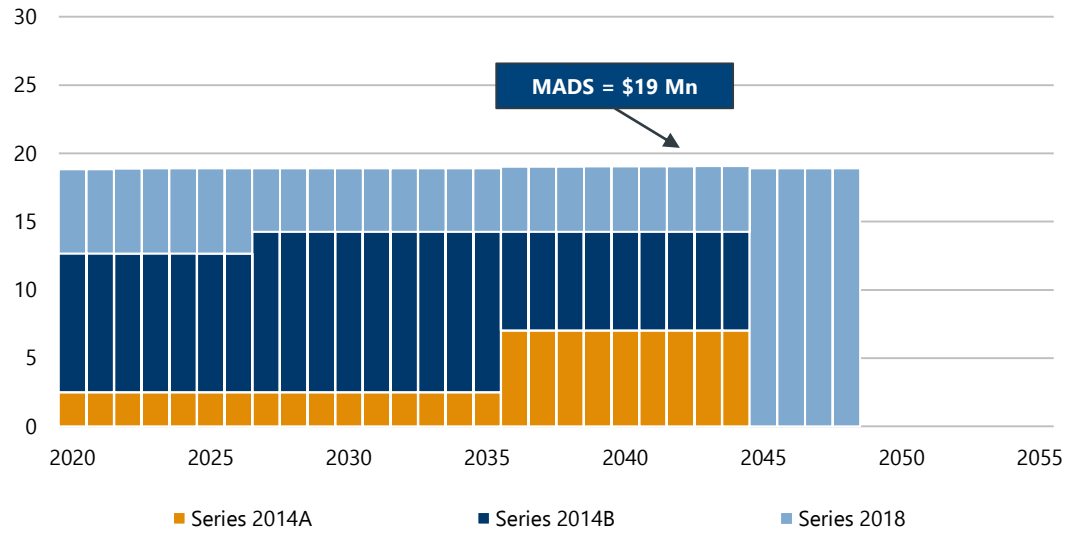
Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

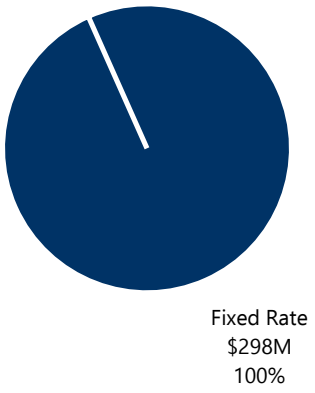
Debt Capital Structure Overview

Conservative capital structure that is currently fully committed with a credit rating of A-

Aggregate Debt Service ($ in millions)



Product / Debt Mix ($Mn)



Debt Portfolio

Series	Principal	Product	Final Mat.	Coupon Rate	Avg. Life	Credit Provider	Credit Type	Credit Exp.	Call Date
Series 2014A	50,000,000	Fixed Rate	7/1/2044	5.00%	21.5	Deutsche Bank	-	-	7/1/2024
Series 2014B	148,295,000	Fixed Rate	7/1/2044	5.00%	13.9	-	-	-	7/1/2024
Series 2018	100,000,000	Fixed Rate	7/1/2048	5.00%	22.9	-	-	-	7/1/2028
TOTAL	**$298,295,000**				**18.2**				

Note: Debt outstanding as of 5/1/2019. Graphic shown by fiscal year.
Sources: Series 2018 OS and FY2018 Audit. Does not include Revolving Line of Credit Facility with $0 outstanding as of FY2018 (authorized for up to $30 million).

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Strategic & Financial Initiatives

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Strategic Plan to Maximize Performance

Strategic Priorities

Physician Collaboration	Value Based Emphasis	Community Connections	Patient-Focused Care	People	World Class Quality

Strategic Objectives

Develop and manage integrated provider and payer strategies that strengthen market position	Cultivate a culture of philanthropy and support	Operating Margin will support organizational/ enterprise goals Implement integrated and functional enterprise technology solutions	Create a Sustainable and World Class environment Provide holistic patient care across the enterprise	Promote an engaged workforce committed to excellence that champions high-quality healthcare	Become a High Reliability Organization

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Strategic Plan to Maximize Performance *(continued)*

Execution



Physician Collaboration

Partner with primary care and specialists, with clinical outcomes focus, to ensure viability of highest ***quality*** partners



Value Based Emphasis

Seek efforts to link financial return with highest ***quality*** outcomes for patients



Community Connections

Emphasize access to right care, at right place, at right time



Patient-Focused Care

National quality leader, compassionate care for all, with patient experience driving design



People

Attract, Engage, Retain and Develop the Country's Best People



World Class Quality

Laser-focus on leading edge quality outcomes across the delivery system

What Success Looks Like:

A cohesive, stable network of physicians with a focus on providing access to highest quality care at right time, regardless of payer, in close collaboration with Huntington.

Increasing revenues linked to value-based models, improving profitability and financial sustainability.

Leadership in community collaboration targeted at meeting the health needs of the Greater Pasadena area.

National leader in patient experience indicators, and innovative delivery adoption focused on the community's needs and desires to access care and information.

National leader in employee engagement. Magnet certification.

Nationally ranked for both acute specialties and broader care delivery for community

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Status of Strategic Plan Efforts

***Patient Focused Care:** Offer a coordinated, accessible network of ambulatory facilities*

- **Status**: Huntington has strong inpatient market share (40%), but is below industry standards for outpatient revenue

***Value-Based Emphasis:** Link financial return to quality*

- **Status**: Huntington has implemented several initiatives to increase revenue and decrease expenses, but needs to pressure the organization to sustain gains while also increasing value-based reimbursement models

***Community Connection:** Implement and maximize value of information technologies*

- **Status**: Huntington is currently evaluating and testing options for integrated and functional enterprise technology solutions

***People:** Possess an engaged and committed work force*

- **Status**: Initiatives are underway to enhance employee engagement and develop leadership

***Physician Collaboration:** Partner with other high-quality providers to ensure access and manage the cost of providing care*

- **Status**: Huntington has improved collaboration with Huntington Health Physicians, DHCP (Optum Care), several ambulatory operators and with other hospital systems, launching several successful initiatives around oncology, urgent care, imaging and primary care

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Overview of Enterprise Capital Needs

Facility Master Plan & Routine Capital

- Estimated at $502 million over 10 years beginning 2019 ($293 million for Facility Master Plan; $165 million for Routine Capital; $45 million for other Facilities Other)
- OR Expansion expected to add $27 million Revenue and $10 million contribution margin annually
- On track to meet seismic compliance requirements

IT Master Plan (Non-EHR)

- Estimated at $137 million over 10 years beginning 2019

Enterprise IT (EHR)

- Estimated at $139 million over 10 years beginning 2019(net of Revenue Offsets and Cost Reductions)
- Enterprise HR estimated to generate $181 million of Revenue Offsets and Costs Reductions over 10 years

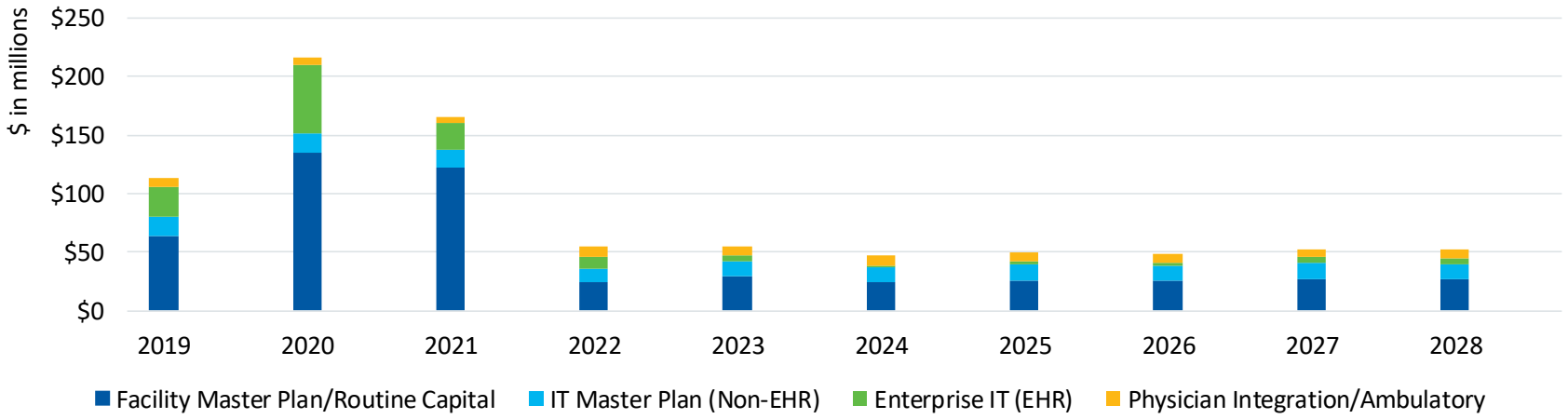
Physician Integration & Ambulatory

- Estimated at $74 million over 10 years beginning 2019 (minimum)

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Enterprise Capital Needs Summary



Huntington Hospital

10-Year Enterprise Capital Needs

($ in millions)

	Fiscal Year Ended December 31,										
	2019	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**Total**
Facility Master Plan/Routine Capital	$63.9	$135.3	$122.1	$23.6	$28.9	$24.7	$25.2	$25.8	$26.3	$26.9	$502.6
IT Master Plan (Non-EHR)	16.4	16.1	15.4	11.5	12.7	11.8	14.1	11.9	15.0	12.2	137.1
Enterprise IT (EHR)	25.6	58.3	22.4	11.0	5.0	1.9	2.6	3.4	4.0	5.0	139.2
Physician Integration/Ambulatory	6.8	7.1	5.6	8.1	8.1	8.1	8.1	7.5	7.5	7.5	74.4
Enterprise Capital Needs Total	**$112.7**	**$216.8**	**$165.5**	**$54.2**	**$54.7**	**$46.5**	**$50.0**	**$48.6**	**$52.8**	**$51.6**	**$853.3**

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Facility Master Plan – Objectives*

Package #1 *(est. completion September 2020)*

- Relocate Cardiac Intervention Services above Emergency Department, to enhance ability to provide time-sensitive care
- Increase Operating Room (ORs) capacity to meet community demand

Package # 2 *(est. completion December 2019)*

- Mitigate campus-wide utility infrastructure risk that supports acute care services

Package # 3 *(est. completion December 2019)*

- Enhance patient, staff, and visitor safety by performing campus wide interior seismic upgrades by January 1, 2020 which satisfies State of California, SB 1953 (OSHPD) statutory requirements

Package 4 *(complete)*

- Maintain Inpatient Bed Capacity – Retrofit existing Inpatient Tower

**Objectives are components of the Huntington Hospital Long Term Campus Master Plan and SB 1953 Compliance efforts are to be complete by January 1, 2020*

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

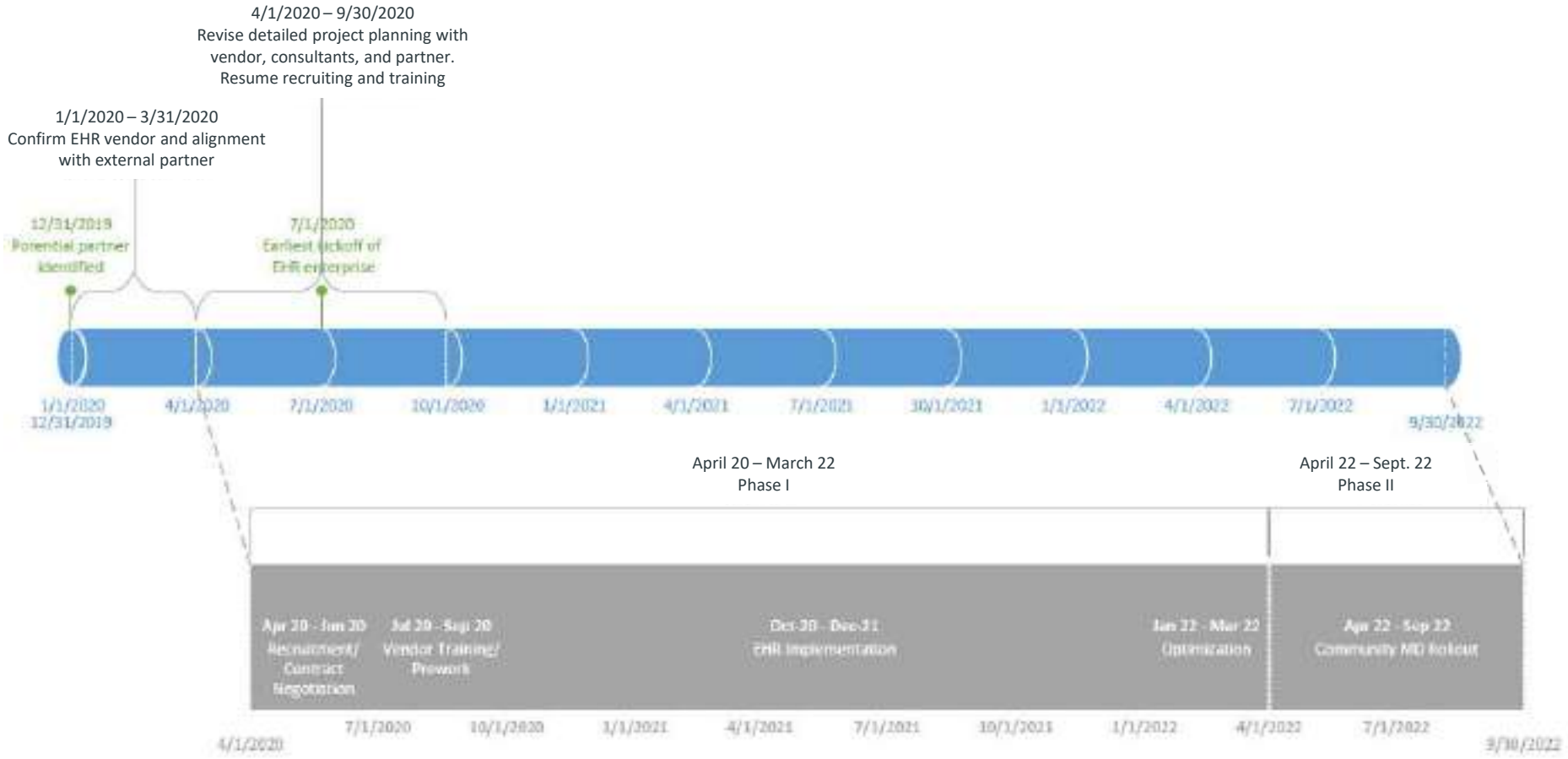
Facility Master Plan – Scope

Package		
1	*est. completion Sept 2020*	• Shell Infill (ED Building) - Cardiac Services Suites; New Cardiac Services Access Corridor on ground floor (East Tower). Level 1 • Shell Infill (ED Building) – New ORs; Expansion of Pre-Operative /Post Operative area and Expansion of OR support areas (East Tower). Level 2 • Build out – New Endoscopy Suites (East Tower Annex). Ground Level
2	*est. completion Dec 2019*	• Campus wide utility Infrastructure Upgrades • Central Utility Plant Capacity Upgrades • La Vina Bldg Utility Make Ready
3	*est. completion Dec 2019*	• La Vina Building Access (elevators, stairs, lobbies) with ADA upgrades. • La Vina Building NPC 4 Upgrades • Campus Wide NPC4 - Seismic Upgrades
4	*complete*	• Seismic Retrofit Wingate Hahn Patient Tower from SPC 1 to SPC2 and NPC 2 to NPC3

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

IT Profile: Enterprise[1] IT Conceptual Implementation Schedule



Source: Huntington Hospital Management
Note: (1) represents inpatient and ambulatory clinic settings, revenue cycle and patient access, product lines, and analytics/population health

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Appendix:
Enterprise Capital Needs Detail

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Capital Needs Detail: Facilities Master Plan & Routine

Huntington Hospital
10-Year Enterprise Capital Needs

($ in millions)	Fiscal Year Ended December 31,										
	2019	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**Total**
Facilities Master Plan (1)											
Compliance Projects	$33.5	$87.2	$20.5	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$141.2
Strategic	18.4	34.8	85.8	7.4	4.7	0.0	0.0	0.0	0.0	0.0	151.0
Facilities Master Plan Total	**$51.9**	**$121.9**	**$106.3**	**$7.4**	**$4.7**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$292.1**
Detailed Facility Master Plan Breakout											
Package 1	$20.8	$42.4	$71.9	$7.4	$4.7	$0.0	$0.0	$0.0	$0.0	$0.0	$147.2
Package 2	6.5	16.3	15.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	38.5
Package 3	16.9	19.2	1.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	38.0
Package 4	7.6	44.0	16.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	68.5
Facilities Master Plan Total	**$51.9**	**$121.9**	**$106.3**	**$7.4**	**$4.7**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$292.1**
Facilities (Currently Uncommitted) (2)											
Facilities Other/ Clinical Technology	$.0	$.0	$.0	$.0	$7.5	$7.5	$7.5	$7.5	$7.5	$7.5	$45.0
Routine Capital (3)											
Routine Capital	$12.0	$13.4	$15.8	$16.2	$16.7	$17.2	$17.7	$18.3	$18.8	$19.4	$165.5

(1) Facility Master Plan includes endoscopy relocation, La Vina utility re-feed, La Vina NPC4 compliance, Wingate Hahn SPC two bed capacity work, new cath labs and surgical suites

(2) Facilities Other Clinical Technology includes additional undefined future needs such as MRI, CT, smart pumps, space, and other needs

(3) Routine Capital includes clinical equipment and other routine replacement needs and increases at 3% per year

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Capital Needs Detail: IT Infrastructure (Non-EMR)

Huntington Hospital
10-Year Enterprise Capital Needs

($ in millions)	Fiscal Year Ended December 31,										
	2019	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**Total**
IT Master Plan (Non-EHR) (1)											
Infrastructure	$10.5	$10.1	$8.0	$8.4	$8.6	$10.5	$10.1	$10.3	$9.5	$9.0	$95.0
Upgrades	4.9	1.4	0.3	0.6	0.7	0.5	0.5	0.5	0.6	0.6	10.6
New	1.0	4.6	7.1	2.5	3.4	0.8	3.5	1.1	4.9	2.6	31.5
IT Master Plan (Non-EHR) Total	**$16.4**	**$16.1**	**$15.4**	**$11.5**	**$12.7**	**$11.8**	**$14.1**	**$11.9**	**$15.0**	**$12.2**	**$137.1**

(1) Includes refresh for 4.500 devices, network infrastructure, server upgrades, workstations on wheels replacement, data center movement/upgrades, and other infrastructure development/replacement

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Capital Needs Detail: Enterprise EHR - Revenue Offsets & Operating Savings

Huntington Hospital

10-Year Enterprise Capital Needs

($ in millions)	Fiscal Year Ended December 31,										
	2019	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**Total**
Enterprise IT (Capital & Operations) (1)											
New Enterprise EHR	$28.3	$65.1	$33.9	$28.1	$28.8	$25.7	$26.4	$27.2	$28.0	$28.9	$320.4
Cost Reductions (2)(3)											
Decommission of Current Systems	$0.0	($1.3)	($1.3)	($1.3)	($5.8)	($5.8)	($5.8)	($5.8)	($5.8)	($5.8)	($38.7)
Current Staffing	(2.7)	(5.5)	(5.5)	(5.5)	(5.5)	(5.5)	(5.5)	(5.5)	(5.5)	(5.5)	(52.2)
Community Connect	0.0	0.0	(0.5)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(1.2)
Revenue Enhancement	0.0	0.0	(2.6)	(6.2)	(8.3)	(8.3)	(8.3)	(8.3)	(8.4)	(8.4)	(58.8)
Cost Reduction	0.0	0.0	(1.6)	(4.0)	(4.1)	(4.1)	(4.1)	(4.1)	(4.2)	(4.1)	(30.3)
Cost Reduction Total	**($2.7)**	**($6.8)**	**($11.5)**	**($17.1)**	**($23.8)**	**($23.8)**	**($23.8)**	**($23.8)**	**($24.0)**	**($23.9)**	**($181.2)**
Net Cost	**$25.6**	**$58.3**	**$22.4**	**$11.0**	**$5.0**	**$1.9**	**$2.6**	**$3.4**	**$4.0**	**$5.0**	**$139.2**

(1) New Enterprise EHR includes capital and operating expense for the 10 year period

(2) Decommissioning of current systems includes Cerner, Allscripts and DB Motion

(3) Current staffing reflects current staff supporting Cerner and Allscripts applications that will move to supporting the new EHR

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Capital Needs Detail: Physician Integration and Ambulatory Footprint

Huntington Hospital

10-Year Enterprise Capital Needs

($ in millions)	Fiscal Year Ended December 31,										
	2019	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**Total**
Physician Integration (1)(2)											
PCP and Specialty Growth	$0.4	$3.1	$3.1	$5.6	$5.6	$5.6	$5.6	$5.0	$5.0	$5.0	$44.0
Affiliate and Ambulatory	6.4	4.0	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	30.4
Physician Integration Total	**$6.8**	**$7.1**	**$5.6**	**$8.1**	**$8.1**	**$8.1**	**$8.1**	**$7.5**	**$7.5**	**$7.5**	**$74.4**

(1) Physician Integration includes capital for development of PCP and specialty network physicians (at $50,000 per physician for PCPs and $100,000 per specialty physician the investment could include 100+ PCP's, 50+ specialty physicians or a combination). No specific funding has been included to "purchase" practices

(2) Affiliate and ambulatory capital includes Urgent Care (currently a revenue generating licensing agreement with ExER), Imaging Center sites, Ambulatory Surgery Center sites, telehealth, and other infrastructure

Source: Huntington Hospital Management

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Qualifications, Assumptions and Limiting Conditions (v.12.08.06):

This Report is not intended for general circulation or publication, nor is it to be used, reproduced, quoted or distributed for any purpose other than those that may be set forth herein without the prior written consent of Kaufman, Hall & Associates, LLC. ("Kaufman Hall").

All information, analysis and conclusions contained in this Report are provided "as-is/where-is" and "with all faults and defects". Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified by Kaufman Hall. No warranty is given as to the accuracy of such information. Public information and industry and statistical data, including without limitation, data are from sources Kaufman Hall deems to be reliable; however, neither Kaufman Hall nor any third party sourced, make any representation or warranty to you, whether express or implied, or arising by trade usage, course of dealing, or otherwise. This disclaimer includes, without limitation, any implied warranties of merchantability or fitness for a particular purpose (whether in respect of the data or the accuracy, timeliness or completeness of any information or conclusions contained in or obtained from, through, or in connection with this report), any warranties of non-infringement or any implied indemnities.

The findings contained in this report may contain predictions based on current data and historical trends. Any such predictions are subject to inherent risks and uncertainties. In particular, actual results could be impacted by future events which cannot be predicted or controlled, including, without limitation, changes in business strategies, the development of future products and services, changes in market and industry conditions, the outcome of contingencies, changes in management, changes in law or regulations. Kaufman Hall accepts no responsibility for actual results or future events.

The opinions expressed in this report are valid only for the purpose stated herein and as of the date of this report.

All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the client.

In no event will Kaufman Hall or any third party sourced by Kaufman Hall be liable to you for damages of any type arising out of the delivery or use of this Report or any of the data contained herein, whether known or unknown, foreseeable or unforeseeable.

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

KaufmanHall

Exceptional Partners. Exceptional Performance.

CHICAGO, IL | PORTLAND, OR | LOS ANGELES, CA | FT. COLLINS, CO | SKOKIE, IL

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Exhibit 8-C

Request for Proposal to Cedars-Sinai

Huntington Hospital

100 West California Boulevard
Pasadena, California 91105
(626) 397-5555
www.huntingtonhospital.com

July 8, 2019

Tom Priselac
President and CEO
Cedars-Sinai
8700 Beverly Boulevard, Suite 2622
Los Angeles, CA 90048
priselac@cshs.org

Dear Tom:

Following up on our conversation in early June, we are excited to explore a potential partnership with Cedars-Sinai. Cedars' longstanding commitment to quality, our shared commitment to the Angel Care Health Network and your recent partnerships have made it natural for us to have this discussion with you. As I mentioned on our phone call, a dedicated subset of our Board of Directors (including Trustees) have been participating in an intensive internal process facilitated by our outside advisors, Kaufman Hall, to better understand both the local and national healthcare environment. We have been evaluating our current partnerships and whether the future needs of the Huntington community would be best served by partnering with another organization inside a fully-integrated alignment. As a result, our Board unanimously elected to pursue a formal process to evaluate Huntington's strategic options.

To that end, we are envisioning a structured but also collaborative process and have directed our advisors as such. Attached hereto, are a number of documents Kaufman Hall developed intended to help "kick-off" the dialogue as well as provide insight into our requested path forward over the coming months:

- Timing Objectives (Attachment 1);
- Huntington Management and Partnership Committee (Attachment 2);
- Huntington's Lead Working Group and Advisors (Attachment 3);
- Huntington's Proposal Evaluation Criteria, for reference (Attachment 4); and
- Proposed Indication of Interest Outline (Attachment 5).

In addition, we have assembled a disclosure package with the latest business and financial updates for Huntington (i.e., the Confidential Information Presentation or "CIP"). This CIP and any other information provided by us or our advisors is subject to the non-disclosure agreement previously executed by your organization. Our objective in providing the CIP is to better inform the collective dialogue, as well as assist in the development of a potential proposal by Cedars-Sinai.

To foster this dialogue, we would like to schedule an in-person meeting in the coming weeks to further describe Huntington's objectives for the process and beyond. Please feel free to contact Rita Schmaeler, Executive Assistant, (rita.schmaeler@huntingtonhospital.com) at your earliest convenience to facilitate calendaring.

Again, I want to thank you in advance for your interest in exploring a partnership with Huntington. We are very much looking forward to the discussions.

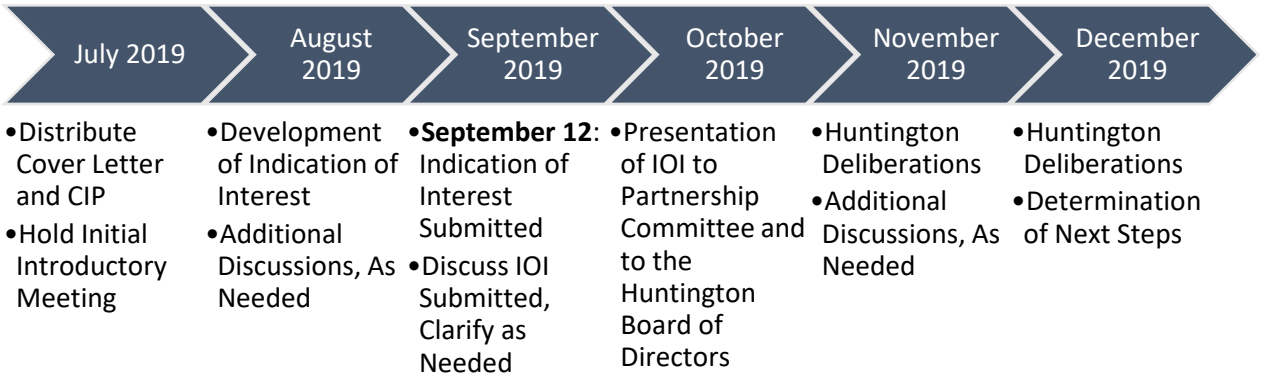
Sincerely,



Lori Morgan, MD, MBA

Attachment 1: *Timing Objectives*

The general timeline below has been developed to provide you with additional visibility into Huntington's timing objectives for the partnership evaluation process. The effort outlined for the remainder of 2019 is intended to culminate in the identification of a partner or partners with whom to develop a non-binding letter of intent, which would begin in early 2020. While we intend to hold to this timeline to the extent possible to ensure efficient use of valuable time and resources, adjustments will be made to this calendar as needed given the importance and complexity of the discussions. Any changes in anticipated timeline will be communicated to you as soon as possible. Please also let us know if there are any factors within your organization that we should be aware of that might affect this timeline.



The Remainder of Page Is Intentionally Blank

Attachment 2: *Huntington Management and Partnership Committee*

To facilitate the Huntington's thoughtful and thorough evaluation of its options, a Partnership Committee comprised of both select Trustees and select Board members has been established to address affiliation matters on a more frequent and in-depth basis and will remain highly engaged in the potential partnership evaluation process. Together with Huntington Management, the Partnership Committee will assess the merits of proposals from potential partners.

Huntington Management

Lori Morgan, MD, MBA
President and CEO

Raj Takhar
Chief Strategy Officer

Steven Mohr
Chief Financial Officer

Partnership Committee

Jaynie M. Studenmund
Trustee, Board Member

Paul Johnson
Trustee, Board Member

Ronald L. Havner, Jr.
Board Member

M. Christian Mitchell
Board Member

David Kirchheimer
Board Member

Attachment 3: *Huntington's Lead Working Group and Advisors*

As mentioned, Huntington's Board has approved the initiation of this partnership evaluation process and will be the ultimate decision-making body with respect to any affiliation actions. The Board will be supported by select members of Huntington Management and the Partnership Committee (previously mentioned) with Kaufman Hall and Davis Wright Tremaine LLP serving as outside advisors.

Please limit your correspondence only to the following individuals below. Any process and/or diligence questions may be directed to Kaufman Hall. Please do not contact anyone else at Huntington management, the Huntington Board or the Trustees regarding this Letter or the partnership process.

Huntington Management

Lori Morgan, MD, MBA
President and CEO

Raj Takhar
Chief Strategy Officer

Steven Mohr
Chief Financial Officer

Kaufman Hall: Strategic and Financial Advisor

Steve Hollis
Senior Vice President
(510) 612-0023
shollis@kaufmanhall.com

Kris Blohm
Senior Vice President
(224) 724-3182
kblohm@kaufmanhall.com

Nick Gialessas
Assistant Vice President
(630) 404-0915
ngialessas@kaufmanhall.com

Omar Farris
Associate
(224) 724-3135
ofarris@kaufmanhall.com

Davis Wright Tremaine LLP: Transaction Counsel

Jason A. Farber
Partner
(206) 757-8041
jasonfarber@dwt.com

Attachment 4: *Huntington's Proposal Evaluation Criteria*

Huntington's Board has developed the following Proposal Evaluation Criteria to help objectively evaluate all affiliation options available.

Category	Proposal Evaluation Criteria
Mission	A partner must enhance Huntington Hospital's ability to fulfill its mission and vision. **Mission**: to provide excellent health care and compassionate service to each person by bringing together outstanding physicians, caring nurses, professional staff and advanced technologies **Vision**: to be the leader in creating community well-being through world-class health care delivered with kindness and dignity
Culture	A partner must have a compatible culture, with a focus on collaboration, and a commitment to quality and community.
Community Perception and Brand	A partner must demonstrate a commitment to support and enhance Huntington's longstanding philanthropic relationship with its community. A partner must recognize Huntington's commitment to and relationship with its community as key foundational assets to be maintained and built upon. For over 125 years, Huntington has provided compassionate community care, and will work to continue to do so in the years to come.
Strategic Alignment	A partner must demonstrate alignment with Huntington's core strategic goal of developing the leading clinically integrated healthcare delivery platform in our service area. A partner must demonstrate a focus on enhancing the relationship with the medical provider community. A partner must demonstrate a commitment to the wellness of our service area. A partnership must balance the current economic realities in the greater Los Angeles area.

Category	Proposal Evaluation Criteria
Value-Based Care	A partnership must position Huntington to be a leader in a value-based care environment, with specific competencies including: The ability to enter into risk-based payment arrangements The ability to coordinate care effectively The ability to perform sophisticated data analytics The collective ability to provide the broad access to care
EHR Platform	A partner must support the implementation of an Enterprise Wide IT strategy (including EHR, ambulatory, population health management and wellness, revenue cycle management) either by extending its own instance (or build) or by new installation.
Physician Integration	A partner must demonstrate the resources necessary to support the development of a full service MSO and offer competitive employment and quasi-employment options to our medical community. A partnership should take into consideration strategic and economic realities, balancing the possible effects on Huntington's current partnerships and relationships. A partnership should maintain and enhance Huntington's current relationship with DaVita Healthcare Partners, now part of OptumCare.
Clinical Programs and Services	A partnership must support the full spectrum of the clinical services Huntington offers to the community, particularly in the areas of cardiology and oncology. A partner must be committed to clinical quality. A partner must demonstrate alignment with Huntington's focus upon excellence in nursing and its medical staff. A partner must demonstrate a commitment to Huntington's existing commitment to research and education.
Ambulatory Alignment	A partner must enable Huntington to continue and enhance its ambulatory growth strategy. A partner must support investment in the ambulatory resources necessary to provide value-based care.
Capital	A partner must demonstrate the financial strength and stability to support the combined capital needs of the partnership.

Category	Proposal Evaluation Criteria
Governance and the Trust	To ensure ongoing commitment to Huntington's relationship with the community as well as its existing mission, a partnership must provide for a meaningful role in governance for the Huntington Board and Trust.

The Remainder of Page Is Intentionally Blank

Attachment 5: *Proposed Indication of Interest Outline*

To the extent Cedars-Sinai has an interest in pursuing a potential partnership with Huntington, we would respectfully request that you provide an indication of interest (IOI) that responds to each of the questions listed below, referencing the Proposal Evaluation Criteria presented in Attachment 4 wherever possible. As you review, please do not hesitate to reach out to Kaufman Hall with any clarifying questions to assist in developing your responses.

1. **Brief Description**. Please provide a brief overview of your organization including organizational structure, facilities operated, geographic market and service focus, and any other relevant background information.
2. **Mission, Vision and Values.** Please describe your organization's mission, vision and values and corresponding alignment with Huntington. How does the relationship that you propose with Huntington help your organization further its mission, vision and values? How do you think it would further the mission, vision and values of Huntington?
3. **Strategic Considerations.** Based upon your organizational strategy and your knowledge of Huntington, please address the following:
    a. Discuss how a relationship with Huntington furthers your organization's medium- and long-term strategic goals and objectives. Are there any specific projects or initiatives within Huntington's service area that you would be interested in collectively pursuing within a partnership?
4. **Proposed Partnership Structure.** Please address the following:
    a. Huntington is interested in exploring fully integrated strategic partnership alternatives including (i) the development of a new regional health system in conjunction with your organization, (ii) joining your system through a member substitution or asset purchase transaction, or (iii) any other relevant strategic partnership structure that furthers Huntington's goals. With that in mind, please describe the nature and structure of your proposed affiliation with Huntington.
5. **Role of the Huntington Trust.** Please describe the role you envision for the Huntington Trust within the proposed partnership. As further described in the CIP, the Trust exists as a supporting organization to Huntington Hospital created with the purpose of supporting the hospital. Specifically, please describe the impact of the proposed partnership on the following:
    a. Trust assets;
    b. The existing lease arrangements between Huntington and the Trust;
    c. The Trust's current status as co-obligor of Huntington debt; and
    d. The Trust's role in governance within the proposed partnership.
6. **Governance Considerations.** The Huntington Board desires a governance approach that preserves influence and a continued voice to ensure fulfillment of Huntington's mission and vision. Please describe your proposed governance structure for Huntington going forward, including any mechanisms that allow Huntington to maintain an appropriate representation following the consummation of the strategic partnership.

a. Please describe your organization's governance structure, physician participation and, specifically, governance mechanisms for hospitals and health systems that join your organization.

b. Please describe the following within the context of your proposed structure:

   i. The authority, purpose, and role of the Huntington Board of Directors post-affiliation, including involvement in strategic planning, operating and capital budgeting and capital spending decisions;

   ii. Reserved powers anticipated to be held by your organization post-affiliation;

   iii. Local medical staff involvement in governance;

   iv. How local Huntington board members will be nominated and appointed post-transaction, including the initial composition of the reconstituted board, as applicable; and

   v. Representation on your organization's board of directors identified by Huntington and their participating in board committees, as applicable.

c. Huntington is aware, via publicly available information, of the recently structured relationship between Torrance Memorial Medical Center ("TMMC") and Cedars-Sinai. Could you please explain any differences between the relationship with TMMC and that which you propose to Huntington? This would include for you to take into consideration any other historic and/or current affiliation structure or relationship that is/or will be entered into with similar and comparable hospitals. How would ongoing governance input from Huntington be integrated into the relationship such as or with TMMC?

7. **Financial and Economic Commitments.** Please describe the financial and economic considerations your organization will provide to Huntington. Specific items for consideration should include:

   a. Your treatment of Huntington's assets and liabilities, including outstanding debt. Please also be sure to specify between your suggested treatment of assets and liabilities attributable to Huntington separately from those of the Trust.

   b. Your commitment to provide capital to Huntington to accomplish the following strategic initiatives, as specified in the CIP:

      i. Physician recruitment and alignment;

      ii. Facilities and equipment;

      iii. Information technology system upgrades;

      iv. Any other capital projects to further Huntington's success and the strategic partnership strategy.

   c. Any other quantitative considerations related to your proposal structure.

   d. Any material assumptions upon which the economic terms of the proposal are based, as well as any conditions or contingencies that may be material to an assessment of your indication of interest.

8. **Operational Infrastructure.** Describe your organization's operational infrastructure and expertise, specifically addressing the following:

a. Please describe your organization's quality of care infrastructure and how you expect to maintain and enhance measurable levels of clinical quality and patient satisfaction at Huntington.

b. Please describe the tools and resources that would be available to Huntington to enhance its delivery of care and facilitate its growth.

c. Please describe economies of scale that could be achieved through shared services (e.g., revenue cycle management, human resources, information systems, purchasing and supply chain, risk management, capital structure, etc.).

d. As applicable, please describe how corporate overhead is allocated within your organization and how those costs might be charged to Huntington in an affiliation.

9. **Information Technology.** Huntington has identified that the implementation of an Enterprise Wide EHR is a top strategic priority within its organization, presenting a meaningful opportunity within a partnership.

    a. How would you support the implementation of an Enterprise Wide IT strategy (including EHR, ambulatory, population health management and wellness, revenue cycle management)?

    b. How would you anticipate that this be accomplished (e.g., extension of your organization's instance of IT software) and do you have any experience in doing so in other partnership or affiliation settings?

    c. What would be the anticipated timeline to fully implement and operationalize the EHR installation contemplated above?

    d. How would implementation costs be factored into a capital commitment as described previously?

10. **Value-Based Infrastructure and Capabilities.** Please answer the following requests related to value-based care infrastructure and capabilities.

    a. Describe your organization's philosophy and experience in transitioning toward value-based healthcare and your organization's infrastructure to support a value-based healthcare business model. Specifically, discuss your organization's experience with bundled payments, risk-based contracting, ACOs, payor integration, and population health management. Please describe how these models have affected your strategy in the past.

    b. Please describe how your organization would further Huntington's infrastructure and capabilities as it relates to the transition to value-based accountable care in the region.

11. **Physician Alignment.** Huntington is proud of the relationships it has developed with its community physicians as well as with those doctors employed by its foundation.

    a. Please describe how a relationship with your organization would impact Huntington's existing relationships with its community and foundation physicians.

    b. Please discuss your approach to the recruitment of new physicians to the community and the growth of Huntington's foundation.

    c. Please describe the resources you would bring to a partnership to support the development of a full service MSO and offer competitive employment and quasi-employment options to our medical community.

12. **Clinical Services.** Huntington has a long history of being deliberate in its development services to meet the needs of the community. Please describe how your proposed partnership will:

    a. Ensure that the community continues receiving the highest quality care in the most appropriate setting.

    b. Maintain and grow key Huntington key service lines and capabilities, including but not limited to trauma, heart and vascular and oncology.

    c. Provide linkages between Huntington and other healthcare providers, within your organization or otherwise, to continue or enhance access to appropriate tertiary and quaternary care.

    d. Enable Huntington to continue its commitment to providing the very highest quality care to its communities at an affordable cost, with a focus on the development of an ambulatory care network. How is this strategy aligned with your own goals? Can you please provide examples of initiatives you have in place in furtherance of these goals?

13. **Impact on Existing Relationships.** Please describe your approach to and perceived impact of a partnership on existing relationships, including the following:

    a. Huntington has built a strong, innovative relationship with DaVita Healthcare Partners, now part of OptumCare. This relationship, as currently configured, is a major source of both revenue and profit to Huntington. Would you seek to maintain this relationship? If not, how would you propose to address Huntington's strategic need for a primary care physician network?

    b. Huntington enjoys a solid clinical and academic relationship with Keck Medicine of USC, particularly with respect to the cardiac and maternal fetal medicine programs. These relationships represent a strong financial contribution to Huntington. What impact, if any, do you anticipate an affiliation between our organizations would have on our relationship with Keck Medicine of USC and the USC School of Medicine? How do you propose addressing any such impact?

    c. Huntington also enjoys a robust clinical relationship with City of Hope on our oncology program. What impact, if any, do you anticipate an affiliation between our organizations would have on our relationship with City of Hope? How do you propose addressing any such impact?

14. **Culture and Employees.** Huntington has a strong culture that is centered on safe, reliable and high-quality healthcare. To build on this culture, Huntington seeks a partner that is committed to offering employees exceptional growth, development and leadership capabilities.

    a. Describe your organization's employee base, human resources infrastructure, and employee environment. Please include tangible examples of employee satisfaction, training and development opportunities, physician engagement, experience operating a highly efficient organization, and tools used to manage productivity.

    b. Describe how your infrastructure would extend to the employees of Huntington within the context of your proposed structure. As applicable, please provide examples of partnership with organizations similar to Huntington, and any learnings that would apply to a partnership with Huntington.

c. Please describe your commitment to existing Huntington employees (including the management team). For ongoing employees of Huntington, describe your approach to compensation and benefits, including the treatment of Huntington employees post-partnership for benefit eligibility and benefit purposes.

d. Please comment on how your proposed structure and partnership experience would minimize disruption to staff, physicians and management.

e. To the extent not addressed, please describe your plans for maintaining or enhancing the culture at Huntington.

15. **Branding.** Huntington has built an extremely valuable and trusted brand within its service area. Please describe your approach to branding and marketing with respect to community hospital affiliates. How might our collective brands and marketing capabilities help further enhance and differentiate our services within the community?

16. **Philanthropy.** Please describe your proposed approach to community fundraising at Huntington and outline any commitment to ensure that any funds from local fundraising efforts remain for the provision of healthcare in Huntington's service area and for their original intended purpose. How will the proposed partnership maintain and enhance Huntington's philanthropic support from the community?

17. **Research and Education.** Please describe how your partnership would enhance Huntington's current capabilities in the areas of research and education.

18. **Financial Capability.** Discuss your organization's financial capability to execute this strategic partnership on the terms described in your indication of interest. Please specify your source(s) of financing, the expected timing of its availability, and any conditions related thereto, as applicable.

19. **Strategic Partnership Execution.** Please describe the timeline to close your proposed transaction, including milestones and regulatory approval. Please describe the regulatory approvals that may be necessary to consummate the proposed strategic partnership and your experience in obtaining such regulatory approvals. Also, describe your organization's approval process, including approvals by members, affiliates, financing sources, public bodies or other relevant groups to consummate this partnership.

The Remainder of Page Is Intentionally Blank

Additional Disclosures and Limiting Conditions

Huntington Hospital expressly reserves the right, in its sole discretion, to conduct the process for a Proposed Transaction as Huntington Hospital may determine (including negotiating with any party, excluding any party and entering into any agreements without prior notice to you or anyone else), change at any time, in whole or in part, such processes, or terminate the process, or discussions and negotiations with you or any other interested party, without notice to you or any other party.

Huntington Hospital will have no obligation to accept any Proposal and expressly reserve the right, in its sole discretion, to evaluate the terms and conditions of any Proposal and to reject or accept you or any other party, Proposal or offer, for any reason whatsoever or no reason, in the sole discretion of Huntington Hospital, without disclosing any reasons. Huntington Hospital and its directors, officers, management, advisors and representatives will have no liability or obligation to you or any other party as the result of any act or omission in connection with the transaction process, including rejection of any Proposal or acceptance of another Proposal.

Unless and until a definitive written agreement between Huntington Hospital and you has been approved, executed and delivered, neither Huntington Hospital nor any of its affiliates will be under any legal or other obligation of any kind whatsoever to negotiate with you, or to proceed with or consummate any Proposed Transaction with you or anyone else. After approval, execution and delivery of a definitive written agreement, the only obligations of Huntington Hospital will be the obligations of Huntington Hospital to the other party to the definitive written agreement and only as set forth in such agreement.

Although Huntington Hospital believes that all the information that has been provided to you to date has been accurate, Huntington Hospital and its directors, officers, management, advisors and representatives disclaim any and all liability for information supplied to you by any of them, written or oral, to date or in the future, and no representations or warranties are made with respect to the accuracy or completeness of any such information. The only representations or warranties, if any, with respect to such information will be those set forth in the finally approved, fully executed and delivered written definitive agreement. You are solely responsible for your own costs incurred during this process including your investigation and due diligence of Huntington Hospital.

You are receiving this letter pursuant to the non-disclosure agreement you previously executed with Huntington Hospital. The existence and contents of this letter are subject to the NDA, as is the fact that Huntington Hospital is considering a Potential Transaction. You are responsible for continuously reminding your board members, officers, and other representatives to comply with the NDA. This letter does not modify or otherwise affect any of the terms in the NDA.

Exhibit 8-D

Cedar-Sinai's Indication of Interest

CEDARS-SINAI HEALTH SYSTEM

Project Rose

CEDARS-SINAI HEALTH SYSTEM PROPOSAL

CEDARS-SINAI

Thomas M. Priselac
President and CEO

September 12th, 2019

Lori Morgan, MD, MBA
President and CEO
100 West California Boulevard
Pasadena, California 91105

Dear Lori:

Cedars-Sinai Health System is very pleased to further our discussions with Huntington Hospital about a potential partnership. While the attached Indication of Interest provides detailed responses to your questions, I'd like to highlight the key reasons that we are very enthusiastic about this possibility.

It has become clear that Huntington's values, culture, quality, and community commitment would be a great fit with Cedars-Sinai Health System. These are the crucial aspects to a successful long-term partnership and guide us in identifying potential partners for Cedars-Sinai Health System. The depth and substance of the questions you asked us to respond to highlight the thoughtful commitment of Huntington's board of directors, the Huntington Trust, and executive leadership to your mission and the continued vitality of Huntington in the decades ahead. This is very meaningful to us.

We have tried to listen carefully to your requirements and aspirations for a partnership with the Cedars-Sinai Health System and attempted to respond accordingly in this response document. Please note that we remain flexible and committed to further exploring options to meet your partnership needs collaboratively.

The strength of Huntington's vision and position is also a good fit because of the governance and operational philosophy of Cedars-Sinai Health System. The system is not a corporate entity that simply mandates standardization in all aspects across its organizations. The CSHS goal is to optimize the success of the system by meeting the needs of each member, bringing the benefits of integrating administrative infrastructure functions according to agreed-upon priorities and timeliness. Similarly, clinical service enhancements are developed collaboratively with the local management and clinical leadership. Strong local governance and management are essential to the success of the system. The system exists to provide scale to its members in ways that enhance the members' success, to share and implement best-practices and other collective strengths when needed, and to help each affiliate best meet the needs of its community.

Many of the examples contained in our attached response come from the work done to date between Cedars-Sinai and Torrance Memorial, the founders of Cedars-Sinai Health System. We used those examples because we are proposing that Huntington's relationship with the health system be that of a member, similar to Torrance Memorial's structural relationship with the health system. Organizations that become part of the health system are distinct legal entities that retain their existing governance and management and operate with a significant degree of independence.

8700 Beverly Boulevard, Los Angeles, CA 90048 | *office* 310.423.5711 | TMP@cshs.org

Based on what we have learned from you about Huntington's goals in today's changing healthcare environment, as well as our understanding of your history and values, we strongly believe that joining Cedars-Sinai Health System would secure your future and that Huntington would be an excellent fit for Cedars-Sinai Health System.

We look forward to continuing our discussion with you about a potential partnership

Sincerely,

Tom

Thomas M Priselac

Contents

EXECUTIVE SUMMARY 2

1 CEDARS-SINAI HEALTH SYSTEM OVERVIEW 7

2 MISSION, VISION, AND VALUES 15

3 PARTNERSHIPS STRATEGIC CONSIDERATIONS 18

4 PROPOSED PARTNERSHIP STRUCTURE 21

5 ROLE OF HUNTINGTON TRUST 23

6 GOVERNANCE CONSIDERATION 25

7 FINANCIAL AND ECONOMIC COMMITMENTS 29

8 OPERATIONAL INFRASTRUCTURE 31

9 INFORMATION TECHNOLOGY 40

10 VALUE-BASED CARE CAPABILITIES 45

11 PHYSICIAN ALIGNMENT 53

12 CLINICAL SERVICES 60

13 IMPACT ON EXISTING RELATIONSHIPS 64

14 CULTURE AND EMPLOYEES 66

15 BRANDING 69

16 PHILANTHROPY 71

17 RESEARCH AND EDUCATION 74

18 FINANCIAL CAPABILITIES 78

19 STRATEGIC PARTNERSHIP EXECUTION 82

20 APPENDIX 1: NOTABLE CEDARS-SINAI CLINICAL PROGRAMS 83

21 APPENDIX 2: CSHS AMBULATORY NETWORK 86

22 APPENDIX 3: ILLUSTRATIVE QUALITY PROGRAM ACCOMPLISHMENTS 88

23 APPENDIX 4: OVERVIEW OF CSHS MSO CAPABILITIES 89

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Executive Summary

The following represents a summary of Cedars-Sinai Health System (CSHS) responses to questions and criteria identified by the Pasadena Hospital Association (PHA) in the Huntington Hospital (Huntington) Indication of Interest (IOI) outline and discussions with Huntington's management team.

IOI Area	Key CSHS Proposal Messages
Mission, Vision, and Values	■ CSHS mission is to "advance the delivery of high-quality care **in support of each partner organization's nonprofit mission**," which is well-aligned with Huntington's mission "to provide excellent healthcare and service to each person." ■ Huntington's vision is to be a **leader in creating community well-being**, which is well-aligned with the CSHS vision of **building on the strengths of its affiliates to advance clinical quality and outcomes, access to value-based equitable care, deliver outstanding patient experience, develop strong community and employee engagement, conduct innovative research and discoveries and increase partner brand recognition**.
Strategic Considerations	■ A partnership with CSHS will, among other things, enable **Huntington to make strategic investments for growth.** As a pillar of the partnership, CSHS is committed to helping Huntington make strategic investments in the following three key areas: facilities master plan, enterprise IT (including replacement of its EHR system), and physician network development (including ambulatory sites of care, MSO offerings, virtual health, and population health). ■ **Support Huntington in advancing its mission and maintaining its unique culture and stakeholder relationships**. The CSHS governance and operating philosophy provides local governance that will enable Huntington to continue to maintain its unique culture and its relationships with its stakeholders, including employees, clinicians, and its community. ■ **Create scale to continue to be relevant in the changing healthcare landscape**. A key function of CSHS is to create scale that benefits all its affiliates. Huntington, like other affiliates of CSHS, will benefit from scale and economies associated with scale to effectively and efficiently advance its organizational mission.
Proposed Partnership Structure	■ CSHS envisions a partnership structure that will **preserve a significant role in governance for the Huntington board of directors and the Huntington Trust**. ■ **CSHS would become the sole corporate member of PHA, and PHA would, together with Torrance Health Associates (THA), maintain a presence on the CSHS governing board**.
Role of the Huntington Trust	■ **Continued role for the Trust.** The Huntington Trust will maintain a role in the governance of Huntington and have influence in CSHS through Huntington's representation on the CSHS board. ■ **Continue Trust's mandate.** Huntington and its community will remain the sole beneficiary of the Trust endowment.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

IOI Area	Key CSHS Proposal Messages
Governance Considerations	■ **Preserve local governance.** The CSHS governance structure will preserve Huntington's fiduciary board to maintain local governance and decision-making. Huntington will also continue to maintain its current management structure and decision-making processes. CSHS board will require reserve powers in certain areas to meet regulatory requirements and advance systemness across CSHS partners. ■ **PHA Role in CSHS Board.** PHA will have the right to nominate an agreed upon number of directors to the CSHS board.
Financial and Economic Commitments	■ **CSHS will offer balance sheet support as needed to address Huntington's strategic plan needs.** As a CSHS affiliate, Huntington will have access to the financial strength of CSHS to support its anticipated capital spend and CSHS is willing to explore all options in the event the affiliation requires any changes to the current co-obligation arrangement with the Huntington Trust. In addition, the affiliation with CSHS is expected to bolster Huntington's credit rating, as it did for TMMC. ■ **CSHS will collaborate with Huntington to develop mutually acceptable economic models.** CSHS is open to exploring multiple financial support models for Huntington, which may include, but are not limited to system-level borrowing as part of a new obligated group or obtaining financing using assets of CSHS, and other creative solutions.
Operational Infrastructure	■ **Large health system scale with collaborative decision making**. CSHS will provide Huntington with scale associated with a larger system, particularly in areas such as revenue cycle, finance operations, quality and performance management infrastructure, IT, supply chain, etc. Prioritization and timeframe for implementation is developed collaboratively to meet member and system goals. ■ **Cost-sharing model for shared services**. CSHS leverages the talent and capabilities of the member organizations and as such does not have a corporate office. CSHS encourages its affiliates to collaborate to share and co-develop capabilities, for which there may be cost-sharing based on the cost of the shared capabilities.
Information Technology	■ **Support for Huntington's EHR replacement project.** CSHS will extend Cedars-Sinai's well-recognized implementation of the Epic platform to Huntington. We estimate that by utilizing the existing Cedars-Sinai platform optimized over the past 7+ years, there would be a **substantial (currently estimated at greater than 25%) cost of implementation savings compared to Huntington pursuing the project independently**. Cedars-Sinai can support Huntington with all phases of the implementation, stabilization, and optimization. **We believe we can meet or exceed the current expectations on timing.** ■ **Share talent and capabilities.** Cedars-Sinai has a well-recognized clinical informatics team and a large workforce with deep experience implementing clinical technology (specifically EHRs, population health platforms, and patient engagement tools). We have developed numerous clinical pathways that include clinical decision support, order sets, specialized workflows, and clinician validated

Highly Confidential and Subject to Executed Non-Disclosure Agreement

IOI Area	Key CSHS Proposal Messages
	department-specific content (e.g., Epic Beacon protocols) that are **available to be leveraged for Huntington's installation**. Our teams can lend support in a wide range of complex and advanced areas; these include cyber-security, analytics, digital consumer-facing technologies, and general support/savings often achieved through scale in items ranging from software to infrastructure.
Value-Based Infrastructure and Capabilities	■ **Share collective CSHS experience with transition to value-based care.** CSHS has significant experience and success across various value-based care models, such as Commercial and Medicare ACOs, Clinically Integrated Networks, Bundled Payment models, Full-Risk Medicare Advantage models, and HMO models. Also, our executive leadership team has extensive experience and expertise leading and operating health systems and physician enterprises in a value-based care environment. ■ **Create access to CSHS value-based care capabilities.** The various people, processes, and technology components that CSHS offers to enable value-based care are readily available to Huntington. Many of these components are easily scalable to meet Huntington's value-based care needs. ■ **Collectively invest in new value-based care capabilities.** CSHS affiliates also recognize the need to evolve and make additional strategic investments in new capabilities to support emerging value-based care operating model needs. With the addition of Huntington, CSHS will have additional scale to make further necessary investments in people, processes, and technology in support of value-based care efforts. ■ **Leverage scale to create differentiated product offerings.** CSHS hospitals and other affiliates will continue leading in care delivery and payment model innovation. With the addition of Huntington to the health system, there will be additional opportunities to create innovative offerings, such as digital health, ASCs, urgent care centers, ambulatory imaging centers, etc.
Physician Alignment	■ **Locally manage and enhance the strong relationship with community physicians.** The CSHS affiliation structure and governance philosophy offer autonomy to locally nurture and enhance relationships with community physicians. ■ **Grow Huntington's physician and ambulatory care network with additional alignment options.** CSHS will support Huntington's local physician network growth requirements by developing and offering additional physician alignment options, including foundation employment models, IPA alignment models, MSO offerings, and ambulatory EHR services. ■ **Create access to CSHS MSO capabilities.** CSHS will leverage the collective capabilities and scale to support Huntington to develop an ambulatory EHR solution that is integrated with a competitive MSO offering to create a strong value proposition for individual physicians and groups looking to align with Huntington. ■ **Co-developing strategy for existing Huntington physician services partnerships.** CSHS is committed to supporting local partnerships and relationships, including local management and governance of those relationships.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

IOI Area	Key CSHS Proposal Messages
Clinical Services	■ **Commitment to the highest clinical quality.** CSHS is committed to maintaining the highest quality of care across the system. CSHS will continue to make strategic investments in people, processes, and technologies that can advance the quality of clinical care across acute care, ambulatory care, and other post-acute settings. ■ **Keep the vast majority of care local and minimize disruptions to existing relationships.** CSHS, in collaboration with community physicians, will help create access to specialized services based on gaps in care, while keeping the majority of care local. ■ **Drive clinical transformation to impact cost and access needs.** CSHS is committed to working with our community physicians to advance clinical transformation across the system to improve reliability, reduce cost, and increase access. ■ **Proactive orientation towards outpatient shift trends.** CSHS is proactively developing clinically-appropriate opportunities to shift care from hospital-based settings to ambulatory settings. CSHS will support Huntington to evaluate and invest in outpatient shift opportunities and develop strategies for managing the transition, working with community physicians and payers.
Impact on Existing Relationships	■ **Support enhancing existing relationships with new capabilities.** CSHS understands and appreciates existing strategic relationship. CSHS's objective is to bolster and enhance, resulting in improved quality and access for patients in the San Gabriel Valley. CSHS would seek to develop a future plan that meets Huntington's aspirations to serve its community. ■ **Enable Huntington's partnership strategy.** When Huntington has interest in developing strategic alternatives for any existing relationships, CSHS will help with partnership transition and assist in the development of glide paths to ensure no disruption in service and/or adverse financial impact.
Culture and Employees	■ **Our people are responsible for our success.** CSHS and Huntington share the philosophy that fully engaged employees, Medical Staff and volunteers are required to deliver excellence in quality and outstanding patient satisfaction. We are committed to partnering with Huntington to advance the people agenda of our shared vision. ■ **Local talent and culture management.** With the affiliation, talent management, culture advancement, and operations will continue to remain local as they are today.
Branding	■ **CSHS supports localized brand strategy.** CSHS hospitals have long-standing reputations with solid brand recognition in their local communities and beyond. CSHS is committed to continuing to support local brand strategy. ■ **CSHS is not the primary consumer-facing brand for its partners.** The CSHS affiliation serves as a consistent "brand energizer" for an existing, well-established brand, further strengthening and differentiating it from its competition. ■ **Leverage CSHS affiliation to amplify partners brand strength.** There are many ways to leverage the affiliation to amplify Huntington's existing strong brand. And,

Highly Confidential and Subject to Executed Non-Disclosure Agreement

IOI Area	Key CSHS Proposal Messages
	CSHS would seek to develop an approach that meets both member and system goals.
Philanthropy	■ **Locally manage and enhance relationships with donors and the community.** The CSHS affiliation structure and governance philosophy offer autonomy to locally nurture and enhance philanthropy programs and donor relationships. CSHS will support Huntington's fundraising campaigns if/when requested by Huntington. ■ **Committed to using funds from local fundraising efforts for the benefit of Huntington communities.** Any funds raised from local efforts will be used solely for the benefit of the local community. CSHS will support Huntington's fundraising efforts with other ongoing CSHS efforts as appropriate to ensure there is no unintended duplication of solicitation of donors and/or activities.
Research and Education	■ **Create access to CSHS capabilities without disrupting existing research and academic relationships**. CSHS will bring the collective capabilities and scale of the Cedars-Sinai's academic enterprise to support Huntington's ongoing development of its research and academic capabilities. CSHS will also not seek to disrupt existing Huntington research and teaching relationships and stands ready to support existing programs as identified by Huntington. ■ **Co-developing strategy for Huntington research and teaching objectives**. CSHS is committed to supporting affiliate organizations to expand access to various research and teaching programs. CSHS will engage Huntington's leadership to identify infrastructure needs to support broader research and teaching programs and is committed to developing a strategy for supporting the current programs.
Financial Capability	■ **CSHS has demonstrated sustained and continuing financial growth,** with an **unrestricted cash position of over $3 billion.** ■ CSHS **is committed to exploring opportunities to increase Huntington's access to capital,** as needed to meet its strategic plans.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

1 Cedars-Sinai Health System Overview

On February 1, 2018, Cedars-Sinai Medical Center (CSMC or Cedars-Sinai) and Torrance Memorial Medical Center (TMMC) affiliated to create an integrated healthcare delivery system (CSHS) to improve the quality of healthcare within their communities and to further their mission of advancing the quality of care.

History of CSHS

Cedars-Sinai

Since its inception in 1902, Cedars-Sinai has evolved to become the largest nonprofit hospital in the western United States — internationally renowned for the best patient care modern medicine has to offer. Our support of the Los Angeles community grows stronger every day with our commitment to providing superior patient care, breakthrough biomedical research, graduate and undergraduate medical education and community service.

Cedars-Sinai, since its founding in 1902 as Kaspare Cohn Hospital in Angelino Heights, continues to reflect the diversity of people and communities we care for, the diversity of our employees, and our wide-ranging community benefit contributions. Cedars-Sinai welcomes and embraces all backgrounds and faiths. This respect for diversity and pluralism extends to many other types of diversity: cultural, gender, social and economic, to name just a few. While this value is not uniquely Jewish, it is certainly a central component of Judaism and the history of our institution. One of Cedars-Sinai's greatest strengths is our shared values, guiding not only what we do, but how we do it.

Torrance Memorial

Since its beginnings in 1925, Torrance Memorial Medical Center has grown from a 32-bed community hospital serving the South Bay area of Los Angeles to a facility with 533 active licensed beds in virtually all new hospital buildings. Under the governance of its community-based Board of Trustees, the medical center has substantially expanded its role as a provider of a range of healthcare services to include: a home health/hospice service, an employed model physician network, an independent physician association ("IPA") which contracts with health maintenance organizations, an ambulatory surgery center joint venture and various organizational structures/programs to address population health and value-based initiatives that include a joint venture ACO with nearly 300 physicians in the community.

Although Torrance Memorial has substantially grown over its almost 100-year history, it has remained a community focused institution. The hospital barely survived the Great Depression and two World Wars but by 1947, had grown to 96 beds. Over the last 95 years, the hospital location has changed and there have been numerous expansion projects but some things will always remain the same: The bylaws, crafted by Mrs. Torrance, state that one half of the non-physician Board members shall always be women; Torrance Memorial is supported by an active community-based Board of Trustees and a separate Foundation Board devoted to fund raising. Torrance Memorial seeks to offer the most current and effective medical technologies rendered in a compassionate, caring manner predominantly to the residents of the South Bay, Peninsula and Harbor communities.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Response to Huntington Questions

	Please provide a brief overview of your organization including organizational structure, facilities operated, geographic market and service focus, and any other relevant background information.

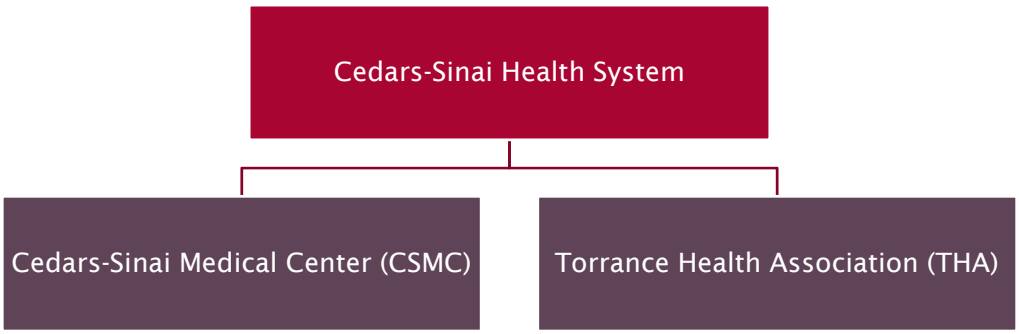
CSHS Structure

Having a shared vision and values, Cedars-Sinai Medical Center (CSMC) and Torrance Health Association (THA) created the Cedars-Sinai Health System (CSHS).

CSHS is a system parent entity established and structured to:

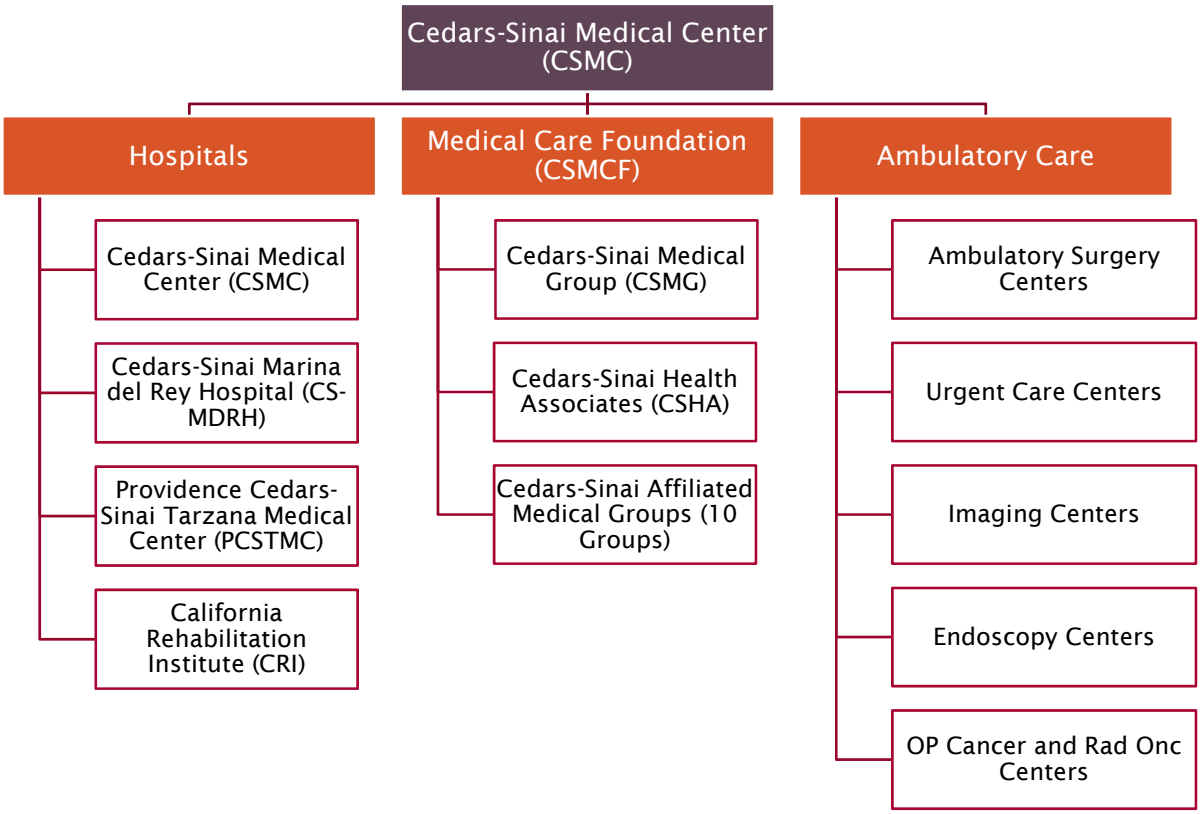
- Strategically address the needs of the evolving health care environment, including the transition to value-based payment models.
- Advance the mission/vision of each organization.
- Allow for local governance responsive to future needs.
- Avoid duplication of roles and responsibilities between the parent board and local boards.
- Allow the system affiliates the organizations be responsive to the unique local community needs and dynamics and accessible across a broad geographic footprint.
- Provide scale to pursue needed investments for strategic expansion and benefit from increased scope and reach.

Cedars-Sinai Health System

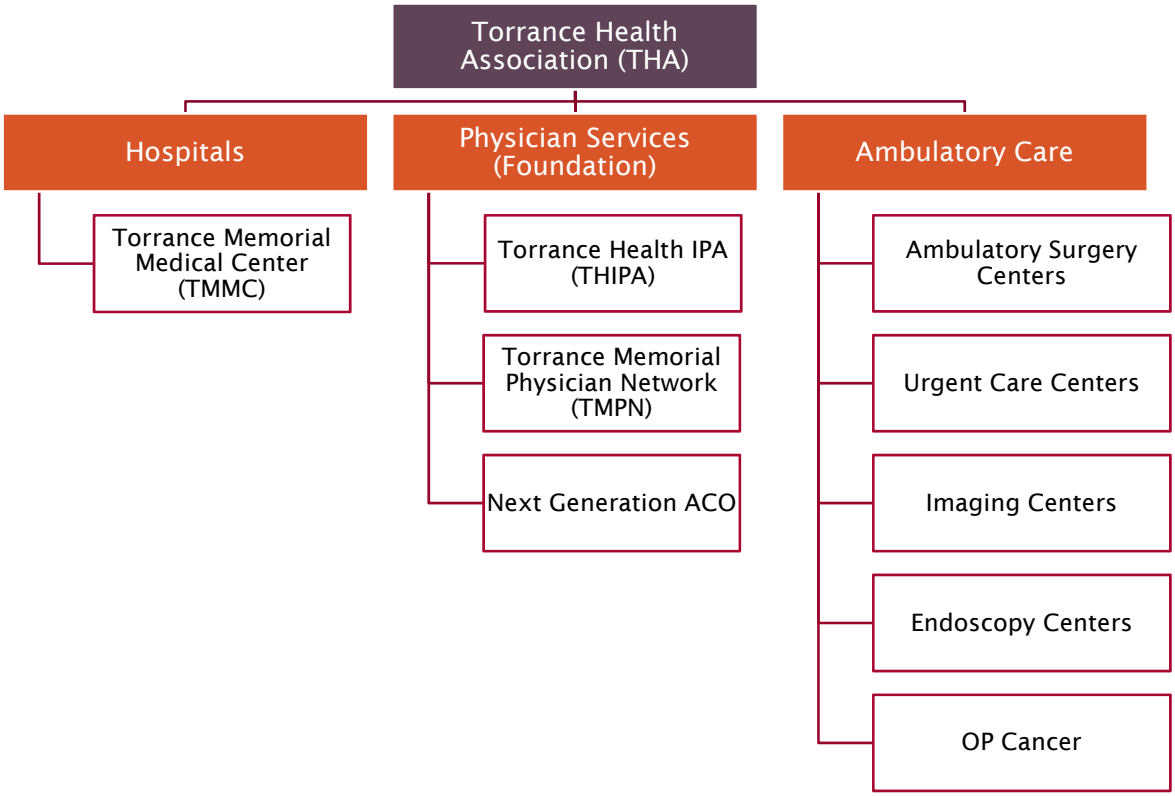


Highly Confidential and Subject to Executed Non-Disclosure Agreement

Cedars-Sinai



Torrance Health Association



Highly Confidential and Subject to Executed Non-Disclosure Agreement

Cedars-Sinai Entities

Cedars-Sinai Medical Center owns and operates a major academic medical center in Los Angeles, California. As a major teaching hospital, the Medical Center serves as a regional resource with a full complement of primary care, specialty and subspecialty services. The Medical Center is located on an approximately 25-acre site and includes a 2.1 million square foot main medical center complex supported by an additional 1.3 million square feet of space in adjacent research and ancillary facilities. The Medical Center is currently licensed for 890 general acute beds. In addition to the main Medical Center, there are multiple additional offsite ambulatory care facilities located throughout the community.

Cedars-Sinai Medical Care Foundation (the "Medical Network") operates as a nonprofit medical practice foundation associated with approximately 1,200 physicians. The Foundation provides urgent, primary and specialty care throughout Beverly Hills, West Hollywood, Playa Vista, Marina Del Rey, Culver City, Santa Monica and San Fernando Valley.

Cedars-Sinai Marina del Rey Hospital is owned and operated by CFHS Holdings, Inc. ("CFHS"), which is nonprofit corporation acquired by Cedars-Sinai in 2015, this 133 bed acute care hospital offers a broad range of services, including internal medicine, spine, weight loss and orthopedics. There is a master facility plan underway for the existing building to be replaced with a new facility with 160 beds set to open in 2024.

California Rehabilitation Institute, LLC, a joint venture with Select Hospital Investors, Inc. and UCLA Health, is a 145-bed acute rehabilitation hospital located in the Century City. Cedars-Sinai owns 38.1% of the venture.

Ambulatory Surgery Centers in which Cedars-Sinai is majority owner include 90210 Surgery Medical Center, LLC, Precision Ambulatory Surgery Center, LLC, Spalding Ambulatory Surgery Center, Linden Surgery Center, Kerlan-Jobe Surgery Center, Surgery Center of the Pacific and The Endoscopy Center of Santa Monica. Cedars-Sinai also wholly owns Cedars-Sinai Endoscopy Center in Beverly Hills.

Freestanding Imaging Centers are community-based and both wholly-owned and joint ventures to support our patients' access and affordability needs in the communities of Beverly Hills, Marina del Rey, Santa Monica and San Fernando Valley.

Providence Cedars-Sinai Tarzana Medical Center is a joint venture currently re-developing the Tarzana medical center campus, including a new patient-care tower, an expanded Emergency Department, new diagnostic and treatment services, and enhanced outpatient and ambulatory services. This partnership is broadly aimed to expand local primary and specialty care services in Tarzana as well as create access to specialized Cedars-Sinai programs, including heart, cancer and women's services to the San Fernando Valley communities.

Torrance Health Association Entities

Torrance Health Association (THA) is the sole corporate member of Torrance Memorial Medical Center. THA also is the entity which operates several divisions focused on physician enterprise and population health management services including a 1206L Foundation, IPA and accountable care organization (a joint venture with physicians) as described further below.

Torrance Memorial Medical Center owns and operates a 533 licensed-bed general acute care hospital. Torrance Memorial seeks to offer the most current and effective medical technologies rendered in a compassionate, caring manner includes an extensive integrated system of physicians and comprehensive medical services to provide a coordinated care continuum.

Torrance Memorial Physician Network (TMPN) operates as a nonprofit medical practice foundation and provides multi-specialty medical services, including primary, urgent care, pediatrics, endocrinology,

Highly Confidential and Subject to Executed Non-Disclosure Agreement

rheumatology, obstetrics/gynecology, cardiology, and oncology care and other specialties, to patients throughout the South Bay region through nearly 115 primary care and specialty care providers.

Torrance Memorial Independent Physician Association (THIPA) is a nonprofit, multi-specialty physician network which contracts for professional services for approximately 40,000 lives with HMO health plans and offers its members access to a network of over 300 physicians and healthcare providers, hospital services, and urgent care centers.

Torrance Memorial Integrated Physicians, LLC is an accountable care organization (ACO) that is 50% owned by Torrance Health Association and 50% owned by over 300 physician investors. It is comprised of a group of physicians and healthcare providers voluntarily working together with Medicare to provide quality healthcare services to Medicare fee-for-service beneficiaries and currently is participating in the CMS Next Generation ACO and several private insurance ACOs.

Torrance Memorial Medical Center Health Care Foundation is dedicated to fundraising for the Medical Center. Charitable donations and endowments help fund the acquisition of new equipment and the expansion of Torrance Memorial Medical Center's facilities, healthcare services, and community outreach programs.

CSHS Distinctive Attributes

As described in more detail later in our responses, CSHS currently has no employees or corporate office; instead, the system approach is to support and enhance local management of each of its hospitals and their affiliates. With CSHS, there is scale, yet local management and local decision-making. Capabilities are available across the system that can be utilized by any of the members. For example, there are 13 work teams led by member executives from clinical, medical network operations and administrative/financial services focused on collaboration and sharing of resources and best practices.



Highly Confidential and Subject to Executed Non-Disclosure Agreement

With scale, CSHS offers a growing spectrum of clinical services in each community. The map on page 11 details all the locations of CSHS and its affiliates. With time, CSHS looks to expand services within the existing service area and beyond with the support of new members.

A key measure of a hospital's success is reflected in outstanding patient satisfaction scores, increasing clinical performance achievements, excellent medical outcomes, outstanding world-class research and academic programs, and national designations and awards. Some of these measures are highlighted below:

- CSMC has been recognized by U.S. News & World Report as one of the ten best hospitals in the nation in its Best Hospitals 2019–20 rankings. **The CSMC is overall ranked No. 8 in a select group of 20 National Honor Roll hospitals**.

Cedars-Sinai Specialty	US News World Report National Ranking: 2019
Cancer	12
Cardiology & Heart Surgery	3
Diabetes & Endocrinology	16
Ear, Nose, and Throat	38
Gastrointestinal Disorders	2
Geriatrics	12
Gynecology	8
Nephrology / Kidney Disorders	10
Neurology & Neurosurgery	12
Orthopedics	3
Pulmonology	4
Urology	12

- U.S. News & World Report ranked Torrance Memorial as 12th best hospital for 2019-20 in California and the 7th best in the Los Angeles/Orange County region. Torrance Memorial also ranked 38th in the nation by Newsweek.
- Torrance Memorial has received a 4-star rating for Patient Experience (HCAHPS) for the last 12 consecutive quarters.
- For more than 20 consecutive years, Cedars-Sinai has won the NRC Health Consumer Choice Award for providing the highest-quality medical care in the Los Angeles region, based on a survey of area households.
- Cedars-Sinai and Torrance Memorial have both earned the coveted Magnet® recognition from the American Nurses Credentialing Center. Cedars-Sinai recently received the recognition for the 5th consecutive time, becoming the hospital with the longest-running Magnet designation in California.
- For 10 consecutive years, Cedars-Sinai has earned the highest ranking from the federal government for low post-hospitalization mortality based on three conditions: pneumonia, heart failure, and acute myocardial infarction. Cedars-Sinai is only 1 of 3 hospitals in the United States to achieve this.
- For six consecutive years, in 2018, the American Hospital Association and the College of Healthcare Information Management and Executives have included Cedars-Sinai on their list of Most Wired U.S. hospitals and health systems. The survey is a leading barometer measuring information technology use and adoption among hospitals nationwide in infrastructure, business and administrative management, clinical quality and safety, and clinical integration.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

- *Becker's*, a healthcare industry publication, identified Cedars-Sinai as one of the "100 Great Hospitals in America" in 2019.
- For four consecutive years, Cedars-Sinai has received the Workplace of the Year Award from The Advisory Board (2016, 2017, 2018) and Press Ganey (2019). The Workplace of the Year recognizes health systems which have achieved the highest levels of employee engagement compared to others in the country.
- Cedars-Sinai and Torrance Memorial received a 5-star rating in the July 2018 hospital rating by Centers for Medicare and Medicaid Services (CMS). Only 9% of U.S. hospitals received a 5-star rating.
- Cedars-Sinai is ranked tenth in the country among non-university hospitals receiving National Institutes of Health (NIH) funding. Total annual research spending is approximately $180 million per year.

Notable Services – Cedars-Sinai

CSMC provides a wide array of hospital services to patients of all ages from newborns and young children to adolescents, adults and the elderly. Cedars-Sinai is one of the largest nonprofit academic medical centers in the U.S. with annually over 50,000 discharges, 6,000 OB deliveries, 91,000 Emergency Department encounters and 790,000 outpatient visits. Clinical programs range from Level I Trauma center to primary care and specialized treatments for rare, complex and advanced illnesses. Notable programs and specialty capabilities include:

- **The Smidt Heart Institute.** Ranked #3 by U.S. News & World Report for cardiology and heart surgery and performs more heart transplants than any other center, including 132 in FY19. Our team has performed more percutaneous mitral and aortic valve procedures than any other U.S. medical center.
- **Samuel Oschin Comprehensive Cancer Institute.** Ranked #12 by US News & World Report, is one of the largest centers of its kind in Southern California. The array of services includes specialty centers for the brain, breast, colon/rectal, head and neck, kidney and bladder, lung, pancreatic, prostate, sarcoma-spine and women's cancers.
- **Digestive Disease Center**. Ranked #2 by US News & World Report, it is known for research innovations ranging from new drug therapies to advanced endoscopic technologies, as well as its clinical expertise. The doctors, surgeons and researchers working within the center lead the field in treating an extensive range of conditions, including inflammatory bowel disease, digestive tract disorders, fatty liver, pancreatic and biliary diseases.
- **Comprehensive Transplant Center.** Ranked in the top 10 programs by Scientific Registry of Transplant Recipients (SRTR), the transplant center conducts solid organ transplants, with excellent one- and five-year survival rates, and aids prospective patients who are highly antibody-sensitized to undergo successful procedures. Services include heart, kidney, liver, lung, and pancreas transplantation. The transplant program in FY19 performed more than 520 transplants.
- **Regenerative Medicine Institute**. The Institute brings together research faculty and clinicians to provide a true "bench to bedside" organization. The Institute has seven key programs: Blood, Brain, Eye, Gut, Lung, Liver and Kidney, and Skeletal. Work within each of these programs benefits from two Research Cores (Induced Pluripotent Stem Cell and Flow Cytometry), which focus on generating induced pluripotent stem cells from adult human skin samples and optimizing differentiation into various tissues of the human body of interest to the seven programs. The pluripotent cells are used to both increase our understanding of human diseases through modeling and provide a foundation for

Highly Confidential and Subject to Executed Non-Disclosure Agreement

preclinical studies aimed at establishing and validating cellular therapeutic approaches to human illness.

Notable Services – TMMC

Torrance Memorial Medical Center has numerous specialty programs: a certified burn center (one of only three in Los Angeles County); the Lundquist Cardiovascular Institute, which provides surgical and interventional procedures for about 3,000 cases per year; a basic 24-hour Emergency Department receiving over 83,000 patient visits per year, which also is a STEMI Receiving Center and paramedic base station; the Hunt Cancer Institute and the newly constructed (as of December 2019) Hunt Cancer Center, which includes oncology physician offices, infusion center, resource center and genetic counseling; a surgical service for over 20,000 cases per year and a nationally ranked orthopedic services; a large hospital and home health division which has over 600 patients/day on its service; a Level III neonatal unit and extensive mother-baby services; a primary stroke center with an application in process to be designated a comprehensive stroke center; the Polak Imaging Pavilion, which along with the Graziadio Radiology Center provides over 300,000 imaging tests and exams per year.

Community Programs

Cedars-Sinai and Torrance Memorial fulfill their vital mission to the community by investing in programs and services to improve the health status of the community. Both organizations work closely with schools, FQHCs, local government, senior centers, and other agencies to improve community health, better meet community needs, and to expand the capacity of other organizations to serve those who are most vulnerable, maximizing the impact of joint efforts to improve lives. Recent programs and impact include:

- From a community benefit program perspective, Cedars-Sinai and Torrance Memorial combined contribute greater than $113 million annually through community health and wellness programs, education and training of physicians and other health professionals, and charitable contributions (this does not include uncompensated care delivered at our Medical Centers).
- In June 2019, Cedars-Sinai deepened its commitment to the health and well-being of underserved populations in Los Angeles County by contributing $15 million to 108 nonprofit programs and safety-net organizations that provide housing stability, sustainable programs for homeless residents, mental health training, services for LGBTQ+ and veterans' groups, as well as a range of social services provided by several Jewish organizations.

CSHS hospitals have a track record of running community programs and finding ways to collaborate to make a greater impact. We believe that expanding the CSHS affiliation to include Huntington will allow us to make greater investments in programs that positively impact our communities.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

2 Mission, Vision, and Values

Huntington Hospital's Mission, Vision, and Values

Mission	To provide excellent health care and compassionate service to each person by bringing together outstanding physicians, caring nurses, professional staff, and advanced technologies.
Vision	To be the leader in creating community well-being through world-class health care delivered with kindness and dignity.
Values	Respect, Integrity, Stewardship, Excellence, and Collaboration

- Huntington is a community treasure and industry leader, serving residents of all types and socioeconomic groups.
- Huntington operates with a 0/100 expectation when it comes to error and embraces a "Just Culture" philosophy to promote an environment where individuals feel free to report errors and learn from mistakes.
- Huntington has earned awards and recognitions from some of the nation's foremost health accreditation organizations.

CSHS Mission

CSHS Mission

The CSHS is a nonprofit healthcare organization that seeks to advance the delivery of high-quality health care **in support of each member's nonprofit mission** to:

- Lead in the delivery of quality patient care.
- Implement innovative approaches in medicine and population health.
- Expand medical knowledge through supporting biomedical research and discovery.
- Educate and train physicians and other health care professionals.
- Expand patient access to high quality and cost-effective services throughout the region.
- Preserve and promote the historical culture and values of each partner hospital.
- Provide substantial community benefit.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

CSHS Strategic Vision

CSHS will be the leading health care organization in the region and recognized nationally for:

Excellence in clinical quality and outcomes	Comprehensive access to value-based equitable care	Innovative translational research and discovery
Outstanding patient experience	Strong community and employee engagement	Member brand recognition

The Role of CSHS

The following are some key principles for how CSHS relates to its members:

- Assist hospitals and affiliates to meet the challenges of a constantly evolving health care environment through development and coordination of system and local strategy.
- Attract and approve new affiliates.
- Avoid unnecessary duplication of governance roles and responsibilities and preserve the local governance and influence.
- Support local governance and management responsibilities for quality of care, operational matters, and financial management.

Response to Huntington Questions

	Please describe your organization's mission, vision and values and corresponding alignment with Huntington. ■ How does the relationship that you propose with Huntington help your organization further its mission, vision and values? ■ How do you think it would further the mission, vision and values of Huntington?

Comparison of the Mission, Vision, and Values

Below are the mission statements for Cedars-Sinai Medical Center, Torrance Memorial Medical Center, and Huntington Hospital. The missions are consistent across the organizations, and each strives **to provide leading-edge, high-quality care to our patients and the communities we serve**.

Organization	Mission Statement
Cedars-Sinai Medical Center	Cedars-Sinai is a nonprofit, independent healthcare organization committed to **improving the health status of the communities** we serve through: ▸ Leadership and excellence in delivering quality healthcare services ▸ Expanding the horizons of medical knowledge through biomedical research

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Organization	Mission Statement
	▸ Educating and training physicians and other healthcare professionals ▸ Strive to improve the health status of the community Quality patient care is our priority. Providing excellent clinical and service quality, offering compassionate care, and supporting research and medical education are essential to our mission. This mission is founded in the ethical and cultural precepts of the Judaic tradition, which inspire devotion to the art and science of healing and to the care we give our patients and staff.
Torrance Memorial Medical Center	Under the governance of a community-based Board of Trustees, Torrance Memorial serves the public interest by: ▸ **Improving the community health** within the scope and expertise of its resources ▸ Offering the most current and effective medical technologies rendered in a compassionate, caring manner ▸ Maintaining long-term stability in order to assure its strength and viability for the benefit of the community
Huntington Hospital	Our mission is to provide **excellent health care and compassionate service to each person** by bringing together outstanding physicians, caring nurses, professional staff and advanced technologies.

Each mission plays an important role in support of the overall vision of CSHS to serve the greater Los Angeles area. CSMC's unique status as a major academic medical center supports the entire system across the Southern California region with advanced capabilities. Marina del Rey Hospital and the new joint venture with Providence for the Tarzana Medical Center, allow for greater geographic span and physician network expansion in the South Coastal and the San Fernando Valley communities. Torrance Memorial and its physician network further expand the system's reach to the South Bay communities. Huntington would further complement the system its vital role in the Pasadena/San Gabriel Valley communities.



How does the relationship that you propose with Huntington help your organization further its mission, vision and values? How do you think it would further the mission, vision and values of Huntington?

CSHS Growth Strategy

Increasing competition and fast-changing payer and purchaser dynamics are putting even greater pressure on hospitals. These dynamics are driving a strategic imperative to develop an adequately sized integrated system to optimize service to the community. CSHS has a strategic goal to grow the system and selectively pursue the addition of new hospitals and other affiliates.

All affiliation opportunities are evaluated based on CSHS's guiding principles, and CSHS has defined criteria for potential new affiliates:

- Align with overall system mission, vision, and culture.
- Provide access to and growth of new services to high priority communities.
- Enhance capabilities, including overall quality, efficiency, and effectiveness of service delivery.
- Maintain or improve the overall brand and reputation of CSHS and its affiliates.

Considering Huntington's history, values, commitment to patient care and the community, Huntington is an optimal fit for CSHS. We intend to draw on the deep talent and expertise of the Huntington management teams to improve our respective operations and grow the services to our community of patients.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

3 Partnerships Strategic Considerations

Huntington's Current State and Requirements

- Huntington is interested in exploring a partnership with a like-minded health system that allows relative independence and ensures the maintenance of its community-oriented mission.
- Such a partnership must create opportunities bestowed by greater scale, in terms of operational efficiencies, cost, and access to capital, and other accelerators for long-term success.
- As a part of the relationship, Huntington still wants to preserve its unique culture and its relationships with its staff, physicians, and community.

CSHS Partnership Guiding Principles in Support of Huntington's Requirements

CSHS sees a strong alignment of the mission, vision, and values between the current CSHS affiliates and Huntington.

The following are some additional principles that will guide a strategic relationship with Huntington:

- **Create scale and operational synergies across CSHS to enable affiliates to continue to be relevant in the changing healthcare landscape.** A key function of CSHS is to create scale that benefits all its affiliates. Huntington, like the other CSHS affiliates, will benefit from scale and economies associated with scale to effectively and efficiently advance its organizational mission. Through this partnership, Huntington can centralize services, where desired, and leverage knowledge, capabilities and best practices that can result in improved efficiencies to increase its financial strength.
- **Enable Huntington to make strategic investments for growth.** As a pillar of the partnership, CSHS is committed to helping Huntington make strategic investments in the following three key areas: facilities master plan, enterprise IT (including replacement of its EHR system), and physician network development (including ambulatory sites of care, MSO offerings, and population health services).
- **Maintain and enhance Huntington's unique culture and relationship with the San Gabriel Valley community.** CSHS is committed to helping Huntington advance its mission of providing excellent health care and compassionate service to each person by bringing together outstanding physicians, caring nurses, professional staff and advanced technologies. The CSHS governance and operating philosophy will enable Huntington to continue to maintain its unique culture and its relationships with its stakeholders that include its employees, clinicians, and its community.

Response to Huntington Questions

	Based upon your organizational strategy and your knowledge of Huntington, please address the following: ■ Discuss how a relationship with Huntington furthers your organization's medium- and long-term strategic goals and objectives.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Huntington is a Strategic Partner to Help CSHS Advance its Strategic Goals

As the current healthcare landscape continues to evolve both nationally and locally, it is creating new challenges for all providers. When CSHS was formed, the following were the key strategic questions that its founders, CSMC and TMMC, were trying to address:

- How will CSHS differentiate itself against current and emerging healthcare providers in the LA market?
- What is CSHS's value proposition for the community, payors, purchasers, and other providers who may consider joining CSHS in the future?
- What key strategic areas of focus should CSHS drive for the benefit of its affiliates?
- How can CSHS establish a cohesive regional strategy to support future network growth and development?
- How will the strategic needs of CSHS and its affiliates evolve and how can CSHS remain responsive to this evolution?
- What are the broad financial and capital impacts for CSHS and its affiliates?

Based on an in-depth strategic planning process, CSHS established the following four strategic goals for the system in the medium and long-term:

- **Markets & Patients Served**. Increase healthcare value for patients, payers, and communities.
- **Growth.** Grow CSHS to meet the needs of communities in our region.
- **Value-Based Care.** Identify opportunities to leverage clinical and operational systems to achieve the highest value system of care across partner organizations.
- **Patient Access.** Enhance access to CSHS services by developing new sites and models of care to meet consumer and community needs.

A partnership with Huntington will add significant scale to CSHS. Huntington will help CSHS increase communities and patients served, advance CSHS's scale to increase efficiencies as well as grow its value-based payer partnerships and create increased access to CSHS services across the region.

	Are there any specific projects or initiatives within Huntington's service area that you would be interested in collectively pursuing within a partnership?

Collective Initiatives to help CSHS Advance its Strategic Goals

To accomplish the four strategic goals for the system, CSHS affiliates have identified numerous medium- and long-term tactics to address the challenges which include, but are not limited to:

Highly Confidential and Subject to Executed Non-Disclosure Agreement



Through a partnership with Huntington, many of the tactics identified can be pursued in Huntington's service area. The following is an illustrative, non-exhaustive elaboration of the potential opportunities that can be jointly pursued in Huntington's communities:

- **Expanding ambulatory/medical networks with new locations.** As consumers seek affordable and convenient options for care, and as care continues to shift from hospital-based setting to ambulatory settings, CSHS and Huntington can together expand current ambulatory offering and capabilities to create differentiation with both consumers and payers. The new ambulatory offerings could include ASCs, imaging centers, urgent care clinics, and virtual/digital health.
- **Continuing to develop and expand service lines.** CSHS would like to work with Huntington to further develop key service lines that will create a standard of care and raise the bar for patent care across the system. CSHS will also focus on clinical service line development to keep the majority of the care local and reduce the need for patients to seek care from providers outside the service area.
- **Implementing clinical and operational efficiency initiatives.** CSHS members can pursue clinical and operational efficiency initiatives to help optimize their cost structure, increase the affordability of their services and improve care outcomes. These clinical and operational efficiency initiatives will also benefit Huntington by helping with margin preservation in the wake of various reimbursement and value pressures on healthcare providers.
- **Developing risk-based and other value-based arrangements with payers and purchasers.** CSHS would like to pursue various value-based contracting and population health initiatives in collaboration with public and private payers. Many of those initiatives require infrastructure investments that offer payback only when the system is managing large populations and across multiple local markets. With a partnership with Huntington, CSHS can continue to make investments in various value-based and population health programs with a larger care delivery network capable of serving the population of the greater Los Angeles region.
- **Creating payer and purchaser partnerships.** Increasingly employers and purchasers of health care are seeking direct partnerships with healthcare delivery systems to offer bundles for high-volume or high-cost services. Examples include employers directly contracting with a health system for comprehensive joint replacement bundles with built-in concierge services. These types of new partnerships require investments and expertise, which is often difficult to develop for a single hospital or local system. CSHS is actively exploring these types of opportunities with regional employers and purchasers and could include Huntington in these opportunities as part of CSHS.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

4 Proposed Partnership Structure

Huntington's Current State and Requirements

- Huntington desires a partnership structure that will preserve a meaningful role in governance for the Huntington board of directors and the Huntington Trust.

CSHS Partnership Guiding Principles in Support of Huntington's Requirements

- **CSHS envisions a partnership structure that will preserve a meaningful role in governance for Huntington's board of directors and the Huntington Trust.** The relationship between CSHS and its partner organizations demonstrates that CSHS is able to create an affiliation model that builds on the strengths of its hospital partners, respects local governance and management, and preserves each partner's mission and community relationships.

Response to Huntington Questions

	Huntington is interested in exploring fully integrated strategic partnership alternatives, including: ▸ The development of a new regional health system in conjunction with your organization ▸ Joining your system through a member substitution or asset purchase transaction, or ▸ Any other relevant strategic partnership structure that furthers Huntington's goals. With that in mind, please describe the nature and structure of your proposed affiliation with Huntington.

Cedars-Sinai Health System (CSHS) is the sole member of Cedars-Sinai Medical Center (CSMC) and Torrance Health Association (THA), and THA is the sole member of TMMC. CSMC appoints a majority of the board members of CSHS, the CSHS CEO serves as an ex officio CSHS board member, and THA designates the remaining CSHS board members. CSMC and TMMC each maintain their own separate fiduciary boards and select their own board members, subject to the approval of CSHS.[1]

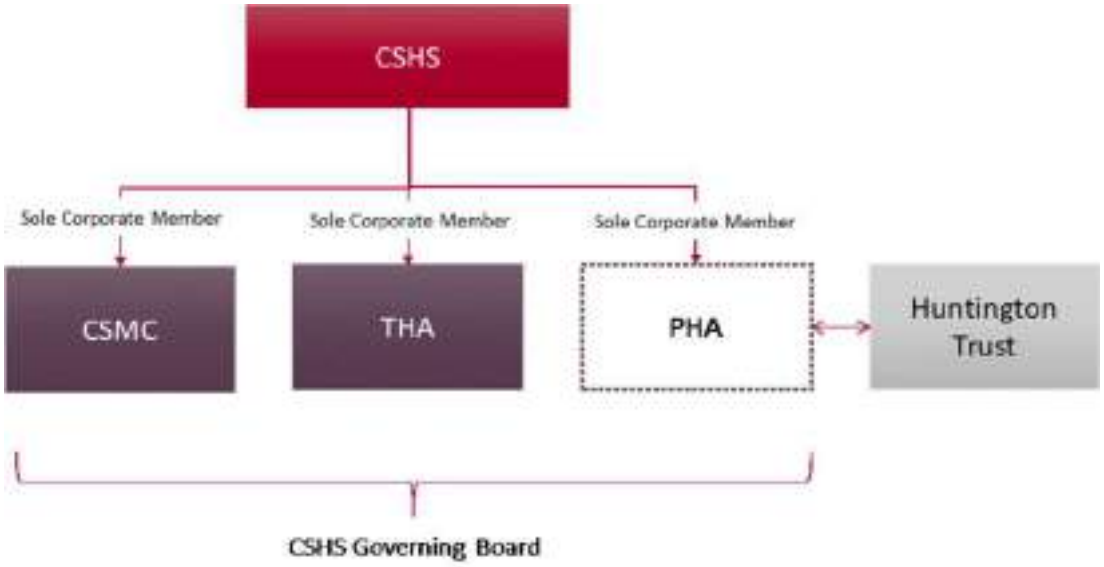
- This structure allows each of CSMC and TMMC to remain responsive to their own local governing bodies for quality, stewardship, fidelity to charitable mission, and responsiveness to the needs of the communities they serve.
- CSHS, as the common parent, maintains an appropriate level of authority to ensure that its hospital partners may present to the market as a single system (rather than as competitors), and to support strategic growth, sharing of resources and collaboration as desired by and for the benefit of the hospital partners.
- The CSHS model avoids unnecessary duplication of governance roles and preserves a strong local governance presence at each of its hospital partners.

[1] Further information about the CSHS governance structure can be found in Section 6, "Governance Considerations".

Highly Confidential and Subject to Executed Non-Disclosure Agreement

CSHS Proposal for PHA

We propose that CSHS would become the sole corporate member of PHA, and PHA would, together with THA, have a presence at the CSHS governing board. This structure allows the Huntington Trust to continue to participate in the governance of PHA through its five Trustees.[2]



Bringing PHA into CSHS in this manner also allows for the CSHS consolidated financial statements to include all of its hospital partners – CSMC, THA, and PHA. Each hospital partner benefits from the financial strength of the system, even if a hospital partner does not ultimately become part of a system obligated group.

[2] See Section 5, "Role of the Huntington Trust".

Highly Confidential and Subject to Executed Non-Disclosure Agreement

5 Role of Huntington Trust

Huntington's Current State and Requirements

- The Trust provides an endowment for the maintenance and operations of Huntington with funds earmarked to specific programs.
- The Trust has five Trustees who hold lifetime appointments on the PHA board.
- Huntington wants to ensure its ongoing mission-oriented relationship with the community, realized through its governance relationship with the Trust, is maintained.
- Huntington is seeking partnership options that will provide for a meaningful role for the Trust in the ongoing governance of Huntington.

CSHS Partnership Guiding Principles in Support of Huntington's Requirements

- **Respect for the Trust Relationship.** CSHS will respect the unique and collaborative relationship between PHA/Huntington and the Huntington Trust.
- **Preserve role for the Trust.** The Huntington Trust will maintain a role in the governance of Huntington and have influence in CSHS through Huntington's representation on the CSHS board.
- **Continue Trust's Mandate.** Huntington and its community will remain the sole beneficiary of the Trust endowment.

Response to Huntington Questions

	Please describe the role you envision for the Huntington Trust within the proposed partnership. As further described in the CIP, the Trust exists as a supporting organization to Huntington Hospital created with the purpose of supporting the hospital. ■ Specifically, please describe the impact of the proposed partnership on the following: ▸ Trust assets; ▸ The existing lease arrangements between Huntington and the Trust; ▸ The Trust's current status as co-obligor of Huntington debt; and ▸ The Trust's role in governance within the proposed partnership.

- Affiliating with CSHS will not disrupt or adversely affect Huntington's relationship with the Trust. CSHS respects the unique and collaborative relationship between Huntington Hospital and the Huntington Trust.
- The Trustees of the Huntington Trust will continue to serve on the Huntington board of directors as required by the governing court order.
- CSHS would like to engage in discussion about how the Trust's participation in governance might be achieved without lifetime appointments (i.e., term limits or rotating trustee service on the Huntington board). We realize that any such changes are subject to appropriate court approval and would welcome Trust counsel's participation in such discussions. The objective of such discussions would be to ensure appropriate Trust influence in the context of evolving standards and best practices in nonprofit hospital governance.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

- CSHS also assumes the Trust will continue to fulfill its charitable purpose as a vehicle for the maintenance and operation of Huntington, and that Huntington will use funds received from the Trust for their proper intended purposes.
- While further diligence is necessary to fully understand the terms of the lease between the Trust and Huntington, we would like to explore the possibility of the Trust donating the realty that is currently leased, and any other contiguous land that could be used to develop ambulatory programs, to PHA as part of any affiliation arrangement. Having Huntington as both the owner and operator of its hospital land creates practical alignment, and efficiency in management, operations and facility planning. We propose that our respective counsel confer to explore this possibility and advise regarding options and necessary court and other approvals.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

6 Governance Consideration

Huntington's Current State and Requirements

- Huntington is governed by a highly engaged board of directors who are local, regional, and national leaders in their respective industries. The board currently has 26 members.
- Huntington board is vested with the responsibility for overseeing the management and financial needs of Huntington Hospital.
- The Huntington Trust maintains a separate board of trustees, appointed for life, and each of the five trustees serves on the Hospital Board. The approval of a majority of the trustees is required for any action to be taken by the Hospital Board.
- Huntington is seeking partnership options that will provide for a meaningful role for the Trust and the Huntington board in the ongoing governance of Huntington.

CSHS Partnership Guiding Principles in Support of Huntington's Requirements

- **Preserve local governance.** The CSHS governance structure will preserve Huntington's fiduciary board. Huntington may also maintain its current management structure and decision-making processes. The CSHS board will require reserve powers in certain areas to meet regulatory requirements and advance systemness across CSHS affiliates.
- **State and Federal Regulatory Requirement.** The governance and affiliation terms will reflect an appropriate level of control by CSHS as the sole member to allow the hospital partners to present collectively to the market as a single system, rather than competitors, which is critical from an antitrust perspective.

Overview of CSHS Governance

- CSHS currently has a 12-member board of directors with representation from CSMC, THA and the CEO of CSHS (ex officio).
- Each affiliate organization maintains its own fiduciary board of directors. Affiliate boards continue to maintain day-to-day oversight of quality, other operational matters, strategic initiatives, philanthropy and donor relations, and community benefit programs.

The CSHS governance structure is designed to avoid unnecessary duplication of governance roles and responsibilities and preserve the strong governance present at CSMC, THA and potential future hospital partners.

Response to Huntington Questions

	Please describe your proposed governance structure for Huntington going forward, including any mechanisms that allow Huntington to maintain an appropriate representation following the consummation of the strategic partnership.

As part of CSHS, Huntington would maintain its own governing body and management. CSHS is not a management or operating entity. Tom Priselac is the CEO of CSHS, and Ed Prunchunas is the CFO. Other than those corporate officers, CSHS has no employees or system headquarters. Rather, CSHS exists to

Highly Confidential and Subject to Executed Non-Disclosure Agreement

support and enhance local governance and management of its hospital partners. CSHS's structure provides the opportunity for scale for its hospital partners but respects local management, local governance, and local decision-making.

CSHS currently has a 12-member board of directors, comprised of representatives of CSMC, THA and the CEO of CSHS (ex officio)

CSHS bylaws provide that THA will have representation on the CSHS board. As part of the proposed affiliation, Huntington will likewise have representation on the CSHS board. PHA would have the right to select directors (which may include one or more of the five Trustees of the Huntington Trust) that serve on the PHA board (which individuals would be subject to approval by the CSHS board).

	Please describe your organization's governance structure, physician participation, and, specifically, governance mechanisms for hospitals and health systems that join your organization.

Below is a governance matrix, which summarizes some of the CSHS governance provisions that would most likely be included in various governing documents (e.g., entity bylaws) or any definitive affiliation agreement for the proposed transaction. CSHS will work with Huntington to develop a mutually-acceptable governance matrix as part of an affiliation agreement. The following is a minimum set of governance requirements that will require CSHS board approval and expected to be included in an affiliation agreement:

Description of CSHS Board Approval Requirement
1. Adopt, repeal, modify, amend or restate the Articles of Incorporation, Bylaws or other governing documents of PHA or any of its subsidiaries
2. Elect individuals to the board of directors of PHA who are nominated by the PHA board
3. Remove individuals from the board of directors of PHA with or without cause
4. Transfer non-cash assets from PHA or any of its subsidiaries to CSHS
5. Establish or consummate a transaction that results in a change of control of PHA or any of its subsidiaries
6. Change the mission, vision and values of PHA
7. Change the corporate structure of PHA if such change would affect PHA's status as a tax-exempt organization
8. Elect to voluntarily dissolve PHA
9. Change the name of PHA or a licensed hospital owned and operated by PHA
10. Sell any real property owned by PHA
11. Approve PHA's strategic plans, capital budgets and operating budgets
12. Form an obligated group among CSHS, PHA and other hospital partners

Other material affiliation terms that would most likely be included in various governing documents (e.g., entity bylaws) or any definitive affiliation agreement for the proposed transaction include the following:

- If CSHS ever decides to close, sell, transfer, change the control of or change the use of substantially all of the assets of Huntington, PHA would have the right to exit CSHS and assume control of the assets after assuming all liabilities.
- PHA will have the right to approve a material reduction, substantial change in use or discontinuation of certain designated services at Huntington if the decision is supported by specific quality and/or economic reasons or if it creates a significant negative effect on the availability of the discontinued or reduced medical services to the residents of Huntington's service area, as determined by CSHS in collaboration with an independent consultant.
- PHA, along with the other CSHS hospital partners, would be required to make periodic payments to CSHS to cover CSHS's operating expenses. PHA's pro rata portion of such operating expenses would be proportionate to PHA's own operating expenses relative to the operating expenses of the other hospital partners. At this point, CSHS operating expenses have been negligible.
- PHA, along with the other CSHS hospital partners, would be required to make capital contributions from time to time to CSHS to fund CSHS investments and initiatives. PHA's pro rata portion of such capital contributions would be proportionate to the number of directors that PHA has the right to nominate to the CSHS Board relative to the total number of directors on the CSHS Board (not including the ex-officio directorship of the CSHS CEO). At this point, no such investments have been made.

	Please describe the following within the context of your proposed structure: ▸ The authority, purpose, and role of the Huntington Board of Directors post-affiliation, including involvement in strategic planning, operating and capital budgeting and capital spending decisions; ▸ Reserved powers anticipated to be held by your organization post-affiliation; ▸ Local medical staff involvement in governance; ▸ How local Huntington board members will be nominated and appointed post transaction, including the initial composition of the reconstituted board, as applicable; and ▸ Representation on your organization's board of directors identified by Huntington and their participating in board committees, as applicable.

The CSHS governance structure will preserve local governance at Huntington's fiduciary board. Huntington may also continue to maintain its current management structure and decision-making processes. The CSHS board will hold reserve powers in certain areas to meet regulatory requirements and advance systemness across CSHS.

CSHS hospital affiliates maintain day-to-day oversight of quality, other operational matters, implementation of strategic initiatives, philanthropy and donor relations, and community benefit programs. Huntington's board will have influence and a voice in CSHS through representation on the CSHS board.

The CSHS governance structure is designed to avoid unnecessary duplication of governance roles and responsibilities and preserve the strong governance present at CSMC, THA, and future hospital partners. Under the CSHS affiliation model, medical staff governance remains local, and each hospital partner maintains its own medical staff with independent governance for medical affairs, consistent with California law.

	Huntington is aware, via publicly available information, of the recently structured relationship between Torrance Memorial Medical Center ("TMMC") and Cedars-Sinai. ▸ Could you please explain any differences between the relationship with TMMC and that which you propose to Huntington?

Highly Confidential and Subject to Executed Non-Disclosure Agreement

	▸ This would include for you to take into consideration any other historic and/or current affiliation structure or relationship that is/or will be entered into with similar and comparable hospitals. ▸ How would ongoing governance input from Huntington be integrated into the relationship such as or with TMMC?

The relationship proposed for Huntington is consistent with the relationship that CSHS has with Torrance Memorial, as described in our response under Section 4, "Partnership Structure" and Section 6, "Governance Consideration". Please refer to those sections.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

7 Financial and Economic Commitments

Huntington's Current State and Requirements

- Huntington has a strong balance sheet between PHA and the Trust, with over $1.37B in assets.
- The Huntington Trust holds significant cash, investments, and real estate assets that support foundational stability for Huntington's health services operations.
- Huntington currently has $298M in debt across three bond portfolios that are co-obligated by the Trust. The Series 2014A bond portfolio of ~$60M is privately placed with Deutsche Bank.
- Huntington currently has a 10-year capital plan that includes over $800 million in spend across Facility Master Plan / Routine Capital, IT Master Plan, Enterprise IT, and Physician Network.
- Huntington is planning to fund its capital plan using a combination of operating cash flow, philanthropy, and debt. Huntington expects its credit rating to be downgraded if it were to proceed with the planned capital spending.
- Huntington anticipates that certain partnership structures may require the Huntington Trust to remove itself from co-obligation for the current outstanding bond portfolio.
- Huntington is looking for balance sheet strength from a partnership to support its anticipated capital spend plans and removal of the trust from the current co-obligation arrangement.

CSHS Partnership Guiding Principles in Support of Huntington's Financial Requirements

CSHS will support Huntington's current debt and future capital spending plans. The following are some key principles that would guide our strategy to support Huntington's needs:

- **CSHS will offer balance sheet support as needed to address Huntington's strategic plan needs.** As a CSHS affiliate, Huntington will have access to the financial strength of CSHS to support its anticipated capital spend and CSHS is willing to explore all options in the event the affiliation requires any changes to the current co-obligation arrangement with the Huntington Trust. In addition, the affiliation with CSHS is expected to bolster Huntington's credit rating, as it did for TMMC.
- **CSHS will collaborate with Huntington to develop mutually acceptable economic models.** CSHS is open to exploring multiple financial support models for Huntington, which may include, but are not limited to system-level borrowing as part of a new obligated group or obtaining financing using assets of CSHS, and other creative solutions.

Overview of CSHS Capabilities

- CSHS has a strong consolidated balance sheet, yet each partner hospitals maintain their own balance sheet and P&L.
- Key financial metrics for CSHS are included in Section 18: Financial Capabilities, however, the total cash assets as of FY19 was $3.05 billion.
- In addition to strong operating performance, CSHS partner hospital organizations have a long history of philanthropic support which augments the financial flexibility provided by the balance sheet.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Response to Huntington Questions

- Please describe the financial and economic considerations your organization will provide to Huntington. Specific items for consideration should include:
  - Your treatment of Huntington's assets and liabilities, including outstanding debt. Please also be sure to specify between your suggested treatment of assets and liabilities attributable to Huntington separately from those of the Trust.
  - Your commitment to provide capital to Huntington to accomplish the following strategic initiatives, as specified in the CIP:
    - → Physician recruitment and alignment;
    - → Facilities and equipment;
    - → Information technology system upgrades;
    - → Any other capital projects to further Huntington's success and the strategic partnership strategy.
  - Any other quantitative considerations related to your proposal structure.
  - Any material assumptions upon which the economic terms of the proposal are based, as well as any conditions or contingencies that may be material to an assessment of your indication of interest.

- Joining CSHS would provide Huntington with vehicles and opportunities for balance sheet support to ensure that the anticipated capital spend (as specified in the CIP document), and any outstanding debt are supported.
- CSHS anticipates working with Huntington to identify options for balance sheet support, which could include system-level borrowing as part of a new obligated group or obtaining financing using assets of CSHS as needed.
- We anticipate that the Huntington Trust will remain a co-obligor on the existing Huntington debt. Should the Huntington Trust not remain a co-obligator on the existing Huntington debt, CSHS would be willing to explore the possibility of replacing the trust as a co-obligator.
- CSHS' objective is for Huntington to maintain its legacy balance sheet with all of its assets and liabilities while accessing the system's financial and operational strengths.
- In addition to balance sheet support, based on our understanding of Huntington's key strategic initiatives, CSHS is willing to consider providing significant in-kind strategy and execution support for Huntington's facilities master plan, physician network expansion and enterprise IT plan, including EHR replacement.

Based on the overall financial strength of CSHS, there are no other quantitative considerations or material assumptions made about our financial support plan. The approach outlined provides the added benefit to Huntington of being able to maintain or improve current bond rating and having access to capital at a lower cost.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

8 Operational Infrastructure

Our Understanding of Huntington's Current State and Requirements

- Huntington has a robust operational and quality infrastructure that serves as its foundation for being able to achieve its clinical outcomes and financial results.
- Huntington has a strong management team and desires to keep decision-making local yet benefit from being part of a large regional health system.
- Huntington recognizes that in response to changes in the external environment, operational synergies through a partnership with a larger health system can result in greater efficiency and effectiveness.
- Huntington is currently pursuing a "Back-to-Budget Plan" to further drive improvements and cost savings across various operational areas. Huntington has identified revenue cycle, ED flow, supply chain, observation stays, labor productivity and ASC performance optimization as major areas of focus for savings.

CSHS Partnership Guiding Principles in Support of Huntington's Requirements

CSHS's main purpose is to support its hospital partners in delivering high-quality care to patients and serving the community. CSHS will partner with Huntington to drive operational synergies and share capabilities to improve performance and reduce cost.

Our general principles on how CSHS will partner with Huntington on operational infrastructure include:

- **Large health system scale with collaborative decision making.** CSHS will provide Huntington with scale associated with a larger system, particularly in areas such as revenue cycle, finance operations, quality and performance management infrastructure, IT, supply chain, etc. Prioritization and timeframe for implementation is developed collaboratively to meet member and system goals.
- **Cost-sharing model for shared services.** CSHS leverages the talent and capabilities of the member organizations and as such does not have a corporate office. CSHS encourages its affiliates to collaborate to share and co-develop capabilities, for which there may be cost-sharing based on the cost of the shared capabilities.

Response to Huntington Questions

	Please describe your organization's quality of care infrastructure and how you expect to maintain and enhance measurable levels of clinical quality and patient satisfaction at Huntington.

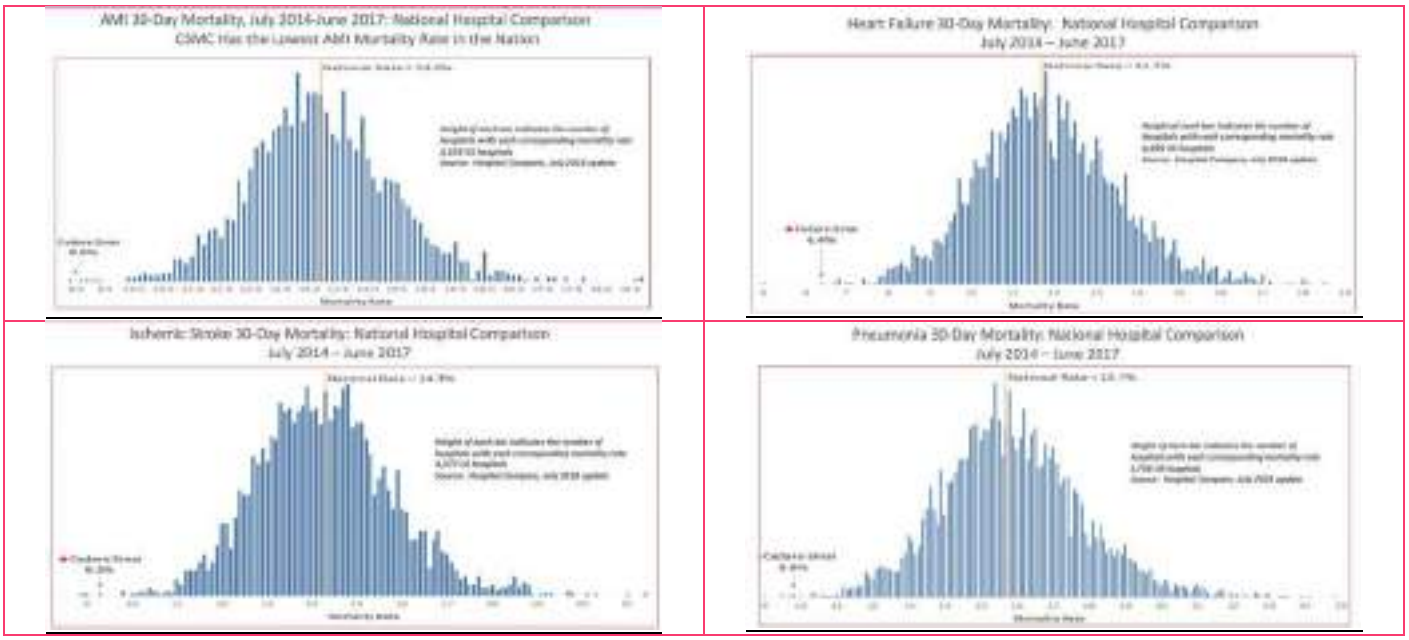
CSHS Quality Program Achievements

The Cedars-Sinai brand has become synonymous with best-in-class care. Over the last several years we have created unique affiliations with multiple community hospitals, ambulatory surgery centers, imaging centers and significantly expanded our Medical Network, including urgent care centers, in support of and in partnership with our hospital affiliates. Every organization is unique, and we have a proven track record of learning from and jointly identifying the infrastructure support that is most beneficial in the service of our partner hospital organizations. Each of these relationships has demonstrated different strategic and tactical approaches to ensuring quality aligned with our values and philosophy.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Example: Cedars-Sinai Mortality Rate Achievements

Ten years ago, CMS began tracking and reporting 30-day mortality rates for all hospitals in the country for Acute Myocardial Infarction or Heart Attack (AMI), Congestive Heart Failure (CHF) and Pneumonia and publicly reporting whether a hospital was "better than the national rate," "no different than the national rate," or "worse than the national rate." For the **ten years** this has been tracked for hospitals nationally, CSMC is **one of only three** hospitals in the nation that has ranked **"better than the national rate" for all three diagnoses.** Curious about where CSMC ranked in actual mortality performance, we analyzed the data and found that CSMC was not only "better than the national rate" but we are one of the top-performing hospitals for all five diagnoses now tracked by CMS.



CSHS can leverage its quality-related capabilities and insights to further enhance Huntington's clinical quality and patient satisfaction.

CSHS Quality Philosophy and Infrastructure

CSHS members have a long and established history of taking on bold and rigorous quality improvement work.

At its core, the Cedars-Sinai philosophy for quality is built upon three questions:

- "How do we know how we are performing?" to assure we know and deeply understand our performance;
- "How do we focus our resources and expertise?" because there are always a multitude of opportunities; and
- "How do we improve?" as problem-solving, particularly in a complex and critical environment like acute care requires analysis, creativity, perseverance and humility.

We use these questions to understand, prioritize and execute quality improvement. Our purpose is to assure the quality programs for all CSHS affiliated facilities are built upon several fundamental building blocks. Having a focus on quality is a key CSHS partnership requirement. CSHS affiliates must commit to

Highly Confidential and Subject to Executed Non-Disclosure Agreement

sharing quality data and working collaboratively to achieve target levels of performance. Although targets will vary by organization, it is expected that best practices and resources will be shared to ensure that the highest quality of care is being delivered to our patients.

Setting and achieving quality targets are the responsibility of local organization leadership and management. We have created system-wide dashboards to monitor inpatient and ambulatory/medical network quality and safety performance. The dashboards were developed collaboratively by the hospital ambulatory care partners and are intended to represent the most meaningful quality and safety objectives for all care settings. Although the dashboards are presented to the CSHS Board, the targets for each metric are established by the hospital partners and the tactics to ensure success are determined and implemented by local management.

CSHS Quality Program Fundamentals

- **Local focus** for data analysis, leadership and front-line staff to assess gaps and opportunities.
- **Performance context** in the bigger picture through reputable and understood local, state and national benchmarks.
- Development of **goals** that are based on local opportunities and gaps that are clear, specific, numeric and set by fiscal year.
- **Transparency** and data visualization of overall and quality goal performance in a consistent format including data validation.
- **Sustainment** of past quality goal efforts for at least 3 years following the end of the project that includes control plans and thresholds for reconvening efforts and consistently reporting ongoing performance.

Quality Infrastructure – People and Process

Quality infrastructure can be shared across the system. If Huntington desires, CSHS and its hospital affiliates can provide structure, expertise, and support for local leaders to drive change while also seeking to teach independent problem-solving various performance improvement methodologies. We have performance improvement experts who can assess, define and visualize problems through data and human insights and collaborate with local leadership and frontline staff in designing sustainable improvement.

In addition to offering expertise, we also believe in "growing our own" and can make available to Huntington an extensive internal professional development program to provide significant experiential and educational exposure for Huntington staff so they can continue to grow to support the needs.

Quality Infrastructure – Technology/Data Analytics

Data analytics are essential piece of every quality improvement project and can be used to enhance care delivery and assess opportunities for growth. We recognize the critical role technology plays in understanding problems through data, automating processes, measuring our performance and improved decision making. Our Enterprise Information Services (EIS) team is a critical partner. If Huntington joins CSHS and is it transitions to Epic, data analytics and decision-support tools will be made available.

	Please describe the tools and resources that would be available to Huntington to enhance its delivery of care and facilitate its growth.

Several capabilities will be available to Huntington as a CSHS partner to enhance its delivery of care and facilitate its growth. The following are some illustrative capabilities that Huntington can benefit from:

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Capabilities to Enhance Delivery of Care and Facilitate Growth	Highlights
Strategic Business Planning	■ Department consists of nearly 10 professionals with significant health system strategy and planning experience. ■ Various tools and data sources (Advisory Board Planning 20/20, Sg2 Analytics, Crimson Market Advantage, OSHPD, etc.) to gain market and patient insights. ■ Strategic business planning processes and templates.
Real Estate and Facility Planning and Design	■ Department consists of nearly 60 professionals including architects, construction project managers, ■ Facility development and large-scale project management expertise. ■ Ambulatory site development templates. ■ Key market relationships with real estate brokers and management companies.
Service Line Clinical Leadership	■ Deep knowledge of developing clinical programs and service lines with national recognition in areas such as: ▸ Heart ▸ Cancer ▸ Orthopedics ▸ Digestive Health ▸ Women's Health ▸ Pulmonology ■ National academic network for recruitment of specialists. ■ Experience in developing and implementing population health and value-based care strategies. ■ Academic and research program development and management capabilities.
Service Line Operations	■ Day-to-day service line operations for various specialties such as Heart, Cancer, Neonatology, Women's Health, Neurosciences, etc. ■ Throughput and clinical efficiency processes and tools for efficient and effective management of clinical service lines.
Performance Improvement and Patient Experience	■ Department consists of nearly 20 professionals with significant experience. ■ People, processes and technology infrastructure to maintain and improve clinical quality, performance, and patient experience.
Ambulatory Network Development	■ Deep expertise in developing and operating ambulatory facilities including primary care clinics, urgent care clinics, infusion centers, ambulatory surgery centers, endoscopy centers, and imaging centers.
Medical Staff Recruitment	■ Internal executive recruitment function to support the hiring of leadership positions for the system.
Managed Care Contracting and Payer Relations	■ People, processes, and technology to support ongoing management of various payer and value-based contracts.
Hospital Operations, Nursing and Training	■ Hospital shared services people, processes, and other knowledge assets in areas such as pharmacy, labs, imaging, supply chain, facility management and productivity management.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Capabilities to Enhance Delivery of Care and Facilitate Growth	Highlights
Health Information Management and Coding	CSMC Health Information CBO division provides services in CDI, coding and auditing. Established resource pool with workflow technology. Virtual work environment. ■ Coding ▸ Resource pools ▸ DNB reductions ▸ Computer-assisted coding. Repeat implementation successes. Leverage AI/NLP technology to prioritize case intervention. ▸ Implement single-path coding. Consolidate hospital and professional coding workstreams. ■ Coding Audit ▸ Application of rules-based technology to identify accounts with audit/error risk. ▸ HAC/PSI reviews to rule out errors prior to submission ▸ Payor rules. ■ Clinical Documentation Integrity Program ▸ Provider education. Standard and customized live and virtual education sessions. ▸ Concurrent review. Leverage technology with automated reviews by RNs and MDs. Real-time support for queries and documentation clarification. ▸ LOS/Working DRG analysis. Concurrent DRG assignment for use in clinical decision-making related to the length of stay, SOI/ROM scores. Physician specific performance compared to peers/benchmarks.
Revenue Cycle	■ Our Revenue Integrity internal consulting division has 40 FTEs with capabilities to: ▸ Analyze CDM to find lost revenue. ▸ Analyze charge protocols to determine revenue enhancement improvement projects. ▸ Implement charge reconciliation practices to stop revenue leakage. ■ Illustrative results of Revenue Integrity program, over the first 5-7 years, netted $35-$50 million annually for CSMC. ■ Current program nets approximately $15-$20 million annually for CSMC. ■ An initial program initiated at Marina del Rey Hospital netted $2 million last year. ■ Revenue Integrity program is being implemented at Torrance Memorial.

	Please describe economies of scale that could be achieved through shared services (e.g., revenue cycle management, human resources, information systems, purchasing and supply chain, risk management, capital structure, etc.).

A priority tactic identified by CSHS affiliates was to achieve value by consolidating vendor and service relationships. In FY19, CSHS achieved an estimated annual recurring savings or cost avoidance of over $9

Highly Confidential and Subject to Executed Non-Disclosure Agreement

million from vendor consolidation, group purchasing, and shared services relationships. For FY20, we have a target of achieving an additional $15 million. Our initial focus is on those areas that we think have minimal disruption to operations yet recognize that there are likely tens of millions of savings opportunities depending on the affiliate organizations' appetite for change.

There are many opportunities for sharing of services. The following are areas where economies of scale through consolidation is underway or being explored:

Opportunities Areas	Key Highlights of Synergies
Information Technology	■ There are several CSHS-wide synergy areas in IT, examples include ▸ Shared Digital health platform ▸ Shared IT development and implementation capabilities ▸ Medical Informatics expertise ▸ Consolidation of IT infrastructures, in areas such as cybersecurity management and Data Center ▸ Consolidation of IT services such as help desk support ▸ Standardization and consolidation of hardware and software purchasing
Human Resources	■ With CSHS, there is no co-employment, so staff are employed by the affiliate, and benefits are specific to each organization. However, there are opportunities related to employee services and/or vendor relationships. Examples of options available include, but are not limited to, ▸ Defined Benefit vendors; ▸ Purchasing Stop Loss Insurance as a system for Medical PPO Plan; ▸ Utilizing a shared employee Help Desk to address employee questions about benefits.
Finance Operations	■ Financial Systems – affiliates are leveraging strengths in: ▸ Finance Operations: → Internal and external financial reporting → Budgeting → Financial decision support → Capital planning → Cost accounting → Accounts payable including digital enhancements allowing on-site support, ACH and EDI capability as well as P Card and rebate/discount support → Banking operations as common paymaster/P Card → Governmental and regulatory filings including items such as cost reporting, OSHPD and survey management. → Taxation ▸ Revenue Cycle: → Health Information Department with centralized coding and Clinical Documentation Improvement (CDI) training and program leveraging outside resources for benchmarking. → Revenue Integrity department to ensure appropriate reimbursement and enhance regulatory compliance with a specific focus on charge capture, charge optimization, etc. → Centralized Customer Service and Support for CSMC and affiliated physicians. → Multi-site Epic support hospital, physician office, and ambulatory operational and implementation support (see EIS Section for Marina del Rey Hospital conversion).

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Opportunities Areas	Key Highlights of Synergies
Supply Chain	■ CSHS has a relationship with Vizient as a system, so affiliates benefit from greater administrative rebate with combined purchasing spend as well as group contracting volume pricing. ■ There are additional opportunities related to sourcing, managing and delivering supplies (including pharmaceuticals) to partner hospitals and their affiliates. There are ways to achieve efficiencies in these processes resulting in cost-reduction opportunities.
Value-based Care	■ Combined, Cedars-Sinai and Torrance Memorial have over 50 years of experience in medical network operations, risk-based payments and care transformation models. Both organizations were early adopters of Medicare programs with Torrance Memorial participating in the Pioneer program and NextGen and Cedars-Sinai being part of the Medicare Shared Savings Program. Affiliates are exploring having consolidated MSO services available to their networks.
Medical Staff Functions	■ Although Medical Staff decisions remain local, there are opportunities to centralize some of the credentialing services across the system to achieve economies of scale such as verification of practitioner credentials and utilization of an electronic application/reappointment process. ■ Utilizing a single process, although not required, can improve the experience for providers who want to work across multiple organizations and can make the process simpler to facilitate peer review sharing (as needed) among CSHS entities regarding critical practitioner competency and risk information.



Example: Revenue Cycle Improvement and Consolidation

Revenue Cycle Improvements - CSMC Results

- *Reduced DNFB due to uncoded accounts by > 3 days*
- *Increased CMI > 30%*
- *CDI initiative netted $10 Million annually*
- *Recouped $14 Million in pre-billing edits*
- *Increased code capture volume by 30-40% (>5 codes per case)*
- *Improved coder productivity by 30-50% using computer assisted coding technology*
- *Reduced record delinquency by > 40%*
- *Enhanced IR/Cath Lab charge capture by $36 Million annually*

Revenue Cycle Consolidation - Marina del Rey Results

- *We transferred all MDRH Rev Cycle employees into a CBO and with turnover had no increase in FTEs 18 months after consolidation*
- *Initial results show an increase in CMI > 10%*

Highly Confidential and Subject to Executed Non-Disclosure Agreement

CSHS Integration Approach

Joining CSHS is intended to make various services and capabilities available to all partner organizations. CSHS encourages its partner organizations to collaborate with each other to advance their respective missions and leverage benefits of scale across the system. CSHS integration focus includes:

- **Focus on quality** – We would expect CSHS members to commit to sharing quality data and working collaboratively to achieve target levels of performance, leverage CSHS member's best practices and resources to advancing quality of care for its patients.
- **Streamlined community benefit planning** – We would expect CSHS hospitals to use the same approach to completing Community Needs Assessments and formats for developing their community benefit plans so that opportunities can be explored to maximize the combined efforts and provide a greater volume of services and impact to those who are most vulnerable.
- **Alignment of financial calendars** – We would expect CSHS affiliates to align financial calendars to enable unified financial statements and optimized capital management across the system. Currently, all CSHS members use July 1 as the start of their financial calendar.
- **Active involvement in integration work teams to ensure maximum benefits realization of affiliation** – We would expect all affiliates to join and collaborate with our systemwide integration work teams to identify and realize synergy opportunities. The current work teams cover the following areas:

Clinical Services	Nursing	Community Benefit	Quality/ Patient Safety	Patient Experience	Medical Network & MSO
Finance	Human Resources	IT	Supply Chain	Marketing & Branding	Managed Care

Work teams are charged with the following:

Identify and prioritize synergy opportunities	•Identify and prioritize synergy opportunities for: •clinical collaboration •operational efficiencies
Share systemwide best practices and information	•Be forthcoming in providing all information on strengths, weaknesses, concerns and opportunities for focus areas.
Jointly develop synergy strategies	•Collaboratively develop proposals/plans. All proposals should be agreed on by the team and submitted by the team to the CSHS Leadership Group which is comprised of member organization CEOs, CSOs and CFOs.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

	As applicable, please describe how corporate overhead is allocated within your organization and how those costs might be charged to Huntington in an affiliation.

CSHS leverages the talent and capabilities of the member organizations and as such does not have a corporate office. CSHS encourages its affiliates to collaborate to share and co-develop capabilities, for which there may be cost-sharing based on the cost of the shared capabilities. With CSHS, there is scale, while retaining local management and local control and decision-making. There are capabilities that are made available across the system that can be utilized by any of the hospital partners and their affiliates.

As an example, if a system affiliate desires consolidation of revenue cycle services, then those capabilities will be shared, and its associated cost will be shared with the affiliate.

Based on our experience, in multiple back office areas, with both Marina del Rey and Torrance Memorial, the cost-sharing for consolidated services has been **less** than their previous expense for having local service.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

9 Information Technology

Our Understanding of Huntington's Current State and Requirements

- Huntington is in the process of evaluating the transition of its Acute Care and Ambulatory Care EHR infrastructure from Cerner and Allscripts to Epic. Huntington has estimated a total budget of $300M, including capital and implementation, for the EHR replacement project.
- Huntington would welcome support in the area of medical informatics, specifically to improve clinical and IT alignment as part of the new EHR rollout.
- Huntington recently outsourced its data center to a vendor in El Segundo yet in the near term, Huntington is interested in moving its second data center offsite and out of state.
- Huntington currently has a shortage of IT staff (approximately 30 FTEs) and is limited by physical space for additional IT staff.
- Huntington would be interested in exploring opportunities for identifying improvements and cost-saving opportunities related to non-clinical systems.
- Huntington would like to maintain the current roadmap for replacement of business systems, for example, continue with the Workday implementation.

CSHS Partnership Guiding Principles in Support of Huntington's Requirements

- **IT as a Strategic Investment and a Differentiator.** Cedars-Sinai's Enterprise Information Services (EIS) department is a strategic investment to support the clinical and administrative functions of the Health System. We do not view the EIS department as a profit center but as a key differentiator in offering key services and capabilities to our patients and clinicians.
- **Strong Clinical – IT Alignment.** Our EIS department is built on the principle of people, process, and technology. The highly skilled and integrated team can support all three. Over 20% of the EIS team is made up of clinicians and a process improvement team is embedded with the group.
- **Using Scale and Complexity to Attract Talent.** Our EIS team are experts in their field and can retain, attract, and grow to scale of CSHS' needs. We have been named to Computerworld's list of Best Places to Work in IT for ten years running. Increasing the number of Epic sites and increasing the complexities and scale of our system is a great opportunity to help EIS continue to attract and retain high-quality staff who are eager for complex and interesting work.

Overview of CSHS Capabilities and Alignment Approach

IT Capability Areas	Distinctive
Clinical System	■ Cedars-Sinai achieved **HIMSS 7 status in 2015**. ■ For the sixth consecutive year in 2018, the American Hospital Association and the College of Healthcare Information Management and Executives have included Cedars-Sinai on their list of Most Wired U.S. hospitals and health systems.
Talent	■ EIS has approximately **540 people** who work in the department and over **20% are clinicians**. ■ The EIS department has been voted one of Best Places to work in IT for ten consecutive years.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Infrastructure	■ Cedars-Sinai has **18,381** managed end-points connected to the network. ■ Cedars-Sinai operates a scalable data center that is housed in 40,000 sq. ft. in El Segundo that hosts approximately 3,000 servers. ■ Cedars-Sinai is a leading user of Amazon Web Services (AWS) with over 700TB of information in the cloud. ■ 3.2 million unique records exist in our patient database. We synchronize in real-time every patient transaction to 138 systems. 11,866,206 transactions are managed every day by our enterprise interface engine.
Cybersecurity	■ We have a leading-edge cybersecurity team with a 24/7 security operations center built upon a $30 million investment in technology. Efforts have resulted in over 200 million suspicious foreign blocks made each year.
Innovation	■ We encourage innovation. Turning promising ideas into breakthroughs for better care and better health is the goal of the **Cedars-Sinai Accelerator,** which is an intensive three-month program that provides mentoring and other support for technology innovators. ■ Approximately 50 companies have participated in the Accelerator and companies are selected based on their potential to dramatically improve and streamline healthcare delivery.

Response to Huntington Questions

	How would you support the implementation of an Enterprise Wide IT strategy (including EHR, ambulatory, population health management and wellness, revenue cycle management)?

Huntington completed a comprehensive assessment of its IT needs and developed a multi-year strategy to support the organization's strategic priorities. Part of that strategy is the replacement of Cerner with an enterprise-wide solution that offers a best in class EHR with capabilities including but not limited to, care pathways, robust clinical decision support, revenue cycle, population health to support care management, and ambulatory functionality to better support network growth and physician engagement.

Recognizing the importance of a solid electronic health record to support the quality of care objectives and Cedars-Sinai's experience with Epic, as Huntington evaluates partners and even prior to making any affiliation decisions, at no expense to Huntington, we are happy to provide help with IT planning. We are confident we can meet or exceed the desired timelines presented to us.

	How would you anticipate that this be accomplished (e.g., extension of your organization's instance of IT software) and do you have any experience in doing so in other partnership or affiliation settings?

CSMC Epic Implementation Experience

Cedars-Sinai maintains a full-time team dedicated to Epic optimizations and follow-up projects to ensure that the EHR evolves as rapidly as healthcare. We also have some of the strongest implementation partner (staff augmentation consultant) relationships available, we have in the past scaled up our team as high as an additional 600 people (at our highest point). We know how to do this.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

If Huntington joins CSHS, we will make the Cedars-Sinai Epic platform and license available. We estimate that by utilizing the Cedars-Sinai license, there would be a substantial (currently estimated at greater than 25%) savings compared to Huntington purchasing it independently. Cedars-Sinai will also support Huntington with implementation.

Cedars-Sinai's experience with Epic is vast. Cedars-Sinai installed Epic in 2007 and has implemented almost every module, with limited exception. Approximately seven years were spent configuring and installing the system, which we refer to as CS-Link. Built with the involvement of hundreds of physicians and staff from across the organization CS-Link captures the patient's entire care experience – from scheduling an appointment to final payment of the appropriate balances from the patient and health plan.

CSMC Epic Implementation Scale

Benefits realized include improved efficiency and communication among caregivers, improved quality and convenience of patient care and increased patient participation in their care. Cedars-Sinai has 4,250 concurrent CS-Link users. The CS-Link database is 23 TB and there are 25 CS-Link environments. Since implementation, we have been involved in co-development with Epic to ensure that with each upgrade, there are enhancements to support clinical and operational priorities.

Since Cedars-Sinai is committed to "one patient, one medical record," we have also helped Epic connect to other EHRs to ensure that clinical and demographic data can easily flow from niche clinical systems. Cedars-Sinai continues to be a leader with shared medical records and IT. All physicians in the Cedars-Sinai community, regardless of their level of implementation, have complete visibility of the content contained within the EHR.

Daily there are over 200,000 logins to CS-Link and for computer order entry, Cedars-Sinai is in the top 1% nationally for adoption, according to HIMSS Analytics.

CSMC Clinical Informatics Capability

We are proud of our clinical informatics capability. Cedars-Sinai has a strong team and there are 32 physicians working in the department. The result of having so many engaged physicians is that we have developed numerous clinical pathways that include clinical decision support that range from reminders and alerts to hard-stops where are medical staff leadership have deemed it necessary. All the tools and pathways we have developed can be made available – ready out of the box- for Huntington to use and/or modify to meet the needs of your organization.

With the advanced EHR and the data that is available, we created a department that has over 100 FTEs that is responsible for Data Integration and Intelligence to leverage the informatics and day to day reporting so that we have advanced predictive analytics. Cedars-Sinai has maintained a data warehouse of all clinical and administrative information for over a decade.

	What would be the anticipated timeline to fully implement and operationalize the EHR installation contemplated above?

Although every implementation is different, we can support rapid implementation of Epic at Huntington. Cedars-Sinai has strong internal talent for implementation. We also have deep strategic relationships with Epic and with consulting implementation partners so can secure support rapidly as needed. With the right clinical teams and leadership, Cedars-Sinai can make content available to accelerate timelines and reduce costs, and where Huntington wants specific and tailored configuration that is also available.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Example: Epic Implementation at Marina del Rey Hospital and Multiple Affiliates

As an example, Cedars-Sinai has successfully deployed Epic to Marina del Rey Hospital, numerous ambulatory affiliates, and a large number of private physician office. Our Epic private physician office program is one of the largest and most successful of its kind in the country. Similar to what we are proposing for Huntington, Marina del Rey utilizes Cedars-Sinai's Epic capabilities, although their system is configured to meet their specific needs; in many cases, they have the same protocols and pathways as Cedars-Sinai, but in areas such as the pharmacy formulary, they have configured Epic to their specific needs.

For implementation, we would utilize the **Epic flight plan methodology** and will aim to abbreviate the typical implementation timeframe by bringing a level of experience and pre-work that will allow capturing of the right data from the beginning to ensure the system is customized for optimized roll out for Huntington. With this approach, we are confident we **can meet or exceed your 15-month implementation** timeline expectation.



At Cedars-Sinai, over 100 physicians at over 85 unique physician offices have elected to be on the Cedars-Sinai CS-Link, this includes over 200 of their office staff. These physicians have the following benefits:

- Easy to use documentation templates for dozens of specialties;
- Private secure data sharing;
- Quick access to data so that information can be seamlessly shared across the entire continuum saving time, increasing productivity, and facilitating physician efficiency;
- Patient safety with drug-drug and drug-allergy interaction checking at the time of medication ordering, as well as electronic medication prescribing directly to pharmacies thereby reducing medication errors;
- Meaningful Use™ tools to satisfy requirements qualify for those initiatives;
- Total integration across all sites of care;
- Interfaces with lab and imaging results; and
- Patient Portal for electronic patient communication with office staff and physicians for prescription refills and appointments and allows patients to view their health information.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

	How would implementation costs be factored into a capital commitment as described previously?

In addition to the Epic licensing synergies, based on further detailed understanding of Huntington's requirements, we can offer significant in-kind support for the implementation program that could include planning, oversight and clinical review, etc.

We are confident that working together, we can successfully, and more rapidly and cost-effectively, achieve Huntington's IT strategic goals. To the extent Huntington is interested in collaborating and/or saving on infrastructure and Non-EHR initiatives, we think there is potentially a strong cost savings yield.

From a capital and implementation cost optimization perspective, Assuming the willingness of Huntington to consider migrating to common platforms, we project the following:

IT Area	Savings Potential
Clinical System (non-Epic)	■ **10 - 20% savings** for Huntington built on the assumption that Cedars-Sinai is using leading clinical systems that can be extended to Huntington at a discount.
Business Applications	■ **10 - 20% savings** for Huntington by eliminating duplicative licensing and/or scaling licenses. As an example, CSHS members achieved $700,000 in savings alone in leveraging Microsoft contracts.
Infrastructure	■ **25 - 35% savings** for Huntington for system rationalization.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

10 Value-Based Care Capabilities

Huntington's Current State and Requirements

- Huntington operates in a competitive market where there is significant ongoing shift-to-value across payers, providers, and consumers. To effectively grow, Huntington recognizes the need to continue the adoption of value-based care models.
- Huntington is seeking a partnership that will bring mature capabilities to position Huntington as a leader in the value-based care environment and enable greater risk-based payment arrangements, coordinate care effectively and perform sophisticated data analytics.
- Huntington desires to be part of a synergistic system that will increase broad access to care across the communities in the Los Angeles region.

CSHS Partnership Guiding Principles in Support of Huntington's Requirements

CSHS members believe scale is critical in a value-based care environment, allowing investments and rapid deployment of population health strategies. Although CSHS members have mature capabilities to support and be successful in value-based care arrangements, CSHS is also committed to collaboratively working with Huntington to offer existing capabilities and explore additional investments that could benefit all its members as the value-based care landscape evolves.

Our commitment to Huntington as part of value-based care alignment is that CSHS will:

- **Share collective CSHS experience with transition to value-based care**. CSHS has significant experience across various value-based care models, including an executive leadership team that has extensive experience and expertise leading and operating health systems and physician enterprises in a value-based care environment.
- **Create access to CSHS capabilities.** The various people, processes, and technology components that CSHS members have developed over the many years are readily available to Huntington. Many of these components are easily scalable to meet Huntington's value-based care needs.
- **Collectively invest in new capabilities.** CSHS members also recognize the need to evolve and make additional strategic investments in new capabilities to support emerging value-based care operating model needs. With the addition of Huntington, CSHS will have greater scale to make further necessary investments in people, processes, and technology in support of value-based care efforts.
- **Leverage scale to create differentiated offerings.** CSHS members will continue leading in care delivery and payment model innovation. Additional value-based products and service opportunities, such as direct-to-employer bundles and payer Centers of Excellence (CoE) for specific conditions will greatly benefit from scale. With the addition of Huntington to the health system, there will be additional opportunities to create new innovative offerings.

Overview of CSHS Value-Based Care Capabilities

Experience with Value-Based Care Models

CSHS is committed to the ongoing evolution of value-based care, reducing the cost of care while at the same time enhancing the care outcomes.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

CSHS members are committed to being on the leading edge of value-based care and payment model innovation. As nonprofit providers, we take our responsibility seriously to support policymakers, purchasers, and payers to test and evaluate the impact and benefits of new value-based care models for patients, populations, and to reduce total healthcare spend.



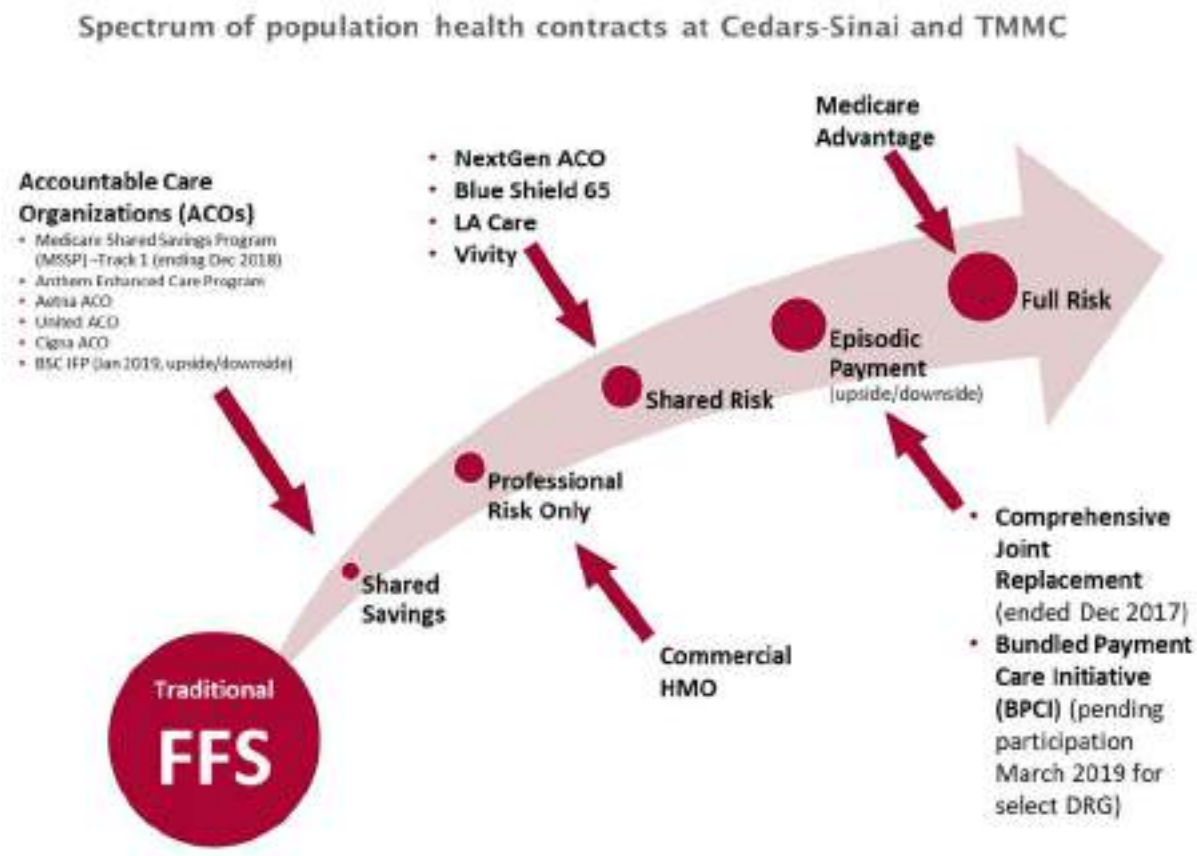
CSHS members collectively have decades of experience in value-based care and risk-based payment models. We continue to pursue an agenda of collaboration with payers, purchasers, patients, and suppliers to advance the objective of healthcare's quadruple aim.

Our collective experience with value-based payment models range from fully capitated risk, partial risk for professional services, shared risk models with fee-for-service commercial payers to bundled payments for episodes of care. CSHS members also have experience working through a variety of payer segments on value-based care initiatives including, Medicare, Medicare Advantage, Commercial Group, and Individual market segments.

ILLUSTRATIVE CSHS VBC ACHIEVEMENTS

- Cedars-Sinai has enhanced patient safety by decreasing hospital-acquired complications. We decreased the rates of methicillin-resistant Staphylococcus aureus (MRSA) infections, catheter-associated urinary tract infections (CAUTI) and Clostridium difficile (C. difficile). As a result, Cedars-Sinai received over **$1M in incentive payments and averted approximately $5M in penalties from CMS**.
- Cedars-Sinai received an Increased Health Outcomes score due to substantial improvements in healthcare-associated infections (HAIs). As a result, Cedars-Sinai was awarded an additional $**2.2M in incentive payments** from Anthem QHIP.
- TMMC received **$6.4 million in shared savings in 2018** for the past year's performance on its MSSP and NextGen ACOs.
- Cedars-Sinai was recognized by Medicare for the Comprehensive Care for Joint Replacement program (CJR) and received **$892,000 in incentive payments**.

Highly Confidential and Subject to Executed Non-Disclosure Agreement



Value-Based Care Capabilities

Over the years, CSHS members have invested significant resources in developing and maturing the capabilities associated with successful organizations thriving in a value-based care environment. Our value-based care capabilities broadly fall into two categories:

- Capabilities that enable us to take risk
- Capabilities that enable us to manage populations

Value-Based Care Capability Areas	Key Capabilities	Highlights
Care & Utilization Management	■ Data aggregation & exchange ■ Population analytics ■ Comprehensive care coordination ■ Chronic disease management ■ Supportive care ■ Wellness/ Prevention	■ Key processes and tools developed in CS-Link (Epic EHR) to enable care gap management and care coordination for population health management.
Clinical integration	■ IT enablement and support tools ■ Clinical network ■ Overall strategy and governance ■ Clinical quality and best practices	■ Support for pluralistic physician integration models and market-oriented clinical network strategies. ■ Clinical quality capabilities that include our Performance Improvement people resources, evidence-based clinical guidelines, and our quality enablers built both into and around our EHR platform to

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Value-Based Care Capability Areas	Key Capabilities	Highlights
		drive quality across our clinical network.
Patient engagement	■ Patient access ■ Patient experience and customer service	■ The CS-Link mobile app, which gets used over 11K times/day by patients to: ▸ Find a doctor ▸ View their appointments ▸ View test results ▸ View medication orders ▸ Send and receive secure messages ▸ Upload and track self-generated health data ■ 70% of our primary care patients are engaged through CS-Link mobile and web-based platforms.
Financial risk management	■ Cost and utilization analytics ■ Contract negotiation and management ■ Payment integrity ■ Documentation and accurate coding ■ TPA services ■ Financial analytics ■ Cost management	■ Custom analytic solutions, including algorithms and dashboards that enable our case management and revenue cycle teams to manage patient care and financial risks associated with value-based contracts.
Product Design	■ Network design ■ Benefit design ■ Product pricing ■ Marketing and distribution	■ Collaborated with multiple payers on network and product design to support products targeted at specific market segments. ■ Partnered with payers and employers on hospital/facility bundles for specifics services such as orthopedics and spine treatments.
MA specific capabilities	■ Stars optimization ■ Risk coding	■ Experience with multiple full-risk arrangements for MA populations. ■ Developed extensions to Epic and custom analytics to enable Stars optimization and specific care pathways, including welcome visits and annual comprehensive appointments to ensure optimal patient management and appropriate RAF coding.
Practice Transformation	■ Lean expertise to redesign primary care models to create operational and clinical efficiency. ■ Improve physician and staff satisfaction.	■ Primary care practices are team-based and include pharmacists, care managers and social workers in support of value-based care models.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Response to Huntington Questions

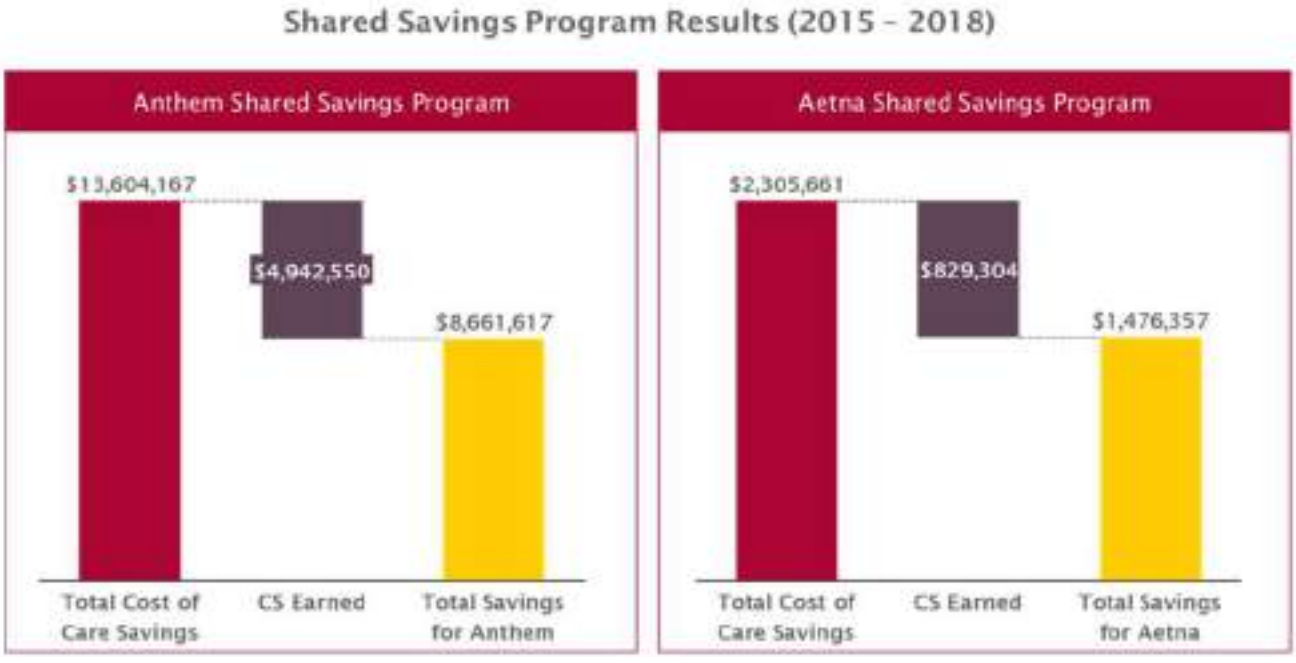
?	Describe your organization's philosophy and experience in transitioning toward value-based healthcare and your organization's infrastructure to support a value-based healthcare business model. Specifically, discuss ■ Your organization's experience with bundled payments, risk-based contracting, ACOs, payor integration, and population health management. ■ Please describe how these models have affected your strategy in the past.

CSHS Value-based Care Philosophy and Experience

CSHS members have a long history of working with payers (both public and private) in the development and evolution of value-based care as a part of our mission to serve our patients and community better and to create affordability and thus access for those needing care. We believe that service to our community means caring for our patients holistically and being accountable for their care, whether within or outside of our facilities. We know this drives the best value in better care, more appropriate care, and the most cost-effective care.

Our experience working with payers has enabled us to understand better their perspective on value requirements for providers, which include a competitive unit price for services, focus on control over the total cost of care for populations, and superior clinical services and quality. We also recognize that many competencies required to achieve these payer value requirements are new to most health systems and venturing into value-based payment models without adequate expertise can be a business risk. CSHS members have been steadily building competencies and have been opportunistic exploring the full spectrum of risk-based contracting and populations health model across payer segments.

CSHS members currently participate in multiple commercial and Medicare accountable care programs, professional risk contracts, shared risk products with payer partners, episodic bundles and full-risk capitation payment models.



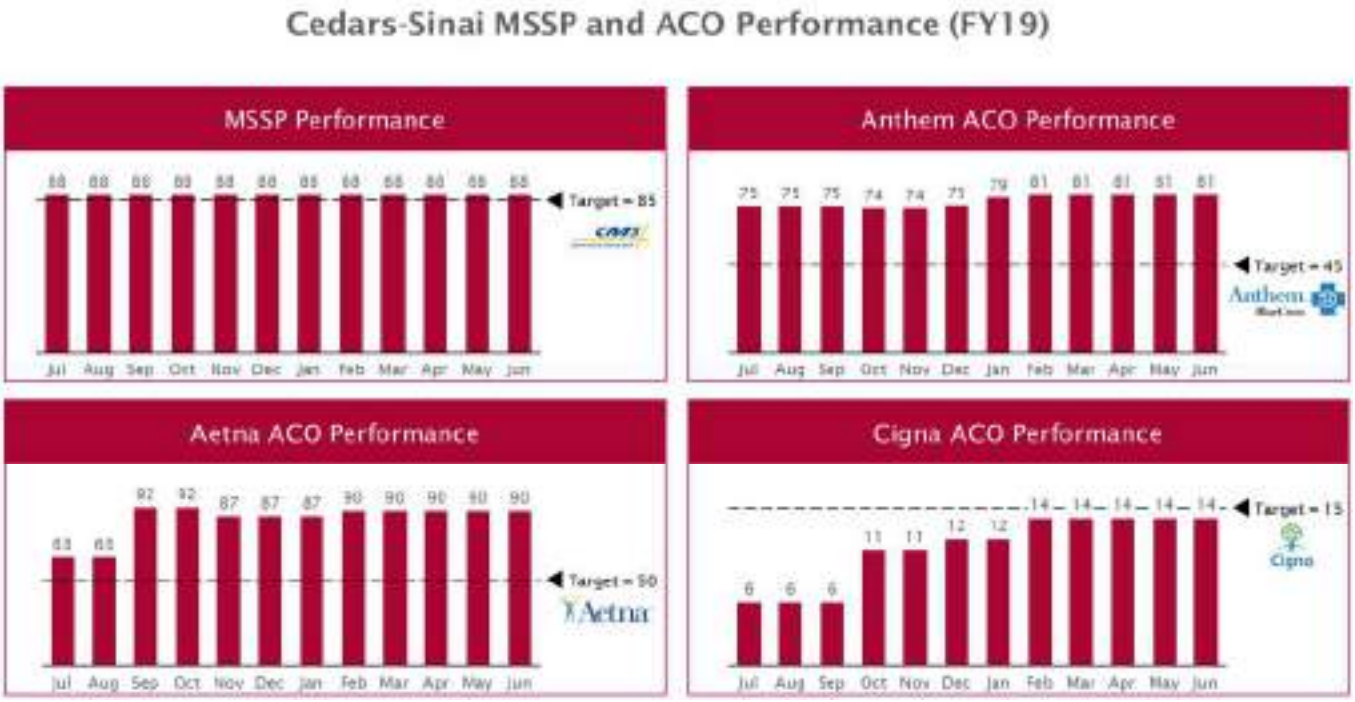
Highly Confidential and Subject to Executed Non-Disclosure Agreement

We are committed to developing our value-based care capabilities for integrating and coordinating care across the patient care continuum. These capabilities allow us to control costs while enhancing outcomes as care continues to move from inpatient to ambulatory and virtual settings.



ACO Quality Performance

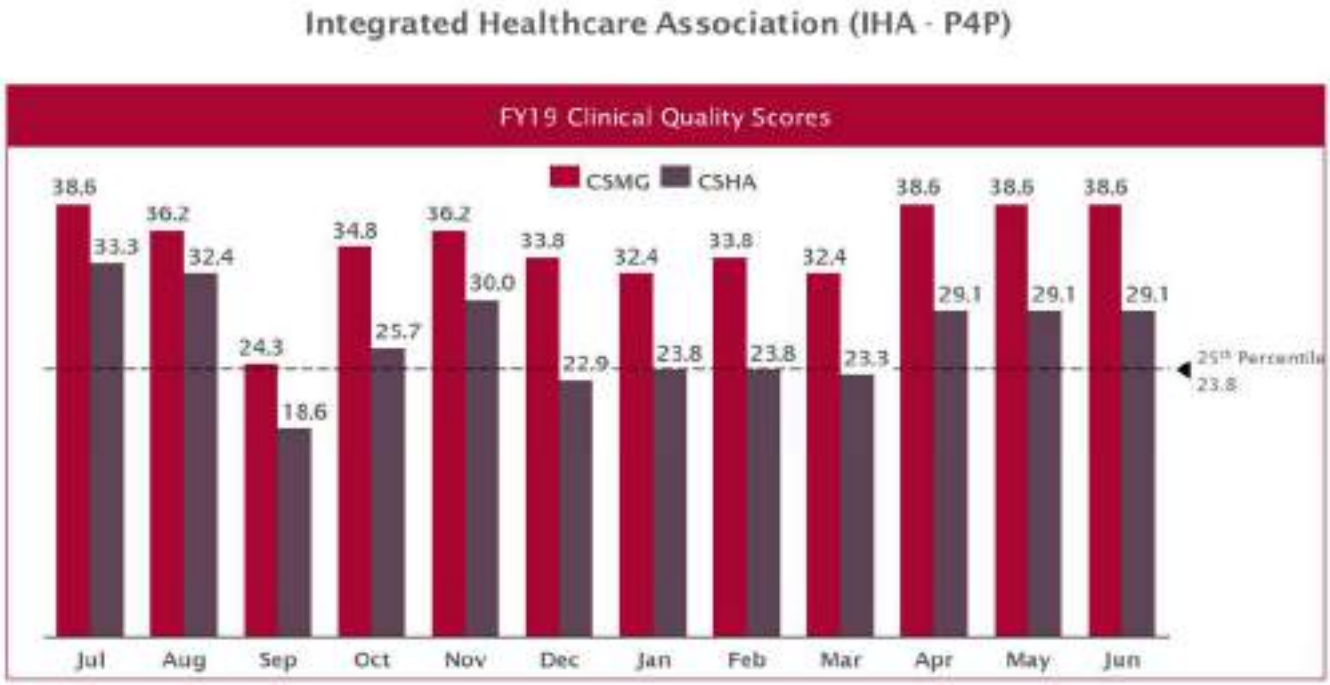
CSHS members have consistently maintained top decile performance across commercial and Medicare ACO quality programs.



Highly Confidential and Subject to Executed Non-Disclosure Agreement

Commercial HMO Performance

CSHS members have consistently maintained top decile performance across commercial HMO program quality scores.



Impact of Value-based Care Market Factors on CSHS Strategy

Our strategic forays into various value-based and risk-based payment models have informed our viewpoint and key levers that are essential to success in the emerging external environment. The following levers have driven, strengthened and made us successful in the value-based care environment and have also impacted our past and current strategies across all patient populations. These shared capabilities can heighten Huntington's success in the value-based environment and improve patient engagement and outcomes, promote continued affordability and continually improve operational efficiencies.

Strategic Levers	CSHS Tactics
Payer / Provider Partnerships	■ Create mutually beneficial partnerships to collaborate on new products and services. ■ Experiment with alternate payment models, including various shared savings and forms of incentive payment models to drive down cost and improve outcomes. ■ Make joint investments in clinical and non-clinical areas that have the potential to create long-term patient and member impact.
Outcome Improvements	■ Develop a common, high-quality, efficient care experience across CSHS, such as: ▸ Preferred clinical pathways and protocols (e.g., cancer treatment pathway implemented in Epic). ▸ Reduction in unnecessary and unwarranted clinical variation across key programs and episodes of care (e.g., standardization of protocols and care protocols resulting in reduced readmissions, reduced bed days/1,000 and lower mortality rates).

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Strategic Levers	CSHS Tactics
Operational Improvements	■ Identify and implement clinical and operational efficiency improvement opportunities, including standardization of certain physician preference items, and care protocols reducing LOS. ■ Develop process and structures to address long-term improvements, including tracking and monitoring of improved performance.
Population Health	■ Develop capabilities to support taking care of populations: from healthy to those with acute episode and those with chronic condition(s). ■ Create a network of assets, partnerships, and IT/digital capabilities to engage patients across the continuum of care with the ability to text physician offices, have virtual visits and access resources and results via a portal. ■ Partner with local community organizations, area businesses, and public service units to offer health screenings, disease-based support groups, and various wellness programs to engage patients in their health beyond traditional care settings.
Ambulatory Expansion	■ Determine high-priority markets for ambulatory expansion with appropriate footprint and clinical capabilities. ■ Identify potential partner relationships (e.g., employers) to support execution of an ambulatory growth strategy. ■ Identify consumer-centered care models and services to be offered at geographically distributed care sites (e.g., imaging, labs, etc.)
Care Model Innovation	■ Plan for ongoing care model innovation, including the shift to outpatient settings and capture opportunities to be a market leader (e.g., Surgery transition from HOPD to ASC).
Virtual Services	■ Develop and deploy digital front door capabilities to enable new channels to access, engage and create affinity with patients.



Please describe how your organization would further Huntington's infrastructure and capabilities as it relates to the transition to value-based accountable care in the region.

As part of the partnership, CSHS will bring the following infrastructure, capabilities and strategic levers to enable Huntington to become a leader in value-based care across its communities:

Value-Based Care Capability Areas and Strategic Levers	Virtual	Inpatient	Ambulatory	Step-down / Post-Acute Care
Care & Utilization Management	✓	✓	✓	✓
Clinical integration	✓	✓	✓	✓
Patient engagement	✓	✓	✓	✓
Financial risk management	✓	✓	✓	✓
Product Design	✓	✓	✓	
MA specific capabilities	✓	✓	✓	✓
Care Model Innovation	✓	✓	✓	✓
Ambulatory Expansion	✓		✓	
Population Health	✓	✓	✓	✓
Operational and Outcome Improvements	✓	✓	✓	✓

Highly Confidential and Subject to Executed Non-Disclosure Agreement

11 Physician Alignment

Huntington's Current State and Requirements

- Huntington operates a pluralistic physician model with strong relationship with its community physicians; currently, there are over 900 physicians on the medical staff across 64 specialties.
- Huntington Medical Foundation has multiple PSAs and affiliations with physicians and groups, totaling over 78 physicians and advanced practice providers.
- Huntington has a partnership with HealthCare Partners (HCP) as the exclusive primary care physician provider for a subset of HMO and MA contracts across multiple payers. Also, Huntington has strategic PSAs with USC and City of Hope for specialty clinical programs.
- Huntington is seeking to expand its physician network through its Foundation to enable it to seek revenue diversification opportunities in PPO, Medicare Advantage, and direct-to-employer segments not covered by the HCP exclusivity.
- In the near term, Huntington is interested in growing its physician network using multiple approaches including the acquisition of primary care and specialty care practices; offering an IPA model for physician alignment with EHR capabilities; and MSO service options; and recruiting physicians under its existing foundation employment model.
- Huntington is open to partnership options that will efficiently advance its network development objectives, including integrating the Huntington Foundation with another CSHS foundation to leverage available capabilities.

CSHS Partnership Guiding Principles in Support of Huntington's Requirements

CSHS is committed to supporting Huntington develop pluralistic physician alignment models and sharing CSHS physician management services capabilities to create a vibrant physician ecosystem. CSHS is also committed to working with Huntington's board and management team to co-develop a physician network development strategy and plan and support its implementation with any structural alignment with existing CSHS member physician network expansion and physician recruitment capabilities.

The following are some additional principles we will use to work with you as we co-develop your physician network strategy and plan:

- **Locally manage and enhance the strong relationship with community physicians.** The CSHS affiliation structure, governance philosophy and history offer autonomy to locally nurture and enhance relationships with community physicians. Huntington would remain the "face" of any network strategy.
- **Grow Huntington's physician and ambulatory care network with additional alignment options.** CSHS will support Huntington's local physician network growth requirements by developing and offering additional physician alignment options, including foundation employment models, IPA alignment models, MSO offerings and ambulatory EHR services.
- **Create access to CSHS capabilities.** CSHS will leverage the collective capabilities and scale to support Huntington to develop an ambulatory EHR solution that is integrated with a competitive MSO offering (refer to Appendix 4 for details) to create a strong value proposition for individual physicians and groups looking to align with Huntington.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

- **Co-developing strategy for existing Huntington physician services partnerships.** CSHS is committed to supporting local partnerships and relationships, including local management and governance of those relationships.

Overview of CSHS Physician Alignment Capabilities

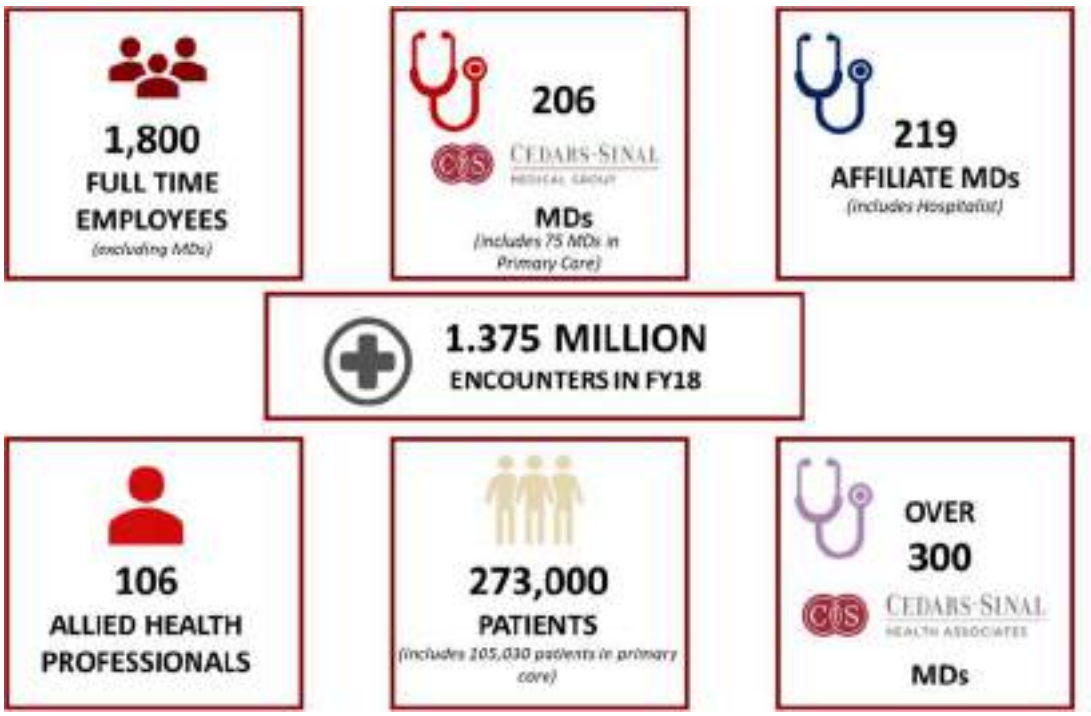
Cedars-Sinai and Torrance Memorial have each deeply invested in physician relations, practice management, and network development for over 25 years and both bring a strong, collaborative, and physician-centric perspective to the changing demands of our healthcare environment. Knowing that expanding the network will require different approaches that consider the specific needs and desires of the physicians in the community, we can help by providing a targeted, yet multi-faceted physician alignment platform including the possibility of a partnership with Cedars-Sinai Medical Care Foundation.

Cedars-Sinai Medical Care Foundation (CSMCF)

CSMCF has developed a medical practice model that is intended to support physicians in their efforts to achieve the highest levels of patient satisfaction and quality.

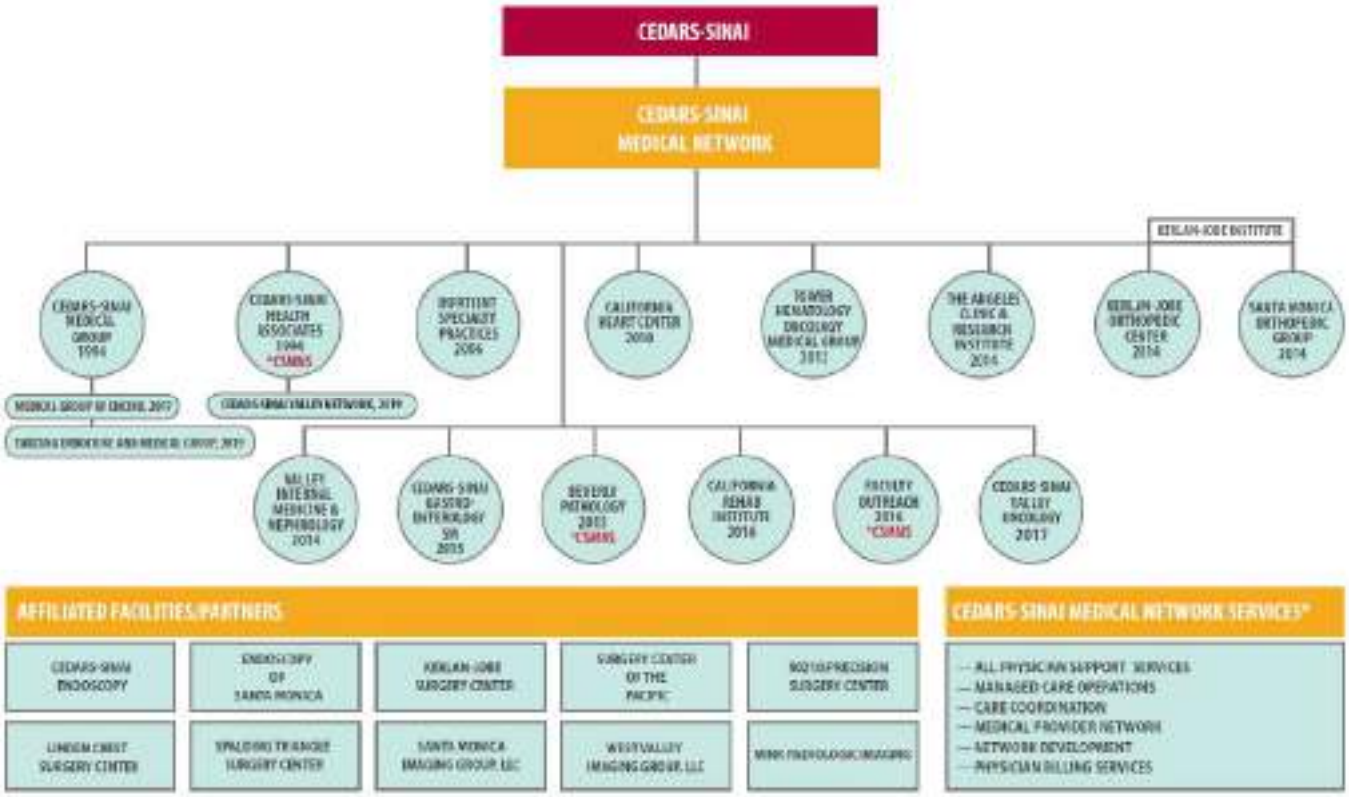
The planning and implementation of new models of care have been informed by both physician and administrative perspectives. Through our foundation model, we have struck a balance between offering physicians various options to achieve their individual practice goals while standardizing to achieve best practice and economies of scale. This model facilitates physicians' desire to serve as leaders of change and provides an effective "laboratory" to explore new models of care. CSMCF offers multiple employment and other models for physicians and allied health professional.

Overview of CSMCF

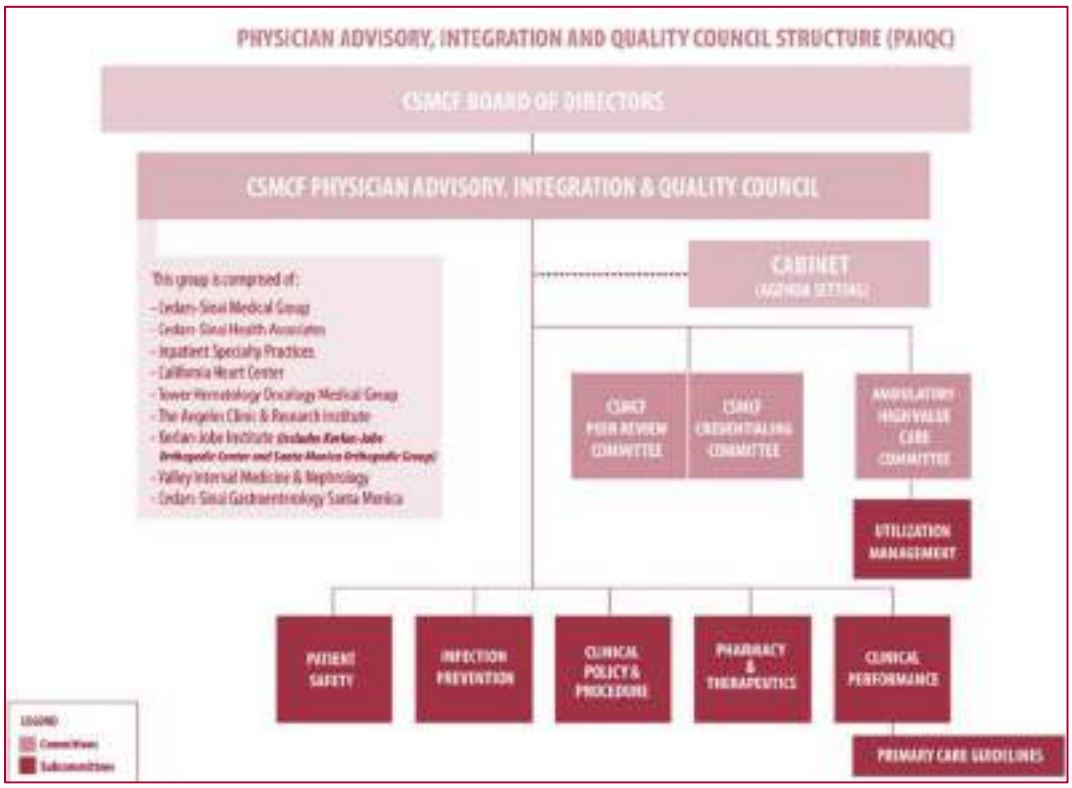


Highly Confidential and Subject to Executed Non-Disclosure Agreement

CSMCF Growth Journey and Services Capabilities



Physician Engagement in CSMCF Governance

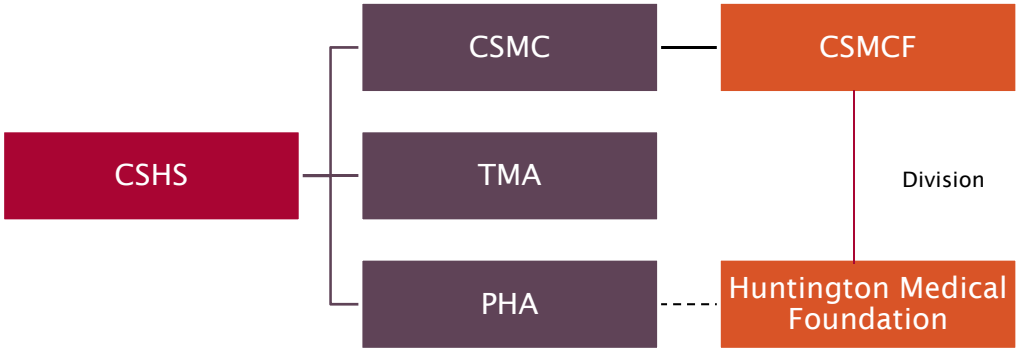


Highly Confidential and Subject to Executed Non-Disclosure Agreement

Response to Huntington Questions

Our Structural Option for The Huntington Medical Foundation

One option that can be explored to quickly accomplish the growth and capability objectives identified in Huntington's requirements, is to make Huntington Medical Foundation a division of Cedars-Sinai Medical Care Foundation (CSMCF). This arrangement will allow CSHS to more readily extend resources needed to grow the physicians within Huntington's Foundation, allow immediate access to infrastructure and create access to shared capabilities between the CSMCF and Huntington Medical Foundation. The foundation division model will allow for local autonomy and control.



?	Please describe how a relationship with your organization would impact Huntington's existing relationships with its community and foundation physicians.

Impact on Existing Physician Relationships

Huntington's relationship with CSHS **should not affect** any existing community and foundation physician relationships. The CSHS affiliation structure and governance philosophy offer autonomy to nurture and enhance local relationships with the physician community, even if the Huntington Foundation becomes a division of CSMCF. The management of all medical staff relationships will continue to be managed locally using existing models and structures. CSHS will not require any changes to existing medical staff management and relationship structures.

Relationship Benefits for Physician Community

The main purpose of CSHS is **to support** its partner hospitals and their affiliates in delivering high-quality care to its patients and serving the community. We think Huntington's physician community can benefit from the CSHS relationship in the following ways:

- **Address local specialty care access gaps.** CSHS will with work with Huntington management and its community physicians to understand unmet specialty care access needs. CSHS will be able to leverage its relationships, reputation, breadth, and depth of capabilities across the system to address those unmet specialty care needs in a timely manner. CSHS focus will also be to work with the local physician community to keep a vast majority of the clinical care local in the San Gabriel Valley.
- **EHR and Population Health Management Tools.** CSHS is committed to supporting Huntington implement Epic to replace the current Cerner and Allscripts EHR platforms across inpatient and ambulatory settings. CSHS will provide Huntington access to various configurations and tools developed

Highly Confidential and Subject to Executed Non-Disclosure Agreement

in partnership with the physician community at CSMC that could be of value to the Huntington physician community. CSHS will also collaborate with the Huntington physician community to create access to any additional tools that may support their strategic objectives.

- **IPA and MSO Infrastructure.** CSHS will also support Huntington expand its foundation by creating access to various MSO capabilities available through the CSMCF (refer to Appendix 4 for details). These IPA and MSO capabilities should offer physicians in the community an opportunity to remain independent, and gain access to cost-efficient back-office services, care management services, and various patient and business analytics tools.
- **Other CSHS Resources.** Huntington's partnership with CSHS will also create access to various system resources to Huntington's physician communities such as:
  - Epic for Physician Offices
  - CME Resources
  - Access to Grand Rounds either provided by CSMC faculty at Huntington or at CSMC
  - Group Purchasing resources
  - Liability Insurance
  - Revenue cycle and payment integrity programs

	Please discuss your approach to the recruitment of new physicians to the community and the growth of Huntington's foundation.

CSHS is committed to supporting Huntington to grow its foundation and create a robust ambulatory network in support of the hospital's overall growth strategy. Based on our understanding of Huntington's needs, we offer the following in support of Huntington's foundation:

- **Growing Primary Care Network.** This includes adding new employed physicians as well as increasing the affiliated physicians through IPA models. This strategy will enable Huntington to pursue niche contracting opportunities not covered by HCP's exclusivity.
- **Growing Specialty Care Network.** This includes recruiting new physicians and groups under an employment model, other clinically integrated network alignment models or through IPA models as needed. The focus of this strategy will be to create access to specialty services to all the community primary care physicians including HCP primary care providers.
- **Expand Alignment Offerings.** CSHS will be able to offer physician alignment models and service offerings, such as an IPA model, MSO offerings, and EHR services.
- **Leveraging CSHS and Huntington's Teaching Programs and Relationship to Support Recruitment.** CSHS will leverage all its residency and fellowship programs and the broad national relationships of our faculty to recruit specialty physicians to Huntington's market based on needs and gaps. In addition, CSHS will help develop a plan with Huntington to retain its physician residents (in the Huntington network or as community providers).

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Example: CSHS support for TMMC's Foundation

When CSMC and TMMC affiliated, there was a thoughtful yet expedited planning process to jointly develop a physician recruitment strategy for TMMC's foundation. Together CSMC and TMMC identified where the local community needed access to services, both primary and specialty care. Using the combined financial strength as well as recruitment network, CSHS developed a plan and an implementation approach to recruit over 40 primary and specialty care physicians over the next five years to fulfill unmet needs and plan for retirements in the communities served by CSHS.

Please describe the resources you would bring to a partnership to support the development of a full-service MSO and offer competitive employment and quasi-employment options to our medical community.

- We understand that in the near-term, Huntington is interested in growing its physician network through:
  - Acquisition of a few small and mid-sized primary care and specialty care practices.
  - Expanding the IPA model for physician alignment with EHR and MSO service options.
  - Expanding primary care physician access using its foundation model.

Expanding the network will require different approaches that consider the specific needs and desires of the physicians in the community, CSHS can help by providing a targeted, yet multi-faceted physician alignment platform. This platform will create a cohesive relationship between Huntington and physicians by:

- Contracting for value-based payment models where HCP is not exclusive and ensure success with those models by building on a solid population health infrastructure.
- Offering employment models, an IPA-model, and other models.
- Creating access to various management services capabilities available at CSMCF.
- Offering Epic Ambulatory EHR to the community physicians using CSMC's CS-Link community partnership program

Various MSO capabilities available to Huntington Foundation include:

Medical Group Administration Services (refer to Appendix 4 for details)

Medical Group Administration Services	Available to Huntington
Health Plan and Provider Contracting	✓
ACO contracting	✓
Credentialing	✓
Group Purchasing	✓
Billing and Collection	✓
Financial Services	✓

Highly Confidential and Subject to Executed Non-Disclosure Agreement

IPA Administration Services

IPA Administration Services	Available to Huntington
Claims Processing	✓
Enrollment	✓
Benefits	✓
Physician Capitation	✓
Clinical Analytics and Business Intelligence	✓

Clinical Utilization Management and Care Coordination Services

Clinical Management and Care Coordination Services	Available to Huntington
Referral Management	✓
Case Management	✓
Quality Management	✓

CS-Link Physician Office Edition

CS Medical Network also offers our Epic EHR to community physicians participating in various affiliation arrangements. CSHS will help Huntington create a similar offering for its IPA model aligned physicians. This will enable Huntington's Foundation to create affinity with its physician community and enable the foundation to participate in various value-based care initiatives.



BENEFITS OF CS-LINK™

You are now joining in a partnership with Cedars-Sinai. You will have the ability to share and access patient information from Cedar-Sinai's Clinical Data Repository.

- Easy to use documentation templates – You can take advantage of templates that have been built for dozens of specialties and physicians that have been in use for many years. The templates can be used whenever you need to create patient documentation.
- Private secure data – Your office can share clinical data safely through CS-Link® architecture, since end user access by role (e.g. nurse, medical assistant, physician, etc.) is managed by security policies and procedures. Advanced security functions are in place to protect sensitive information and to comply with HIPAA.
- Quick access to data – You can have seamless access across the Cedars' care continuum: outpatient, inpatient, and emergent. CS-Link® enables access whether you are in the office, home, or working in the hospital; thereby saving time, increasing productivity, and facilitating physician efficiency.
- Patient safety – You can take advantage of CS-Link® drug-drug and drug-allergy interaction checking at the time of medication ordering, as well as electronic medication prescribing directly to pharmacies thereby reducing medication errors.
- Meaningful Use® – You will receive the CS-Link® tools necessary to satisfy Meaningful Use requirements qualifying your office to attest for those initiatives.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

12 Clinical Services

Our Understanding of Huntington's Current State and Requirements

- Huntington seeks a partner that will enable it to continue to offer a comprehensive array of clinical services.
- Huntington operates the only Level II Trauma center in the San Gabriel Valley and a Level III pediatric intensive care unit.
- Huntington is designated as the Preferred Tertiary Provider for HCP's Greater San Gabriel Valley communities.
- Huntington is interested in expanding the specialty and sub-specialty services available in the acute setting and further developing its ambulatory presence to support providing care in the most appropriate setting.

CSHS Partnership Guiding Principles in Support of Huntington's Requirements

CSHS is committed to supporting Huntington with developing and maintaining a comprehensive array of clinical services to address the needs of the San Gabriel Valley communities. CSHS is also committed to supporting and enhancing existing strategic clinical partnerships and physician relationships in the community. At the same time, CSHS will seek to increase access at Huntington to some of the nationally ranked service lines at CSMC.

Our strategies include:

- **Keep vast majority of care local and minimize disruptions to existing relationships.** CSHS, in collaboration with community physicians, will help create access to specialized services based on gaps in care, while keeping the majority of care local.
- **Commitment to the highest clinical quality across the system.** CSHS is committed to maintaining the highest quality of care across the system. CSHS will continue to make strategic investments in people, processes, and technologies that can advance the quality of clinical care across acute care, ambulatory care, and other post-acute care settings.
- **Drive clinical transformation to impact cost and access needs.** CSHS is committed to working with our community physicians to advance clinical transformation across the system to improve reliability, reduce cost, and increase access.
- **Proactive orientation towards outpatient shift trends.** CSHS is committed to proactively developing clinically-appropriate opportunities to shift care from hospital-based settings to ambulatory settings. CSHS will support Huntington evaluate and invest in outpatient shift opportunities and develop strategies for managing the transition, working with community physicians and payers.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

CSHS Clinical Capabilities

CSMC has 12 nationally ranked clinical specialties. CSMC is committed to working with Huntington to create access to various clinical specialties based on the needs of the community.

Cedars-Sinai Specialty	US News World Report National Ranking: 2019
Cancer	12
Cardiology & Heart Surgery	3
Diabetes & Endocrinology	16
Ear, Nose, and Throat	38
Gastrointestinal Disorders	2
Geriatrics	12
Gynecology	8
Nephrology / Kidney Disorders	10
Neurology & Neurosurgery	12
Orthopedics	3
Pulmonology	4
Urology	12

Response to Huntington Questions

Huntington has a long history of being deliberate in its development of services to meet the needs of the community. Please describe how your proposed partnership will:

- Ensure that the community continues receiving the highest quality care in the most appropriate setting.

CSHS is committed to continuing to maintain and enhance access to services that the community is currently receiving from Huntington. CSHS is also committed to working with Huntington and its physicians to understand potential access gaps and to address those gaps. CSHS will work with Huntington, as needed, to enhance its ambulatory network, including enhancing access to specialists and other outpatient care capabilities such as outpatient imaging, endoscopy, ambulatory surgery, etc. CSHS will support the growth of programs and facilities throughout the entire continuum of care to ensure patients have access to high-quality care in the most appropriate setting.

- Maintain and grow key Huntington key service lines and capabilities, including but not limited to trauma, heart and vascular and oncology.

CSHS is committed to maintaining and growing all of Huntington's key service line capabilities. In the areas identified by Huntington, CSMC has nationally recognized capabilities:

- CSMC is a Level 1 trauma center and has deep expertise in running a highly effective trauma service in support of its communities.
- The CSMC Cardiology and Heart surgery program is nationally ranked at #3 and performs the highest volume of heart transplants in the world.
- The CSMC cancer program is ranked nationally at #12 and continues to be a focus for investment across the health system.

CSHS understands and respects the existing partnership that Huntington has in areas such as Trauma, Oncology, and Heart and Vascular. CSHS will work with Huntington, and as needed, bring new capabilities to its communities collaborating with existing partners and enhancing the services.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

- Provide linkages between Huntington and other healthcare providers, within your organization or otherwise, to continue or enhance access to appropriate tertiary and quaternary care.

CSHS will create linkages between Huntington's physician community and tertiary/quaternary capabilities at CSMC using the following tactics:

- CSMC Specialist Rotations. Based on input from Huntington and its physicians, CSMC will support rotations of CSMC faculty in the local community to enhance access to these sub-specialties. This tactic will be most appropriate for highly specialized care and when demand does not justify a dedicated physician to be based in the community. The objective will be to continue to keep the majority of the care local.
- Recruit Specialist to Local Community. Based on input from Huntington and its physicians, CSHS will help recruit specialists to be based in the Huntington community through either our faculty or one of the medical foundations. This tactic will be most appropriate when there is significant demand and limited access to care in the local community, requiring a dedicated local presence.

With these tactics, CSHS will strive to develop local physician community relationships and enable patients to receive the vast majority of their care locally, and only other system sites of care for high-acuity tertiary or quaternary care (e.g., transplants).

Example: CSHS support for TMMC's Comprehensive Stroke Designation

TMMC was the first hospital in Torrance to receive the Joint Commission's Certificate of Distinction as a Primary Stroke Center. Even before the affiliation, Cedars-Sinai and TMMC had a relationship for offering Telestroke consults. To advance the clinical program it was a priority to achieve Comprehensive Stroke Center (CSC) designation. With the CSHS affiliation, Cedars-Sinai and TMMC worked together to reach this goal.

Cedars-Sinai and TMMC share a Medical Director for Stroke Programs. The Medical Director serves as the clinical leader for developing and implementing policies and procedures for treating stroke patients. Protocols are leveraged across Medical Centers and clinical teams from both organizations convene to discuss care improvements and monitor quality outcomes.

A key element of CSC is having neuroendovascular capabilities. Cedars-Sinai and TMMC jointly recruited a neuroendovascular surgeon to be based at TMMC. Cedars-Sinai faculty neuroendovascular surgeons provide coverage to ensure there is a surgeon available 24 hours per day, 7 days per week for patients' needs.

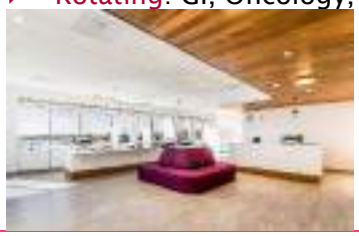
From a training perspective, physicians and staff from both organizations EDs, ICUs, Neuro and Interventional Radiology Labs collaborate. The staff from TMMC observe and learn onsite at Cedars-Sinai and staff from Cedars-Sinai spend time at Torrance to provide real-time training, competency assessments and as necessary, consult on complex cases.

Affiliating has allowed a greater degree of clinical collaboration and has created scale that has resulted in enhancing care for patients in the South Bay.

- Enable Huntington to continue its commitment to providing the very highest quality care to its communities at an affordable cost, with a focus on the development of an ambulatory care network. How is this strategy aligned with your own goals? Can you please provide examples of initiatives you have in place in furtherance of these goals?

CSHS understands the importance of a robust ambulatory network to serve the needs of the community and to support the hospital. In every CSHS community, we've invested in several ambulatory capabilities to serve the needs of the community. The following are some examples of our initiatives:

Highly Confidential and Subject to Executed Non-Disclosure Agreement

CSHS Community	Key Ambulatory Network Capabilities
Santa Monica	■ Developed new ambulatory clinic at 1919 Santa Monica Blvd. ■ Specialty presence include: ▸ Neurology, ENT, Cardiology, OBGYN (Faculty), Internal Medicine, Gastroenterology, Surgical Oncology and Medical Oncology.  
West Los Angeles	■ Developed new ambulatory clinic at 11800 Wilshire Blvd. ■ Specialty presence include: ▸ Surg/Med Onc, Pharm, Inf, MRI, Dexa, Hot Lab, Research, PET-CT, SPEC-CT, IR, Lab, Retail Pharmacy.  
Marina Del Rey	■ Developed new ambulatory clinic at 4676 Admiralty Way. ■ Specialty presence include: ▸ Permanent: Cardiology, Urology, ENT, Neurology and Internal Medicine ▸ Rotating: GI, Oncology, Peripheral Vascular, KJI and, others as identified  
Tarzana	■ Developed new ambulatory clinic at 18133 Ventura Blvd. ■ Specialty presence include: ▸ Permanent: Imaging Center JV with RadNet, Radiation Oncology, Surgical Oncology (Breast), Medical Oncology, Internal Medicine and Orthopedics ▸ Rotating: Thoracic Surgery, GynOnc, Hepatobiliary, Bladder Cancer, Head and Neck Cancer  

Highly Confidential and Subject to Executed Non-Disclosure Agreement

13 Impact on Existing Relationships

Our Understanding of Huntington's Current State and Requirements

- Huntington has numerous strategic relationships that are of critical importance to clinical operations and financial performance.

CSHS Partnership Guiding Principles in Support of Huntington's Requirements

As part of the partnership, CSHS will work with Huntington to manage existing relationship based on the following guiding principles:

- **Support enhancing existing relationships with new capabilities.** CSHS understands and appreciates existing strategic relationship. CSHS's objective is to bolster and enhance, resulting in improved quality and access for patients in the San Gabriel Valley. CSHS would seek to develop a future plan that meets Huntington's aspirations to serve its community.
- **Enable Huntington's partnership strategy.** When Huntington has interest in developing strategic alternatives for any existing relationships, CSHS will help with partnership transition and assist in the development of glide paths to ensure no disruption in service and/or adverse financial impact.

Response to Huntington Questions



- Please describe your approach to and perceived impact of a partnership on existing relationships, including the following:
  - Huntington has built a strong, innovative relationship with DaVita Healthcare Partners, now part of OptumCare. This relationship, as currently configured, is a major source of both revenue and profit to Huntington. Would you seek to maintain this relationship? If not, how would you propose to address Huntington's strategic need for a primary care physician network?

Joining CSHS should not disrupt Huntington's existing relationships with HCP. Huntington can continue to work with HCP as their preferred tertiary care partner in the San Gabriel Valley.

- **Our experience with maintaining HCP relationship.** CSHS partner organizations have long-standing, positive relationships with HCP. As an example, HCP represents approximately 20% of Torrance Memorial's payer mix. The relationship between THA and HCP has not been negatively impacted by the affiliation with CSHS.

Based on the information provided in the IOI, we understand that Huntington is interested in expanding its physician network, both primary and specialty care, in the San Gabriel Valley. CSHS is committed to supporting Huntington's physician network development objectives.



- Please describe your approach to and perceived impact of a partnership on existing relationships, including the following:
  - Huntington enjoys a solid clinical and academic relationship with Keck Medicine of USC, particularly with respect to the cardiac and maternal fetal medicine programs. These relationships represent a strong financial contribution to Huntington. What impact, if any, do you anticipate an affiliation between our organizations would have on our relationship with Keck Medicine of USC and the USC School of Medicine? How do you propose addressing any such impact?

Highly Confidential and Subject to Executed Non-Disclosure Agreement

	▸ Huntington also enjoys a robust clinical relationship with City of Hope on our oncology program. What impact, if any, do you anticipate an affiliation between our organizations would have on our relationship with City of Hope? How do you propose addressing any such impact?

Although Cedars-Sinai can likely offer similar services provided by USC and City of Hope, we do not recommend any immediate changes. Cedars-Sinai hopes to develop a relationship with Huntington over time would encourage being considered as Huntington's longer-term specialty care partner. We understand that there needs to be an appropriate glide path to that type of relationship, and a transition which includes understanding Huntington's specific needs and developing trust that Cedars-Sinai can exceed the service that is currently being provided. We also recognize the need for a transition strategy to mitigate any disruption of services or adverse financial consequences.

With all the above stated, in the event Huntington joins CSHS and this unexpectedly results in any of your existing partners terminating their relationship, we will be prepared with contingency plans to a) provide the services that they currently provide, and/or b) support a transition strategy to mitigate any adverse financial consequences.



Example of CSHS support for TMMC Heart Program

When TMMC affiliated with CSHS, TMMC had a strong cardiovascular program in place. At the time, Torrance Memorial had a relationship with the Cedars-Sinai Heart Failure team to provide professional services for a heart failure clinic at TMMC. For its cardiovascular surgery program, TMMC contracted with another academic medical center for the professional services of one cardiac surgeon to supplement the coverage of the onsite cardiac surgeon in the community.

When, due to unforeseen circumstances, the contracted cardiac surgeon left for a position at another academic medical center, the faculty physicians in the Department of Cardiac Surgery at Cedars-Sinai stepped in within weeks to provide coverage for both inpatient and ambulatory services at TMMC. In time, CSMC was able to recruit the replacement of a full-time cardiac surgeon at TMMC who starts in the coming months.

This situation is an excellent example of the support CSMC was able to provide TMMC when asked to help provide a critically important service on very short notice.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

14 Culture and Employees

Our Understanding of Huntington's Current State and Requirements

- Huntington has a strategic priority to focus on people and promote an engaged workforce committed to excellence that champions high-quality healthcare. Initiatives are underway to enhance employee engagement and develop leadership.
- Huntington is in the process of implementing Workday for talent management.
- Huntington still wants to preserve its unique culture and its relationships with its staff, physicians and community

CSHS Partnership Guiding Principles in Support of Huntington's Requirements

- **Our people are responsible for our success.** CSHS and Huntington share the philosophy that fully engaged employees, Medical Staff and volunteers are required to deliver excellence in quality and outstanding patient satisfaction. We are committed to partnering with Huntington to advance the people agenda of our shared vision.
- **Local talent and culture management.** With the affiliation, talent management, culture advancement, and operations will continue to remain local as they are today.

Overview of CSHS People Capabilities

- CSHS aims to provide a strong foundation of operational efficiency and enhanced service, recognizing that our employees are critical to our success.
- CSHS members' cultures contribute to our market differentiation. CSHS members have shared values and patient-centric cultures yet each organization has its own culture. Our members leverage strengths from each other and collaborate only where it can improve results for all involved.
- For four (4) consecutive years in a row, CSMC has been awarded the Workplace of the Year Award from The Advisory Board (2016, 2017, 2018) and Press Ganey (2019). The Workplace of the Year recognizes health systems which have achieved the highest levels of employee engagement compared to other health systems in the country.
- A metric of engagement is employee giving; in 2019, more than $2.6 million was raised from nearly 5,000 employees, representing 19% of staff (significantly higher than the national average of 2-4%) at Cedars-Sinai.
- The scale of the system creates expanded opportunities for our employees – there is the ability to share talent across the system to allow professional development of our staff, provide career stimulation by solving complicated problems resulting in increased retention making our system better.

Response to Huntington Questions

	Describe your organization's employee base, human resources infrastructure, and employee environment. Please include tangible examples of employee satisfaction, training and development opportunities, physician engagement, experience operating a highly efficient organization, and tools used to manage productivity.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Our employees are responsible for our success. It is a strategic priority to maintain a highly engaged workplace and our partner organizations have been recognized by Press Gainey for this achievement.

Patient experience and satisfaction aren't based solely on diagnosis and treatment. It includes every interaction with doctors, nurses, volunteers, and support staff, from the moment a patient calls to schedule an appointment, through the completion of patient care and the follow-up during recovery. High employee satisfaction is correlated with high patient experience. CSHS members have unique cultures, yet we evaluate employee engagement efforts and leverage those across the entire system to improve the patient experience.

Talent Management and Development Infrastructure

From an infrastructure perspective, there have been many enhancements made over the last three (3) years to support the growth of CSHS and specifically professional growth and satisfaction for our employees. CSHS members have access to an HR platform if they chose. The platform is used by Cedars-Sinai and although it is fully functional, it is still in its early stages so can be enhanced as needed to help support Huntington's needs and/or fill any local gaps that may exist.

The HR strategy is built on a foundation of operational efficiency and enhanced service. This underpinning allows the HR department to efficiently offer a greater volume of transactions with a higher level of service. The infrastructure encompasses an HR Service Center, Cloud-based technology, and harmonized policies. The HR Service Center, which is staffed by Cedars-Sinai employees, is best in class as measured by volumes and employee satisfaction. The Center receives approximately 200 calls/day, reducing the number of transactions previously dealt with by management or the HR vendor partner.

Cloud-based technology is enabled throughout the HR process. Technology is used for onboarding, which expedites the process from hire to start, eliminates unnecessary hardcopy paperwork and allows for virtual interactions. In addition, personnel files have been digitized allowing easy access to information and supplements the HR Service Center.

Policies are continuously evaluated to ensure that they support the needs of the organization. Each partner organization has its own HR policies. As an example, the vacation policies vary within and across partner organizations – Cedars-Sinai Medical Center, Cedars-Sinai Marina del Rey, Cedars-Sinai faculty and Medical Network physicians and TMMC. As we mature, member organizations will evaluate if and where it makes sense to standardize policies across the System. Although we do not anticipate standardizing benefits across the system, we have started evaluating where there are opportunities to leverage the purchasing of benefits together.

The structure is intended to facilitate talent mobility and employee professional development, allowing our people to deliver their best.

Training and Development – Physicians and Employees

CSHS has identified the below priority areas:

- Developing leaders;
- Developing physicians;
- Developing nurses;
- Developing IT professionals.

A strategy has been developed to build or enhance these capabilities.

Employees of partner organization have benefitted not just from the clinical and financial strength but also from the increased access to resources. Specifically, employees have access to more training. The Geri and Richard Brawerman Nursing Institute, created in 2002 to address the increasing demand for specialty

Highly Confidential and Subject to Executed Non-Disclosure Agreement

nurses, continues its commitment to quality education and opportunities for CSHS's nursing workforce. Annually, the institute provides clinical training for over 800 undergraduate and graduate nurses. Additionally, the institute offers more than 100 continuing education courses annually while providing preceptor experiences and clinical rotations every year for students from more than 20 affiliate nursing schools. These types of resources are available to the entire CSHS.

There are many examples of how CSHS members have worked together to provide real-time training and competency assessments. To provide just a couple: when TMMC expanded its clinical services to include neuroendovascular services physicians and staff from both organizations EDs, ICUs, Neuro and Interventional Radiology Labs came together to ensure all involved had appropriate training; and when TMMC wanted to provide additional training for staff for ECMO, members of the Cedars-Sinai Smidt Heart Institute, offered sessions in the Cedars-Sinai simulation lab for Torrance Memorial ICU nurses.

	Describe how your infrastructure would extend to the employees of Huntington within the context of your proposed structure. As applicable, please provide examples of partnership with organizations similar to Huntington, and any learnings that would apply to a partnership with Huntington.

The HR infrastructure discussed above has been designed to scale and can be offered as a shared service to Huntington. As a specific example, the Service Center can be expanded, and as needed, staff can be located in Pasadena to meet the needs of Huntington's workforce. Since the Center is built on 'knowledge articles,' regardless of call center staff location they can respond to questions for any facility. Creating this as a shared service would create economies of scale.

There are other opportunities for collaboration and partnership to achieve greater efficiency in HR operations, HR administration, and benefits management. HR functions such as personnel record management and compliance may be an opportunity for synergy. Shared services are available and create opportunities for efficiencies or utilization of an organization's best in class functions are readily available to our partner organizations.

	Please describe your commitment to existing Huntington employees (including the management team). For ongoing employees of Huntington, describe your approach to compensation and benefits, including the treatment of Huntington employees post partnership for benefit eligibility and benefit purposes.

Individuals working for Huntington remain employees of Huntington, and there are no required changes to employment status, benefits, etc. Huntington also remains completely and solely responsible for all employment decisions so hiring, firing, reporting relationships do not change with the affiliation and Huntington management continues to be responsible and oversee all staffing decisions.

A key priority for CSHS is the growth and development of our people. Where it makes sense, CSHS is willing to partner with Huntington to leverage our talent and people management programs across the system.

	Please comment on how your proposed structure and partnership experience would minimize disruption to staff, physicians and management.

With the affiliation, management and operations remain as they are today so there should be no disruption or change for staff, physicians or management. At the discretion of Huntington's management, staff may be asked to participate in affiliation efforts, including identifying focus areas and priorities.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

15 Branding

Our Understanding of Huntington's Current State and Requirements

- For over 125 years, Huntington has been the foremost health care provider to the San Gabriel Valley. Huntington has a strong and trusted brand in San Gabriel Valley and broader communities.
- Huntington wants to maintain its brand identity.

CSHS Partnership Guiding Principles in Support of Huntington's Requirements

- **CSHS supports localized brand strategy.** CSHS hospitals have long-standing reputations with solid brand recognition in their local communities and beyond. CSHS is committed to continuing to support local brand strategy.
- **CSHS is not the primary consumer-facing brand for its partners.** The CSHS affiliation serves as a consistent "brand energizer" for an existing, well-established brand, further strengthening and differentiating it from its competition.
- **Leverage CSHS affiliation to amplify partners brand strength.** There are many ways to leverage the affiliation to amplify Huntington's existing strong brand. And, CSHS would seek to develop an approach that meets both member and system goals.

Overview of CSHS Capabilities

CSHS members use a strategic, data-driven approach to marketing and communications. They focus on first understanding the underlying behavioral, economic, geographic and other drivers of the different key stakeholder groups as they relate to healthcare decisions that affect the member's institutional goals. This research is then used to develop and execute compelling marketing and communications initiatives to influence perception and behavior. Lastly, rigorous ongoing evaluation and data review are used to make adjustments in the execution of the initiatives as needed to continually improve the results.

CSHS members can benefit from sharing expertise and experience on a variety of marketing/communications issues, including:

- Digital marketing
- Measuring return on investment from marketing activities
- Consumer research
- Crisis communications
- Social media
- Call center management
- Brand strategy
- Media relations
- Effective communication with a diverse region
- Internal communications

Additionally, CSHS affiliates explore opportunities for collaboration and partnership to achieve greater efficiency. For example, there may be opportunities for some economies of scale by sharing certain back-office capabilities and resources, such as consumer research/polling, CRM (Customer Relationship Management) software licenses, syndicated web content, volume-related printing discounts, etc.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Response to Huntington Questions

	Huntington has built an extremely valuable and trusted brand within its service area. Please describe your approach to branding and marketing with respect to community hospital affiliates. ▸ How might our collective brands and marketing capabilities help further enhance and differentiate our services within the community?

Huntington has a very strong brand and outstanding community reputation, especially throughout the San Gabriel Valley. The affiliation with CSHS would be designed to energize Huntington's existing brand, not to change or replace it. The objective would be to enhance and supplement Huntington's brand to improve visibility, recognition and patient access.

Each CSHS affiliate remains the primary consumer-facing brand in its local communities. In its marketing, each partner organization benefits from the CSHS partnership, which serves as an important differentiator from its competitors. All CSHS affiliates further benefit when CSHS conducts regional, statewide or national marketing efforts or media coverage, as it reinforces the strength of the overall Cedars-Sinai name for all the CSHS affiliates.

As examples of that, Torrance Memorial Medical Center is now known as "Torrance Memorial Medical Center, a Cedars-Sinai affiliate" and Kerlan-Jobe is now known as "Cedars-Sinai Kerlan-Jobe Institute."

Highly Confidential and Subject to Executed Non-Disclosure Agreement

16 Philanthropy

Our Understanding of Huntington's Current State and Requirements

- Huntington has strong community support with impressive philanthropy in excess of $16M per year over the past 15 years, $19M per year over the past five years and $29M in 2018 as part of the ongoing $140M 5-year philanthropic campaign.
- Although Pasadena has many nonprofits, Huntington is supported by the community through over 1,500 volunteers donating over 100,000 hours per year.

CSHS Partnership Guiding Principles in Support of Huntington's Requirements

CSHS is committed to continuing support for Huntington's philanthropy program and capabilities locally. CSHS will offer Huntington its access to partner organizations' experience and capabilities, enabling Huntington to create an operational advantage for its philanthropy efforts.

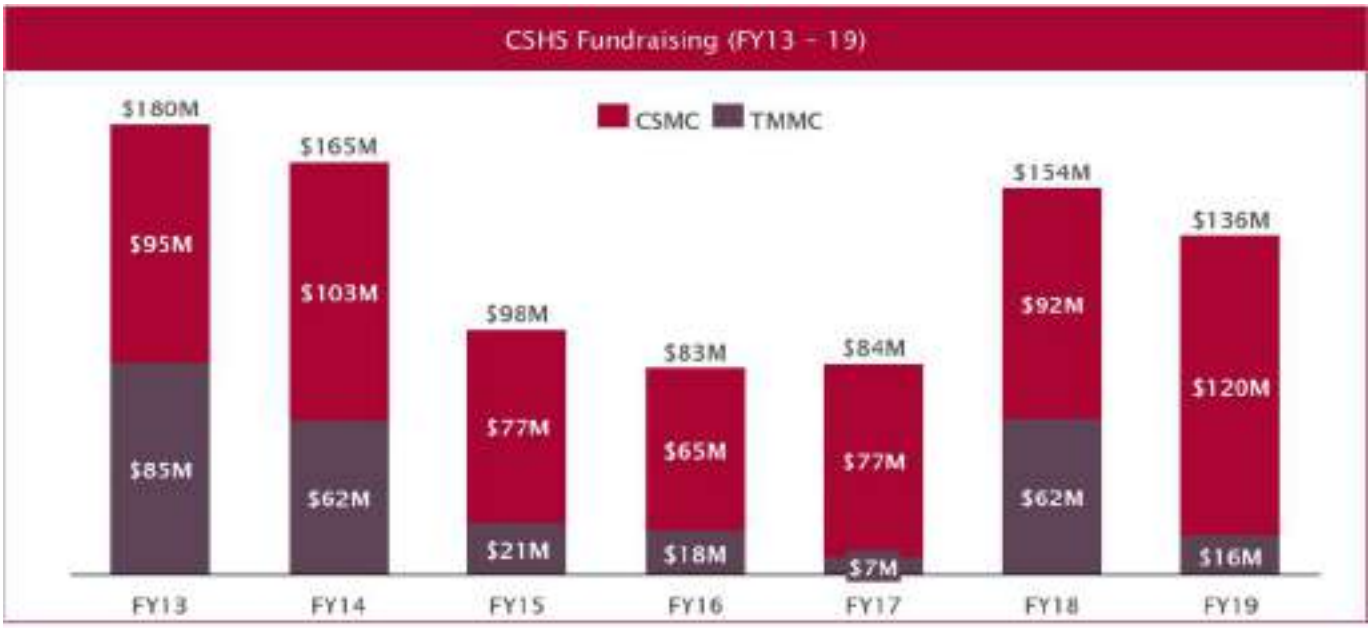
The following are some additional principles we will use to work with Huntington on philanthropy:

- **Locally manage relationships with donors and the community.** The CSHS affiliation structure and governance philosophy offer autonomy to locally nurture and enhance philanthropy programs and donor relationships. CSHS will support Huntington's fundraising campaigns if/when requested by Huntington.
- **Committed to using funds from fundraising efforts for the benefit of Huntington communities**. CSHS is committed that any funds raised from Huntington's efforts benefit Huntington. CSHS will support Huntington's fundraising efforts with other ongoing CSHS efforts as appropriate to ensure there is no unintended duplication of solicitation of donors and/or activities.
- **Create access to CSHS fundraising infrastructure capabilities.** CSHS will bring the collective capabilities and scale of CSHS to enhance and lower the cost of fundraising for Huntington. Huntington will be in the position to have the option of leveraging those capabilities based on its own strategy and needs.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Overview of CSHS Capabilities and Alignment Approach

- CSHS hospital partners have strong community support with fundraising exceeding $120 million in FY 19. Over 90% of the funds raised are for areas that identified as "A" priorities; this success is due to the structures and approaches that are in place for community development.



- In July 2018, CSMC started its 10-year, "1 Billion" campaign to support Transforming Cancer, Personalized Disease Management, Novel Therapeutic and Technological Interventions Delivering an Exceptional Patient Experience and Training the Next Generation. Per the charts below, CSMC's previous campaigns raised almost $1billion.

Campaign Numbers

	Current Campaign as of 8/20/19		Campaign for Cedars-Sinai		Discovering for Life	
Gift Purpose	Total Gift Amount	% of Total	Total Gift Amount	% of Total	Total Gift Amount	% of Total
Endowment	$96,149,640	77.25%	$473,185,841	76.91%	$120,250,266	33.67%
Current Use	$28,318,748	22.75%	$142,068,126	23.09%	$236,862,902	66.33%
Total	$124,468,388	100.00%	$615,253,967	100.00%	$357,113,168	100.00%

Academic Priorities		
A-Priorities	B-Priorities	C-Priorities
90% of $$ Raised	3% of $$ Raised	7% of $$ Raised

Total Gift Processing Transactions		
FY19	FY18	FY17
73,611	60,994	50,836

Highly Confidential and Subject to Executed Non-Disclosure Agreement

- CSHS hospitals have robust volunteer programs. At CSMC alone, there were over 2,848 volunteers actively volunteering in the calendar year 2019, which totaled 127,981 hours donated.

Response to Huntington Questions

?	Please describe your proposed approach to community fundraising at Huntington and outline any commitment to ensure that any funds from local fundraising efforts remain for the provision of healthcare in Huntington's service area and for their original intended purpose. ■ How will the proposed partnership maintain and enhance Huntington's philanthropic support from the community?

Huntington's community relations functions and fundraising operations, including the funds raised, will remain for the benefit at Huntington and donor intent for use will be respected. Not only is this legally required, but CSHS partner organizations know their local markets and donors best, so we do not interfere or negatively impact those relationships and achievement of goals related to philanthropic support.

With that stated, there are benefits and opportunities with system scale:

- **Collaboration**: Fundraising teams of the CSHS hospital partners are encouraged to collaborate. These relationships enhance efforts and professional growth of the local management teams.
- **Attract Donors and Larger Gifts**: Being part of CSHS is intended to support the growth, mission, and reputation of each of the hospital partners. As part of CSHS, partner hospitals may have 'big ideas' to attract donors, creating greater opportunities for developing and realizing greater philanthropic support.
- **Shared Services for Economies of Scale**: If Huntington is interested, opportunities for shared services to gain back-office efficiencies can be explored. As examples, CSMC has 71 FTEs in its Development department, which includes divisions for gift receiving/gift processing, donor records, development communications, planned giving and direct mail outreach.



These functions can be leveraged by Huntington, allowing for back-office efficiencies, potentially resulting in Huntington being able to reallocate resources to have more front-line fundraising staff. If this type of shared model for back-office services were to be contemplated, there would still not be any change to any donor facing activities, which would all continue to remain local at Huntington.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

17 Research and Education

Our Understanding of Huntington's Current State and Requirements

- Huntington is an active teaching hospital with ACGME residency programs in internal medicine and general surgery training about 43 residents per year.
- Huntington hosts 15 other residents and fellows affiliated with the USC Keck School of Medicine in specialties including OB, Cardiac Surgery, Maternal-Fetal Medicine and Vascular Surgery.
- Huntington has an RN residency program covering several specialties, including critical care, neonatal ICU, maternity, med-surg, etc.
- Huntington's cancer program, which is staffed with specialists from UCLA, CoH and Norris Center, offers access to multiple clinical trials.
- Huntington also has a clinical research program with industry-sponsored studies (pharma, med-devices), and national consortium studies.
- Huntington has collaborative relationships in place with HMRI & CalTech.

CSHS Partnership Guiding Principles in Support of Huntington's Requirements

CSHS is committed to supporting Huntington to advance its research and education mission and capabilities. CSHS is overall committed to its mission of **"expanding medical knowledge through supporting biomedical research and discovery and educating and training physicians and other health care professionals."**

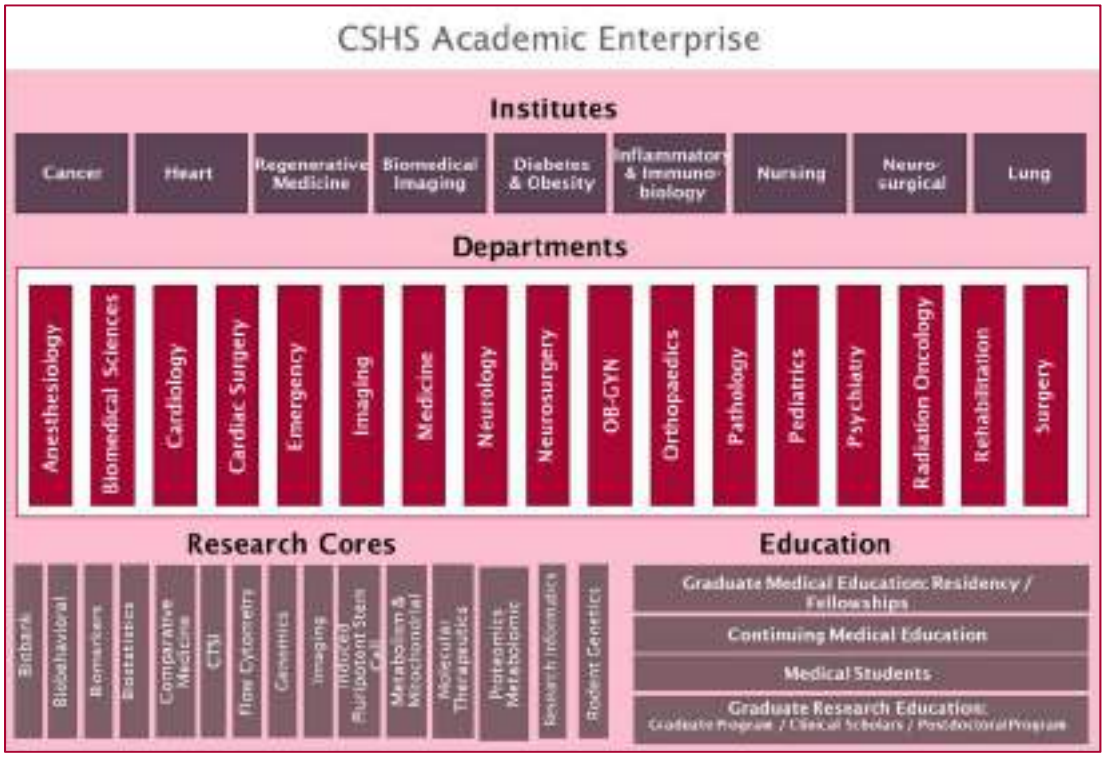
The following are some additional principles we will use to work with you to advance Huntington's research and education objectives:

- **Create access to CSHS capabilities without disrupting existing research and academic relationships.** CSHS will bring the collective capabilities and scale of the Cedars-Sinai's academic enterprise to support Huntington's ongoing development of its academic and research capabilities. CSHS will also not seek to disrupt existing Huntington research and teaching relationships and stands ready to support existing programs as identified by Huntington.
- **Co-developing strategy for Huntington research and teaching objectives**. CSHS is committed to supporting affiliate organizations to expand access to various research and teaching programs. CSHS will engage Huntington's leadership to identify infrastructure needs to support broader research and teaching programs and is committed to developing a strategy for supporting the current programs.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Overview of CSHS Research and Education Capabilities

- Education and training for physicians and health professionals at Cedars-Sinai provides extensive, highly competitive medical training programs in more than 76 specialty and subspecialty areas.





- The Cedars-Sinai Graduate School of Biomedical Sciences currently offers Ph.D. and Master's programs and has over 150 Postdoctoral Scientists across several research areas.

Highly Confidential and Subject to Executed Non-Disclosure Agreement



- Cedars-Sinai ranked #10 in the country among non-university hospitals receiving National Institutes of Health (NIH) funding. Total annual research spending is approximately $180 million per year.
- There are approximately 500 active clinical trials and more than 1,300 research projects underway encompassing basic, translational, clinical, and health services research.
- Cedars-Sinai's revenue from the Technology Transfer Program totaled $34 million in 2018. In addition, 70 invention disclosures were received, and 27 patents on new technologies were issued. Net income from the technology transfer program is reinvested in research.
- Cedars-Sinai's Technology Transfer Program ranked among the top 6 of 24 reporting peer institutions (academic medical centers) and among the top 25 of 186 reporting institutions in the more competitive class that includes university programs.
- Over the years, Cedars-Sinai has had significant translations research achievements, which created innovative research that was taken from bench to bedside in record time – these include:
  - Swan-Ganz catheter
  - Minimally invasive surgery technology
  - Blood product safety design
  - Nuclear cardiology imaging software
  - Heart and CNS stem cell therapy
  - Endovascular cardiac valve repair
  - IBD diagnostics and treatment
  - Kidney transplant tolerance
  - Health Services Research – Clinical Decision Support

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Response to Huntington Questions

	Please describe how your partnership would enhance Huntington's current capabilities in the areas of research and education.

CSHS is committed to co-developing a research and education strategy with Huntington's management team. We will work to understand Huntington's research and teaching program objectives and work to bring many of CSMC capabilities to Huntington. Some initial areas of collaboration based on our experience at TMMC include:

- Making CSMC clinical trials available at Huntington so that patients can remain in their community for cutting-edge treatments.
- Expanding our translational research capabilities for bench-to-bedside discoveries available at Huntington – these include device trials being expanded to include Huntington campus.
- Expanding Nursing Research Collaborations and offering multi-site studies.
- Identifying economies of scale in GME programs to leverage various people, process and technology infrastructure available at CSMC.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

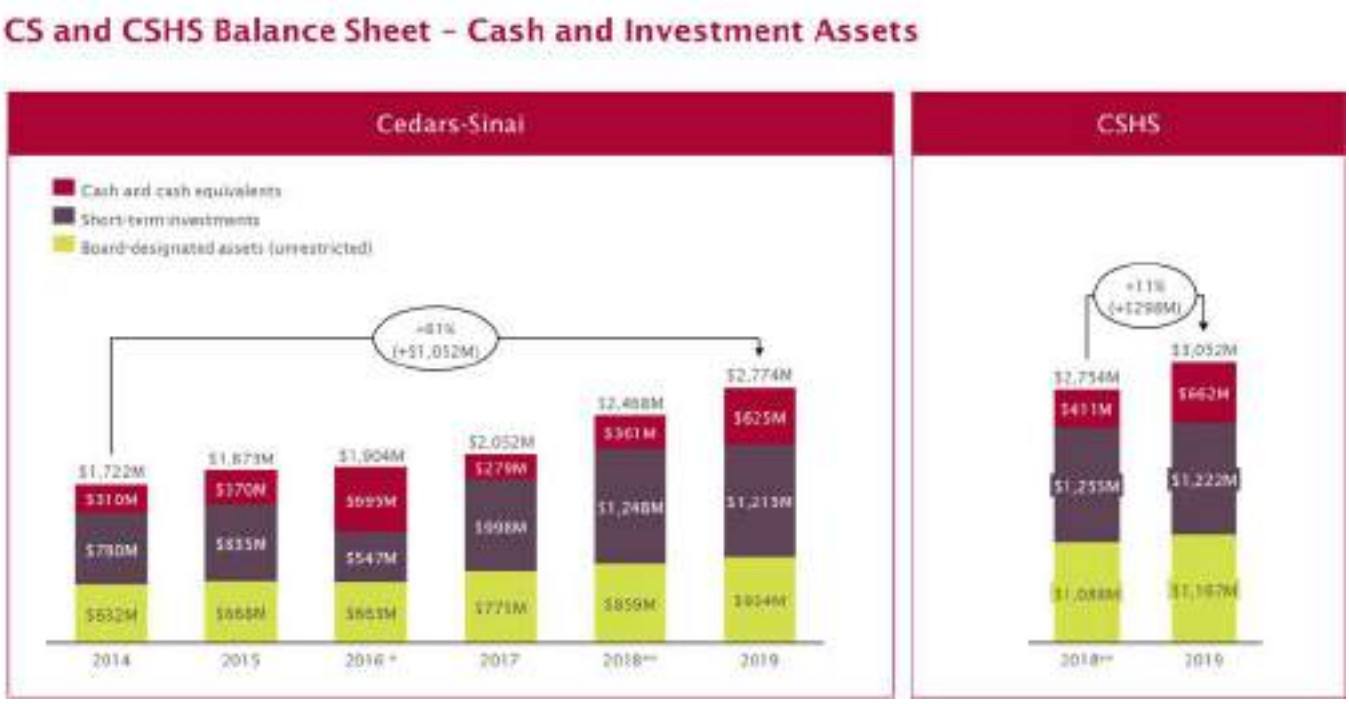
18 Financial Capabilities

Overview of CSHS Financial Capabilities

The financial strength and stability of CSHS provide the flexibility and resources necessary to face the challenges of future industry uncertainty, as well as to meet the immediate and longer-term needs of Huntington.

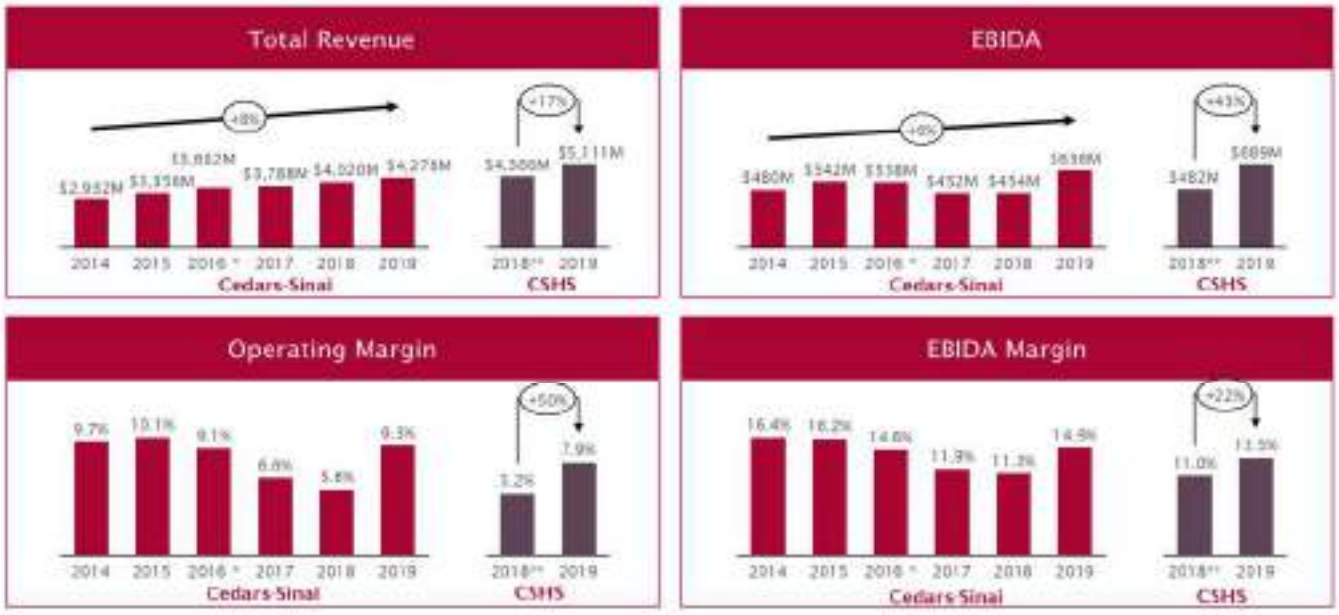
- **CSHS has demonstrated sustained and continuing financial growth**, with an unrestricted cash position of over $3 billion.
- **CSHS is committed to exploring opportunities to increase Huntington's access to capital**, as needed to meet its strategic plans.

The following are key financial highlights and metrics for Cedars-Sinai and CSHS:

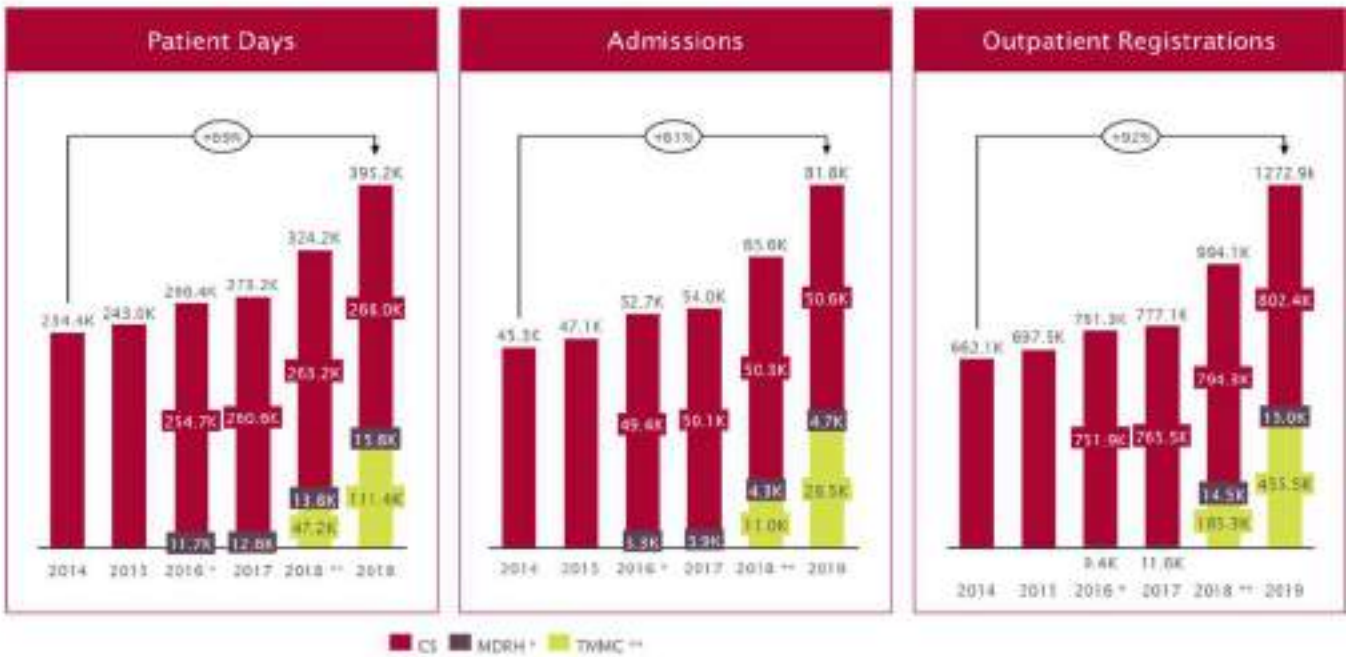


Highly Confidential and Subject to Executed Non-Disclosure Agreement

CS and CSHS Operational Finance Metrics

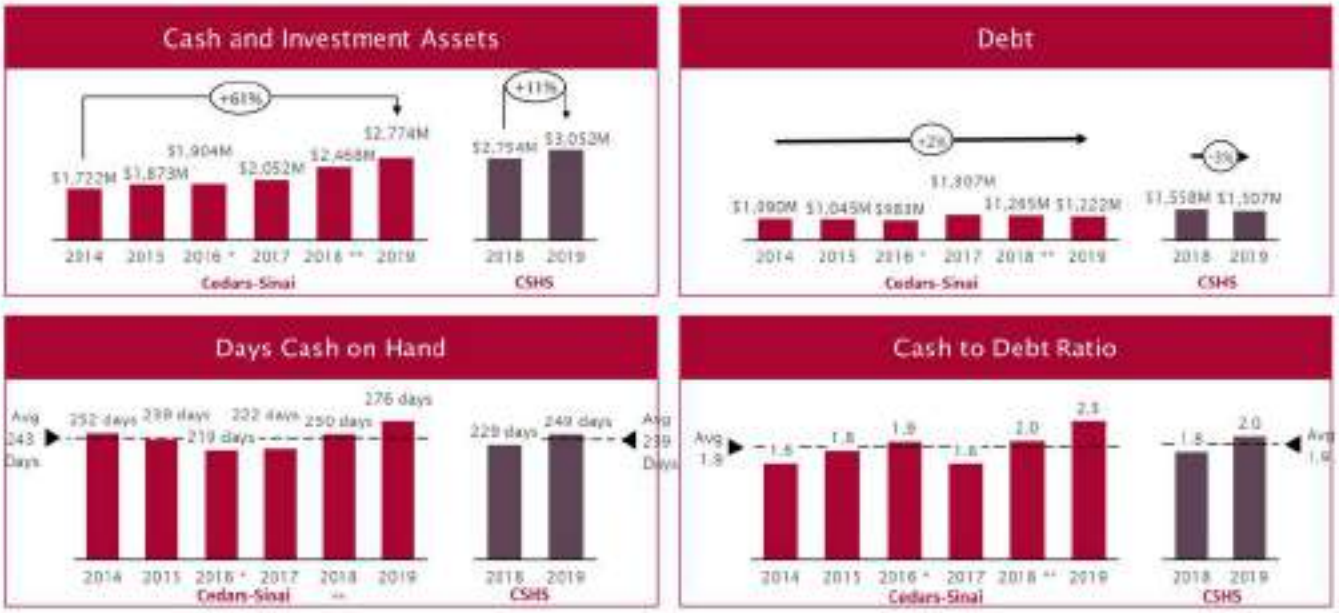


CSHS Operational Metrics



Highly Confidential and Subject to Executed Non-Disclosure Agreement

CS and CSHS Balance Sheet Metrics



* FY16 information includes ten months of actuals for Marina del Rey based on the acquisition date of September 1, 2015.
** Prior year to date includes five months of actuals for Torrance as affiliation became effective on February 1, 2018.

Response to Huntington Questions

?	Discuss your organization's financial capability to execute this strategic partnership on the terms described in your indication of interest. Please specify your source(s) of financing, the expected timing of its availability, and any conditions related thereto, as applicable.

CSHS can deliver on the terms described in this indication of interest through its substantial assets.

As this process further develops, and even continuing post-affiliation, we would anticipate continued dialog regarding optimal financing strategies, which may include such things as including Huntington in the CSHS obligated group and removing the Huntington Trust as a co-obligor, However, even without doing so, the needs of Huntington, and the plans outlined in this document can be supported.

- **CSHS has demonstrated sustained and continuing financial growth**. This sustained improvement has been largely attributable to CSHS's leadership, brand/reputation, positive utilization trends, strategic geographic and programmatic expansion, access to capital, revenue cycle management, system-wide performance improvement initiatives, and experienced management team. Continued growth and accelerating performance trends, a sizable revenue base, comfortable coverage of annual debt service requirements, and a significant balance sheet further highlight's CSHS' current financial profile. Our recent financial performance stems from the continued focus on targeted revenue growth combined with a successful implementation of cost containment initiatives. In FY19 CSHS's EBIDA was $689M and Revenue from Operations increased to $5.1B. We feel Cedars-Sinai is well-positioned to capitalize on the benefits that emanate from greater scale, and CSHS's financial position and size will be an invaluable asset in assisting Huntington to better achieve its strategic goals and fulfill its mission by participating in:

Highly Confidential and Subject to Executed Non-Disclosure Agreement

- **The CSHS's financial resources** will increase Huntington's access to capital. Given its scale, current financial profile, significant cash reserves, and leading market position, CSHS will be a strong partner that can provide the support needed to grow and expand Huntington's mission and vision. CSHS has a philosophy and demonstrated history of making the strategic capital investments necessary to ensure that its facilities are positioned and available to meet the needs of the communities they serve.
- **Financing Market Access.** CSMC has a favorable reputation and position with external financial markets as demonstrated by participation in our most recent bond offering, which was oversold by over seven times on certain maturities. CSMC's positive credit ratings combined with good standing in the investor community, enable CSHS to efficiently access the capital markets. For example, in its latest bond issue, CSMC secured a weighted average yield to maturity of 3.42%. The success of this bond offering demonstrates the strength and recognition of Cedars-Sinai name both locally and nationally by institutional investors.

STANDARD & POORS ON CSHS

"We expect CSMC and TMMC to increase clinical collaborations and implement innovative approaches in medicine and population health. In addition, we expect the two organizations to find synergistic opportunities in many clinical and nonclinical areas that will derive value for the system"

- **Investment and Commitment of Capital**. Huntington's near-term capital needs fit well within CSHS's projected capital funding capabilities. In addition to the potential need for CSHS replacing the Trust as a co-obligor on Huntington's outstanding debt, CSHS has the resource and financial access to commit to ensuring that Huntington will have adequate financial resources to fund these needs and remain compliant under the Master Trust financial covenants.
- **Credit Strength.** CSMC's credit ratings continue to be strong with Aa3 Moody's rating and an AA- Fitch rating. CSHS does not manage to a particular credit rating but focuses instead on what investments and performance goals are best to achieve the organization's mission and long-term growth goals. The credit rating agencies have noted CSHS's favorable financial trends.
- **Liquidity.** As a result of steady improvement in profitability and cash flow generation, CSHS has increased unrestricted liquidity to $3.05 billion at June 30, 2018, an increase of more than 77% over the past five years despite significant capital investment in facilities over that period (61% not including the acquisition of TMMC). CSHS has made a business decision to strategically deploy capital across its facilities in lieu of solely maximizing cash reserves for credit improvement over the short-term. CSHS's capital investment policies recognize that the return on capital relating to strategic "revenue-producing" and market-positioning projects will generate significant cash flow and ultimately enhance liquidity and overall financial performance over the long run.
- **Leverage.** Compared to the size of its revenue base and cash flow generation, CSHS carries a reasonable debt burden. CSMC has historically outperformed comparably sized and rated healthcare systems in ratios measuring coverage of maximum annual debt service (MADS). MADS coverage, MADS as a percentage of revenues, and cash to debt are 5.3x, 2.7%, and 177%, respectively, for the fiscal year ended June 2018. These strong ratios provide CSHS with a significant amount of flexibility and the future debt capacity required to continue a high level of strategic investment.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

19 Strategic Partnership Execution

Response to Huntington Questions

	Please describe the timeline to close your proposed transaction, including milestones and regulatory approval. Please describe the regulatory approvals that may be necessary to consummate the proposed strategic partnership and your experience in obtaining such regulatory approvals. Also, describe your organization's approval process, including approvals by members, affiliates, financing sources, public bodies or other relevant groups to consummate this partnership.

Below please find an anticipated timeline including the regulatory approvals required for this type of transaction.

Step	Process Step	Timing	Remarks
1	Execute Letter of Intent	by 12/31/2019	
2	Conduct due diligence	1/1/20 – 3/31/20	■ Timing of due diligence is subject to document production/availability and issues that may arise during due diligence review requiring follow-up
3	Draft and negotiate Definitive Agreements, including (i) Affiliation Agreement, (ii) amended and restated Huntington organizational documents, and (iii) amended and restated CSHS organizational documents	1/1/20 - 3/31/20	■ Timing of drafting/negotiating Definitive Agreements is subject to the complexity of transaction (*e.g.*, potential changes to relationship with Huntington Trust and/or combining medical foundations)
4	Approval of transaction by: (i) CSHS Board, (ii) CSMC Board, (iii) THA Board and (iv) Huntington Board	by 4/30/20	
5	Execute Affiliation Agreement	5/1/20	
6	Huntington to file a notice of transaction with the California Attorney General	by 6/1/20	■ California Attorney General review period is up to 105 days
7	Huntington to file a change of ownership applications with California Board of Pharmacy	by 8/1/20	■ California Board of Pharmacy review period is at least 60 days
8	Obtain consents or provide notices in connection with all other Huntington licenses and contracts, as necessary	5/1/20 – 9/30/20	
9	Close Transaction	10/1/20	

Highly Confidential and Subject to Executed Non-Disclosure Agreement

20 Appendix 1: Notable Cedars-Sinai Clinical Programs

- **The Smidt Heart Institute** – Ranked #3 by U.S. News & World Report for cardiology and heart surgery, performs more heart transplants than any other center, including 132 in FY19. Our team has performed more percutaneous mitral and aortic valve procedures than any other U.S. medical center. Our structural heart disease program targets all major heart valves with innovative interventions. New percutaneous approaches to closing a patent ductus streamline the care of newborns, while transcatheter valve replacements give new life to elderly patients too frail for conventional surgery. The Barbershop Study, conceived and executed here, validated a new paradigm for treating neglected populations at high risk for hypertension: take testing and treatment to the patient, and they will respond. The Barbra Streisand Women's Heart Center continues to challenge our preconceptions regarding heart disease: it affects women at high rates and with different presentations than in men.

- **Samuel Oschin Comprehensive Cancer Institute.** Ranked #12 by U.S. News & World Report, is one of the largest centers of its kind in Southern California, is staffed by physicians and scientists who are dedicated to the treatment of adult and pediatric cancer patients. The array of services includes specialty centers for the brain, breast, colon/rectal, head and neck, kidney and bladder, lung, pancreatic, prostate, sarcoma-spine and women's cancers. The Cedars-Sinai Outpatient Cancer Center (the "Outpatient Center"), part of the Cancer Institute, is one of just a few such centers in the nation that provides outpatient support 24 hours per day, seven days per week. The Cancer Institute has been honored with a 3-year accreditation with commendation from the American College of Surgeons (ACS). The accreditation is recognized by the National Cancer Institute, CMS, the Joint Commission, the ACS, and other prominent national organizations, and is awarded only to programs that comply with all standards at the time of a comprehensive on-site survey.

- **Digestive Disease Center**. Ranked #2 by U.S. News & World Report, from innovative drug therapies to advanced endoscopic technologies, the doctors, surgeons and researchers working within our Digestive and Liver Diseases Program lead the field in treating an extensive range of conditions, including inflammatory bowel disease, digestive tract disorders, fatty liver, pancreatic and biliary diseases. The program is a national leader in advancing the diagnosis and treatment of irritable bowel syndrome and other disorders and includes a Hepatology Program that provides technologically sophisticated and clinically effective treatments in a patient-centered, compassionate environment.

- **Comprehensive Transplant Center.** Ranked in the top 10 programs by Scientific Registry of Transplant Recipients (SRTR) conducts solid organ transplants, with excellent one- and five-year survival rates, and aids prospective patients who are highly antibody-sensitized to undergo successful procedures. Services include heart, kidney, liver, lung, and pancreas transplantation. Our transplant program in FY19 performed over 520 transplants. The Liver Transplant Program continues breaking new ground in clinical volume and outcomes and performs over 110 liver transplants per year. Patient and graft survival — the two most common benchmarks for transplant programs —both exceed 90 percent.

- **Regenerative Medicine Clinic at the Smidt Heart Institute.** Led by Eduardo Marbán, MD, Ph.D., the clinic offers consultative services for patients with heart and vascular disease who may qualify for investigative stem cell therapy. Since the Cedars-Sinai team completed the world's first cardiac stem cell infusion in 2009, research continues to develop novel therapeutics for the treatment of cardiovascular diseases using cardiac-derived stem cells The goal of the clinic is to devise a comprehensive treatment strategy for patients who remain symptomatic on their current management regimen, or for patients with stable heart disease who are concerned about disease progression.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

- **Transgender Community Care.** From gender-affirming surgery to hormone management and mental health counseling, the Transgender Surgery and Health Program at Cedars-Sinai offers comprehensive, interdisciplinary and individualized services. In addition to providing clinical care, the team is committed to research to develop better surgical techniques and gender-affirming options for transgender patients. Cedars-Sinai is one of only two academic medical centers in the Western U.S. offering genital reassignment surgery and has treated patients from across the nation as well as Canada, Asia, and Mexico. Few surgeons are trained to perform gender-affirming surgery, so Cedars-Sinai plays a key role in addressing the health needs of the underserved U.S. transgender population, which is estimated to be as large as 1.4 million adults, including 218,000 in California.

- **Cedars-Sinai's Women's Guild Lung Institute.** Provides comprehensive screening, diagnostic, medical and surgical services for the complete range of pulmonary diseases and disorders. The Lung Institute offers modern technology for detecting lung disease at the earliest stages when treatment is most effective. Other services include lung cancer treatment, lung transplantation, critical care medicine, pulmonary medicine, and thoracic surgery. Lung Institute members also perform basic and translational research on interstitial lung diseases, such as idiopathic pulmonary fibrosis, acute lung injury, acute respiratory distress syndrome, Chronic Obstructive Pulmonary Disease, lung transplantation and bronchiolitis obliterans syndrome, and lung infection, among others.

- **S. Mark Taper Foundation Imaging Center.** Provides a complete range of sophisticated imaging services. In addition to standard imaging procedures, the Imaging Center also offers cardiac imaging, including cardiac MRI. The Imaging Center also conducts research on detecting disease processes using PET and Single Photon Emission Computed Technology systems.

- **Neurosciences Services.** Offers a full range of diagnostic and therapeutic services. Physicians use advanced research and sophisticated diagnostic techniques to identify neurologic disease and disorders. The range of specialized neurologic services include services provided through Maxine Dunitz Neurosurgical Institute, Stroke Center, Spine Center, Neurology Department, Neurophysiology Laboratory, Radiosurgery, and Neuro-Oncology Divisions. The Medical Center earned Comprehensive Stroke Center certification from The Joint Commission and the American Heart Association/American Stroke Association. The Corporation's Stroke Program also earned the highest possible honors from The Joint Commission and AHA/ASA, including the Get With The Guidelines Gold Plus and Target: Stroke Honor Roll awards. Neurosciences Research includes vaccines to battle brain tumors and brain cooling to reverse the harms of stroke.

- **Regenerative Medicine Institute.** Brings together research faculty and clinicians to provide a true "bench to bedside" organization with five key program areas: brain, eye, pancreas and liver, blood, and skeletal. Its mission includes: bringing together researchers and clinicians across the spectrum of departments at the Medical Center to work in the area of regenerative medicine; providing services and an environment that enhances this research; facilitating recruitment of specialists involved with regenerative medicine; educating and training a new generation of clinical scientists in regenerative medicine; providing a central source of information on regenerative medicine through the Institute's website; and providing outreach and support to the Greater Los Angeles community regarding stem cells and regenerative medicine.

- **Orthopedic Center.** Cedars-Sinai's orthopedics program consistently ranks among the nation's best, and in US News and World Report is #3. The program includes many world-renowned sports medicine specialists in the Cedars-Sinai Kerlan-Jobe Institute, which has offices throughout Southern California. Its doctors also serve as team physicians for many professional sports teams and athletes in the region and nationwide. Diagnosis to care management and treatment is offered both on an inpatient and

Highly Confidential and Subject to Executed Non-Disclosure Agreement

outpatient basis. The Medical Center's approach to patient care integrates the full spectrum of treatment options available from conservative approaches (such as pain management and physical therapy) to the most complicated.

- **Pediatric Services and Subspecialties.** Offer expertise ranging from general surgery to neurosurgery, from cardiology to neonatology and from oncology to medical genetics. Among other things, the Maxine Dunitz Children's Health Center includes outpatient clinical care, the Department of Pediatrics, the Ahmanson Pediatric Center for children's inpatient care, and a 45-bed Level IV neonatal intensive care unit.

- **Surgery Services.** Provide a full range of inpatient and outpatient procedures from minimally invasive to complex procedures in adults and children. The Medical Center performs minimally invasive procedures, such as video-assisted thoracoscopic surgery, laparoscopic live-donor nephrectomy, laparoscopic gallbladder, colon and spleen procedures, bariatric surgery, stereotactic image-guided neurosurgery, direct coronary artery bypass, robotic-assisted procedures, neuro MRI (neurovascular and brain tumors) and minimally invasive pediatric surgery.

- **Women's Health** has long been a focus of the Medical Center, which treats the unique physical and emotional needs of women of all ages. Maternity Services at the Medical Center offer care for high-risk pregnancies. Women's health care includes programs for heart, breast health, continence, reproductive endocrinology, mammography, mental health, gynecologic oncology and research for all women's issues. The gynecology program at Cedars-Sinai is ranked #8 by US News and World Report.

- **Pain Center.** Complements all the Medical Center's programs and services, offers pain management (acute, chronic and cancer pain) to many patients. In addition, support services are offered through palliative care and rehabilitation.

- **Precision Medicine.** Cedars-Sinai is leading a revolution in healthcare by translating genetic discoveries into therapies geared to each patient's individual needs and biology. Since debuting in 2016, Cedars-Sinai Precision Health has launched an array of projects using big data, digital technology, and other advanced methods to promote care that is as personalized as it is patient-centric. Cedars-Sinai has been successful in receiving funding from California's and President Obama's initiatives on precision health or personalized medicine. The initiative joins scientists and clinicians with industry partners to create solutions that not only react to disease but also might predict dangers so they can be prevented entirely. For example, a remote-monitoring system was designed at Cedars-Sinai to accurately forecast cardiovascular conditions. Patients will wear a specialized watch paired to a smartphone or computer that measures activity, sleep, heart rate, stress levels, self-report anxiety, depression and other health data. By integrating "big data" into patients' medical records, investigators can seek signals that predict who is at risk for a heart attack or stroke.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

21 Appendix 2: CSHS Ambulatory Network

Ambulatory Network Across CSHS

CHSH members have developed a strong ambulatory network around each of our hospital facilities to serve their primary service area communities. These include primary care offices, specialty clinics, urgent care centers, imaging centers, and ASCs.

CSMC– Ambulatory Network with CSMC as the Anchor Hospital



South Bay – Ambulatory Network with TMMC as the Anchor Hospital



Highly Confidential and Subject to Executed Non-Disclosure Agreement

North and South Coast – Ambulatory Network with MDRH as the Anchor Hospital



Valley– Ambulatory Network with PCSTMC as the Anchor Hospital



Highly Confidential and Subject to Executed Non-Disclosure Agreement

22 Appendix 3: Illustrative Quality Program Accomplishments

In a few key examples, we'd like to share just some of the areas where we were able to enhance measurable levels of clinical quality within Cedars-Sinai.

Example: Cedars-Sinai Antimicrobial Stewardship Achievements

We recognized that opportunities exist at Cedars-Sinai to reduce the misuse, overuse, and underuse of antimicrobials which contribute to antimicrobial resistance, C. difficile infections, increased length of stay, and readmissions. Over the past 5+ years, we have applied several strategies and interventions targeting information available at the time of ordering, tailored education of physicians regarding the benefits of antibiotic stewardship and modification of antibiotic panels.



Example: MDRH Sepsis Achievement

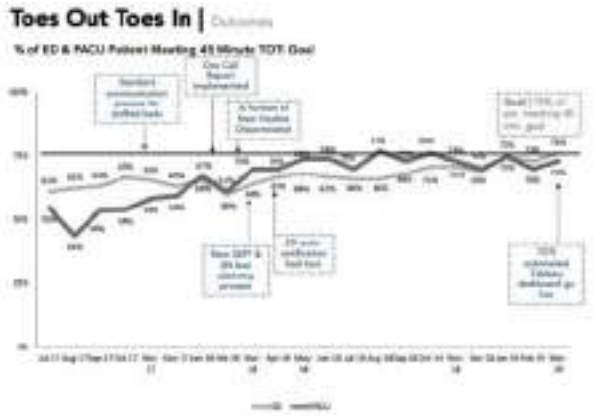
In work with Marina del Rey Hospital to improve their Sepsis compliance we have seen an increase in core measure compliance from 43.8% in 2017 to above 85% in 2018. Using data analytics, focused interventions, and education, Sepsis compliance rates continue to remain high.



Example: Cedars-Sinai Hospital Flow Achievement

Cedars-Sinai has experienced significant and consistent volume growth over the past three years. As we began to analyze our opportunity for assuring access to care and increasing our capacity, we recognized that we were challenged with both patients waiting for inpatient beds in the Emergency Department and Surgical/Procedural post-anesthesia recovery units (PACUs) as well as optimizing the timing of discharges for inpatients ready to leave the hospital. This work led to two projects:

- Room readiness: Toes Out Toes In (TOTI)
- Inpatient discharges by 11 am



We have seen a marked improvement in the number of patients who are discharged before 11 am, thus creating capacity for patients who require admission from the ED.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

23 Appendix 4: Overview of CSHS MSO Capabilities

CSMCF Physician Enterprise Services / Medical Services Organization Capabilities

Medical Group Administration Services

Administration Areas	Overview
Health Plan and Provider Contracting	■ Cedars-Sinai has a managed care contracting department that includes both health plan and provider contracting. Our Health plan contracting staff have significant payer and provider experience dealing with all contract types including HMO, PPO, and specialty contracts to include vision, behavioral health and the full range ancillary providers. ■ The provider contracting team also has extensive experience in contract operations and management to include the implementation and onboarding of new physicians, operational compliance with contracts, provider dispute resolution, adverse selection management and rapid deployment of letters of agreement to manage network leakage.
ACO contracting	■ CSHS has successfully negotiated multiple ACO contracts (government and commercial) and has several others in the pipeline. We have created physician governance and care management infrastructure necessary to be successful in these new models of care.
Credentialing	■ CSMCF Credentialing Department can credential all providers following NCQA Standards and Guidelines which include verifying that the credentialing application is correct and complete, conducting primary source verification for the provider's license, DEA (if applicable), malpractice case history (via NPDB), education/training, board certification status and hospital privileges, ensuring that a copy of the provider's malpractice certificate is current and within limits (1M/3M). ■ All providers are recredentialed every three years. ■ The Credentialing Department is audited annually by designated representatives of the Health Plans.
Group Purchasing	■ CSHS partners with GPOs for discounts on a variety of products and services including medical supplies, office supplies, pharmacy & services such as hazardous waste, water, phone, mobile, accounting, etc., for private practice physicians. The more physicians that join, the stronger the discounts become. The group purchasing also offers savings opportunities for malpractice insurance.
Billing and Collection	■ CSMCF Physician Billing Services (PBS) provides professional fee billing services with a staff of 193 FTEs for more than 900 physicians on Cedars-Sinai faculty, in the Foundation and ER MDs at Cedars-Sinai. Services include physician credentialing, centralized registration with automated insurance verification, electronic inpatient billing, electronic payor billing with multiple scrubbers and edit functionality, reimbursement and collection management automated with contract analysis and procedural coding performed by certified professional coders. ■ Currently, support 14 different provider types: ▸ Acupuncturist

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Administration Areas	Overview
	▸ Audiologist ▸ Certified Nurse Midwife ▸ Registered Dietician ▸ Doctor of Psychology ▸ Fellow ▸ Genetic Counselor ▸ Nurse Practitioner ▸ Optometrist ▸ Pharmacist ▸ Physician ▸ Physician Assistant ▸ Psychologist ▸ Social Worker ■ The team supports surgical, non-surgical, and pathology practices resulting in the submission of over 220K claims per month. Net Collection Rate, Days in AR and Gross Collection rates **all at or above best practice** (per 2018 independent ECG Revenue Cycle Audit).
Finance Services	■ CSMCF offers various financial services across its various alignment models that include the following: ▸ General Accounting ▸ Budgeting ▸ Taxes ▸ Financial Analysis/Reporting ▸ New Business Development Analyses ▸ Accounts Payable

IPA Administration Services

IPA Administration Service Area	Overview
Claims Processing	■ CSMCF has the following claims processing capabilities that are used to support its captive IPA, which can also be scaled for Huntington's Foundation: ▸ Both professional and institutional claims are logged, adjudicated and paid. ▸ Claims quality control uses review software to detect, correct and document coding errors during adjudication. ▸ Conduct prospective and retrospective audits.
Enrollment	■ CSMCF has a robust process for enrollment and benefits management from health plans, which is required to effectively administer claims, capitation, medical management, and benefits administration. These capabilities can also be scaled to support Huntington Foundation. ▸ Monthly eligibility file received from health plan. ▸ Mapping errors corrected. ▸ Eligibility audit reports printed. ▸ Delete duplicate members and make other changes as needed.
Benefits	■ CSMCF manages benefits for multiple plans in the managed care model. Key processes include:

Highly Confidential and Subject to Executed Non-Disclosure Agreement

IPA Administration Service Area	Overview
	▸ Benefit plans added and/or changes mapped based on EDI Enrollment mapping error report. ▸ Benefit plan details downloaded from health plan websites. ▸ Co-pay details and benefit limits entered.
Physician Capitation	■ CSMCF has several capitation payment arrangements with health plans and physicians. Each specialty has a unique methodology which requires calculations and reporting to accompany physician payments. Key processes include: ▸ Payments processing ▸ Monthly audits ▸ Payment reconciliations
Clinical Analytics and Business Intelligence.	■ CSMCF has an enterprise data warehouse (EDW) that collects, transforms, and stores data from multiple sources and disparate data streams including, but not limited to, claims, authorizations, labs, prescriptions, clinical, and supplemental data. ■ We have more than 10 years of experience leveraging data to provide actionable information and reports allowing administration, analysts, and business users to make informed operational, clinical, and financial decisions. ■ Our EDW solution brings together the existing silos of data and unifies them into a data model built specifically for health systems. ■ Through the of pre-built dashboards, reports, and applications, our organizations empower our users with the healthcare analytics they need for critical decision making.

Clinical Management and Care Coordination Services

Clinical Management and Care Coordination	Overview
Referral Management	■ CSMCF has implemented the Tapestry module within Epic for referral management. ▸ Provides patient eligibility, authorizations and claims tracking, all available within the Epic Ambulatory system. ▸ Protocols and guideline rules are set up in the Tapestry. These rules can be customized as needed. They can be used to educate the physician offices on the type of clinical information that is required to ensure a timely referral response. They can also be set up to automate any specific type of referral. The rules can be based upon diagnosis codes, procedure codes, providers, provider specialty type, etc. The protocol and guidelines assist in providing the most efficient processing of authorizations.
Care Management	■ CSMGF supports care management for our various managed care, ACO, and MA segments. These capabilities can also be scaled to support Huntington Foundation. ▸ On-site inpatient case management: Nurses provide onsite case management services seven (7) days a week. The nurses work closely with the patient, physician, and hospital staff to facilitate timely and safe discharge plans.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Clinical Management and Care Coordination	Overview
	These plans may require transfers to other facilities, home care, equipment, outpatient referrals, and even at times educating the patient or caregiver regarding their home care needs. ▸ Discharge Bridging Program: Case Managers follow-up with their patients within 1-2 days after discharge. They confirm that every item listed in the discharge plan has been delivered to or arranged for the patient: DME, home health, medication reconciliation, scheduling of PCP and specialist appointments. ▸ Ambulatory Care Management/Care Coordination Team: Outpatient Case Management is done by a team made up of nurses, social workers, support staff and pharmacists. Patients can be referred by their PCP and/or a patient's family member, the inpatient case management team, or identified as high risk from the claims and clinical data. ▸ Preparation for Elective Surgery: A nurse reaches out to pre-operative patients to ensure appropriate assessment of needs with the goal is to effectively prepare patients for elective surgery. This service is most effective for patients electively scheduled for Spinal Surgery (cervical, thoracic, lumbar), Joint Replacement (hip, knee, shoulder), Mastectomy, Ostomies, Amputation, Laryngectomy, Craniotomy, and Multiple complex surgeries. ▸ Physician or Nurse Practitioner Home Program: Managed through Case Managers, the home visit program is available to patients who need a provider to evaluate, treat and manage their care in the home setting. ▸ Senior and Special Needs Plan (SNP) New Member Program: All newly enrolled seniors and SNP members receive an outreach phone call to schedule their initial wellness and assessment visit. At that visit, the Outpatient Case Manager will meet the patient and conduct an initial assessment to determine potential case management needs. The health survey and recommended care plan are then discussed with the patient's PCP. ▸ Skilled Nursing Facilities: Nurse Practitioners and Nurse Educators are assigned to the most commonly used SNFs to round on patients, ensure coordination from SNF to home, coach the SNF staff on techniques to improve infection control, medication reconciliation and other proven methods for lowering readmission. ▸ Advanced Care Planning Program: We have developed patient-friendly materials and an operational process to introduce advance directives to patients starting at age 53.
Quality Management	■ CSMCF has a robust quality management function to support various delegated and value-based care arrangements. Key processes include: ▸ Quality and Risk Management: Research, review and prepare cases for Medical Director and Peer Review Committee presentations. ▸ Medical Group Risk Management: A robust physician education program on consents, HIPAA, documentation, non-compliant patients. Management of malpractice claims, medical board inquiries, insurance management and deposition requests. ▸ Member or provider appeals: Research and follow-up on denied or modified authorization requests. These require research, review, Medical Director assessment to provide responses to the member's health plan.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Clinical Management and Care Coordination	Overview
	▸ Patient and Provider Services: Call center of well-trained customer service staff are available to respond to patient and provider inquiries and conduct outbound calls for special projects. ▸ Member grievances: Research, review and prepare cases for Medical Director to determine if the case should be sent to Peer Review Committee for presentation and to provide a response back to the member's health plan. ▸ Utilization Management & Quality Committee (UM/QMC), and Peer Review Committee (PRC): The function is responsible for the preparation of all necessary information that will be covered at the committee meeting. The committee brings physicians and operations staff together to review the overall performance of the group's utilization, quality, disease management, special programs, etc. ▸ HEDIS Collection: The QM staff uses EHR to assist providers in ensuring that timely submission of required documents is made to the health plans. This approach is lessening the burden on our physician offices allowing them to focus more of their time on patient care. ▸ Access Audits: This function is responsible for conducting audits on the ease of access for making appointments with the PCPs and Specialists contracted with the group. All providers are assessed annually with results of performance reported to the physician office as well as to UM/QMC. ▸ Care Coordination with Skilled Nursing Facilities (SNF): The UM Department holds quarterly meetings with the most often used SNFs. These meetings are used to review the performance of the SNF facility compared to their peer facilities. We provide a comprehensive, metrics-driven dashboard. This program has created a more collaborative relationship with the skilled nursing facilities and as a result, we have seen a reduction in their hospital admission and ER visit rates.

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Highly Confidential and Subject to Executed Non-Disclosure Agreement

Exhibit 8-E

Follow-Up Questions to Cedars-Sinai

Overview

Thank you for your initial submission in response to the Project Rose RFP and for your continued interest in a potential affiliation with Huntington Hospital ("Huntington"). Upon reviewing your initial response submitted Thursday, September 12th, the Huntington working group in conjunction with its partnership committee has prepared targeted follow up questions for your consideration, attached herein. The intent of these follow up questions is to clarify a number of elements in your proposal and further provide Huntington with a comprehensive set of information under which to continue to evaluate a partnership with your organization. Where appropriate, we have referenced your original response. We respectfully request your organization submit written responses no later than close of business on **Wednesday, October 23rd**.

Separately, Kaufman Hall has contacted you regarding a follow up meeting with Huntington. The purpose of this meeting is to: (i) give you the opportunity to clarify any item that may require additional explanation from Huntington in order for you to provide a response as contemplated above; and (ii) preview your written responses.

Please reach out to the Kaufman Hall team if you have any questions related to Project Rose.

Steve Hollis
Senior Vice President
shollis@kaufmanhall.com

Kris Blohm
Senior Vice President
kblohm@kaufmanhall.com

Nick Gialessas
Assistant Vice President
ngialessas@kaufmanhall.com

John Ahn
Associate
jahn@kaufmanhall.com

Follow up Questions

1. **Form and Structure:**
    a. Your proposal highlights a strategic goal to grow the system and selectively pursue the addition of new hospitals and other affiliates. What are your expectations for future growth, including identified geography, beyond an affiliation with Huntington (e.g. number of hospitals, revenue base, etc.)? What role and influence do you anticipate Huntington would have related to this strategic goal?
    b. In the event the strategic goal to grow the system results in an acquisition(s) in and near Huntington's service area, how would any conflicts of interest relative to growth be addressed?
2. **Governance:**
    a. In addition to the minimum CSHS board approval requirements outlined in your proposal (e.g. election/termination of Huntington board members, changes to Huntington bylaws, approve strategic plans and operating/capital budgets, etc.), are there other reserve powers that you

CONFIDENTIAL

expect to be maintained at the parent level under any "mutually-acceptable governance matrix"?

b. We note the intent of your proposal to preserve Huntington's fiduciary board, including decision-making authority to be maintained by Huntington (e.g. Huntington right to exit upon change of control/sale/closure, approval of material service line changes, etc.). What specific decision-making authority do you expect to be maintained at the local Huntington board?

c. The proposal indicates that Huntington will have representation on the CSHS board under the proposed affiliation, similar to Torrance representation on the CSHS board. How are seats on CSHS Board to be allocated?

d. The proposal indicates that Huntington will have the right to nominate an agreed upon number of directors to the CSHS board. What is Cedars' policy re: term limits and the nomination process for Board members?

e. How would the CSHS Board composition change as new partners are added as the system grows? Will all new partners be granted CSHS seats? Will CSHS expand beyond the 12 current board members or replace existing members? Will representation for Huntington be proportionate to the new size of the board or will the number of seats allocated to Huntington remain fixed?

3. **Trust:**

a. Huntington appreciates Cedars' acknowledgement of Huntington's desire to maintain the important relationship with the Trust, and in particular Cedars' guiding principles to "respect the relationship with the Trust, preserve a role for the Trust, and continue the Trust's mandate". Cedars raises two possibilities regarding changes to the Trust: (i) donating currently leased real estate and any other continuous land to Huntington and (ii) continuing the Trust's participation in governance without lifetime appointments.

   i. Please describe the particular land, other than the Hospital property, that Cedars anticipates would be donated from the Trust to Huntington. Additionally, does Cedars' have preliminary thoughts regarding development of non-leased land (i.e. hospital adjacent property)?

   ii. Please describe your proposed alternative to lifetime appointments including length of terms, term limits, number of Trustees on the local board, number of Trustees on the parent board, and the nomination process. Please also specify your expectations regarding the Trust's current voting block rights.

b. In the event the Trustees elect not to transfer the land as part of an affiliation, please describe key terms your organization would seek (e.g. length of lease) with respect to the current lease structure.

4. **Debt:**

a. Your proposal indicates a willingness to evaluate Huntington becoming a member of Cedars' obligated group, but also anticipates the Trust will remain a co-obligor on the existing Huntington debt. Do you anticipate Huntington Hospital joining your organization's obligated group and removing the co-obligation of the Trust? If so, what are your expectations regarding timing?

CONFIDENTIAL

5. **Capital:**
    a. The proposal clearly articulates Cedars' willingness to "support Huntington's current debt and future capital spending plans". In an effort to create a consistent framework from which Cedars' commitment can be evaluated by Huntington, please articulate your capital commitment to Huntington in the following format:

    Cedars commits to spend $____ at Huntington over ____ years.

    If you provide a range, the lowest dollar amount and the longest time period will be used to compare against other proposals.

    Please specify what, if any, costs you expect Huntington would be responsible for.

    Please specify if this capital commitment includes strategic capital, routine capital or both.

    Please specify if this capital commitment includes IT/EHR capital expenditures.

    Please specify if this capital commitment includes operating costs and/or implementation costs related to IT/EHR capital expenditures.

    Please specify any material assumptions, qualifications or other considerations as it relates to your organization's capital commitment to Huntington.

    b. Please describe the capital allocation process Huntington would be subject to under an affiliation with Cedars, including threshold levels and the recommendation/approval process of each of the following:
        i. Routine Capital Expenditures (e.g. ongoing facility maintenance, equipment replacement, etc.)
        ii. Strategic Capital Expenditures (e.g. new tower project, ambulatory expansion, physician alignment, etc.)
        iii. IT applications and systems

6. **Key Decision Processes:**
    a. Please describe the process, indicating the operational steps as well as ultimate legal responsibility for decision-making, for each of the following under an affiliation with Cedars (including the exercise of reserve powers by Cedars):
        i. Hiring and firing the CEO of Huntington
        ii. Approval of change of control
        iii. Development and approval of capital and operating budgets
        iv. Approval and funding for construction of major capital projects such as a new tower
        v. Implementation of new IT initiatives
        vi. Amendments to governing documents, including changes in governance/decision-making

CONFIDENTIAL

7. **Existing Relationships:**
    a. It is our understanding, based on your proposal, that the initial intent regarding Huntington's existing relationship with HCP is to continue that relationship upon affiliation with Cedars and to minimize potential for disruption. How would Cedars look to mitigate Huntington's reliance on HCP over time? Please describe your anticipated plan to do so. Furthermore, if an affiliation with Cedars disrupted the HCP relationship, would Cedars support Huntington's existing budget and can Cedars' assist in rebuilding a primary care referral base?
    b. Please indicate which Commercial and Medicare Advantage agreements that Cedars' foundation and/or affiliates assume professional risk or are considered risk bearing organizations? Does Cedars accept institutional risk? Are all related MSO support functions/operations performed by Cedars or outsourced? If the latter, who is the party and which functions?
    c. The proposal acknowledges the existing relationships with City of Hope and USC and demonstrates the intent to mitigate any service disruptions or adverse financial consequences. If City of Hope or USC terminates its existing relationship with Huntington upon its affiliation with Cedars, how quickly can Cedars mobilize a specific plan to replace the terminated relationship? Would care be provided at Huntington or referred to other Cedars facilities?
8. **Information Technology:**
    a. Your proposal indicates that, upon affiliation with Cedars, Cedars' Epic platform and license will be made available to Huntington. Please indicate when this would be completed by in terms of "time from closing date". Will the Epic implementation be funded by Cedars or by Huntington? Please confirm if Cedars Foundation, Cedars Sinai Health Associates, Cedars Sinai Medical Group and Affiliate MDs are on the Epic Ambulatory platform.
    b. Please describe your program to extend Epic to affiliated, non-foundation physicians? Please also describe the support structure available to these physicians?
    c. Are there IT applications other than EHR that Cedars would immediately seek to deploy at Huntington?
9. **Physician Alignment:**
    a. How would management of the Huntington medical foundation be affected by the Huntington medical foundation joining the CSMS medical foundation?
    b. Specifically for foundation physicians in primary care, does Cedars subscribe to the "medical home" model?
    c. The proposal shows Cedars' intent to co-develop a physician network development strategy upon affiliation. How does Cedars envision specific physician recruitment initiatives for Huntington's service area being developed?
    d. How would Cedars practically approach growing Huntington's medical foundation?
    e. Please describe the different components of the physician enterprise in more detail including the Cedars foundation, Torrance foundation, Cedars Sinai Health Associates, Cedars Sinai Medical Group and Affiliate MDs and also describe how they relate to the organization.

CONFIDENTIAL

f. The proposal touches on strategy for ambulatory and urgent care. Please elaborate on Cedars' strategy regarding ambulatory. Please elaborate on Cedars' strategy regarding urgent care.

10. **Clinical Services:**
    a. The proposal demonstrates Cedars' intent to collaborate with Huntington to further develop key service lines and improve patient care. Does Cedars have any specific plans re: service line growth and development at Huntington?
    b. What are Cedars' preliminary thoughts regarding where pediatric services would fit within a combined organization upon affiliation with Huntington?
    c. Does Cedars anticipate that the proposed relationship would have any impact on any of Huntington's existing quaternary transfer arrangements?
    d. The proposal cites 13 work teams focused on collaboration and sharing of best practices. What infrastructure is in place within these work teams to ensure best practices across the system? Is decision-making authority granted to the work teams or is it centralized? Please describe how the work team structure works in the context of quality initiatives.
    e. In the Torrance affiliation, were their commitments to grow/support certain service lines?
11. **Residency:**
    a. How would Huntington's existing residency programs be impacted upon affiliating with Cedars, a leading institution in research and education?
    b. Would physician educators be on-site supporting the Huntington campus?
    c. Does Cedars' utilize "standard" education/simulation training across the entire organization?
12. **Operational Infrastructure:**
    a. Understanding Cedars' intentional strategy to keep limited corporate infrastructure centralized at CSHS, how are decisions made regarding utilization and management of corporate functions across the system, specifically legal, HR and philanthropy?
    b. Related to this organizational structure, how are shared services ultimately made available across the system if not through channels from a centralized infrastructure?
    c. Does Cedars anticipate a transition to a model where shared services are provided at the corporate level? Will functions such as HR, legal, finance, etc. be transitioned to a corporate office as Cedars continues to grow?
    d. Are there specific corporate services that Cedars believes would create immediate efficiencies for Huntington?
    e. The proposal provides examples of back-office efficiencies, such as services provided by the CSHS development department. Given the select nature of shared service offerings available affiliates, how does Cedars' maximize the benefits of scale if members are potentially on shared services for some functions but not others?
    ~~f.~~ Noting Cedars provides certain corporate services to some members based on need but not all corporate services are necessarily provided to all members, how would Cedars work with Huntington in instances where Cedars identifies an area for potential cost savings, but Huntington desires to pursue different opportunities?

CONFIDENTIAL

g. Your proposal indicates the notion of cost-sharing for corporate overhead services citing revenue cycle as one possible example. Please describe the specific methodology for which corporate overhead costs will be allocated?

13. **Employees:**
    a. Your proposal indicates that Huntington would remain "solely responsible" for all employment decisions and that employment status and benefits for pre-affiliation employees of Huntington would remain consistent post-affiliation. Would Cedars make an explicit commitment to maintain current compensation, benefits, and seniority for all Huntington employees in good standing?
    b. Over time, does Cedars anticipate transitioning Huntington employees to a common benefit offering provided throughout the broader organization? If so, please describe your expectations regarding timing of the transition. Also, please describe at a high level your anticipated benefit design.
    c. It is our understanding, historically, that Cedars' collective bargaining agreements with the Service Employees International Union and the California Nurses Association. How does Cedars anticipate integrating with Huntington which has a nonunionized labor force? What is Cedars' philosophy to follow National Labor Relations Act (NLRA) to allow employees the right to choose?
    d. To the extent available, please provide employee engagement scores for your organization.
    e. What are Cedars' experiences regarding employee reaction in your previous affiliations at Torrance and Marina del Rey?
    f. Huntington recognizes the importance of deliberate executive succession planning to preserve and continue the mission of an organization. Can Cedars' please describe its approach to succession planning related to c-suite executives?
14. **Brand:**
    a. We understand Cedars' strategy to utilize the local brand (i.e. Huntington Brand) as the primary consumer facing brand while also leveraging the Cedars' affiliation as a "brand energizer". Does Cedars anticipate this brand strategy would mirror the convention used at Torrance – "Torrance Memorial Medical Center, a Cedars-Sinai affiliate"? What are expectations regarding co-branding, timing of brand transition (if any), commitment to maintain Huntington brand for a specified period of time, etc.?
15. **Philanthropy:**
    a. Noting Cedars' impressive track record of philanthropic support, would Huntington have access to philanthropic funds donated generally (e.g. general needs) to Cedars?
    b. The proposal shows intent to provide support for Huntington's fundraising campaigns, if the support is requested by Huntington. Has there been any discussion with other affiliated partners of centralizing fundraising at the system level?
16. **Other:**
    a. Cedars' fiscal year begins July 1. Does Cedars' anticipate all members shift to this fiscal year upon affiliation?

CONFIDENTIAL

Exhibit 8-F

Cedars-Sinai's Responses to Follow-Up Questions



CEDARS-SINAI HEALTH SYSTEM®

Project Rose

CEDARS-SINAI HEALTH SYSTEM RESPONSE TO FOLLOW UP QUESTIONS

Table of Contents

1	Form and Structure	2
2	Governance	2
3	Trust	5
4	Debt	5
5	Capital	6
6	Key Decision Processes	12
7	Existing Relationships	12
8	Information Technology	14
9	Physician Alignment	15
10	Clinical Services	20
11	Residency	22
12	Operational Infrastructure	22
13	Employees	24
14	Brand	26
15	Philanthropy	26
16	Other	27
17	Appendix A: CSHS Strategic Plan Summary	28
18	Appendix B: Summary of Torrance Health Associates (THA) Affiliation Agreement	29
19	Appendix C: CS-Link for Private Offices Overview	32
20	Appendix D: Overview of CSMCF Entities	33
21	Appendix E: CSMC Employee Engagement Scores	35

1 Form and Structure

	a) Your proposal highlights a strategic goal to grow the system and selectively pursue the addition of new hospitals and other affiliates. What are your expectations for future growth, including identified geography, beyond an affiliation with Huntington (e.g., number of hospitals, revenue base, etc.)? What role and influence do you anticipate Huntington would have related to this strategic goal?

- CSHS is still a relatively new health system with just two members and is primarily focused on new member growth in the greater LA region.
- CSHS has a strategic plan that identifies ten priority communities of interest in the greater LA region. Please refer to Appendix A for a summary of the CSHS strategic plan developed in 2018.
- Huntington will be able to have an influence on the system's growth strategy, including potential partners near Huntington's service area and potential partners in the broader LA region, through its role on the CSHS board. Since Huntington will be an early member of CSHS, it will have considerable influence on the system's growth strategy, along with the two founding members.

	b) In the event the strategic goal to grow the system results in an acquisition(s) in and near Huntington's service area, how would any conflicts of interest relative to growth be addressed?

- All new CSHS partners will be vetted through the CSHS board. Huntington, through representation on the CSHS board, will have the ability to influence the selection of new affiliates. Huntington will be able to identify potential conflicts of interest, and those conflicts will be managed as part of the CSHS partnership decision-making process.
- CSHS leadership is committed to a growth strategy that is accretive to the overall system considering the existing member's service areas and in compliance with applicable antitrust law.

2 Governance

	a) In addition to the minimum CSHS board approval requirements outlined in your proposal (e.g., election/termination of Huntington board members, changes to Huntington bylaws, approve strategic plans and operating/capital budgets, etc.), are there other reserve powers that you expect to be maintained at the parent level under any "mutually-acceptable governance matrix"?

- The list of CSHS board reserve powers shared in our 9/12 proposal reflects the minimum necessary to allow the system to present as a single entity to the market under applicable law. We do not anticipate any other reserved powers would be essential to Huntington joining the system. However, we anticipate that the parties will seek antitrust counsel to ensure that the agreed upon reserved powers are sufficient for antitrust purposes.

The following is a recap of our reserve powers requirements:

Description of CSHS board Approval Requirements
1. Adopt, repeal, modify, amend or restate the Articles of Incorporation, Bylaws or other governing documents of Pasadena Hospital Association (PHA) or any of its subsidiaries
2. Elect individuals to the board of directors of PHA who are nominated by the PHA board
3. Remove individuals from the board of directors of PHA with or without cause
4. Transfer non-cash assets from PHA or any of its subsidiaries to CSHS
5. Establish or consummate a transaction that results in a change of control of PHA or any of its subsidiaries
6. Change the mission, vision and values of PHA
7. Change the corporate structure of PHA if such change would affect PHA's status as a tax-exempt organization
8. Elect to voluntarily dissolve PHA
9. Change the name of PHA or a licensed hospital owned and operated by PHA
10. Sell any real property owned by PHA
11. Approve PHA's strategic plans, capital budgets and operating budgets
12. Form an obligated group among CSHS, PHA and other hospital partners

Other material affiliation terms that would most likely be included in various governing documents (e.g., entity bylaws) or any definitive affiliation agreement for the proposed transaction include the following:

- If CSHS ever decides to close, sell, transfer, change the control of or change the use of substantially all of the assets of Huntington, PHA would have the right to exit CSHS and assume control of the assets after assuming all liabilities.
- PHA will have the right to approve a material reduction, substantial change in use or discontinuation of certain designated services at Huntington if the decision is supported by specific quality and/or economic reasons or if it creates a significant negative effect on the availability of the discontinued or reduced medical services to the residents of Huntington's service area, as determined by CSHS in collaboration with an independent consultant.
- PHA, along with the other CSHS hospital partners, would be required to make periodic payments to CSHS to cover CSHS's operating expenses. PHA's pro rata portion of such operating expenses would be proportionate to PHA's own operating expenses relative to the operating expenses of the other hospital partners. At this point, CSHS operating expenses have been negligible.
- PHA, along with the other CSHS hospital partners, would be required to make capital contributions from time to time to CSHS to fund CSHS investments and initiatives. PHA's pro rata portion of such capital contributions would be proportionate to the number of directors that PHA has the right to nominate to the CSHS board relative to the total number of directors on the CSHS board (not including the ex-officio directorship of the CSHS CEO). At this point, no such calls for capital have been made.

	b) We note the intent of your proposal to preserve Huntington's fiduciary board, including decision-making authority to be maintained by Huntington (e.g., Huntington right to exit upon change of control/sale/closure, approval of material service line changes, etc.). What specific decision-making authority do you expect to be maintained at the local Huntington board?

- CSHS expects Huntington's fiduciary board to maintain local governance over major strategic, clinical, operational and financial decisions, subject to applicable CSHS reserve powers.
- CSHS expects Huntington board's decision-making authority to be structured similar to that of the Torrance Health Associates (THA) board, as described in Appendix B.
- CSHS expects to work with Huntington to develop a mutually acceptable decision-making matrix as part of the definitive agreement negotiation process.

	c) The proposal indicates that Huntington will have representation on the CSHS board under the proposed affiliation, similar to Torrance representation on the CSHS board. How are seats on CSHS board to be allocated?

- We expect Huntington will have representation on the CSHS board proportional to its overall size relative to CSMC and THA.
- CSMC will maintain majority representation on the CSHS board, and CSMC and THA have agreed that regardless of any system expansion, THA will maintain the right to nominate at least ten (10) percent of the total number of directors serving on the CSHS board.

	d) The proposal indicates that Huntington will have the right to nominate an agreed upon number of directors to the CSHS board. What is Cedars' policy re: term limits and the nomination process for Board members?

- CSHS board members are elected for terms of one or two years, and at this time have no term limits. Affiliates have continued to maintain their respective policies regarding board terms and term limits. For example, CSMC continues to have a board member age limit.
- CSHS board members are nominated by CSHS affiliates based on their own criteria and nominating process.
- Currently, all the CSHS board members are also members of the board of directors of their respective affiliate organizations.

	e) How would the CSHS board composition change as new partners are added as the system grows? Will all new partners be granted CSHS seats? Will CSHS expand beyond the 12 current board members or replace existing members? Will representation for Huntington be proportionate to the new size of the board or will the number of seats allocated to Huntington remain fixed?

- CSHS board composition will adapt as members are added, which may include expanding the size of the CSHS board to allow for proportionality and to ensure that (1) CSMC will maintain majority

representation on the board, and (2) THA will maintain at least ten (10) percent of the total number of CSHS board seats.

3 Trust

	a) Huntington appreciates Cedars' acknowledgement of Huntington's desire to maintain the important relationship with the Trust, and in particular Cedars' guiding principles to "respect the relationship with the Trust, preserve a role for the Trust, and continue the Trust's mandate". Cedars raises two possibilities regarding changes to the Trust: (i) donating currently leased real estate and any other continuous land to Huntington and (ii) continuing the Trust's participation in governance without lifetime appointments. i. Please describe the particular land, other than the Hospital property, that Cedars anticipates would be donated from the Trust to Huntington. Additionally, does Cedars' have preliminary thoughts regarding the development of non-leased land (i.e. hospital adjacent property)? ii. Please describe your proposed alternative to lifetime appointments including length of terms, term limits, number of Trustees on the local board, number of Trustees on the parent board, and the nomination process. Please also specify your expectations regarding the Trust's current voting block rights.

- We understand and respect the role of the Trust and its purpose of supporting the Hospital. For this reason, we agree that the Trust retains the Hospital adjacent property.
- Ideally, the Trustees on the Hospital board would have the same terms as other members of the Hospital board. However, we respect that this is a matter between the Trust and the Hospital board, and would not require that as a condition of Huntington joining the system.

	b) In the event the Trustees elect not to transfer the Hospital land as part of an affiliation, please describe key terms your organization would seek (e.g., length of lease) with respect to the current lease structure.

- If the Trust does not transfer the Hospital land to PHA, we will expect the Trust to extend the lease on its current terms for the longest possible period.

4 Debt

	a) Your proposal indicates a willingness to evaluate Huntington becoming a member of Cedars' obligated group, but also anticipates the Trust will remain a co-obligor on the existing Huntington debt. Do you anticipate Huntington Hospital joining your organization's obligated group and removing the co-obligation of the Trust? If so, what are your expectations regarding timing?

- CSHS currently does not have an obligated group, and we do not intend to immediately form a new obligated group as part of the proposed transaction. We anticipate that the Trust could remain a co-obligator on Huntington's existing debt for a period of time. If that is not possible (i.e., due to legal constraints or current bond covenants), CSHS is prepared to step in to fill the co-obligation role currently supported by the Trust.

- We are exploring the possibility of forming a new CSHS obligated group in the next 12 – 24 months, and are open to Huntington joining the new group and removing the Trust from its current obligation requirements at that time. We are also open to evaluating an accelerated schedule for the formation of a new CSHS obligated group.

5 Capital

	a) The proposal clearly articulates Cedars' willingness to "support Huntington's current debt and future capital spending plans". In an effort to create a consistent framework from which Cedars' commitment can be evaluated by Huntington, please articulate your capital commitment to Huntington.

- CSHS considers Huntington's planned strategic initiatives appropriate and important for the long-term sustainability of the Hospital and its services to the community. CSHS is willing to accept Huntington's current strategic capital plan of ~$800M over ten (10) years. CSHS is willing to incorporate Huntington's current strategic capital plan into the definitive affiliation agreement, subject to further discussion.
- In addition, CSHS is prepared to commit to the following as part of the proposed transaction:

1. $100M in support over ten (10) years for the portion of the capital plan related to Master Facility Plan and IT infrastructure (EMR and Non-EMR) that may be impacted due to operational shortfalls, making it difficult to fund.
2. $100M to support over ten (10) years for additional strategic capital needs in areas such as physician network development, specialist and PCP recruitment, ambulatory network strategy, and other related projects.
3. Significant in-kind support to unlock synergies and help Huntington execute its strategic initiatives in the following key areas where CSHS has both scale and capability advantages to support Huntington's strategic initiatives:

CSHS Capability Areas	Highlights of capabilities that can offer in-kind support to Huntington's Strategic Initiatives	Areas of in-kind support
Information Technology	■ Cedars-Sinai achieved HIMSS 7 status in 2015. ■ EIS has approximately 540 people who work in the department and over 20% are clinicians. ■ Cedars-Sinai operates a scalable data center that is housed in 40,000 sq. ft. in El Segundo that hosts approximately 3,000 servers. ■ Cedars-Sinai is a leading user of Amazon Web Services (AWS) with over 700TB of information in the cloud. ■ We have a leading-edge cybersecurity team with a 24/7 security operations center built upon a $30 million investment in technology. ■ We encourage innovation. Turning promising ideas, such as Artificial Intelligence, into breakthroughs for better care and better health is the goal of the **Cedars-Sinai Accelerator**, which is an intensive three-month program that provides mentoring and other support for technology innovators.	■ Cost savings from license synergies. ■ In-house Epic implementation support resources in areas such as clinical informatics, architecture, etc. ■ Key management and technical expertise to manage Epic implementation. ■ Cost savings from shared infrastructure, such as data center. ■ Access to CSMC's digital health infrastructure such as video visits and secure provider messaging tools. ■ Significant resources for analytics, including advanced tools such as data lakes, predictive models, and access to scarce data scientists. ■ Access to development resources for mobile digital initiatives. ■ Access to shared clinical systems (non-Epic) from digital document management to PACS. ■ Access to innovation infrastructure.
Strategic Business Planning	■ Department consists of over 10 professionals with significant health system strategy and planning experience. ■ Various tools and data sources (Advisory Board Planning 20/20, Sg2 Analytics, Crimson Market Advantage, OSHPD, etc.) to gain market and patient insights. ■ Strategic business planning processes and financial planning templates and tools.	■ Access to in-house expertise and tools for strategic planning.

CSHS Capability Areas	Highlights of capabilities that can offer in-kind support to Huntington's Strategic Initiatives	Areas of in-kind support
Real Estate and Facility Planning and Design	■ Department consists of nearly 60 professionals including architects and construction project managers with facility development and large-scale project management expertise. ■ Ambulatory site development templates. ■ Key market relationships with real estate brokers and building management companies.	■ Access to in-house expertise and tools for project development and management.
Service Line Development	■ Over 25 Department Chairs with deep knowledge of developing clinical programs and service lines with national recognition in areas such as: ▸ Heart ▸ Cancer ▸ Orthopedics ▸ Digestive Health ▸ Women's Health ▸ Pulmonology ■ National academic network for recruitment of specialists. ■ Experience developing and implementing population health and value-based care strategies. ■ Academic and research program development and management capabilities.	■ Access to in-house expertise for development of clinical programs. ■ Strategic service line leadership and recruitment support.
Service Line Operations	■ Day-to-day service line operations for various specialties such as Heart, Cancer, Neonatology, Women's Health, Neurosciences, etc. ■ Throughput and clinical efficiency processes and tools for efficient and effective management of clinical service lines.	■ Access to in-house expertise for service line operations.

CSHS Capability Areas	Highlights of capabilities that can offer in-kind support to Huntington's Strategic Initiatives	Areas of in-kind support
Performance Improvement and Patient Experience	■ Department consists of nearly 20 professionals with significant industry experience driving quality and performance improvement initiatives. ■ Proven processes and technology infrastructure to maintain and improve clinical quality, performance, and patient experience across the health system.	■ Access to in-house expertise, processes and tool to improve quality and other performance areas.
Ambulatory Network Development and Management	■ Deep expertise in developing and managing ambulatory facilities, including primary care and specialty care practices, urgent care clinics, infusion centers, ambulatory surgery centers, endoscopy centers, and imaging centers.	■ Access to in-house ambulatory management expertise.
Medical Staff and Executive Recruitment	■ Internal network development, medical staff and executive recruitment function to support the hiring of leadership positions for the system.	■ Access to in-house recruitment and network development expertise.
Managed Care Contracting and Payer Relations	■ Extensive relationships and expertise across various payer products, segments, and networks. ■ People, processes, and technology to support the development and management of various payer and value-based contracts.	■ Access to in-house managed care relationships, contracting expertise and various analytic tools.

CSHS Capability Areas	Highlights of capabilities that can offer in-kind support to Huntington's Strategic Initiatives	Areas of in-kind support
Revenue Cycle: **Health Information Management and Coding**	■ CSMC Health Information Central Business Office (CBO) division provides services in CDI, coding, and auditing. Established resource pool with workflow technology. Virtual work environment. ■ Coding ▸ Resource pools ▸ DNB reductions ▸ Computer-assisted coding. Repeat implementation successes. Leverage AI/NLP technology to prioritize case intervention. ▸ Implement single path coding. Consolidate hospital and professional coding workstreams. ■ Coding Audit ▸ Application of rules-based technology to identify accounts with audit/error risk. ▸ HAC/PSI reviews to rule out errors prior to submission ▸ Payor rules. ■ Clinical Documentation Integrity Program ▸ Provider education. Standard and customized live and virtual education sessions. ▸ Concurrent review. Leverage technology with automated reviews by RNs and MDs. Real-time support for queries and documentation clarification. ▸ LOS/Working DRG analysis. Concurrent DRG assignment for use in clinical decision-making related to the length of stay and SOI/ROM scores. ▸ Physician specific performance compared to peers/benchmarks.	■ Access to various in-house tools and consulting resources to improve the performance of HIM and Coding functions.

CSHS Capability Areas	Highlights of capabilities that can offer in-kind support to Huntington's Strategic Initiatives	Areas of in-kind support
Revenue Cycle: **Revenue Integrity, Billing and Collections**	■ Revenue Integrity internal consulting division has 40 FTEs with capabilities to: ▸ Analyze CDM to find lost revenue. ▸ Analyze charge protocols to determine revenue enhancement improvement projects. ▸ Implement charge reconciliation practices to stop revenue leakage. ■ Illustrative results of the Revenue Integrity program, over the first 5-7 years, netted $35-$50 million annually for CSMC. ■ Current program nets approximately $15-$20 million annually for CSMC. ■ An initial program initiated at Marina del Rey Hospital netted $2 million last year.	■ Access to various in-house tools and consulting resources to improve the performance of revenue cycle functions.
Other Corporate Services	■ CSMC has significant capabilities and capacity in other corporate services areas as a result of its size and ongoing investments. These include: ▸ Legal ▸ Compliance ▸ Risk Management ▸ Human Resources ▸ Supply Chain ▸ Facility Management	■ Access to various in-house resources across multiple niche areas of expertise.

b) Please describe the capital allocation process Huntington would be subject to under an affiliation with Cedars, including threshold levels and the recommendation/approval process of each of the following:

i. Routine Capital Expenditures (e.g., ongoing facility maintenance, equipment replacement, etc.)
ii. Strategic Capital Expenditures (e.g., new tower project, ambulatory expansion, physician alignment, etc.)
iii. IT applications and systems

■ Huntington's board will be responsible for initial recommendation/approval of routine and strategic capital and IT expenditures, subject to CSHS reserve powers for final approval of Huntington's strategic plans, capital budgets, and operating budgets.

6 Key Decision Processes

	a) Please describe the process, indicating the operational steps as well as ultimate legal responsibility for decision-making, for each of the following under an affiliation with Cedars (including the exercise of reserve powers by Cedars): i. Hiring and firing the CEO of Huntington ii. Approval of change of control iii. Development and approval of capital and operating budgets iv. Approval and funding for construction of major capital projects such as a new tower v. Implementation of new IT initiatives vi. Amendments to governing documents, including changes in governance/decision-making

- For the items (i) through (vi) listed above, under an affiliation agreement with CSHS, the Huntington board will be responsible for initial recommendation/approval, subject to CSHS's reserve powers for final approval.

7 Existing Relationships

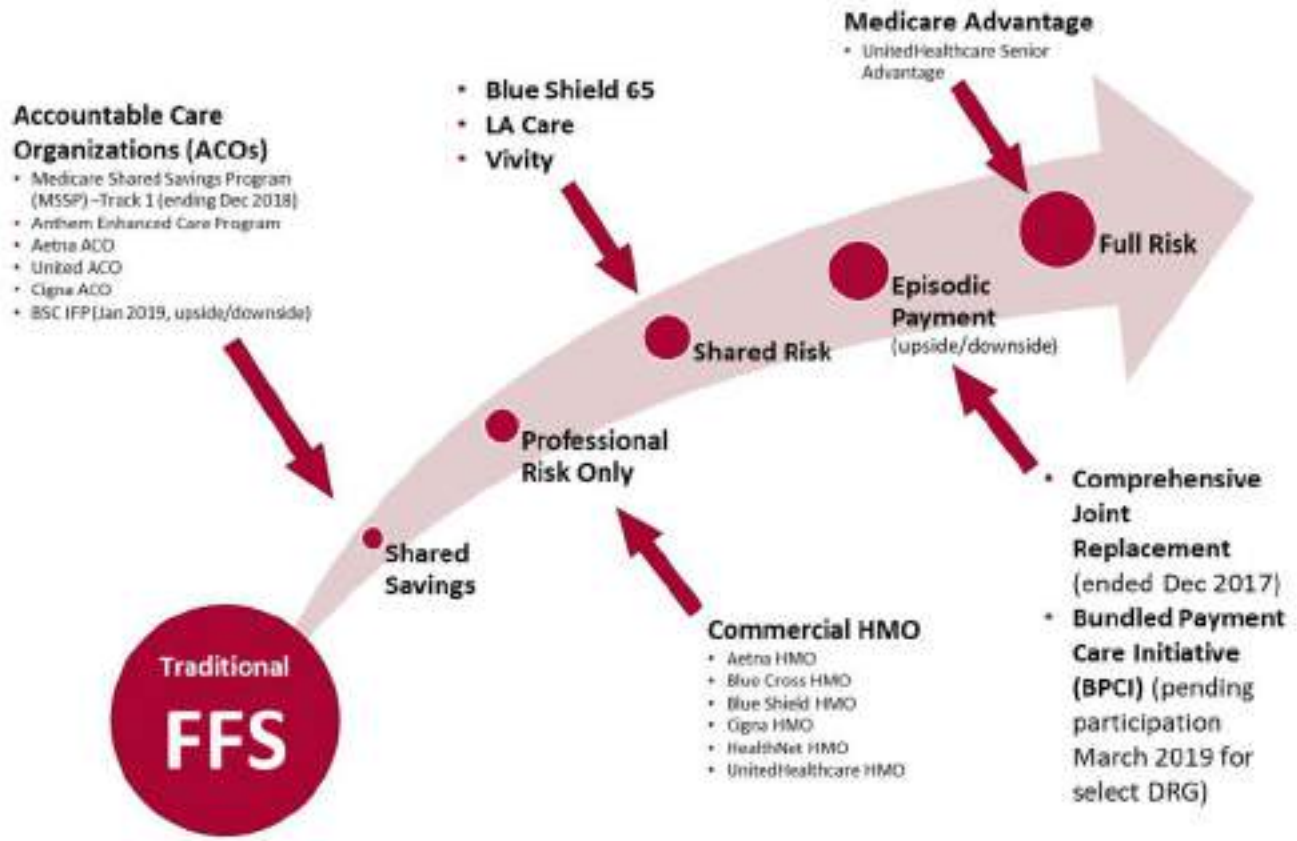
	a) It is our understanding, based on your proposal, that the initial intent regarding Huntington's existing relationship with HCP is to continue that relationship upon affiliation with Cedars and to minimize potential for disruption. How would Cedars look to mitigate Huntington's reliance on HCP over time? Please describe your anticipated plan to do so. Furthermore, if an affiliation with Cedars disrupted the HCP relationship, would Cedars support Huntington's existing budget and can Cedars' assist in rebuilding a primary care referral base?

- CSHS does not expect to disrupt the current HCP relationship. CSHS has significant experience in the Torrance service area working effectively with HCP.
- CSHS expects to jointly develop a physician alignment and ambulatory strategy to help Huntington diversify its primary care and specialty network. Key elements of Huntington service area ambulatory strategy will include:
  - Recruitment of PCPs and Specialists in five strategic specialties into the Huntington's Foundation, including geographic diversification across Huntington's communities.
  - Development of clinically integrated networks, including ACOs and IPA models.
  - Development of MSO and EHR services for independent community physicians.
  - Ambulatory sites of care in Huntington's service area, including primary care clinics, urgent care, imaging centers, ASCs, and other non-traditional options such as virtual care, etc.

	b) Please indicate which Commercial and Medicare Advantage agreements that Cedars' foundation and/or affiliates assume professional risk or are considered risk bearing organizations? Does Cedars accept institutional risk? Are all related MSO support functions/operations performed by Cedars or outsourced? If the latter, who is the party

	and which functions?

- The following graphic highlights the spectrum of Commercial and Medicare risk agreements currently held by the Cedars-Sinai Medical Care Foundation (CSMCF).
- CSMCF also currently accepts institutional risk on select Medicare Advantage contracts, such as the United Healthcare Senior Advantage Plan, which has over 5,000 lives.
- CSMCF also has innovative shared savings models with certain payers for specific segments, such as BSC IFP, where there is a significant institutional risk component as part of a total cost of care savings contract.



- Since 2018, all CSMCF MSO functions are performed in-house.

?	c) The proposal acknowledges the existing relationships with City of Hope and USC and demonstrates the intent to mitigate any service disruptions or adverse financial consequences. If City of Hope or USC terminates its existing relationship with Huntington upon its affiliation with Cedars, how quickly can Cedars mobilize a specific plan to replace the terminated relationship? Would care be provided at Huntington or referred to other Cedars facilities?

- CSHS does not expect to disrupt the USC and CoH relationships, but if there is disruption, we will work to provide coverage and develop a recruitment strategy to maintain near-term and long-term services in the community.

8 Information Technology

	a) Your proposal indicates that, upon affiliation with Cedars, Cedars' Epic platform and license will be made available to Huntington. Please indicate when this would be completed by in terms of "time from closing date". Will the Epic implementation be funded by Cedars or by Huntington? Please confirm if Cedars Foundation, Cedars Sinai Health Associates, Cedars Sinai Medical Group and Affiliate MDs are on the Epic Ambulatory platform.

- CSHS is committed to sharing our Epic instance with Huntington and is confident that doing so will achieve the benefits and cost savings highlighted in our 9/12 proposal.
- CSHS is open to begin working with Huntington on validating its Epic implementation plans during the negotiation process and beginning the Epic build at the earliest date from closing.
- All our CSMCF affiliated entities are currently on Epic. Details are provided in Appendix D.

	b) Please describe your program to extend Epic to affiliated, non-foundation physicians? Please also describe the support structure available to these physicians?

- Please refer to Appendix C for details of our "CS-Link for Private Offices Overview" program, including capabilities offered.

	c) Are there IT applications other than EHR that Cedars would immediately seek to deploy at Huntington?

- In addition to Epic, we believe Huntington could benefit from IT shared services and licensing synergies in the following areas that we will make available to Huntington:
  - Front-office IT tools (e.g., Office 365, etc.)
  - Revenue cycle tools (e.g., 3M coding tools, etc.)
  - IT security tools (e.g., VPN, end-point security, etc.)
  - Clinical applications (e.g., PACS, CareStream for documentation management, etc.)
  - IT infrastructure services (e.g., ServiceNow, data center, etc.)

9 Physician Alignment

a) How would management of the Huntington medical foundation be affected by the Huntington medical foundation joining the CSMC medical foundation?

- CSHS is open to discussing various models for developing Huntington's foundation. If Huntington's foundation were to affiliate with CSMCF, we expect to develop an optimal model for continued local management to support the needs of the Huntington medical community and create access to CSMCF capabilities and expertise.
- CSHS support for Huntington's foundation is not contingent on Huntington's foundation becoming a subsidiary or part of CSMCF, although that is our preferred approach to share capabilities and to benefit from synergies.

b) Specifically, for foundation physicians in primary care, does Cedars subscribe to the "medical home" model?

- CSMCF has developed a "Transformed Practice Model" for our primary care and specialty care (e.g., GI and OB/GYN practices), which is an enhanced version of the "Medical Home" model. The Transformed Practice Model is being rolled out across all CSMCF clinics.
- Our goal through practice transformation is to create the preeminent physician office practice, which simultaneously brings patient, physician, and staff joy by solving for operational and clinical efficiency within the clinical space.
- Through improved clinical and administrative efficiencies, the Transformed Practice Model has enabled CSMCF to create space for care teams and patients to consistently connect in a meaningful and personal way through co-location and new workflows.
- The Transformed Practice Model creates first call clinical problem resolution, improved digital engagement (video visit, text messaging, online appointments) and supports our improved quality and efficiency outcomes for defined populations (IHA and 5 STAR performance) by leveraging lean management systems, solving for efficiencies in new areas, and effectively embedding population health and care management into the practices.
- Additionally, we are starting to see the benefits of expanding the Transformed Practice Model beyond primary care to specialty clinics, in areas such as GI and OB/GYN, which has resulted in improved efficiencies and provider and patient satisfaction.

c) The proposal shows Cedars' intent to co-develop a physician network development strategy upon affiliation. How does Cedars envision specific physician recruitment initiatives for Huntington's service area being developed?

- Based on preliminary discussions with Huntington management, the following are our high-level ideas for physician network development strategy for Huntington:
  - **Current State** – We understand that Huntington's medical foundation has over 50 primary care physicians mainly consisting of internal medicine and pediatric physicians.

- → **Internal Medicine** - 24 Physicians (equivalent to ~21 FTEs)
- → **Pediatric** – 25 Physicians (equivalent to 18.5 FTEs)

- **Ideal Target State** – Over a three to five-year period, develop a physician network of a total of 150 physicians, including:
  - → **Internal Medicine** – Additional 50 – 75 physicians
  - → **Specialties** – Additional 25 – 50 physicians across five strategic specialties such as neurology, orthopedics, cardiology, cancer, etc.

- In addition to recruitment of physicians, develop additional multi-specialty clinics in the following communities, beyond the current footprint in the Pasadena and Arcadia communities:
  - Verdugo Hills
  - La Cañada Flintridge
  - Eagle Rock
- Working with Huntington's management, we will identify areas of needs, and using the CS network development team to execute the above strategy. The CS network development team has a successful track record of recruiting over 40 physicians year over year for both CS and THA. In addition, we will work with Huntington to identify existing primary and specialty groups that are potential targets for acquisition.

	d) How would Cedars practically approach growing Huntington's medical foundation?

- CSHS is committed to supporting Huntington grow its medical foundation and create a robust physician network in support of the Hospital's overall growth strategy. Based on our understanding of Huntington's needs, we offer the following in support of Huntington's foundation:
  - **Growing Primary Care Network.** This includes adding newly employed physicians as well as increasing the number of affiliated physicians through IPA and ACO models. This strategy will enable Huntington to pursue niche contracting opportunities not covered by HCP's exclusivity.
  - **Growing Specialty Care Network.** This includes primarily aligning existing physicians and groups in the community, and subsequently recruiting new physicians overtime, both under Foundation/PSA model. In addition, we will also explore additional commercial segment focused clinically integrated network and IPA models as needed. The focus of this strategy will be to create access to specialty services for all the community primary care physicians.
  - **Expanding Alignment Offerings and Services.** CSHS will help Huntington develop additional physician alignment models by developing services that can help attract independent physicians. Examples of services that can be offed to independent physicians to create alignment include MSO and EHR services.
  - **Leveraging CSHS and Huntington's Teaching Programs and Relationship to Support Recruitment.** CSHS will leverage all its residency and fellowship programs and the broad national relationships of our faculty to recruit specialty physicians to Huntington's market based on needs and gaps. In addition, CSHS will help develop a plan with Huntington to retain its physician residents (in the Huntington network or as community providers).

	e) Please describe the different components of the physician enterprise in more detail including the Cedars foundation, Torrance foundation, Cedars Sinai Health Associates,

	Cedars Sinai Medical Group and Affiliate MDs and also describe how they relate to the organization.

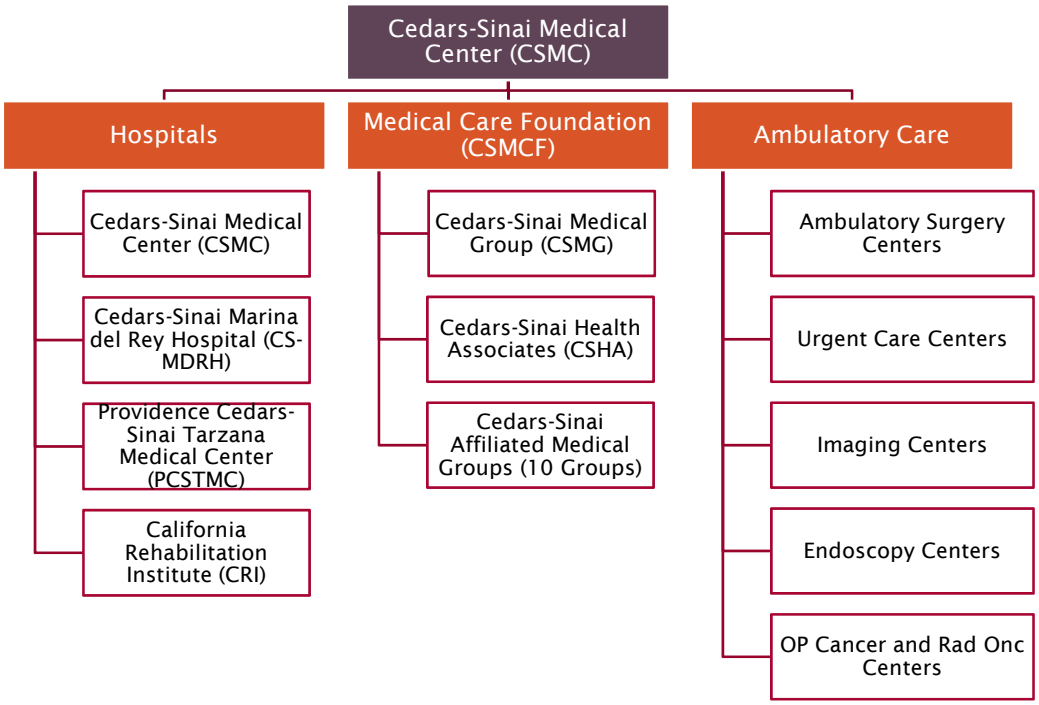
Cedars-Sinai Physician Enterprise Entities

- **Cedars-Sinai Medical Care Foundation (CSMCF)** operates as a nonprofit medical care foundation associated with approximately 1,200 physicians. CSMCF provides urgent, primary and specialty care throughout Beverly Hills, West Hollywood, Playa Vista, Marina del Rey, Culver City, Santa Monica, and the San Fernando Valley.
- Additional details for various CSMCF entities provided in Appendix D.

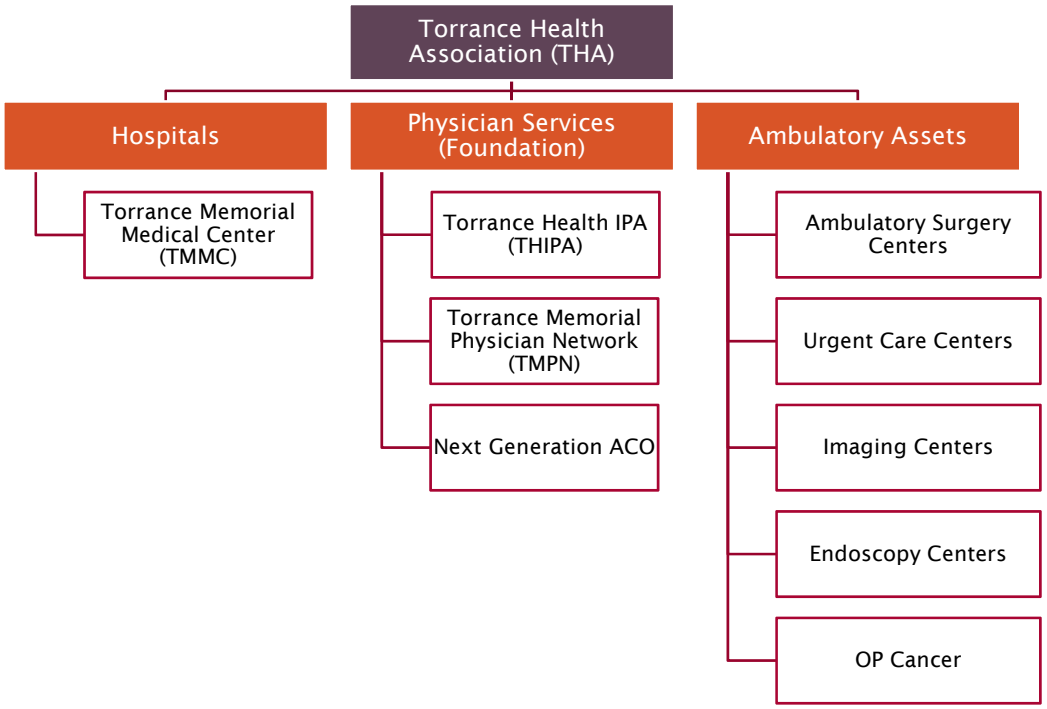
Torrance Health Association Physician Enterprise Entities

- **Torrance Memorial Physician Network (TMPN)** operates as a nonprofit medical care foundation and provides multi-specialty medical services, including primary, urgent care, pediatrics, endocrinology, rheumatology, obstetrics/gynecology, cardiology, and oncology care and other specialties, to patients throughout the South Bay region through nearly 115 primary care and specialty care providers.
- **Torrance Memorial Independent Physician Association (THIPA)** is a nonprofit, multi-specialty physician network that contracts for professional services for approximately 40,000 lives with HMO health plans and offers its members access to a network of over 300 physicians and healthcare providers, hospital services, and urgent care centers.
- **Torrance Memorial Integrated Physicians, LLC** is an accountable care organization (ACO) that is 50% owned by Torrance Health Association and 50% owned by over 300 physician investors. It is comprised of a group of physicians and healthcare providers voluntarily working together with Medicare to provide quality healthcare services to Medicare fee-for-service beneficiaries and currently is participating in the CMS Next Generation ACO and several private insurance ACOs.

Cedars-Sinai

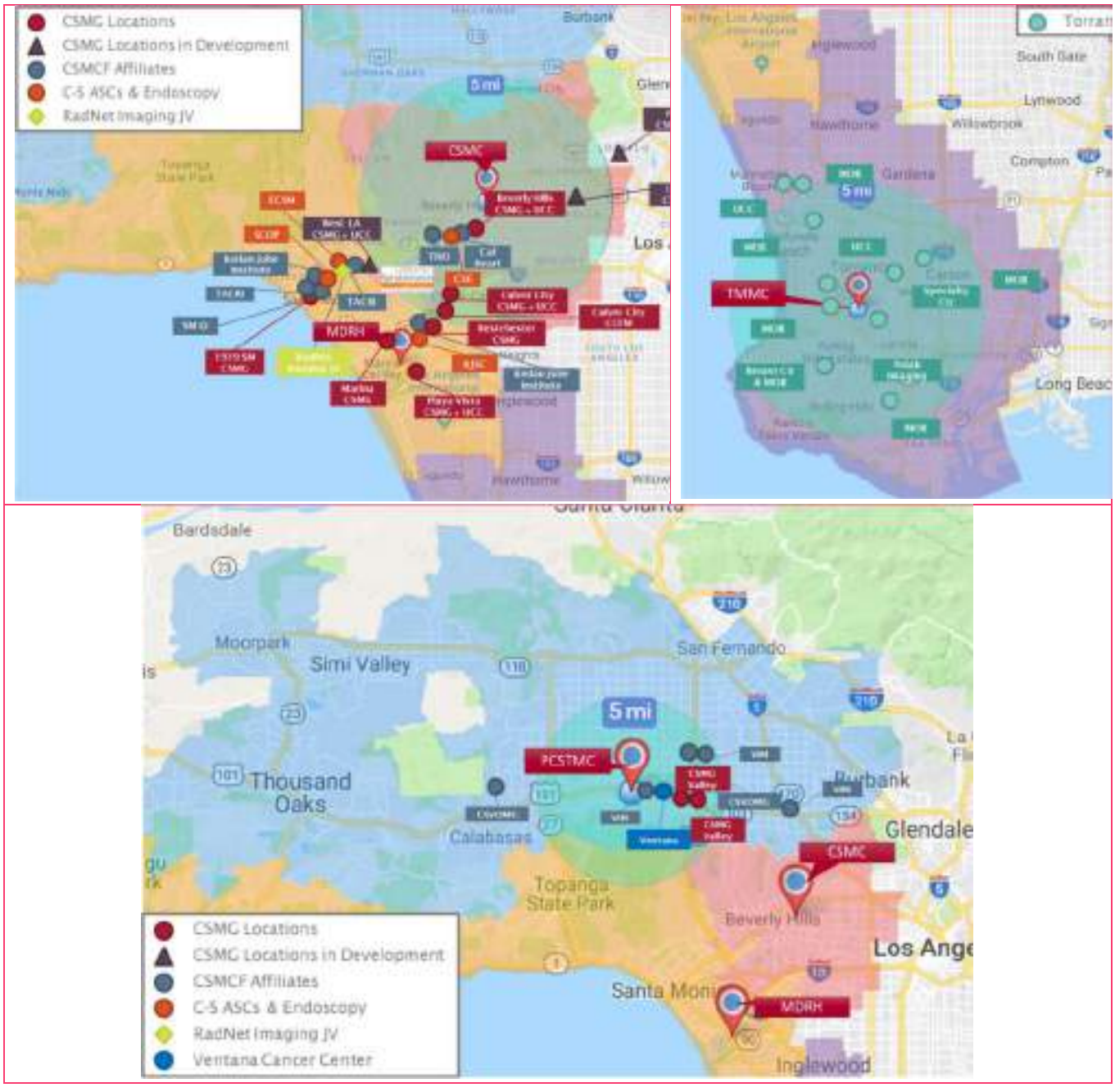


Torrance Health Association



	f) The proposal touches on strategy for ambulatory and urgent care. Please elaborate on Cedars' strategy regarding ambulatory. Please elaborate on Cedars' strategy regarding urgent care.

- CSHS philosophy is to develop physician alignment and ambulatory network strategies that are tailored to the needs of our communities. In each community we currently serve, we continue to invest in a robust physician and ambulatory network that supports our anchor hospital.



- CSHS is in the early stages of integrating our ambulatory network across our communities to create population health value proposition to payers and employers. Today, the different ambulatory EMR platforms across TMMC and CSMC create challenges for integration and population health management that we are working to overcome. If Huntington foundation is on the same ambulatory EMR platform as CSMCF, then additional synergies and value propositions can be realized sooner.

- For urgent care clinics, CSHS currently has both "build" and "partner" strategies based on local market dynamics. We hope to work with Huntington to identify the most appropriate urgent care strategy for the Hospital's service area.

10 Clinical Services

	a) The proposal demonstrates Cedars' intent to collaborate with Huntington to further develop key service lines and improve patient care. Does Cedars have any specific plans re: service line growth and development at Huntington?

CSMC has 12 nationally ranked clinical specialties. CSMC is committed to working with Huntington's management to create access to various clinical specialties based on the needs of the community.

Cedars-Sinai Specialty	US News World Report National Ranking: 2019
Cancer	12
Cardiology & Heart Surgery	3
Diabetes & Endocrinology	16
Ear, Nose, and Throat	38
Gastrointestinal Disorders	2
Geriatrics	12
Gynecology	8
Nephrology / Kidney Disorders	10
Neurology & Neurosurgery	12
Orthopedics	3
Pulmonology	4
Urology	12

CSHS will create linkages between Huntington's physician community and tertiary/quaternary capabilities at CSMC using the following tactics:

- **CSMC Specialist Rotations.** Based on input from Huntington and its physicians, CSMC will support the rotations of CSMC faculty in the local community to enhance access to these sub-specialties. This tactic will be most appropriate for highly specialized care and when demand does not justify a dedicated physician to be based in the community. The objective will be to continue to keep majority of the care local.
- **Recruit Specialist to Local Community.** Based on input from Huntington and its physicians, CSHS will help recruit specialists to be based in the Huntington community through either our faculty or one of the medical foundations. This tactic will be most appropriate when there is significant demand and limited access to care in the local community, requiring a dedicated local presence.

With these tactics, CSHS will strive to develop local physician community relationships and enable patients to receive the vast majority of their care locally, and only travel to other system sites for high-acuity tertiary or quaternary care (e.g., transplants).

	b) What are Cedars' preliminary thoughts regarding where pediatric services would fit within a combined organization upon affiliation with Huntington?

- We believe that pediatric services are an important part of Huntington's services to its communities. CSMC has one of the largest level IV NICU in the greater Los Angeles region and sub-specialty pediatrics capabilities. CSMC is open to working with Huntington's management to develop a pediatric service line plan based on the needs of the community Huntington serves.

	c) Does Cedars anticipate that the proposed relationship would have any impact on any of Huntington's existing quaternary transfer arrangements?

- CSHS does not plan to impact any existing quaternary transfer arrangements in the near-term. In the long-term, we hope to work with Huntington's management and its community physicians to develop quaternary programs that integrate care across CSHS sites with the goal of creating seamless care transition across CSHS affiliates.

	d) The proposal cites 13 work teams focused on collaboration and sharing of best practices. What infrastructure is in place within these work teams to ensure best practices across the system? Is decision-making authority granted to the work teams or is it centralized? Please describe how the work team structure works in the context of quality initiatives.

- The Work Teams, described in the proposal document dated 9/12, are primarily meant to be a collaboration and best practice sharing platform across CSHS affiliate organizations. While the Work Teams do not have any decision-making authority over CSHS affiliate organizations, the Work Teams consist of key functional leaders who have decision-making authority within their respective organizations, and these functional leaders collaboratively develop initiatives that help advance systemness across the CSHS affiliates. Further, each Work Team has been assigned annual goals by the CSHS Executive leadership team of which Huntington's CEO will be a member.
- As an example, in the context of quality initiatives, the work teams serve in the following ways across CSHS affiliates:
  - Share best practices for various local quality objectives.
  - Share tools, processes, and metrics to advance the local quality agenda.
  - Develop system-wide dashboards to monitor inpatient and ambulatory/medical network quality and safety performance.

	e) In the Torrance affiliation, were there commitments to grow/support certain service lines?

- There were no explicit commitments to grow specific service lines as part of the Torrance affiliation. However, based on the needs of the Torrance community and with valuable input from local physicians, CSMC supported Torrance to develop advanced capabilities in the following three areas: Cancer, Heart, Neurosurgery, and Neurology (Stroke).

11 Residency

	a) How would Huntington's existing residency programs be impacted upon affiliating with Cedars, a leading institution in research and education?

- CSHS does not expect any impact on Huntington's existing residency program. CSHS intends to continue to support Huntington's current residency programs and will look to bring any additional capabilities from CSMC based on needs identified by Huntington's residency program director.

	b) Would physician educators be on-site supporting the Huntington campus?

- CSMC is open to providing additional faculty and training resources as needed to support Huntington's residency programs. CSMC has over 400 house staff internally in every specialty and over 450 full-time faculty. CSMC will collaborate with the residency program director to understand potential needs and work to address them in the best possible way.

	c) Does Cedars' utilize "standard" education/simulation training across the entire organization?

- CSMC has a 10,000 square-foot Simulation Center comprised of two fully equipped and functioning operating rooms, an ICU, OB/GYN room and a trauma bay. It has a PICU/NICU and multiple rooms for skills training and development. The center also includes a fully equipped computerized simulation room with simulators for practicing almost every procedure, as well as robotic surgery.
- While the Simulation Center resources are available to all CSHS partners, we currently do not utilize a standard education/simulation training across the entire system. We are open to exploring opportunities to offer access to this unique training resource to Huntington as desired by Huntington's leadership team.

12 Operational Infrastructure

	a) Understanding Cedars' intentional strategy to keep limited corporate infrastructure centralized at CSHS, how are decisions made regarding utilization and management of corporate functions across the system, specifically legal, HR and philanthropy?

- CSHS is still a relatively new health system. CSHS is continuing to evaluate the benefits and risks of centralization for key business service functions. We have not developed a definitive playbook for shared services across the system.
- As one of the early members of CSHS, Huntington will have the opportunity to influence the development of the system's shared services strategy. CSMC, being the largest of the CSHS affiliates, has many strong corporate functions (such as revenue cycle, managed care contracting, risk

management, compliance, legal, HR and philanthropy), that can be scaled to support Huntington's needs.

	b) Related to this organizational structure, how are shared services ultimately made available across the system if not through channels from a centralized infrastructure?

- CSHS intends to use a Center of Excellence (CoE) approach for the development and implementation of shared services across the system. In the CoE approach, CSHS will rely on the Work Teams to identify CSHS affiliates with mature / best-of-breed capabilities that will benefit from being made available to other system members.
- CoEs have the potential to become a centralized infrastructure for a specific functional capability.

	c) Does Cedars anticipate a transition to a model where shared services are provided at the corporate level? Will functions such as HR, legal, finance, etc. be transitioned to a corporate office as Cedars continues to grow?

- CSHS will pursue a CoE approach for shared business functions. We will identify mature / best-of-breed capabilities within the system and create access to those capabilities to other CSHS affiliates.
- Currently, CSMC has mature capabilities in the areas mentioned above as well as those listed in under Section 5 (pg. 7 – 11), which we believe can act as CoE to support Huntington's needs in the near term.

	d) Are there specific corporate services that Cedars believes would create immediate efficiencies for Huntington?

- The following are illustrative corporate services areas that we believe have the potential to create immediate efficiencies for Huntington:
  - Revenue Cycle
  - Legal
  - Compliance
  - Risk Management
  - Human Resources
  - Supply Chain
  - Facility Management
- Additional areas are listed in detail as part of Section 5 (pg. 7 – 11).

	e) The proposal provides examples of back-office efficiencies, such as services provided by the CSHS development department. Given the select nature of shared service offerings available affiliates, how does Cedars' maximize the benefits of scale if members are potentially on shared services for some functions but not others?

- CSHS is continuing to evaluate and refine our approach to shared services. We want to preserve aspects of localized services and operating model innovation as we explore the CoEs for shared services.
- Nonetheless, the system encourages adoption and integration of CoE where the benefits outweigh the cost of change.

	f) Noting Cedars provides certain corporate services to some members based on need but not all corporate services are necessarily provided to all members, how would Cedars work with Huntington in instances where Cedars identifies an area for potential cost savings, but Huntington desires to pursue different opportunities?

- As described in response to question 12(e), CSHS does not require or expect all affiliates to adopt all CoEs established across the system.
- Huntington can leverage CSHS CoEs in areas where it is able to derive the greatest benefits for Huntington specifically, and for the system overall.

	g) Your proposal indicates the notion of cost-sharing for corporate overhead services citing revenue cycle as one possible example. Please describe the specific methodology for which corporate overhead costs will be allocated?

- Our cost-sharing model for shared services will rely on the proportional allocation of direct costs for any resources extended to support Huntington's needs.
- Our model does not envision a fixed corporate overhead, and instead will be based on Huntington's participation in a shared services CoE, for which Huntington will be responsible for its share of the direct costs.
- We believe in almost all cases the direct costs allocated from a CSHS CoE will result in savings compared to having the service locally, as a result of both economies of scale and economies of capabilities.

13 Employees

	a) Your proposal indicates that Huntington would remain "solely responsible" for all employment decisions and that employment status and benefits for pre-affiliation employees of Huntington would remain consistent post-affiliation. Would Cedars make an explicit commitment to maintain current compensation, benefits, and seniority for all Huntington employees in good standing?

- CSHS will commit that current compensation, benefits, and seniority for all Huntington employees in good standing will not change as a result of Huntington joining the system.
- It will be the responsibility of Huntington's board and management to determine employment strategy based on local market dynamics.

	b) Over time, does Cedars anticipate transitioning Huntington employees to a common benefit offering provided throughout the broader organization? If so, please describe your expectations regarding timing of the transition. Also, please describe at a high level your anticipated benefit design.

- CSHS does not anticipate transitioning Huntington employees to common benefits. CSHS currently does not have a common benefit offering and there are no immediate plans to create a common benefit offering across the system.

- However, the HR Work Team may explore opportunities for consolidation of selected purchased services, including benefits, as part of systemness opportunity in the future.

	c) It is our understanding, historically, that Cedars' collective bargaining agreements with the Service Employees International Union and the California Nurses Association. How does Cedars anticipate integrating with Huntington which has a nonunionized labor force? What is Cedars' philosophy to follow National Labor Relations Act (NLRA) to allow employees the right to choose?

- CSHS affiliates are separate legal entities, each solely responsible for all employment relationships with their respective employees.
- Currently, both CSMC and Marina del Rey Hospital have collective bargaining agreements for a subset of their workforce.
  - CSMC – Has a collective bargaining agreement for ~1,300 service workers represented by SEIU.
  - MDRH – Has a collective bargaining agreement for both its nurses (~190 represented by CNA) and its service workers (~335 represented by SEIU).
- Torrance Memorial does not have any organized labor in its workforce.

	d) To the extent available, please provide employee engagement scores for your organization.

- We continue to have strong employee engagement scores – in the most recent survey, CSMC is in the top quartile performance compared to national healthcare organizations. Please refer to Appendix E for the most recent engagement survey results.

	e) What are Cedars' experiences regarding employee reaction in your previous affiliations at Torrance and Marina del Rey?

- We have had a very positive reaction to previous affiliations at both Torrance Memorial and Marina del Rey Hospital. In both those cases, the organizations and its employees benefited from the advantages of having access to additional resources across the system, without any changes in their local employment relationship. In addition, employees at both organizations are excited about the career growth and mobility options that come from the expansion of CSHS across the greater Los Angeles region.

	f) Huntington recognizes the importance of deliberate executive succession planning to preserve and continue the mission of an organization. Can Cedars' please describe its approach to succession planning related to c-suite executives?

- Individual CSHS affiliates have a formal succession planning process for all senior levels of the organization with their Board.

- In addition, before hiring senior executives, individual CSHS affiliates conduct an executive assessment with their C-Level to ensure that they are recruiting the right individuals in leadership roles based on their succession plans.
- CSHS affiliates have executive coaching and talent review capabilities to continue the development of key individuals as part of their succession plans.
- CSMC and Torrance Memorial have recently started discussions to expand and integrate their respective succession planning and talent review processes across the two organizations to create synergies and increase talent mobility across CSHS.

14 Brand

	a) We understand Cedars' strategy to utilize the local brand (i.e. Huntington Brand) as the primary consumer facing brand while also leveraging the Cedars' affiliation as a "brand energizer". Does Cedars anticipate this brand strategy would mirror the convention used at Torrance – "Torrance Memorial Medical Center, a Cedars-Sinai affiliate"? What are expectations regarding co-branding, timing of brand transition (if any), commitment to maintain Huntington brand for a specified period of time, etc.?

- We will work with Huntington to understand how best to fit the Cedars-Sinai brand into Huntington's brand architecture. We are flexible to work with Huntington on the timing.

15 Philanthropy

	a) Noting Cedars' impressive track record of philanthropic support, would Huntington have access to philanthropic funds donated generally (e.g., general needs) to Cedars?

- CSHS does not have a system-level fundraising function. All fundraising functions are at the local affiliate organization, for the sole benefit of the local affiliate's organization and its community.

	b) The proposal shows intent to provide support for Huntington's fundraising campaigns, if the support is requested by Huntington. Has there been any discussion with other affiliated partners of centralizing fundraising at the system level?

- We are currently not exploring any options to centralize fundraising at the system level. We continue to see value in allowing our system partners to develop and execute their community relationship strategy based on local dynamics.
- As originally stated in our proposal, if Huntington is interested, opportunities for shared services to gain fundraising back-office efficiencies can be explored. As examples, CSMC has 71 FTEs in its Development department, which includes divisions for gift receiving/gift processing, donor records, development communications, planned giving and direct mail outreach.



These functions can be leveraged by Huntington, allowing for back-office efficiencies, potentially resulting in Huntington being able to reallocate resources to have more front-line fundraising staff. If this type of shared model for back-office services were to be contemplated, there would still not be any change to any donor facing activities, which would all continue to remain local at Huntington.

16 Other

	a) Cedars' fiscal year begins July 1. Does Cedars' anticipate all members shift to this fiscal year upon affiliation?

- CSHS does expect all members to shift to a July 1 fiscal year calendar to create operational and reporting alignment.

17 Appendix A: CSHS Strategic Plan Summary

The following is a summary of the strategic plan developed in 2018 that captures the vision and growth strategy for CSHS.

Health System Strategic Plan

CEDARS-SINAI HEALTH SYSTEM®

Strategic Plan Table of Contents

a. Strategic Planning Context
   i. Health System Role
   ii. Health System Overview
b. Members Current Focus Areas and Goals
c. Strategy
   i. Health System Mission and Vision
   ii. Health System Value Proposition
   iii. Health System Strategies

a. Strategic Planning Context

Health System Role

The role of the Cedars-Sinai Health System is to:

- Assist member organizations to meet the challenges of a constantly evolving health care environment through development and coordination of system and member level strategy
- Attract and approve the addition of new system members
- Avoid unnecessary duplication of governance roles and responsibilities and preserve the strong governance present at current and future member organizations
- Support the member organizations as they continue governance and management responsibilities for quality of care, operational matters and financial management

Cedars-Sinai Health System Serves Over 500,000 Patients Annually

Health System Statistics	Value
2016 LA County IP Market Position	#3
Acute Care Facilities	• Cedars-Sinai Medical Center • Torrance Memorial Medical Center • Marina del Rey Hospital
Total IP Beds	1,446
Ambulatory Surgery Centers	10
Urgent Care Centers	5
Imaging & Breast Centers	12
Primary Care Clinics	45
Specialty Clinics	45
Annual Unique Patients Served (IP and OP)	564,000

- In 2016, the System's members held the #3 IP market position in LA County
- CSHS members have developed growing ambulatory and physician sites and networks


CSHS Locations
CSVOMG
CSMG Valley
VIM
CSVOMG
VIM
VIM
CSMG Valley
RadNet Imaging JV
Ventana
Spalding
Linden
Precision
90210
ECSM
SCOP
West LA CSMG + UCC
Kerlan-Jobe Institute
TACRI
TACRI
SM GI
1919 SM CSMG
RadNet Imaging JV
Marina CSMG
Playa Vista CSMG + UCC
KJSC
Kerlan-Jobe Institute
Westchester CSMG
Culver City CSMG + UCC
Culver City CCFM
CSE
THO
Cal Heart
Beverly Hills CSMG + UCC
Hillhurst CSMG + UCC
Larchmont CSMG + UCC
Cedars-Sinai Hospitals
Torrance Memorial
California Rehab Institute
Providence Cedars-Sinai Tarzana
CSMG Locations
CSMG Locations in Development
CSMCF Affiliates
C-S ASCs & Endoscopy
RadNet Imaging JV
Torrance Locations
Ventana
MOB
UCC
UCC
MOB
MOB
MOB
Specialty Ctr
Polak Imaging
Breast Ctr & MOB
MOB
Google

b. Members' Current Strategic Focus Areas and Goals

Cedars-Sinai

- **Quality and Patient Experience**
  - Continue to improve patient satisfaction in the hospitals, medical network and faculty clinics
  - Achieve quality and safety targets for Medical Center and Medical Network
  - Achieve clinical efficiency and population health management goals
  - Improve faculty resource utilization
- **Tertiary, Quaternary, Primary and Ambulatory Growth**
  - Grow clinically appropriate inpatient, procedural services
  - Expand medical network, ambulatory sites and accountable lives
  - Scale Medical Network practice transformation model to other offices
  - Continue digital initiatives including video, web, mobile and engagement
- **Research and Graduate Medical Education**
  - Increase peer reviewed research funding
  - Increase quality of graduate medical education programs
  - Increase research faculty salary coverage through outside funding
- **Physician Excellence and Growth**
  - Grow number of Medical Network primary and needed selected specialty physicians

Cedars-Sinai

- **Employee Performance**
  - Continue to increase employee engagement
  - Improve leadership effectiveness, communication and responsiveness
  - Implement a three year talent strategy plan to close key gaps
- **Philanthropy**
  - Meet fund raising goals for annual philanthropy
  - Create awareness and a culture of employee giving
  - Align community benefit, health improvement and strategic grantmaking initiatives
- **Financial Performance**
  - Meet annual income from operations budget
  - Decrease cost per adjusted discharge and patient day

Torrance Memorial

- **Strategic Affiliations and Integration of System Goals**
  - Pursue strategic integration opportunities with Cedars-Sinai
  - Achieve 2020 growth targets for managed care lives and TMPN physician participation
  - Drive service development for key specialty service lines
  - Add primary care and extenders to replace retiring physicians and meet patient demand
  - Advance technology for EMR and related population health platforms
- **Quality and Patient Experience**
  - Maintain 4 star quality scores for THIPA and TMPN; Maintain quality score over 80% for MSSP and ACO populations
  - Leverage EMR implementation to identify quality improvement opportunities
  - Improve patient experience survey results
- **Resource Management and Operational Results**
  - Achieve annual budget goals
  - Achieve MSSP shared savings
  - Advance the Lean Culture
  - Enhance cybersecurity
- **Patients First**
  - Promote patient safety by reducing harm events
  - Achieve top-20 State ranking in US News and World Report
  - Maintain 4 star CMS Patient Experience rating

Torrance Memorial

- **People and Operations**
  - Continue to advance the lean culture
  - Enhance workforce talent and improve engagement scores through recruitment, retention, and development
  - Reduce non staff costs and maintain adjusted patient day costs
  - Optimize coordination of care to decrease Medicare length of stay
  - Enhance and increase awareness of cybersecurity to reduce patient and organizational risk
- **Program and Facility Development**
  - Service line development
  - Enhance the Palliative Care program
  - Complete and occupy the Hunt Cancer Center
  - Complete and occupy the Pediatric and NICU units
- **Community**
  - Achieve integration goals developed mutually with Cedars-Sinai
  - Increase funding from philanthropic sources

c. Strategy

Health System Mission

The Cedars-Sinai Health System is a non profit healthcare organization that seeks to advance the delivery of high quality health care in support of each member organizations' charitable missions to:

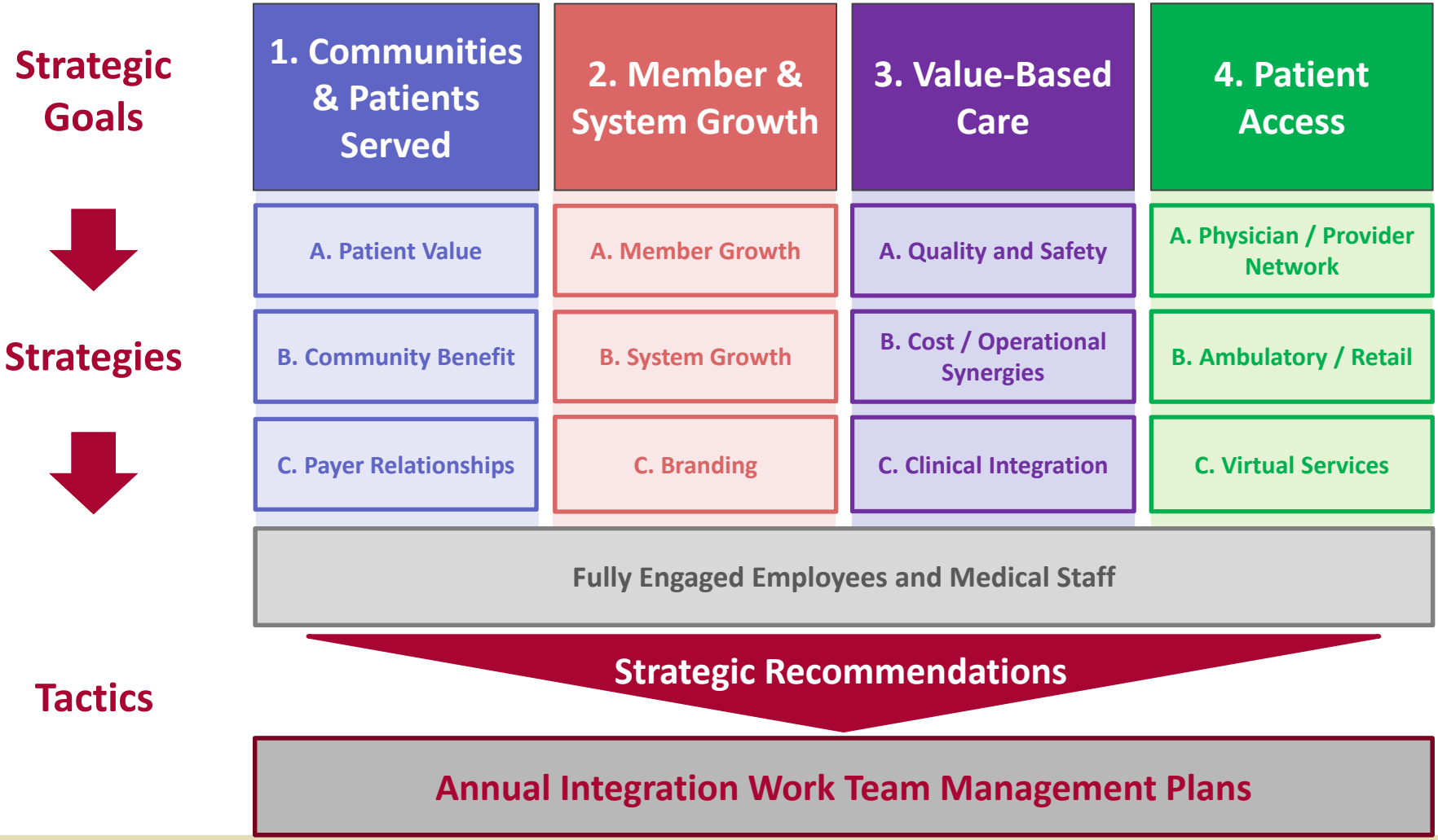
- Serve as a leader in the delivery of quality patient care
- Implement innovative approaches in medicine and population health
- Expand medical knowledge through supporting biomedical research and discovery
- Educate and train physicians and other health care professionals
- Expand patient access to high quality and cost effective services throughout the region
- Preserve and promote the historical culture and values of each member organization
- Meet the needs of each members' community and provide for substantial community benefit.

Health System Strategic Vision

The Cedars-Sinai Health System, building on the strengths of its members, will be the leading health care organization in the region and recognized nationally for:

- Excellence in clinical quality and outcomes
- Comprehensive access to value-based equitable care
- Innovative translational research and discovery
- Outstanding patient experience
- Strong community and employee engagement
- Member brand recognition

Health System Strategic Planning Framework



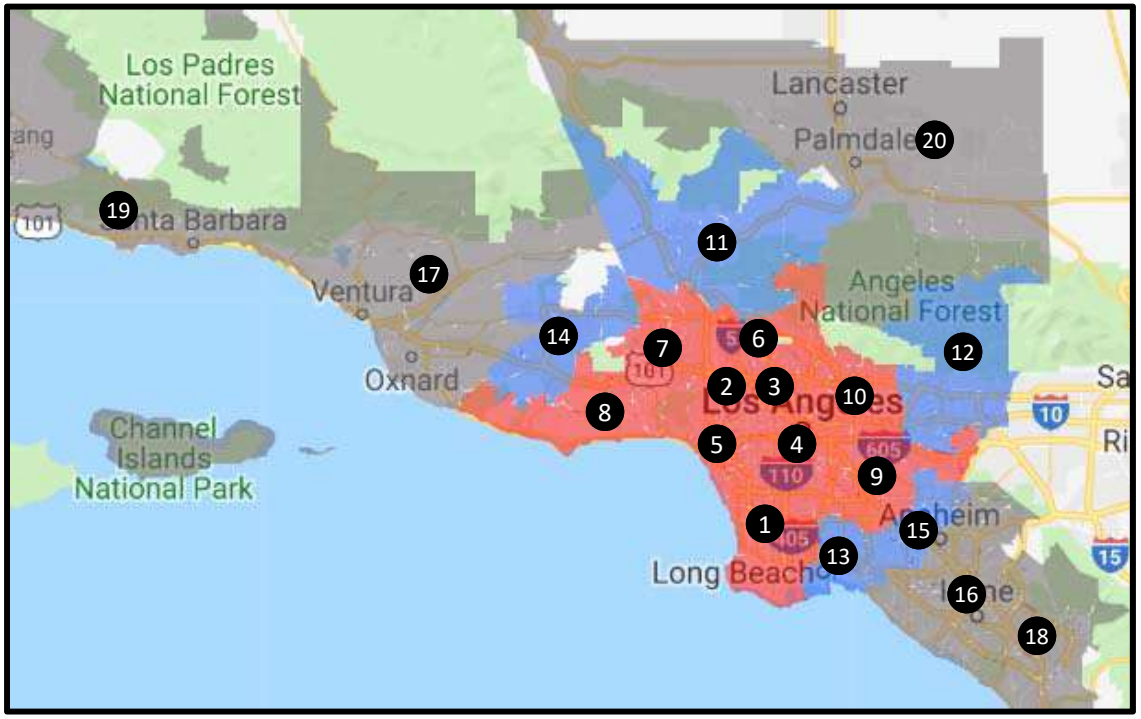
Strategic Goal 1- Communities & Patients Served

Increase healthcare value for patients, payers and purchasers

Strategies	Strategic Recommendations	Value Proposition to Members	External Stakeholder Value Prop
A. Patient Value	1. Continue to build population health and clinical management capabilities 2. Further develop care models for key patient care segments ensuring patients receive appropriate care in the right setting 3. Continue to enhance the patient and consumer experience	• Develop new competencies to deliver more effective value-based care	▪ Access ▪ Experience ▪ **Pricing** ▪ **Quality** ▪ Product / Service Mix ▪ Cost
B. Community Benefit	1. Improve the health of underserved populations 2. Achieve improvements in health equity	• Advance member organizations' abilities to fulfill their community missions	▪ **Access** ▪ **Experience** ▪ Pricing ▪ **Quality** ▪ Product / Service Mix ▪ Cost
C. Payer Relationships	1. Develop future-state revenue and reimbursement models 2. Pursue innovative payer / provider collaborations (e.g., Vivity model)	• Attain greater access to risk-based arrangements • Gain access to covered lives	▪ **Access** ▪ **Experience** ▪ **Pricing** ▪ Quality ▪ Product / Service Mix ▪ Cost

CSHS is Targeting Selected Communities in LA Region

Geographic Community Definitions



		Target Demographics		
		Sub-Market	Population (Est. 2019)	5-Year Pop CAGR
Priority	1	South Bay	1,071K	0.5%
	2	West LA	313K	0.5%
	3	North LA	976K	0.6%
	4	Pasadena & Adj + West San Gabriel Valley	881K	0.5%
	5	South Coastal	226K	0.7%
	6	East SF Valley	1,036K	0.6%
	7	West SF Valley	760K	0.7%
	8	North Coastal	230K	0.7%
	9	Whittier & Adj	998K	0.4%
	10	South LA	1,503K	0.6%
Secondary	11	Santa Clarita	408K	1.0%
	12	East San Gabriel Valley	679K	0.5%
	13	Long Beach & Adj	555K	0.5%
	14	East Ventura	318K	0.6%
	15	North OC	692K	0.7%
Other	16	Central OC	1,562K	0.7%
	17	West Ventura	532K	0.6%
	18	South OC	981K	0.9%
	19	Santa Barbara	453K	0.8%
	20	Lancaster	413K	1.1%

Source: Sg2 Market demographics; Claritas

Priority Community Profiles

		System Position		Competitive Landscape		Service Opportunity		
	Sub-Market[1]	**2017 IP Patient Origin[2]**	**2017 CSHS Mkt. Share**	**IP Mkt. Share #1 & #2 [3[**	**Leading Physician Orgs.[4]**	**Market Pop**	**IP Mkt Oppt Size[5]**	**3rd Tier Competitor Oppt[6]**
Priority	South Bay	35.0%	26.1%	#1: CSHS (26.1%) #2: Providence Little Company of Mary MC – Torrance (15.4%)	CSHS, HCP+, Prov / SJ	1,071K	37.7K	7.3K
Priority	West LA	16.5%	47.1%	#1: CSHS (47.1%) #2: UCLA (RR & SM) (14.5%)	CSHS, Prospect, Prov / SJ	313K	9.6K	1.6K
Priority	North LA	10.8%	9.6%	#1: CSHS (9.6%) #2: Hollywood Presbyterian Med Ctr (9.5%)	Global Care, Bella Vista, HCP+	976K	36.3K	9.7K
Priority	Pasadena & Adj + West San Gabriel Valley	1.2%	1.1%	#1: Huntington Memorial Hosp (21.5%) #2: Methodist Hosp of S. California (11.2%)	Allied Pacific, HCP+, Alta Med, Heritage, Citrus Valley	881K	49.3K	12.6K
Priority	South Coastal	5.2%	23.1%	#1: UCLA (RR & SM) (24.4%) #2: CSHS (23.1%)	CSHS, Access IPA	226K	9.2K	1.7K
Priority	East SF Valley	5.3%	4.2%	#1: Providence St. Joseph Med Ctr (13.0%) #2: Adventist Health Glendale (12.4%)	Lakeside, Prospect, Facey, Heritage, Allied Pacific	1,036K	53.4K	10.9K
Priority	West SF Valley	3.8%	4.4%	#1: Northridge Hosp Med Ctr (15.1%) #2: Providence Tarzana Med Ctr (13.9%)	Heritage, Facey (Prov)*, HCP+	760K	38.7K	4.8K
Priority	North Coastal	2.9%	12.6%	#1: UCLA (RR & SM) (35.5%) #2: Providence St. Johns Health Ctr (26.5%)	UCLA, Prov / SJ	230K	12.5K	0.5K
Priority	Whittier & Adj	1.4%	1.2%	#1: PIH (20.6%) #2: Kaiser (13.4%)	Applecare+, PIH, Angeles IPA	998K	45.1K	9.8K
Priority	South LA	10.0%	4.9%	#1: Kaiser (9.2%) #2: St. Francis Med Ctr (9.2%)	Applecare+, Angeles IPA	1,503K	50.0K	19.4K

Notes: *Part of Providence / St. Joseph's medical network; +Part of Optum health

Notes: [1] Sub-market definitions different from previous analyses shown at hospital system level [2] Calculated as % of CSHS SMA discharges originating in sub-market [3] IP market share shown by individual hospital institution (CSHS, UCLA (RR&SM), Kaiser, PIH grouped) [4] Leading physician org. identified by locations per Cattaneo & Stroud & locations per physician group websites; [5] Market opp. represents commercial & Medicare discharges less Kaiser & CSHS facilities; [6] 3rd tier competitor opp. represents commercial & Medicare discharges from AHMC, Avanti, Prime, Prospect, Verity & Valley Presbyterian; Sources: Claritas; OSHPD; Cattaneo & Stroud; Physician group websites

Secondary & Other Regional Community Profiles

		System Position		Competitive Landscape		Service Opportunity		
	Sub-Market[1]	2017 IP Patient Origin[2]	2017 CSHS Mkt. Share	IP Mkt. Share #1 & #2 [3[	Leading Physician Orgs.[4]	Market Pop	IP Mkt Oppt Size[5]	3rd Tier Competitor Oppt[6]
Secondary	Santa Clarita	0.8%	2.0%	#1: Henry Mayo Newhall Hospital (33.5%) #2: Providence Holy Cross Med Ctr (15.2%)	Facey (Prov)*, HCP+	408K	18.4K	1.1K
Secondary	East San Gabriel Valley	0.6%	0.7%	#1: Citrus Valley Med Ctr – QV Campus (17.2%) #2: Kaiser (12.4%)	Allied Pacific, Citrus Valley, Heritage	679K	34.9K	5.0K
Secondary	Long Beach & Adj	1.3%	1.8%	#1: Long Beach Memorial Med Ctr (20.5%) #2: St. Mary Med Ctr – Long Beach (12.1%)	MemorialCare, Accountable, HCP+	555K	28.7K	1.5K
Secondary	East Ventura	0.9%	2.5%	#1: Los Robles Hosp & Med Ctr (40.2%) #2: Adventist Health Simi Valley (23.2%)	Community Memorial, Ventura Co.	318K	18.5K	0.3K
Secondary	North OC	0.6%	0.8%	#1: St. Jude Med Ctr (13.0%) #2: Kaiser (11.5%)	Prov / SJ, HCP+, Prospect	692K	34.5K	8.6K
Other Regional	Central OC	1.0%	0.6%	#1: Hoag Memorial Hosp Presbyterian (12.2%) #2: St. Joseph Hospital – Orange (11.6%)	Prov / SJ, HCP+, Prospect	1,562K	70.2K	6.6K
Other Regional	West Ventura	1.0%	1.7%	#1: Community Memorial Hosp – San Buenaventura (26.5%) #2: St. Johns Regional Med Ctr (23.0%)	Community Memorial, Ventura Co.	532K	29.3K	0.2K
Other Regional	South OC	0.7%	0.8%	#1: Mission Hosp Regional Med Ctr (21.3%) #2: Hoag Memorial Hosp Presbyterian (18.4%)	Prov / SJ, Prospect	981K	50.0K	0.4K
Other Regional	Santa Barbara	0.3%	0.7%	#1: Santa Barbara Cottage Hospital (44.0%) #2: Marian Regional Med Ctr (31.2%)	Sansum, Santa Barbara Co.	453K	23.0K	0.1K
Other Regional	Lancaster	0.7%	1.4%	#1: Antelope Valley Hospital (47.5%) #2: Palmdale Regional Med Ctr (20.5%)	HCP, Facey, Heritage	413K	17.2K	0.4K

Notes: *Part of Providence / St. Joseph's medical network; +Part of Optum health

Notes: [1] Sub-market definitions different from previous analyses shown at hospital system level [2] Calculated as % of CSHS SMA discharges originating in sub-market [3] IP market share shown by individual hospital institution (CSHS, UCLA (RR&SM), Kaiser, PIH grouped) [4] Leading physician org. identified by locations per Cattaneo & Stroud & locations per physician group websites; [5] Market opp. represents commercial & Medicare discharges less Kaiser & CSHS facilities; [6] 3rd tier competitor opp. represents commercial & Medicare discharges from AHMC, Avanti, Prime, Prospect, Verity & Valley Presbyterian; Sources: Claritas; OSHPD; Cattaneo & Stroud; Physician group websites

Strategic Goal 2- Member & System Growth

Grow the Health System and selectively pursue the addition of new System members and affiliates

Strategies	Strategic Recommendations	Value Proposition to Members	External Stakeholder Value Prop
A. Member Growth	1. Optimize the relationships between system members to ensure seamless care transitions and experience 2. Evaluate adding capabilities for specialized services in consultation with clinical leaders experts 3. Pursue quality designations and distinctions for key service lines 4. Expand System patient locations and access points 5. Increase patient access to translational research and new discoveries	• Expand System reach for key services • Access populations to support tertiary / quaternary programs • Increase quality reputation of the member organizations • Enhance reputation as a leading innovators for clinical excellence	▪ **Access** ▪ **Experience** ▪ Pricing ▪ **Quality** ▪ **Product / Service Mix** ▪ Cost
B. System Growth	1. Build a system of care with a meaningful level of local and regional market scale and scope 2. Identify high-priority markets, based on growth criteria, where network expansion would help achieve System goals 3. Identify select member organizations for partnership that align with CSHS's mission, vision and culture and other relevant criteria	• Retain high priority populations • Advance financial / operational performance of the System • Enhance service delivery quality, efficiency and effectiveness • Increase brand recognition and enhance the reputation of the Health System and its members	▪ **Access** ▪ Experience ▪ Pricing ▪ Quality ▪ **Product / Service Mix** ▪ **Cost**
C. Branding	1. Coordinate resources and communications between organizations 2. Build on the value of the current brands: Identify opportunities to enhance brand value in the future	• Increase members' brand recognition • Understand consumers' perceptions including opportunities to communicate member value	▪ **Access** ▪ **Experience** ▪ Pricing ▪ Quality ▪ Product/Service Mix ▪ Cost

Strategic Goal 3- Value-Based Care

Identify opportunities to leverage clinical and operational systems to achieve the highest value system of care across member organizations

Strategies	Strategic Recommendations	Value Proposition to Members	External Stakeholder Value Prop
A. Quality and Safety	1. Create robust quality, safety, & outcomes key performance indicators and dashboards to monitor member hospital and medical network / foundation performance 2. Advance performance improvement opportunities based on the organizations' results	• Increase / maintain quality and safety reputation • Improve provider satisfaction and experience • Improve clinical performance across sites of care	▪ Access ▪ **Experience** ▪ Pricing ▪ **Quality** ▪ Product / Service Mix ▪ **Cost**
B. Operational Synergies	1. Identify and implement clinical and operational efficiency improvement opportunities 2. Develop process and structures to address long-term improvement including tracking and monitoring of improved performance	• Reduce operating costs • Increase capabilities to transition to total cost of care delivery	▪ Access ▪ Experience ▪ Pricing ▪ **Quality** ▪ Product / Service Mix ▪ **Cost**
C. Clinical Integration	1. In targeted service lines, develop a common, high-quality, efficient care experience across the System: a) Preferred clinical pathways and protocols b) Reduction in unnecessary and unwarranted clinical variation across key programs and episodes of care	• Reduce unwarranted variation in performance • Improve cost performance • Reduce the total cost of care delivery	▪ Access ▪ **Experience** ▪ Pricing ▪ **Quality** ▪ Product / Service Mix ▪ **Cost**

Strategic Goal 4- Patient Access

Enhance access to CSHS services by developing new sites and models of care to meet consumer and community needs

Strategies	Strategic Recommendations	Value Proposition to Members	External Stakeholder Value Prop
A. Medical Networks	1. Begin integration of Medical Network support services infrastructure, such as practice management solutions and other key MSO elements 2. Develop and execute a physician recruitment and retention strategy to ensure growth and expansion of the medical network 3. Pursue practice transformation to enhance and increase physician and patient satisfaction	• Improve access to populations and consumer segments • Improve provider satisfaction and experience • Build capabilities to compete in the evolving provider marketplace	▪ **Access** ▪ Experience ▪ Pricing ▪ Quality ▪ Product/Service Mix ▪ **Cost**
B. Ambulatory / Retail	1. Determine high-priority markets for an ambulatory expansion business plan 2. Identify potential partner relationships as appropriate to support execution of an ambulatory growth strategy 3. Identify consumer centered care models and services to be offered at geographically distributed care sites	• Build a well-distributed system of care with key access points across target markets • Improve access to populations and consumer segments to support tertiary / quaternary care delivery • Position member organizations for success in consumer-driven healthcare market	▪ **Access** ▪ **Experience** ▪ Pricing ▪ Quality ▪ **Product / Service Mix** ▪ Cost
C. Virtual Services	1. Define and prioritize a comprehensive set of virtual services that meet consumers needs and expectations 2. Identify common virtual services technology platforms	• Build new capabilities and competencies to compete for consumer-directed services • Build an infrastructure to reduce total cost of care delivery	▪ **Access** ▪ **Experience** ▪ Pricing ▪ Quality ▪ **Product / Service Mix** ▪ **Cost**

18 Appendix B: Summary of Torrance Health Associates (THA) Affiliation Agreement

The major provisions of the Affiliation Agreement, dated June 5, 2017, include the following:

Overview

Cedars-Sinai Health System shall become the sole corporate member of Torrance Health Association as of the closing date of the Affiliation Agreement;

- Torrance Health Association shall adopt an amendment to its Articles of Incorporation and shall adopt Amended and Restated Bylaws to cause Cedars-Sinai Health System to become the sole corporate member of Torrance Health Association; and
- Torrance Health Association shall cause Torrance Memorial Medical Center to adopt the Amended and Restated Bylaws to cause Cedars-Sinai Health System to become the sole corporate member of Torrance Health Association.

THA Board Reserve Powers

The Torrance Health Association Board of Trustees shall have reserved powers, including the following:

- Nomination of the candidates for approval and election by Cedars-Sinai Health System to the Torrance Health Association Board of Trustees;
- Nomination of three (3) representatives to be appointed to Cedars-Sinai Health System's Board of Directors and the right to nominate at least ten (10) percent of the total number of directors serving on Cedars-Sinai Health System's Board of Directors;
- Approval of the following changes to Torrance Health Association's Bylaws related to the makeup of the Board of Trustees:
  - Requiring a minimum number of women;
  - Requiring a minimum number of physicians; and
  - Setting a maximum total number of individuals authorized to serve on the Board of Trustees.
- Approval of the discontinuation of, or reduction to, any medical service provided at Torrance Memorial Medical Center that is not supported by reasonable quality or economic justifications;
- Approval of the successor to Torrance Health Association's current Chief Executive Officer;
- Termination of Cedars-Sinai Health System's membership in Torrance Health Association and assumption of the assets and liabilities of Torrance Health Association and its affiliates[1]; and
- Approval of a change in the control, management, administration of, or transfer to Cedars-Sinai Health System of any gifts, grants, donations, or endowments received by Torrance Health Association or its affiliates.

[1] If Cedars-Sinai Health System approves of a closure, sale, transfer, change of control, or dissolution of Torrance Memorial Medical Center, Torrance Health Association shall have the right to execute its Unwind Rights to terminate Cedars-Sinai Health System's membership in Torrance Health Association and assume the assets and liabilities of Torrance Health Association and its affiliates.

CSHS and THA Board Joint Approval Powers

Cedars-Sinai Health System and Torrance Health Association shall have joint approval powers, including the following:

- Dissolution of Torrance Health Association;
- Approval of any change to Cedars-Sinai Health System's Bylaws that results in Cedars-Sinai Medical Center and Torrance Health Association together not having the right to nominate at least a majority of the total number of directors serving on Cedars-Sinai Health System's Board of Directors;
- Approval of branding guidelines for how Torrance Health Association will identify itself as an affiliate of Cedars-Sinai Health System;
- Modification of the name of Torrance Health Association or Torrance Memorial Medical Center;
- Approval of the sale or transfer of all or substantially all assets owned by Torrance Health Association that are used exclusively for the operation of Torrance Memorial Physician Network or Torrance Health Independent Practice Association unless the sale or transfer is part of a restructuring by Cedars-Sinai Health System of its entire affiliated physician enterprise;
- Modification of the mission, vision, and values of Torrance Health Association;
- Modification of the structure of Torrance Health Association if it would affect its tax-exempt status;
- Oversight and authority over the quality of care;
- Approval of the community benefit plan of Torrance Health Association; and
- Sale of real property owned by Torrance Health Association.

CSHS and THA Board Joint Approval Powers During First Five Years

Cedars-Sinai Health System and Torrance Health Association shall have joint approval of the following actions for the first five years as of the Closing Date. After the first five years, the following actions will require only the approval of Cedars-Sinai Health System, subject to Torrance Health Association's reserved powers:

- Amendment or restatement of Torrance Health Association's Bylaws or Articles of Incorporation;
- Amendment or restatement of Torrance Memorial Medical Center's Bylaws or Articles of Incorporation;
- Transfer of the administration or sponsorship of a pension plan of Torrance Health Association or the merger of a pension plan of Torrance Health Association with a pension plan of Cedars-Sinai Health System if the changes are implemented uniformly across all member organizations;
- Change of the employer of any individual that is employed by Torrance Health Association;
- Establishment of an obligated group amongst Cedars-Sinai Health System, Torrance Health Association, and the other entities of which Cedars-Sinai Health System is the sole corporate and voting member;
- Transfer of any of the non-cash assets from Torrance Health Association to Cedars-Sinai Health System; and
- Entrance into a settlement or consent decree by Torrance Health Association or Torrance Memorial Medical Center.

CSHS Reserve Powers

Cedars-Sinai Health System shall have, subject to Torrance Health Association's reserved powers, exclusive power over the following actions:

- Election of individuals nominated by Torrance Health Association to the Torrance Health Association Board of Trustees and removal of individuals from the Torrance Health Association Board of Trustees;
- Appointment or removal of the Torrance Health Association Chief Executive Officer;
- Ability to require Torrance Health Association to make periodic payments to Cedars-Sinai Health System to cover Cedars-Sinai Health System's budget operating expenses in proportion to the ratio of operating expenses incurred by Torrance Health Association;
- Ability to require Torrance Health Association to make capital contributions to Cedars-Sinai Health System for any investments, capital initiatives, transaction, or growth in proportion to the number of individuals that Torrance Health Association has the right to nominate to Cedars-Sinai Health System's Board of Directors;
- Amendment or restatement of the Torrance Health Association Bylaws, Articles of Incorporation, or other governing documents;
- Entrance into a transaction that results in the closure, sale, transfer or change of control of Torrance Memorial Medical Center; and
- Approval of the strategic plans, capital budgets, and operating budgets of Torrance Health Association.

19 Appendix C: CS-Link for Private Offices Overview

The attached information brochure provides an overview of the CSMC program to provide Epic to private physician offices. While the brochure is illustrative of the program features, value proposition, and implantation requirements, we will need to work with Huntington to develop a similar program to support the needs of Huntington's community physicians.

CS Link™
One Patient. One Record.

Introduction to CS-Link™

As part of its “one patient – one record” vision, Cedars-Sinai is implementing CS-Link™, an integrated electronic health record (EHR) system. CS-Link™ houses a comprehensive data solution with all of your patient’s information.



CS-Link™ is based on industry-standard Epic software. Prestigious KLAS ratings have ranked Epic the highest-rated among physician practices. Nearly 335 health care systems worldwide have selected Epic as their EHR vendor. As a result, nearly 280,000 physicians are using Epic and approximately 173 million patients are accessing their electronic medical record.

Recent regulation now enables health systems to subsidize the cost of certain components of EHR systems. As a result, Cedars-Sinai is pleased to offer CS-Link™ to its credentialed independent physicians for use in their private offices. Cedars-Sinai’s CS-Link™ service is provided at a discount, helping to offset the costs associated with a practice implementing a robust EHR system.

Built with the involvement of hundreds of physicians and staff from across the organization, CS-Link™ captures the patient’s entire care experience – from scheduling an appointment to receiving a bill for services. Benefits realized include improved efficiency and communication among caregivers, improved quality and convenience of patient care and increased patient participation in their care.

CS Link™
One Patient. One Record.

BENEFITS OF CS-LINK™

You are now joining in a partnership with Cedars-Sinai. You will have the ability to share and access patient information from Cedar-Sinai's Clinical Data Repository.

- **Easy to use documentation templates –** You can take advantage of templates that have been built for dozens of specialties and physicians that have been in use for many years. The templates can be used whenever you need to create patient documentation.

- **Private secure data –** Your office can share clinical data safely through CS-Link™ architecture, since end user access by role (e.g. nurse, medical assistant, physician, etc.) is managed by security policies and procedures. Advanced security functions are in place to protect sensitive information and to comply with HIPAA.

- **Quick access to data –** You can have seamless access across the Cedars' care continuum: outpatient, inpatient, and emergent. CS-Link™ enables access whether you are in the office, home, or working in the hospital; thereby saving time, increasing productivity, and facilitating physician efficiency.

- **Patient safety –** You can take advantage of CS-Link™ drug-drug and drug-allergy interaction checking at the time of medication ordering, as well as electronic medication prescribing directly to pharmacies thereby reducing medication errors.

- **Meaningful Use™ –** You will receive the CS-Link™ tools necessary to satisfy Meaningful Use requirements qualifying your office to attest for those initiatives.



- **Interfaces with lab and imaging results from Cedars-Sinai –** You will receive immediate use of existing laboratory results interfaces with Cedars-Sinai, Schuyler Labs, LabCorp, and Quest allowing you to access your results electronically via CS-Link™.

- **Patient Portal –** You can communicate with your patients electronically, any time or anywhere, through the Patient Portal. It will also allow your patients to request prescription refills and appointments, view their health information, and communicate with both you and your office staff electronically.

©2015 Cedars-Sinai. All Rights Reserved.
A 501(c)(3) Non-profit Organization

CS Link™
One Patient. One Record.

CS-Link™ Partner Criteria

One of the many benefits of installing this highly integrated EHR is process improvement and the opportunity to thoroughly examine clinic workflows. However, it is important that private offices interested in adopting CS-Link™ understand the commitment and preparation required to undergo this transformation. Private practices that qualify to partner with Cedars-Sinai in the adoption of CS-Link™ need to demonstrate financial, operational and technical readiness.

LEADERSHIP COMMITMENT

Strong physician leadership is required for successful adoption of CS-Link™. Hands-on involvement from you and/or your office manager is important in supporting the clinical staff in adoption. A Clinical Leader should be identified – someone who understands the operational and workflow components of the practice and embraces change. Being familiar with current technology and having a desire to adopt new technology are also important.

CAPACITY AND FINANCIAL COMMITMENT

The financial requirements of an EHR implementation project go above the baseline project costs (see the Your Investment page). Consideration should be given for procurement and support of all hardware and network support required, as well as for the initial decrease in productivity during the implementation process. The initial learning curve will be steep, but can be overcome with dedicated time and effort.

It is strongly recommended that practices reduce schedules (typically between 25-50 percent) during the preliminary implementation period – depending on the practice specialty and patient volume. This helps with user adoption and allows practices to take advantage of on-site, CS-Link™ at-the-elbow support opportunities for the two weeks following the implementation.

OPERATIONAL READINESS

Full staffing, smooth day-to-day operations, and a stable environment are all factors that will make for a successful CS-Link™ EHR implementation. The implementation process will bring about changes in workflows and significant operational changes that require both physicians and office staff to be flexible, adaptable, and open to change.

TECHNICAL READINESS

One of the most significant factors causing EHR implementation delays and additional financial impact is insufficient technical readiness. Hardware and network infrastructure must meet minimum guidelines as outlined in the contract between Cedars-Sinai and the physician office.

CEDARS-SINAI AFFILIATION

The implementation of CS-Link™ is contingent upon affiliation with Cedars-Sinai. This offer does not extend to unaffiliated physician offices. Additional details are addressed in the contract.

CS Link™
One Patient. One Record.

QUALIFYING FOR IMPLEMENTATION

Please gather the following practice information:

- Legal name of organization to include address and contact information
- Number of physicians/practitioners who will be using the system
- Name and specialty of physicians/practitioners who will be using the system
- Primary contact

Please send this information to the Community Physician Office (CPO) Project Team at **GroupEISApplicationCPOProjectTeam@cshs.org.** Upon receiving your information, the CPO team will contact you.

Cedars-Sinai Enterprise Information Systems will evaluate your request and determine implementation options available for your office.

©2015 Cedars-Sinai. All Rights Reserved.
A 501(c)(3) Non-profit Organization

CS Link™
One Patient. One Record.

Your Investment

Implementing CS-Link™ is an investment in improved patient care and the future of your office.

COST

The cost to implement CS-Link™ in your private practice is $295 per physician, per month. After a successful implementation, your office will be invoiced on a quarterly basis.

Included with the Implementation

- CS-Link™ access
- System setup
- Implementation services (standard 7 week implementation)
- Training and related materials
- On-site support during weeks 6 and 7 of the implementation process
- 24/7 CS-Link application software support via the Help Desk
- CS-Link™ system upgrades
- Interfaces with results access from Cedars-Sinai's lab and imaging departments

Not Included with the Implementation (Responsibility of Physician Office)

The implementation team will engage with you early in the process to discuss project scope in more detail, however items and services not included are:

- Hardware such as monitors, computers, printers, and network cabling and related support
- Data storage devices
- Device integration with third party hardware such as vital signs monitors, EKG machines, etc.
- New interfaces not currently existing in CS-Link™, including third party scanning interfaces or office lab systems
- Conversion of existing patient data from legacy systems



SECURITY OF PATIENT INFORMATION

The "one patient – one record" concept embodied by CS-Link™ benefits both patients and physicians. Others will have the ability to see your patient's medical record, in accordance with Federal and State laws and Cedars-Sinai's policies regarding confidentiality and access authorization. Workflows and system settings protecting privacy are available for sensitive information, as well as settings for high-profile patients. During your implementation Cedar-Sinai will work closely with you to ensure that configurations are satisfactory for patient confidentiality needs. CS-Link™ is HIPAA certified and offers a robust suite of standard security functions to protect your patients' information. Your physician office is responsible for ensuring proper security of patient information, including not sharing login information among staff.

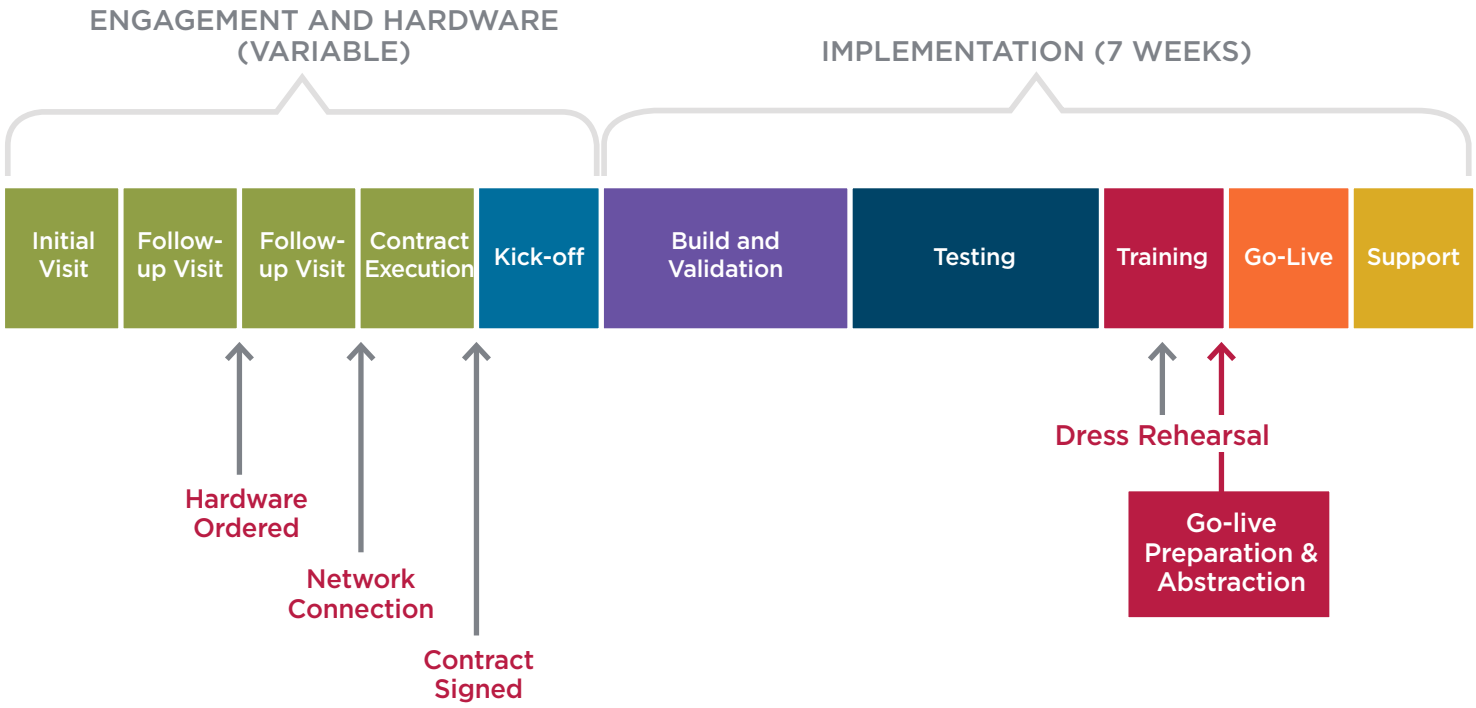
©2015 Cedars-Sinai. All Rights Reserved.
A 501(c)(3) Non-profit Organization

CS Link™
One Patient. One Record.

CS-Link™ Implementation

THE IMPLEMENTATION PROCESS

Implementing CS-Link™ takes seven weeks from the implementation kick-off. An overview of the steps involved in the implementation process is depicted below.



See **Glossary of Terms** on reverse.

*Additional printed materials outlining the implementation process will be provided at the Implementation Kick-off Meeting.

CS Link™
One Patient. One Record.

Glossary of Terms

INITIAL VISIT

Your practice and the Community Physician Office (CPO) project team will review CS-Link features and functionality, as well as the engagement and implementation process. We will also address any questions you may have. The CPO project team will collect relevant practice information and primary office contact information for follow-up meetings with both the IT support person and the office.

FOLLOW-UP VISITS

There may be 1-2 follow up visits to fully assess the hardware and network readiness for the CPO. A formal hardware assessment document will be supplied outlining infrastructure requirements. Practice information will be continually gathered from the primary office contact during follow-up visits. An optional CS-Link demo can be provided as needed.

HARDWARE ORDERED

After you receive the formal hardware assessment, please make the needed hardware and network purchases and inform the project team when the orders have been placed and your timeline for installation. We will plan on a follow-up meeting to validate the completion of installation.

NETWORK CONNECTION

Final inspection of the required network and hardware set up will be performed during this visit. If the required hardware elements are installed and tested successfully, a go-live date can be determined.

CONTRACT EXECUTION

After the network connection is validated, the CPO project team will deliver the formal contract for you to review. Your kick-off meeting will be scheduled, once the contract is signed by both the practice and Cedars-Sinai Enterprise Information Services.

KICK-OFF MEETING

The CPO project team will meet with your practice to discuss the 7-week implementation process in detail, continue the collection of information, schedule weekly calls with your practice, and answer any remaining questions you have.

BUILD AND VALIDATION

The CPO project team will start and complete the build of your CS-Link system and validate its design relative to practice specifications.

TESTING

Once the build is complete and validated, the CPO project team will execute testing of your build by performing an in depth round of integrated testing on both the CS-Link system and infrastructure.

TRAINING

Training is required for all practice providers and staff prior to using CS-Link. Physicians will receive 5 hours, and Medical Assistants (MAs) will receive 4 hours, of Clinical Training. Schedulers will receive 4-6 hours of Access Training. Some MAs will go to both Clinical and Access Training.

DRESS REHEARSAL

The CPO project team will validate the project to ensure go-live readiness. The CPO project team will walk through a mock patient visit in your specific environment, testing your CS-Link build and hardware infrastructure.

GO-LIVE PREPARATION & ABSTRACTION

After training, your practice can choose to scan existing patient charts and enter patient demographics into CS-Link, a process referred to as abstraction. Providers' schedule templates will be finalized by your practice. Your staff will also schedule future appointments into CS-Link for go-live.

GO-LIVE

On the day of go-live, your practice will officially start using CS-Link for patient care activities, including scheduling, check-in, rooming activities, clinical care documentation, and check out. It is critical for each patient's encounter to be closed in CS-Link in a timely manner for the generation of a daily super bill.

SUPPORT

At-the-elbow support will be provided by the CPO project team for two weeks from your initial go-live date.

©2015 CEDARS-SINAI. ALL RIGHTS RESERVED.
A 501(C)(3) NON-PROFIT ORGANIZATION

20 Appendix D: Overview of CSMCF Entities

Category	Description	Alignment Model	MSO Offering*	On Epic Platform?
Cedars-Sinai Medical Group (CSMG)	Cedars-Sinai Medical Group is a clinically integrated, multi-specialty medical group with locations in Beverly Hills, Culver City, Playa Vista, Marina Del Rey, Westchester, and the San Fernando Valley.	PSA	Medical Group Administration Services	✓
Cedars-Sinai Health Associates (CSHA)	Cedars-Sinai Health Associates (CSHA) is a network of individual physicians with private practice offices located throughout Los Angeles, which is affiliated with Cedars-Sinai Health System. CSHA is an Independent Physician Association (IPA) that allows community physicians access to many health plan contracts to accommodate physician contracting needs.	IPA model	IPA Administration Services	✓
Inpatient Specialty Practices (ISP)	Inpatient Specialty Practices (ISP) is a medical group comprised of hospitalists who provide personalized care to high-risk and acutely ill patients in multiple settings including the hospital, skilled nursing facilities, and at home.	PSA / managed by CSMCF	Medical Group Administration Services	✓
California Heart Center (UCMG)	California Heart Center consists of cardiologists that specialize in pre & post-transplant services, offering comprehensive, individualized care and the latest in diagnostic testing and access to the newest research advances.	PSA with CSMCF	Medical Group Administration Services	✓
Tower Hematology Oncology Medical Group (THOMG)	Tower Hematology Oncology Medical Group consists of physicians who specialize in high quality & comprehensive hematological and oncological cancer care including conventional, innovative and investigational modalities.	PSA with CSMCF	Medical Group Administration Services	✓
The Angeles Clinic & Research Institute (TACRI)	The Angeles Clinic and Research Institute in Santa Monica and West LA is comprised of physicians who specialize in hematology and oncology care and are heavily involved in cancer research.	PSA with CSMCF	Medical Group Administration Services	✓
Kerlan-Jobe Orthopedic Center (KJOC)	Kerlan-Jobe Orthopedic Clinic is a group of orthopedic surgeons who specialize in the diagnosis and treatment of the spine, shoulder, elbow, knee, hand, and foot, as well as orthopedic trauma, arthritis, and work-	PSA with CSMCF	Medical Group Administration Services	✓

Category	Description	Alignment Model	MSO Offering*	On Epic Platform?
	related injuries. Part of the newly named Kerlan-Jobe Institute.			
Santa Monica Orthopedic Group (SMOG)	Santa Monica Orthopedic Group is a leading orthopedic practice located in Santa Monica with a commitment to provide leading-edge treatments in orthopedic medicine and a broad range of services for acute and sports injuries. Part of the newly named Kerlan-Jobe Institute.	PSA with CSMCF	Medical Group Administration Services	✓
Valley Internal Medicine & Nephrology (VIM)	Valley Internal Medicine and Nephrology Medical Group is a group of internal medicine physicians and nephrologists with 3 locations in the San Fernando Valley.	PSA with CSMCF	Medical Group Administration Services	✓
Cedars-Sinai Gastroenterology SM (SMGI)	Cedars-Sinai Gastroenterology in Santa Monica is a group of physicians with many years of clinical practice and expertise in gastroenterology.	PSA with CSMCF	Medical Group Administration Services	✓
Beverly Pathology (BevPath)	Beverly Pathology is an independently contracted pathology group.	PSA with CSMCF	IPA Administration Services	✓
California Rehabilitation Institute Medical Group (CRIMG)	California Rehabilitation Institute Medical Group is a group of physical medicine and rehabilitation specialists.	PSA with CSMCF	Medical Group Administration Services	✓
Faculty Outreach	Faculty Outreach engages Cedars-Sinai Medical Center faculty to provide physician services at various outreach locations.	Legal Structure / PSA with CSMCF	Medical Group Administration Services	✓
Cedars-Sinai Valley Oncology (CSVO)	Cedars-Sinai Valley Oncology Medical Group is a newly formed oncology group specializing in medical and surgical oncology located in the San Fernando Valley.	PSA with CSMCF	Medical Group Administration Services	✓
Cedars-Sinai Valley Network	Clinically integrated network consisting of specialty providers in the San Fernando valley area.	CIN / IPA Model	NA	Some

Definitions:

MSO Offering	Administration Services
Medical Group Administration Services	• Health Plan and Provider Contracting • ACO Contracting • Credentialing • Group Purchasing • Billing and Collection • Finance Services
IPA Administration Services	• Claims Processing • Enrollment • Benefits • Physician Capitation • Clinical Analytics and Business Intelligence

21 Appendix E: CSMC Employee Engagement Scores

THE ENGAGEMENT SURVEY

Keeping our fingers on the pulse!



September 2019 Pulse Survey

Executive Summary Report

CEDARS-SINAI

Sep Engagement Index

80

62%

15k

7296 Responses
+ 10% pts since Nov

14906 Comments

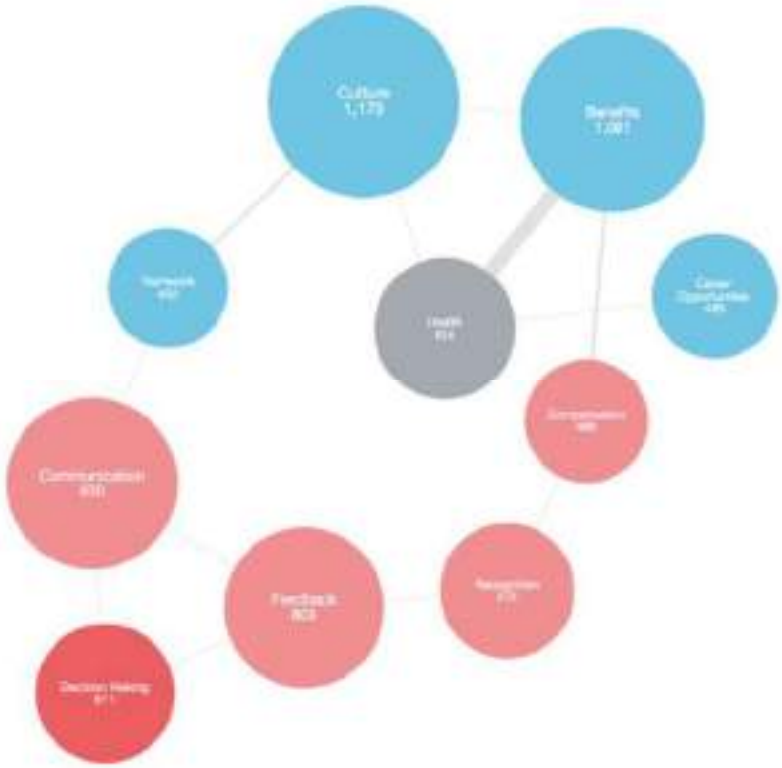


- Favorable 81%
- Neutral 14%
- Unfavorable 5%

Topics
These topics are mentioned most in the comments

Culture (1,170) Benefits (1,081)
Communication (930) Feedback (809)
Health (634)

Benchmark
74



Leadership	71	-2	--	Very High	66%	402	I have confidence in the leadership team. Sep 9, 2019
Speak My Mind	68	-2	--	High	63%	256	I feel free to speak my mind without fear of negative consequences. Sep 9, 2019
Performance Conversations	75	+9	--	High	72%	332	I have ongoing conversations with my manager about my performance. Sep 9, 2019
Communication	71	+9	--	Very High	67%	281	Cedars-Sinai does a good job of communicating with employees. Sep 9, 2019

Key Takeaways

- **Engagement score of 80 - +6 over the healthcare benchmark of 74 from Glint**
- **62% response rate = 7,296 response**
- **Nearly 15,000 comments**
- **Overall favorability of 81% (combination of top two scores)**
- **Overall un-favorability of 5% (combination of the lowest two scores)**

- **Most common topics mentioned:**
  - **Strengths = Culture and Benefits**
  - **Opportunities = Communication and Feedback**

- **Top two scoring strengths when compared to HC benchmark:**
  - **Performance Conversations (+9)**
  - **Communication (+9)**
  - ***Important note that Communication is one of our area of improvement, but we are significantly outperforming other HC orgs who use this same question.***

- **Bottom two scoring opportunities when compared to HC benchmark:**
  - **Leadership (-2)**
  - **Speak my mind (-1)**

- **Comments:**
  - **Strengths**
    - Culture
    - Benefits
    - Career Opportunities
    - Teamwork
  - **Opportunities:**
    - Communication
    - Decision Making
    - Feedback
    - Recognition
    - Compensation

Exhibit 8-G

Project Rose: Workstreams Overview

[Draft for discussion purposes]

KaufmanHall

Exceptional Partners. Exceptional Performance.

Project Rose: Workstreams Overview

Pasadena, CA | November 15, 2019

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Overview

1. Workstreams Overview
2. Partnership Committee Due Diligence
3. Management Due Diligence
4. Letter of Intent Negotiation
5. Trust Oversight
6. “Buy-side” Due Diligence

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Workstreams Overview

- Following the Huntington Board's recommendation to continue the transaction process with certain potential partners, Kaufman Hall identified the following 5 distinct workstreams:
  1. Partnership Committee Due Diligence
  2. Management Due Diligence
  3. Letter of Intent Negotiations
  4. Trust Oversight
  5. "Buy-side" Due Diligence
- Key responsibilities are assigned to the following parties:
  - Huntington Management
  - Huntington Partnership Committee
  - Huntington Board
  - Huntington Trust & Trust Counsel
  - Kaufman Hall
  - Davis Wright Tremaine

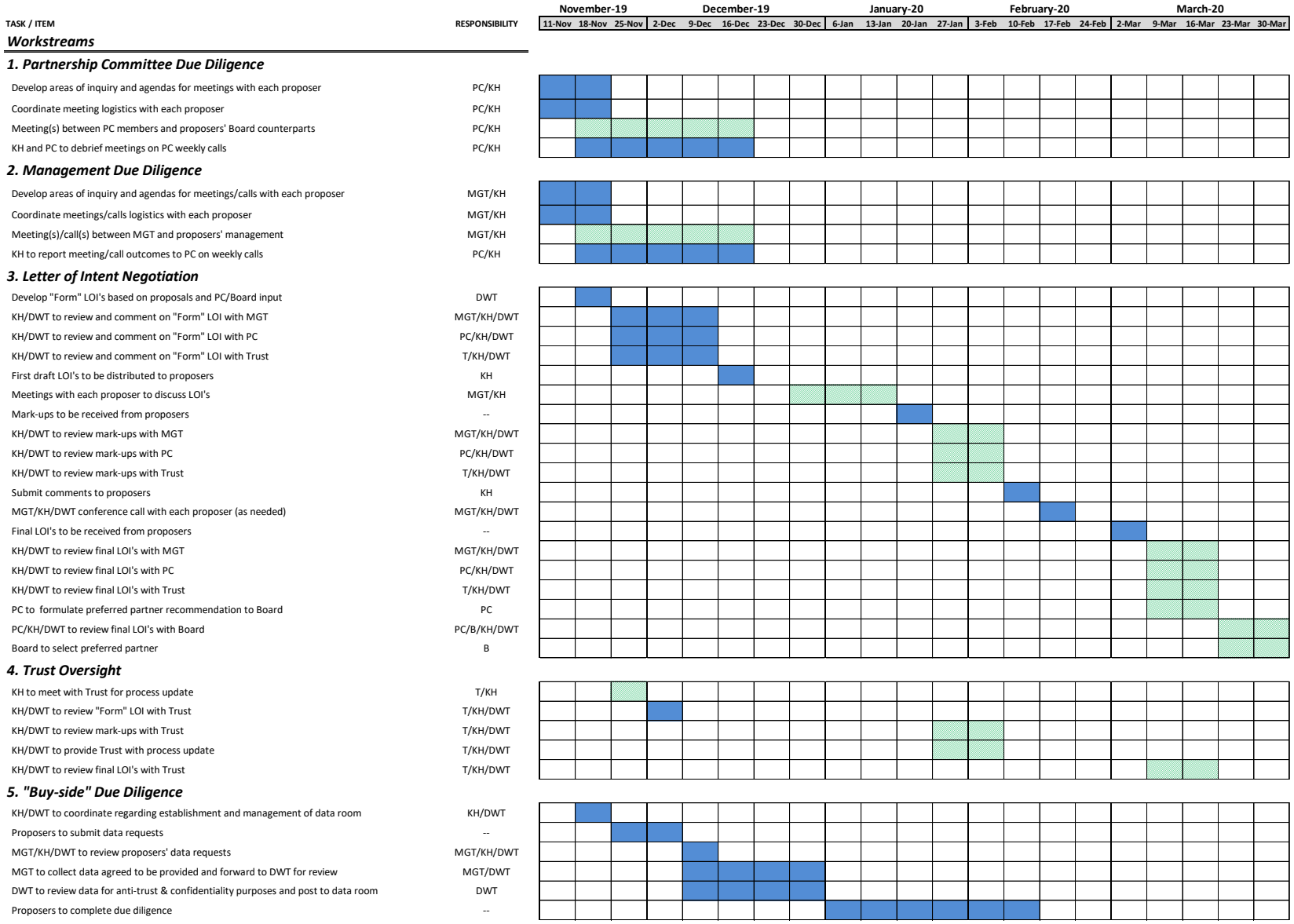
CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

[Draft for discussion purposes]

Workstreams Overview (Continued)

In-person Meeting

MGT – Huntington Management
PC – Huntington Partnership Committee
B – Huntington Board
T – Huntington Trust & Trust Counsel
KH – Kaufman Hall
DWT – Davis Wright Tremaine



TASK / ITEM	RESPONSIBILITY
Workstreams	
1. Partnership Committee Due Diligence	
Develop areas of inquiry and agendas for meetings with each proposer	PC/KH
Coordinate meeting logistics with each proposer	PC/KH
Meeting(s) between PC members and proposers' Board counterparts	PC/KH
KH and PC to debrief meetings on PC weekly calls	PC/KH
2. Management Due Diligence	
Develop areas of inquiry and agendas for meetings/calls with each proposer	MGT/KH
Coordinate meetings/calls logistics with each proposer	MGT/KH
Meeting(s)/call(s) between MGT and proposers' management	MGT/KH
KH to report meeting/call outcomes to PC on weekly calls	PC/KH
3. Letter of Intent Negotiation	
Develop "Form" LOI's based on proposals and PC/Board input	DWT
KH/DWT to review and comment on "Form" LOI with MGT	MGT/KH/DWT
KH/DWT to review and comment on "Form" LOI with PC	PC/KH/DWT
KH/DWT to review and comment on "Form" LOI with Trust	T/KH/DWT
First draft LOI's to be distributed to proposers	KH
Meetings with each proposer to discuss LOI's	MGT/KH
Mark-ups to be received from proposers	--
KH/DWT to review mark-ups with MGT	MGT/KH/DWT
KH/DWT to review mark-ups with PC	PC/KH/DWT
KH/DWT to review mark-ups with Trust	T/KH/DWT
Submit comments to proposers	KH
MGT/KH/DWT conference call with each proposer (as needed)	MGT/KH/DWT
Final LOI's to be received from proposers	--
KH/DWT to review final LOI's with MGT	MGT/KH/DWT
KH/DWT to review final LOI's with PC	PC/KH/DWT
KH/DWT to review final LOI's with Trust	T/KH/DWT
PC to formulate preferred partner recommendation to Board	PC
PC/KH/DWT to review final LOI's with Board	PC/B/KH/DWT
Board to select preferred partner	B
4. Trust Oversight	
KH to meet with Trust for process update	T/KH
KH/DWT to review "Form" LOI with Trust	T/KH/DWT
KH/DWT to review mark-ups with Trust	T/KH/DWT
KH/DWT to provide Trust with process update	T/KH/DWT
KH/DWT to review final LOI's with Trust	T/KH/DWT
5. "Buy-side" Due Diligence	
KH/DWT to coordinate regarding establishment and management of data room	KH/DWT
Proposers to submit data requests	--
MGT/KH/DWT to review proposers' data requests	MGT/KH/DWT
MGT to collect data agreed to be provided and forward to DWT for review	MGT/DWT
DWT to review data for anti-trust & confidentiality purposes and post to data room	DWT
Proposers to complete due diligence	--

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Workstream 1: Partnership Committee Due Diligence

TASK / ITEM	RESPONSIBILITY	November-19			December-19				
		11-Nov	18-Nov	25-Nov	2-Dec	9-Dec	16-Dec	23-Dec	30-Dec
Workstreams									
1. Partnership Committee Due Diligence									
Develop areas of inquiry and agendas for meetings with each proposer	PC/KH								
Coordinate meeting logistics with each proposer	PC/KH								
Meeting(s) between PC members and proposers' Board counterparts	PC/KH								
KH and PC to debrief meetings on PC weekly calls	PC/KH								

- **Coordinate meeting logistics with each proposer:** Partnership Committee and Kaufman Hall finalize logistics (location, attendees, date, etc.) for meetings with proposers including site visits
- **Develop areas of inquiry and agendas for meeting with each proposer:** Partnership Committee and Kaufman Hall formalize additional topics of discussion for each proposer including questions regarding contents of proposals to date and further areas of interest
- **Meeting(s) between PC members and proposers' Board counterparts:** Partnership Committee meets with select management team member and board members of each proposer to discuss respective proposals and assess cultural fit in order to further refine evaluation of the proposers
- **KH and PC to debrief meetings on PC weekly calls:** Partnership Committee and Kaufman Hall to discuss and debrief each proposer meeting on the next weekly Partnership Committee call following respective meeting

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

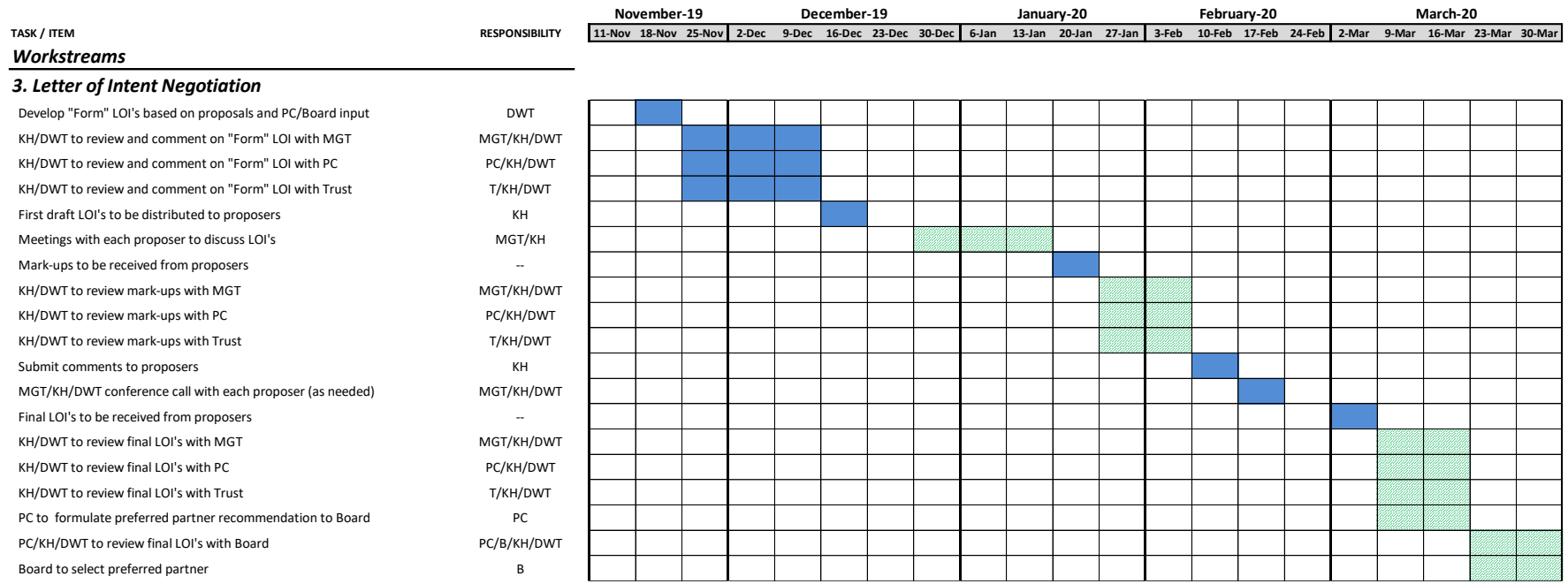
Workstream 2: Management Due Diligence

TASK / ITEM	RESPONSIBILITY	November-19			December-19				
		11-Nov	18-Nov	25-Nov	2-Dec	9-Dec	16-Dec	23-Dec	30-Dec
Workstreams									
2. Management Due Diligence									
Develop areas of inquiry and agendas for meetings/calls with each proposer	MGT/KH								
Coordinate meetings/calls logistics with each proposer	MGT/KH								
Meeting(s)/call(s) between MGT and proposers' management	MGT/KH								
KH to report meeting/call outcomes to PC on weekly calls	PC/KH								

- **Coordinate meetings/calls logistics with each proposer:** Huntington Management and Kaufman Hall finalize logistics (location, attendees, date, etc.) for meetings with proposers
- **Develop areas of inquiry and agendas for meetings/calls with each proposer:** Huntington Management and Kaufman Hall formalize additional topics of discussion for each proposer including questions regarding contents of proposals to date and further areas of interest – particularly certain organizational capabilities and strategies
- **Meeting(s)/call(s) between MGT and proposers' management:** Huntington Management and Kaufman Hall meet with select management team members of each proposer to discuss respective proposals and further assess capabilities and resources of each proposer
- **KH to report meeting/call outcomes to PC on weekly calls:** Partnership Committee and Kaufman Hall to discuss and debrief each meeting on the next weekly Partnership Committee call following respective meeting

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Workstream 3: Letter of Intent Negotiation



TASK / ITEM	RESPONSIBILITY
Workstreams	
3. Letter of Intent Negotiation	
Develop "Form" LOI's based on proposals and PC/Board input	DWT
KH/DWT to review and comment on "Form" LOI with MGT	MGT/KH/DWT
KH/DWT to review and comment on "Form" LOI with PC	PC/KH/DWT
KH/DWT to review and comment on "Form" LOI with Trust	T/KH/DWT
First draft LOI's to be distributed to proposers	KH
Meetings with each proposer to discuss LOI's	MGT/KH
Mark-ups to be received from proposers	--
KH/DWT to review mark-ups with MGT	MGT/KH/DWT
KH/DWT to review mark-ups with PC	PC/KH/DWT
KH/DWT to review mark-ups with Trust	T/KH/DWT
Submit comments to proposers	KH
MGT/KH/DWT conference call with each proposer (as needed)	MGT/KH/DWT
Final LOI's to be received from proposers	--
KH/DWT to review final LOI's with MGT	MGT/KH/DWT
KH/DWT to review final LOI's with PC	PC/KH/DWT
KH/DWT to review final LOI's with Trust	T/KH/DWT
PC to formulate preferred partner recommendation to Board	PC
PC/KH/DWT to review final LOI's with Board	PC/B/KH/DWT
Board to select preferred partner	B

- **"Form" Letter of Intent ("LOI"):** DWT to draft "Form" LOI containing non-binding term conditions for a formalized affiliation. Upon review and comment from the Partnership Committee, Trust and Huntington Management, Kaufman Hall will distribute the "Form" LOI to each proposer. Proposers will then submit mark-ups of the LOI to Huntington
- **LOI Evaluation:** Kaufman Hall and DWT to work with the Partnership Committee and Huntington Management, separately, to review and evaluate initial LOI submissions from each proposers – including conference calls with each proposer as necessary. Upon review, Huntington's comments and revisions to be circulated to each proposers. Proposers then submit final LOI to Huntington
- **Selection of preferred partner:** Upon receipt of the final LOI from proposers, KH and DWT to review the final LOI with the Partnership Committee, Trust, and Huntington Management. Upon completion of review, the Partnership Committee will select a preferred partner and formulate recommendation to the Board for selection of preferred partner via formal Board vote

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Workstream 4: Trust Oversight

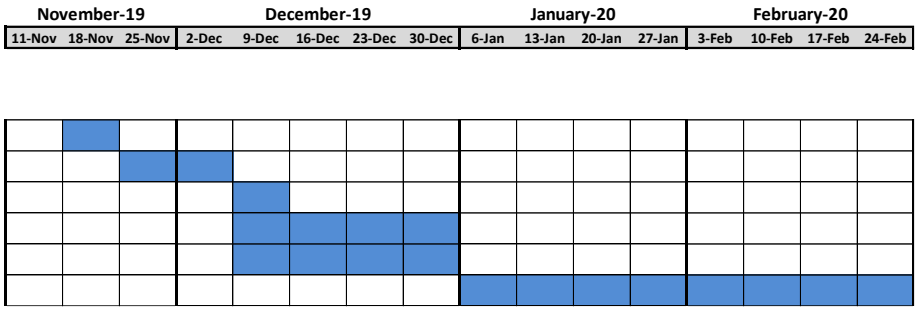
TASK / ITEM	RESPONSIBILITY	November-19			December-19					January-20				February-20				March-20				
		11-Nov	18-Nov	25-Nov	2-Dec	9-Dec	16-Dec	23-Dec	30-Dec	6-Jan	13-Jan	20-Jan	27-Jan	3-Feb	10-Feb	17-Feb	24-Feb	2-Mar	9-Mar	16-Mar	23-Mar	30-Mar
Workstreams																						
4. Trust Oversight																						
KH to meet with Trust for process update	T/KH																					
KH/DWT to review "Form" LOI with Trust	T/KH/DWT																					
KH/DWT to review mark-ups with Trust	T/KH/DWT																					
KH/DWT to provide Trust with process update	T/KH/DWT																					
KH/DWT to review final LOI's with Trust	T/KH/DWT																					

- **KH to meet with Trust for process update:** Kaufman Hall to meet with the Trust to provide a Project Rose process update, including a review of initial proposal terms and an overview of next steps
- **KH/DWT to review "Form" LOI with Trust:** Trust, Kaufman Hall and DWT to review "Form" LOI containing non-binding term conditions for a formalized affiliation. Upon review and comment from the Trust, Kaufman Hall will distribute the "Form" LOI to each proposer
- **KH/DWT to review LOI mark-ups with Trust:** Trust, Kaufman Hall and DWT to review LOI mark-ups as received from each proposer focusing particularly on the terms and conditions related to the Trust
- **KH/DWT to provide Trust with process update:** Kaufman Hall and DWT to deliver the Trust a secondary Project Rose process to review LOI mark-ups received from each proposer
- **KH/DWT to review final LOIs with Trust:** Trust, Kaufman Hall and DWT to review final LOIs as received from each proposer focusing particularly on the terms and conditions related to the Trust

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Workstream 5: "Buy-side" Due Diligence

TASK / ITEM	RESPONSIBILITY
Workstreams	
5. "Buy-side" Due Diligence	
KH/DWT to coordinate regarding establishment and management of data room	KH/DWT
Proposers to submit data requests	--
MGT/KH/DWT to review proposers' data requests	MGT/KH/DWT
MGT to collect data agreed to be provided and forward to DWT for review	MGT/DWT
DWT to review data for anti-trust & confidentiality purposes and post to data room	DWT
Proposers to complete due diligence	--



- **KH/DWT to coordinate regarding establishment and management of data room:** Kaufman Hall and DWT to establish data room logistics for completion of "buy-side" due diligence by each proposer
- **Proposers to submit data requests:** Proposers to aggregate and submit data requests identifying the information needed to complete initial due diligence required to submit an LOI to Huntington
- **MGT/KH/DWT to review proposers' data requests:** Huntington Management, Kaufman Hall, and DWT to assess the proposers' individual data requests and to determine information to be all proposers as appropriate
- **MGT to collect data agreed to be provided and forward to DWT for review:** Upon determination of the data to be provided to the proposers, Huntington Management aggregate data for DWT anti-trust and legal review
- **DWT to review data for anti-trust & confidentiality purposes and post to data room:** DWT to review data and post to the data room to enable completion of "buy-side" due diligence by each proposer
- **Proposers to complete due diligence:** Proposers to evaluate available data to complete "buy-side" due diligence

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Qualifications, Assumptions and Limiting Conditions (v.12.08.06):

This Report is not intended for general circulation or publication, nor is it to be used, reproduced, quoted or distributed for any purpose other than those that may be set forth herein without the prior written consent of Kaufman, Hall & Associates, LLC. ("Kaufman Hall").

All information, analysis and conclusions contained in this Report are provided "as-is/where-is" and "with all faults and defects". Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified by Kaufman Hall. No warranty is given as to the accuracy of such information. Public information and industry and statistical data, including without limitation, data are from sources Kaufman Hall deems to be reliable; however, neither Kaufman Hall nor any third party sourced, make any representation or warranty to you, whether express or implied, or arising by trade usage, course of dealing, or otherwise. This disclaimer includes, without limitation, any implied warranties of merchantability or fitness for a particular purpose (whether in respect of the data or the accuracy, timeliness or completeness of any information or conclusions contained in or obtained from, through, or in connection with this report), any warranties of non-infringement or any implied indemnities.

The findings contained in this report may contain predictions based on current data and historical trends. Any such predictions are subject to inherent risks and uncertainties. In particular, actual results could be impacted by future events which cannot be predicted or controlled, including, without limitation, changes in business strategies, the development of future products and services, changes in market and industry conditions, the outcome of contingencies, changes in management, changes in law or regulations. Kaufman Hall accepts no responsibility for actual results or future events.

The opinions expressed in this report are valid only for the purpose stated herein and as of the date of this report.

All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the client.

In no event will Kaufman Hall or any third party sourced by Kaufman Hall be liable to you for damages of any type arising out of the delivery or use of this Report or any of the data contained herein, whether known or unknown, foreseeable or unforeseeable.

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

KaufmanHall

Exceptional Partners. Exceptional Performance.

CHICAGO, IL | PORTLAND, OR | LOS ANGELES, CA | FT. COLLINS, CO | SKOKIE, IL

CONFIDENTIAL – ©2019 Kaufman, Hall & Associates, LLC. All rights reserved.

Exhibit 8-H

Cedars-Sinai Site Visit Materials

Overview of Cedars-Sinai Health System

Presentation to Project Rose Partnership Committee

Cedars Sinai Health System

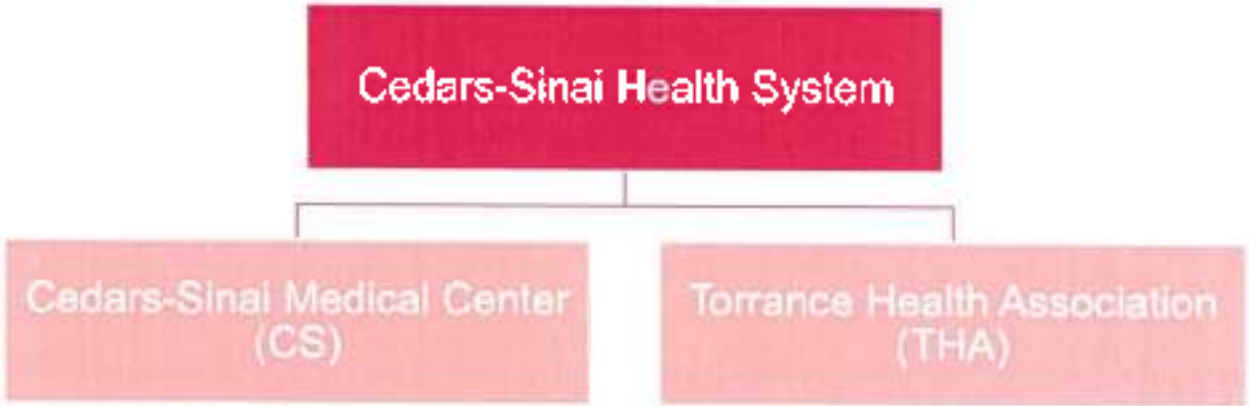
cedars-sinai.org

Agenda

1. Cedars-Sinai Background and Evolution
2. TMMC Background and Evolution
3. Context for Development of CSHS
4. CSHS Strategic Direction
5. CSHS Governance Model

Cedars Sinai Health System

CSHS Member Overview



Cedars Sinai Health System

Agenda

1. Cedars-Sinai Background and Evolution
2. TMMC Background and Evolution
3. Context for Development of CSHS
4. CSHS Strategic Direction
5. CSHS Governance Model

Cedars Sinai Health System

More than 100 years CSMC rooted in the community, and serving patients from every corner of the world

1902: Kaspare Cohn Hospital (Cedars of Lebanon's predecessor) opens



1910: Bikur Cholim Society opens a two-room hospice (predecessor of Mount Sinai Hospital)



1926: A new and larger Mount Sinai is built on Bonnie Beach Place



1955: The new Mount Sinai Hospital opens on the future site of Cedars-Sinai Medical Center



1961: Cedars of Lebanon and Mount Sinai hospitals merge as Cedars-Sinai Medical Center



1972: Groundbreaking ceremony is held for construction Cedars-Sinai Medical Center



Cedars Sinai Health System

Our Continuing Commitment to Serve Our Communities

2006: The Saperstein Critical Care Tower opens with 150 intensive care unit beds

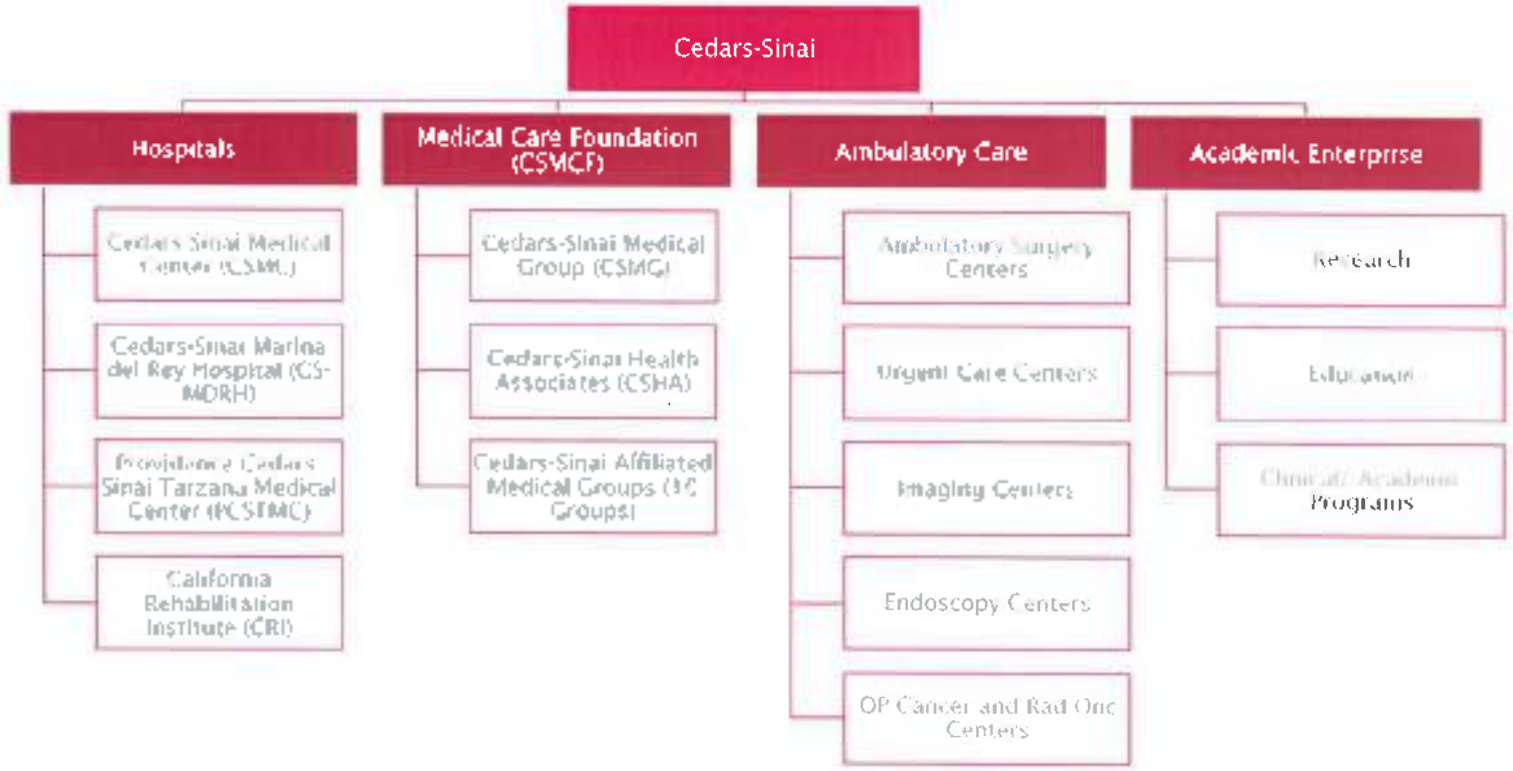


2013: The Advanced Health Sciences Pavilion opens on campus



Cedars Sinai Health System

Cedars-Sinai



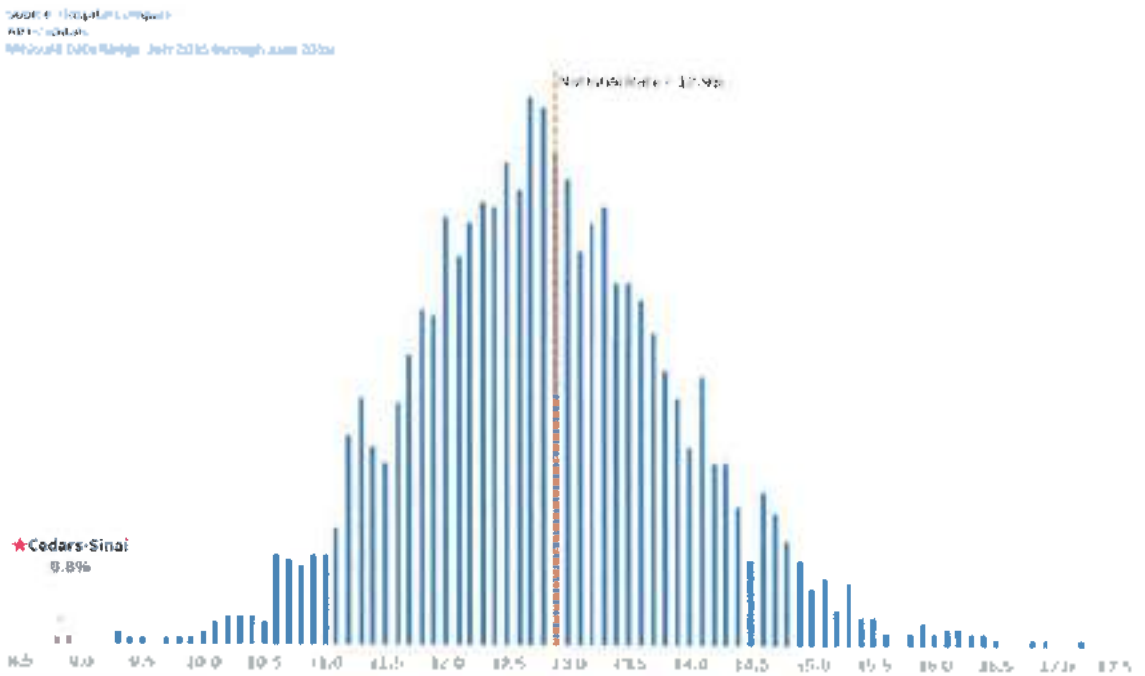
Cedars Sinai Health System

Cedars-Sinai Patient Care Mission Profile



Cedars Sinai Health System

Quality Recognitions:
Acute MI 30-Day Mortality Rate



For the ten years this has been tracked for hospitals nationally, CSMC is one of only three hospitals in the nation that has ranked "better than the national rate" for Acute Myocardial Infarction or Heart Attack (AMI), Congestive Heart Failure (CHF) and Pneumonia.

Cedars Sinai
Health System



Cedars-Sinai is ranked nationally in 12 specialties and has been named to the "Honor Roll" in U.S. News & World Report "Best Hospitals 2019-20."



#2



#3



#3



#4



#8



#10



#12



#12



#12



#12



#16

Cedars Sinai Health System

Recognition and Accomplishments



For the 20th year in a row, Cedars-Sinai has won NRC Health's Consumer Choice Award for providing the highest-quality medical care in the Los Angeles region.



Cedars-Sinai has been awarded Healthgrades's America's 50 Best hospitals. This prestigious recognition makes the third year in a row that Cedars-Sinai has been among top 1% in the nation for consistent clinically quality.



Cedars-Sinai Medical Group and Cedars-Sinai Health Associates, independent physician associations, both ranked among the top 10 physician groups in Southern California by Integrated Health Care Association (IHA).



Cedars-Sinai has received its fourth consecutive Magnet® designation for nursing excellence from the American Nurses Credentialing Center (ANCC), becoming the hospital with the longest-running Magnet designation in California.



BlackDoctor.org, the popular online health information resource for African-American consumers, has named Cedars-Sinai to its 2018 Top Hospitals for Diversity List.



Cedars-Sinai received a 5-star rating in the July 2018 hospital rating by Centers for Medicare and Medicaid Services (CMS). Only 9% of U.S. hospitals received a 5-star rating.

Cedars Sinai Health System

Medical Education – 2019 Highlights

CS Residency Programs

- **293 Positions and 75 Fellowships**
  - *~110 active applicants per slot*
  - Board Passage : 96%
  - Matching : 96%
  - 141 Fellowship Positions

Medical Student Rotations

- **897 Medical Student Rotations**
  - 505 UCLA
  - 363 Visiting
  - 29 Podiatry

Continuing Medical Education

- **174 CME courses**
  - 1,700 hrs accredited
  - >25,000 professionals
  - ACCME Accreditation w/ Commendation for 25 yrs



Teaching Innovation

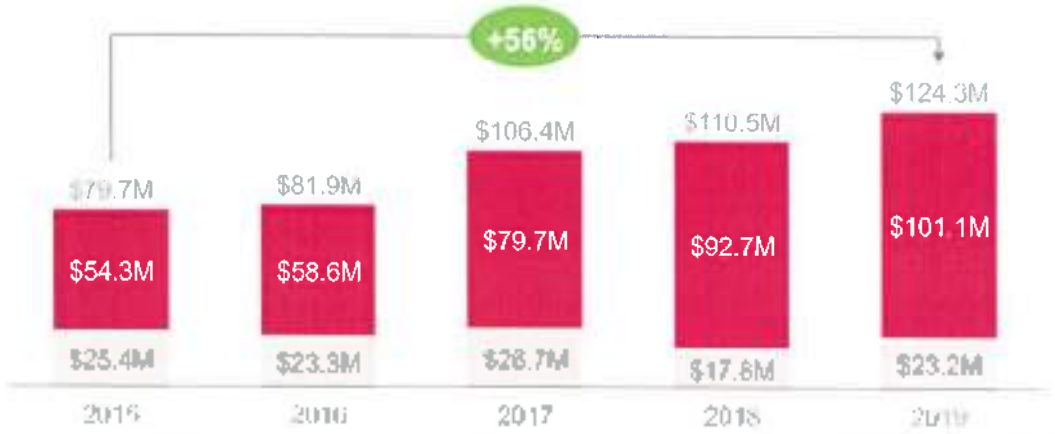
- **Women's Guild Simulation Center**
  - Patient simulators, devices
  - 120,000 learner contact hours (Top 5% Nationally)

Cedars Sinai Health System

Medical Research – 2019 Highlights

Research Awards and Acomplishments

- Extramural expenses: $194M
- 2,600 Publications
- ~1,700 IRB Studies
- 320 PIs
- 15 Cores



$ 38M Revenue from Research Commercialization (Top 10 based on autm)

Cedars Sinai Health System

Agenda

1. Cedars-Sinai Background and Evolution
2. TMMC Background and Evolution
3. Context for Development of CSHS
4. CSHS Strategic Direction
5. CSHS Governance Model

Cedars Sinai Health System

Over its almost 100-year history, TMMC has remained a community focused institution.

1902: 32 bed hospital donated by Helena Childs Torrance



- The hospital barely survived the Great Depression and two World Wars but by 1947, had grown to 96 beds. Over the last 95 years, the hospital location has changed and there have been numerous expansion projects.
- The bylaws, crafted by Mrs. Torrance, state that one half of the non-physician Board members shall always be women.
- Torrance Memorial is supported by an active community-based Board of Trustees and a separate Foundation Board devoted to fund raising.
- Torrance Memorial is the market leader in South Bay and seeks to offer the most current and effective medical technologies rendered in a compassionate, caring manner predominantly to the residents of the South Bay, Peninsula and Harbor communities.

Cedars Sinai Health System

TMMC - Our Continuing Commitment to Serve Our Communities

2014: Opened the new Lundquist Tower

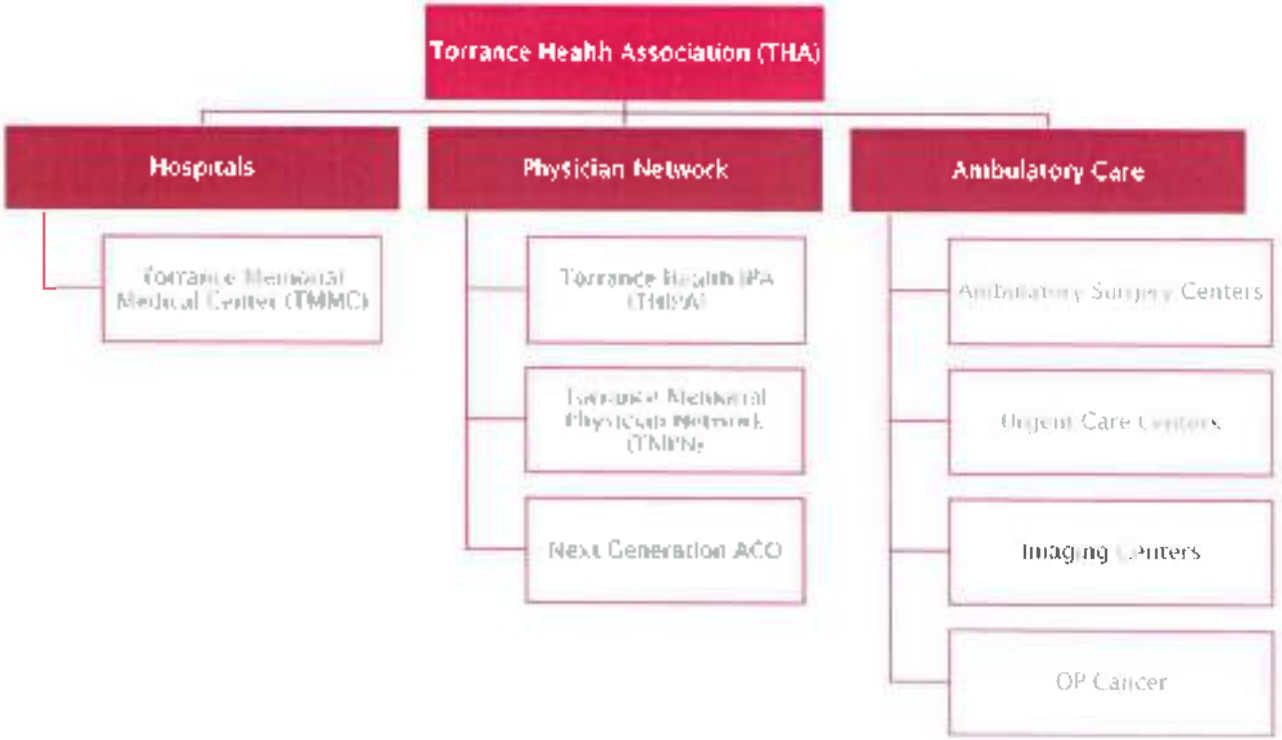


2019: The Hunt Cancer Center is opened in Torrance



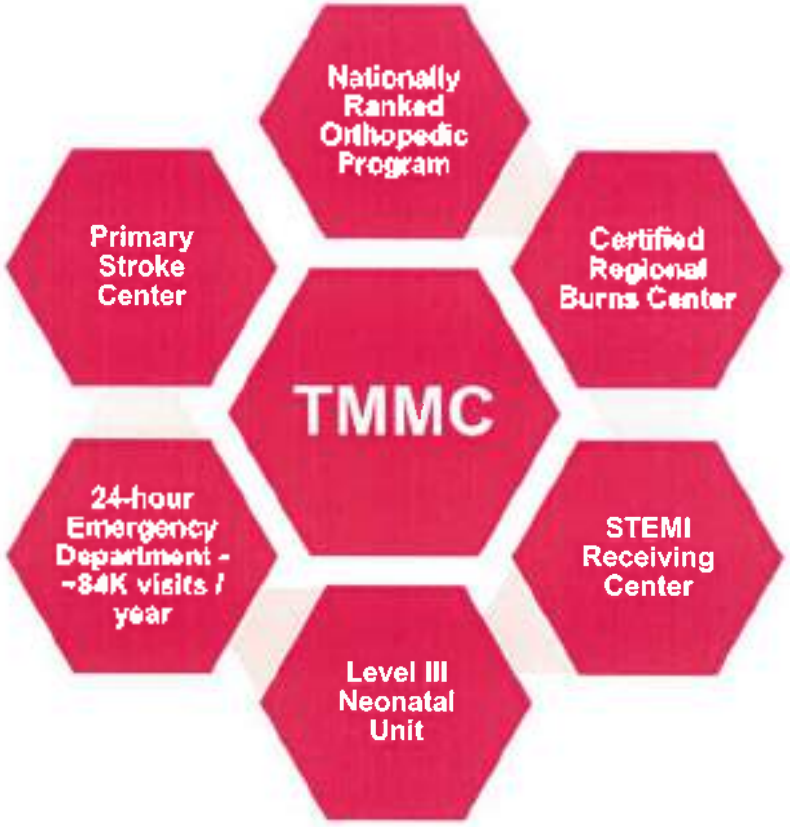
Cedars Sinai Health System

Torrance Health Association



Cedars Sinai Health System

TMMC Patient Care Mission Profile



Cedars Sinai Health System

TMMC - Recognition and Accomplishments

U.S. News & World Report - Best Regional Hospitals

U.S. News & World Report Best Hospitals - Orthopedics

U.S. News & World Report High Performing Hospital – 19 Programs

Newsweek
World's Best Hospital Report

Magnet Facility for Nursing Excellence
American Nurses Credentialing Center

TMMC received a 4-star rating by Centers for Medicare and Medicaid Services (CMS).

Healthcare Accreditation Services
Certified Primary Stroke Center

Cedars Sinai Health System

Agenda

1. Cedars-Sinai Background and Evolution
2. TMMC Background and Evolution
3. Context for Development of CSHS
4. CSHS Strategic Direction
5. CSHS Governance Model

Cedars Sinai Health System

National and Local Trends Driving Fundamental Changes in Healthcare

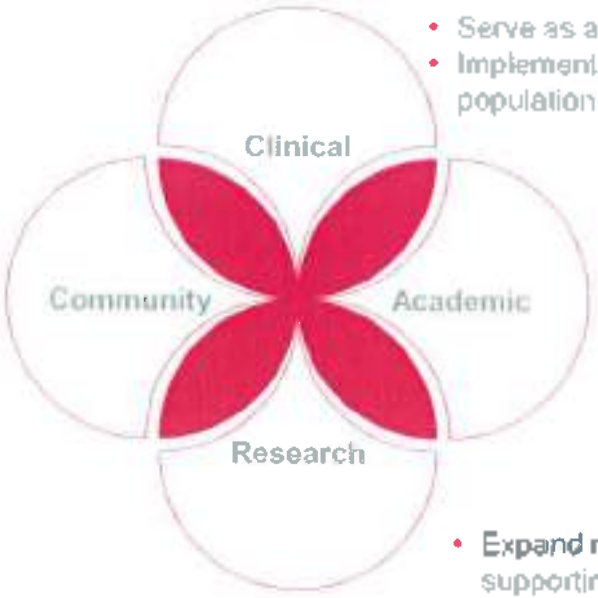
 **Payer Dynamics**	• Reimbursement and policy trends across both Government and Commercial payers are **impacting health systems' margins.**
 **Care Delivery**	• Care delivery systems are being redesigned to become more **consumer focused and clinically efficient** in response to value-based reimbursement models.
 **Consumerism**	• Innovative providers are responding to the increasing expectations of consumers for **greater access, engagement and seamless virtual services.**
 **Competetion**	• Large, well-capitalized firms are **making significant investments in healthcare** causing disruption, but potentially creating opportunities.
 **Consolidation**	• The development of integrated health systems is increasing - strengthening the ability of freestanding hospitals to serve their communities by benefiting from **economies of scale and capabilities** available as part of a larger health system.

Cedars Sinai Health System

Cedars-Sinai Health System Mission

Advance the delivery of high quality health care in support of each member organizations' non-profit missions

- Preserve and promote the historical culture and values of each member organization
- Meet the needs of each members' community and provide for substantial community benefit.

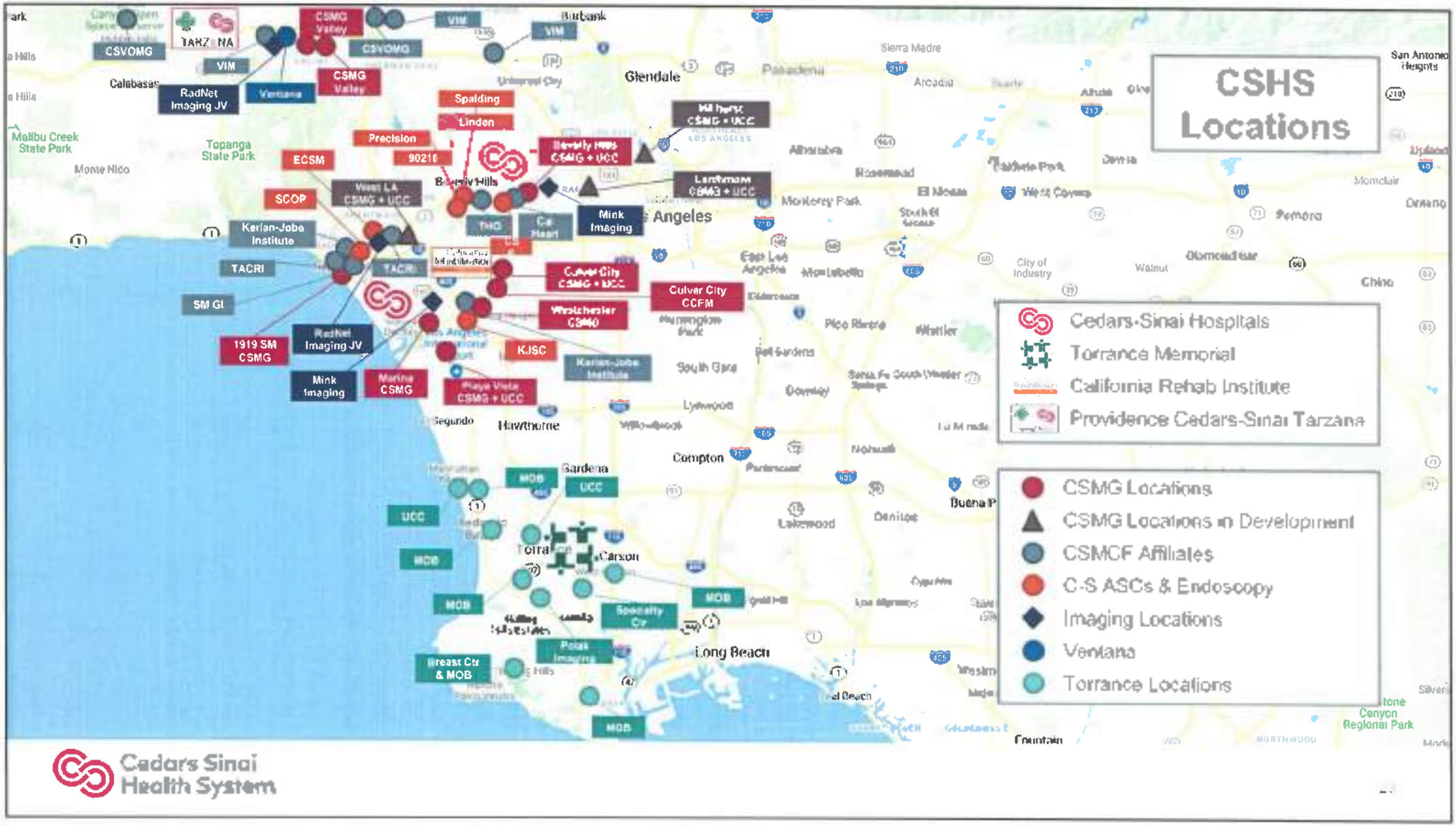


- Serve as a leader in the delivery of quality patient care
- Implement innovative approaches in medicine and population health

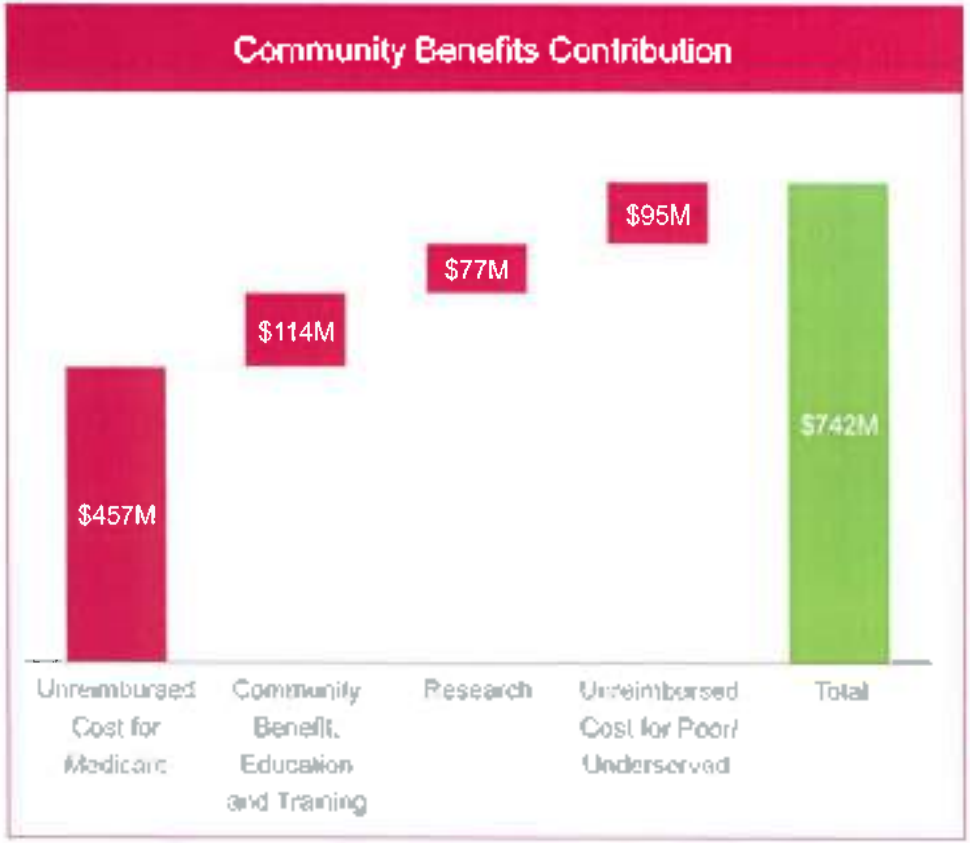
- Educate and train physicians and other health care professionals

- Expand medical knowledge through supporting biomedical research and discovery

Cedars Sinai Health System


CSHS Locations
Cedars-Sinai Hospitals
Torrance Memorial
California Rehab Institute
Providence Cedars-Sinai Tarzana
CSMG Locations
CSMG Locations in Development
CSMCF Affiliates
C-S ASCs & Endoscopy
Imaging Locations
Ventana
Torrance Locations
Cedars Sinai Health System
CSVOMG
VIM
CSMG Valley
RadNet Imaging JV
Ventana
Spalding
Linden
Precision
90210
ECSM
SCOP
Kerlan-Jobe Institute
TACRI
SM GI
1919 SM CSMG
RadNet Imaging JV
Mink Imaging
Marina CSMG
KJSC
Playa Vista CSMG + UCC
Beverly Hills CSMG + UCC
Mink Imaging
Culver City CSMG + UCC
Culver City CCFM
Westchester CSMG
Landmark CSMG + UCC
MOB
UCC
Specialty Ctr
Breast Ctr & MOB
Polaris Imaging
Glendale
Burbank
Pasadena
Long Beach
Torrance
Carson
Gardena
Hawthorne
Compton
Lakewood
Downey
Whittier
Pico Rivera
Monterey Park
El Monte
Arcadia
Sierra Madre
Malibu Creek State Park
Topanga State Park
Calabasas
Monte Nido
Beverly Hills
Los Angeles
East Los Angeles
City of Industry
Walnut
Chino
Diamond Bar
Pomona
Claremont
Montclair
Ontario
San Antonio Heights
Buena Park
Cerritos
Lynwood
South Gate
Bell Gardens
Pico Rivera
Whittier
Irvine Canyon Regional Park

Community Benefits Programs



- Cedars-Sinai COACH for Kids®
- TMMC Healthy Ever After – Kids
- Cedars-Sinai Healthy Habits
- TMMC Community Health Lectures
- Cedars-Sinai Community Health and Education
- TMMC Senior Advantage Program
- Cedars-Sinai Youth Employment and Development (YED)
- Community Benefit Giving Office

Cedars Sinai Health System

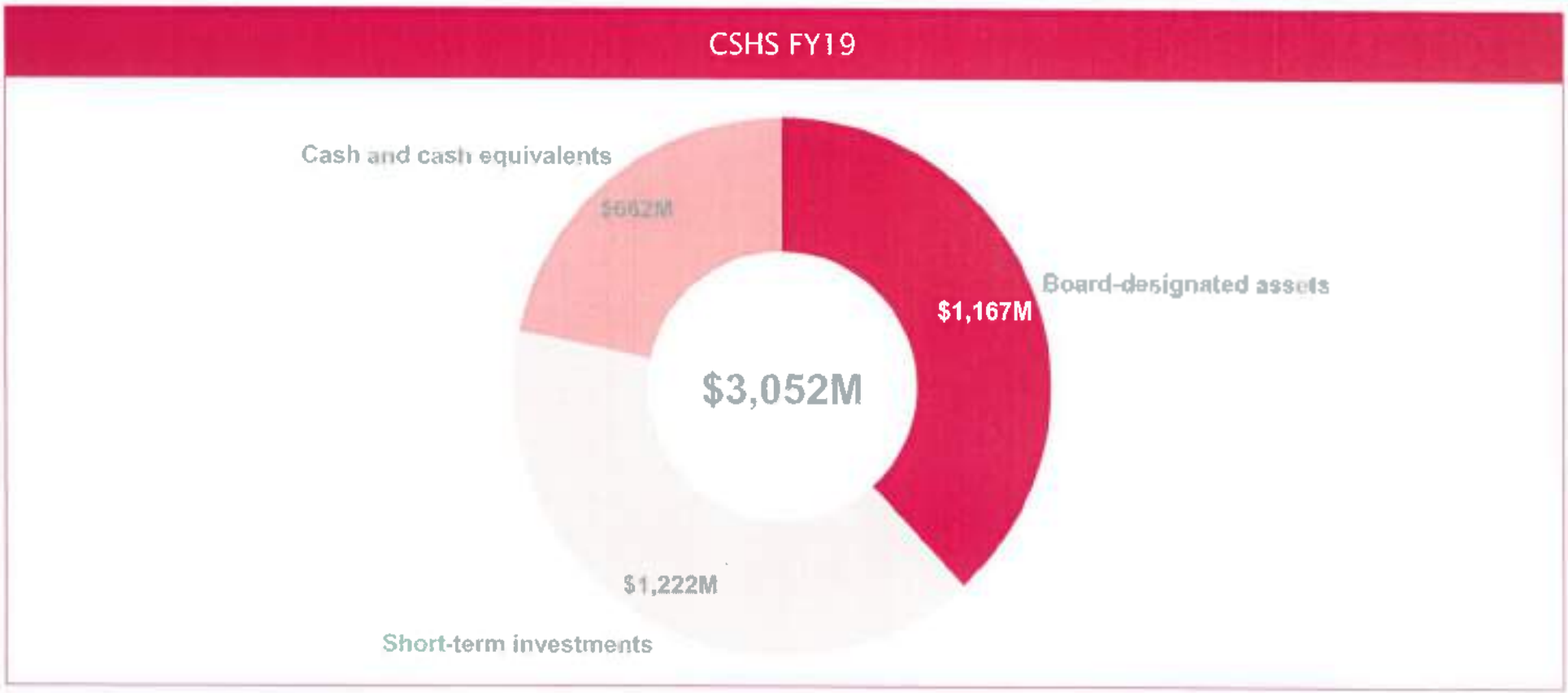
CSHS Performance – 2019 Operational and Financial Highlights

Patient Days	Admissions	Outpatient Registrations
395.2K	81.8K	1.27M

Revenue	EBIDA	Margin	
		Operating	EBIDA
$5.1B	$689M	7.9%	13.5%

Cedars Sinai Health System

CSHS Balance Sheet – 2019 Cash and Investment Assets



Cedars Sinai Health System

Agenda

1. Cedars-Sinai Background and Evolution
2. TMMC Background and Evolution
3. Context for Development of CSHS
4. CSHS Strategic Direction
5. CSHS Governance Model

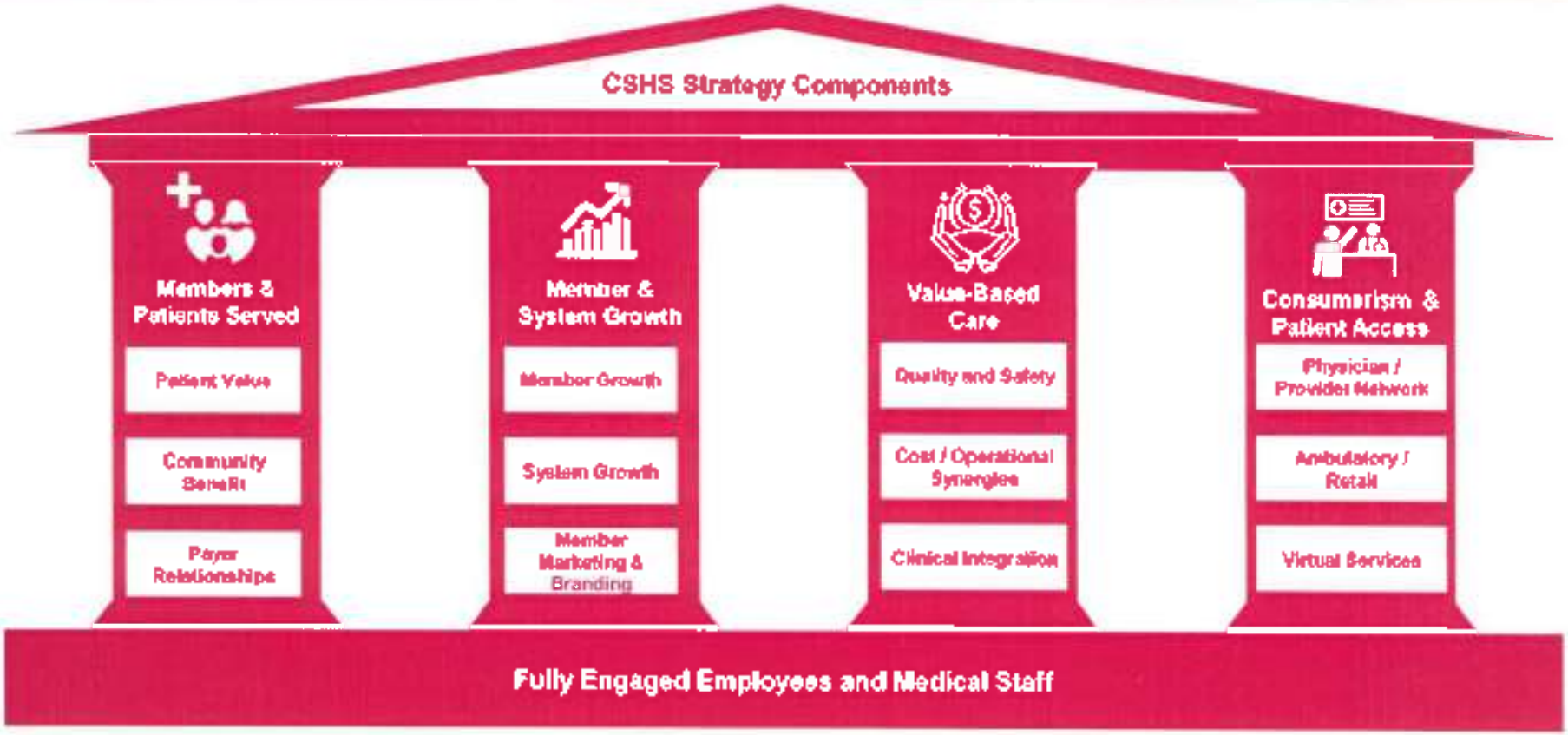
Cedars Sinai Health System

Health System Role and Philosophy



Cedars Sinai Health System

CSHS Strategy Overview



Cedars Sinai Health System

Integrating Quality Across CSHS

Goals of System Synergy Initiatives in Quality

- Identify economies of scale
- Standardize key program elements
- Implement best practices
- Provide support and expertise

Unified Dashboard

- Health System inpatient and ambulatory network performance dashboards

Resource Sharing

- Availability of expertise/partnership sharing in areas such as:
  - Performance Improvement,
  - Epidemiology
  - Risk Management/Legal,
  - Patient Safety
  - Medical Staff Governance and Peer Review,
  - Regulatory and Accreditation

Process Harmonization

- Connecting credentialing processes and Medical Staff privileging between TMMC and CSMC

Joint Projects

- Synergy of multiple projects
  - Flow and accessibility
  - Opioid stewardship
  - Patient experience
  - Eliminating patient harm

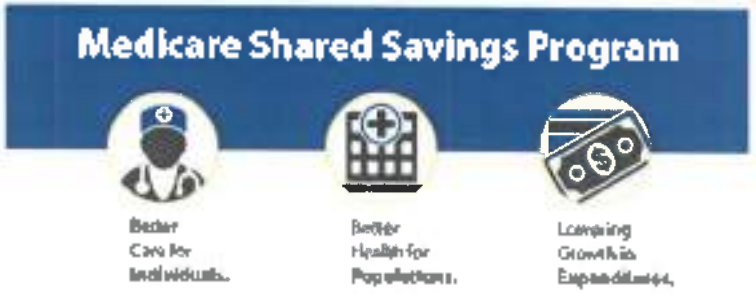
Cedars Sinai Health System

Payer Partnerships – JVs, ACO and Value-Based Care Models

Vivity
offered by
Anthem. BlueCross

blue
california
IFP

NextGen ACO



UnitedHealthcare
Senior Advantage

Cedars Sinai
Health System

Making Strategic Investments in Digital Health Capabilities to Align with Consumerism Trends



Manage My Health

- My CS-Link
- Patient Smart Tools
- Billing & Insurance

Get Care

- Find a Doctor & Schedule Appointments
- Virtual Consults
- On Demand Care

Find Us

- Locations & Directions

Get Health Information

- Conditions & Treatments

Contact Us

- Help & Questions
- Secure Texting

Cedars Sinai Health System

Agenda

1. Cedars-Sinai Background and Evolution
2. TMMC Background and Evolution
3. Context for Development of CSHS
4. CSHS Strategic Direction
5. CSHS Governance Model

Cedars Sinai Health System

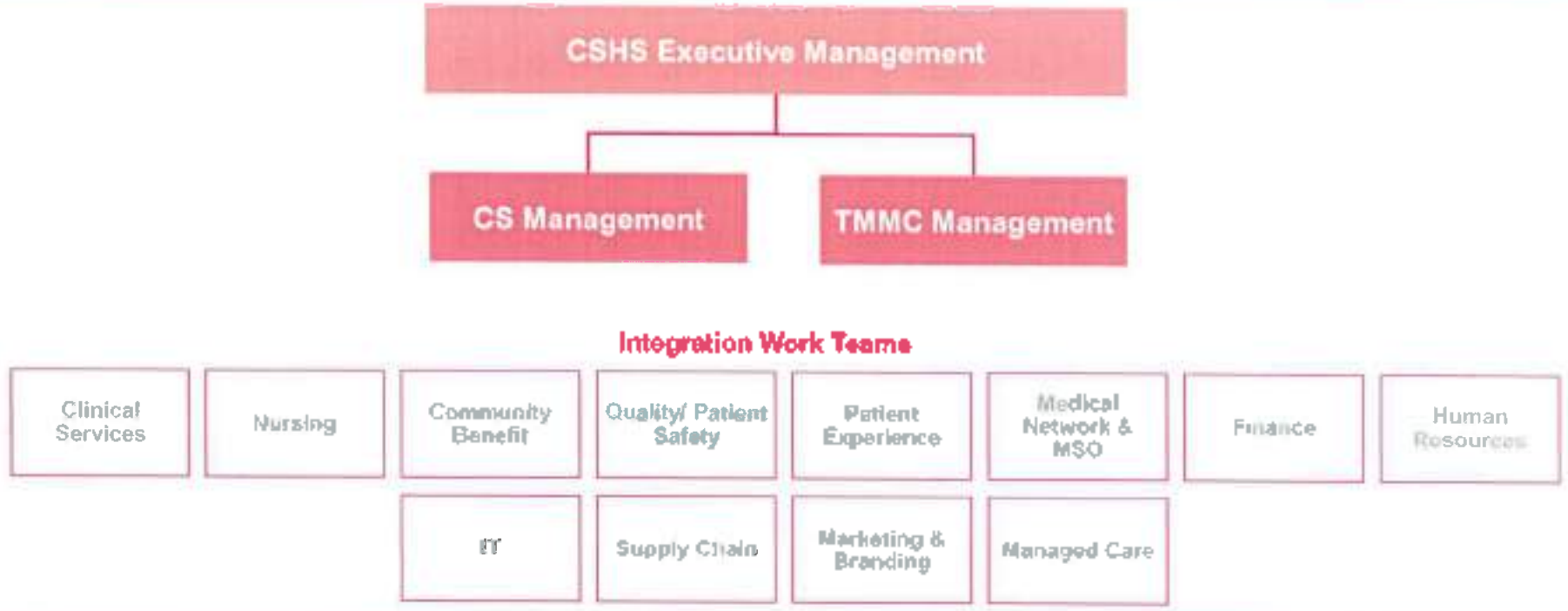
CSHS Operating Model Overview - Board



Cedars Sinai Health System

CSHS Operating Model Overview - Management

Management Structure



Cedars Sinai Health System

Exhibit 8-I

Letter of Intent with Cedars-Sinai

LETTER OF INTENT

This Letter of Intent (LOI), dated as of March 6, 2020 (the **Effective Date**), is between Pasadena Hospital Association, Ltd., a California nonprofit public benefit corporation d/b/a Huntington Hospital (**Huntington**), and the Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust (the **Trust**), on the one hand, and Cedars-Sinai Health System, a California nonprofit public benefit corporation (**Cedars-Sinai**), on the other hand. Huntington, the Trust, and Cedars-Sinai are sometimes referred to herein collectively as the "**Parties**" and each individually as a "**Party**.

1. Background

1.1 Huntington has been engaged in its charitable mission of delivering healthcare services in the San Gabriel Valley for over 125 years, with the support of the Trust. Huntington is governed by a board of directors consisting of trustees of the Trust and other directors elected by the board.

1.2 Huntington and its affiliates own and operate a 619-licensed bed general acute care hospital (the **Hospital**) located on a 28-acre campus in Pasadena, California, as well as other healthcare operations in the surrounding communities. The Trust owns the land beneath the Hospital (the **Hospital Real Property**) and leases the Hospital Real Property to Huntington.

1.3 Huntington and the Trust are recognized as exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986 (as amended, the **Code**). Huntington s affiliates include The Huntington Medical Foundation, a California nonprofit public benefit corporation.

1.4 Cedars-Sinai has been engaged in its charitable mission of delivering healthcare services in Los Angeles, California, for over 100 years. Cedars-Sinai is governed by a board of directors consisting of not less than twelve and not more than eighteen directors, all elected by the board of Cedars-Sinai except for one ex-officio director.

1.5 Cedars-Sinai owns and operates an integrated healthcare delivery system which includes a major academic medical center located in Los Angeles, community hospitals in Torrance and Marina del Rey, as well as other healthcare operations in surrounding communities.

1.6 Cedars-Sinai is recognized as exempt from federal income tax under Section 501(c)(3) of the Code. Cedars-Sinai s tax-exempt subsidiaries include the entities identified on Exhibit 1.6, attached hereto.

1.7 The Parties seek to improve the quality of and access to healthcare in the communities each serves and to further their respective charitable missions, and to that end, they desire to strengthen Huntington and its affiliates and the services they provide to their communities by making available to Huntington the resources and services of Cedars-Sinai, and to have Huntington and its affiliates lead the development and execution of the strategy for Cedars-Sinai's, Huntington's and their affiliates' operations in the San Gabriel Valley, through a transaction (the **Proposed Transaction**) in which Cedars-Sinai would become the sole member of Huntington, all as described in this LOI. The Parties wish to expedite the negotiation, execution and delivery of a definitive written agreement providing for the Proposed Transaction (the **Affiliation Agreement**) and such other documents and agreements as the Parties deem necessary or appropriate to complete the Proposed Transaction (collectively, the **Definitive Documents**), consistent with the terms of this LOI.

2. Goals

Cedars-Sinai acknowledges the goals of Huntington in pursuing the Proposed Transaction, as outlined in Exhibit A, attached hereto. Huntington acknowledges Cedars-Sinai s goals of growing its

integrated healthcare delivery system to fulfill its mission of providing excellent clinical and service quality, offering compassionate care, supporting research and medical education, and developing a common culture around that mission that respects the traditions of Cedars-Sinai.

3. Proposed Transaction

Consummation of the Proposed Transaction (the "**Closing**") would consist of the following actions, on the terms and subject to the conditions of the Definitive Documents:

3.1 Amendment of Huntington Governing Documents. Huntington would cause the amendment of its articles of incorporation and bylaws as necessary to provide that Cedars-Sinai is the sole member (as defined in as defined in Section 5056(a) of the California Corporations Code) of Huntington and to implement the applicable governance provisions described in Section 4 of this LOI.

3.2 Amendment of Cedars-Sinai Governing Documents. Cedars-Sinai would cause the amendment of its articles of incorporation and bylaws as necessary to implement the applicable governance provisions described in Section 4 of this LOI.

3.3 Trust Actions. The Trust would do each of the following:

(a) Transfer the Hospital Real Property to Huntington at the Closing.

(b) Retain ownership of all other assets of the Trust.

(c) Continue to determine the investment and (except to the extent provided in Section 3.3(d) of this LOI) distribution of Trust assets in the discretion of the trustees of the Trust.

(d) Commit to make the following distributions (the "Distributions") to Huntington:

(i) All Distributions are contingent on Huntington and its subsidiaries that are currently exempt from federal income tax under Code Section 501(c)(3) remaining exempt under such section, Huntington continuing to operate and maintain the Hospital as a licensed general acute care hospital, Cedars-Sinai continuing to be the sole member of Huntington, and Cedars-Sinai complying in all material respects with its obligations under the Definitive Documents.

(ii) During the Commitment Period, the Trust would make annual distributions for the use and benefit of Huntington equal to the sum of:

(A) $5,300,000 for fiscal year 2021 (increased by 2.5% per annum in future years), which must be used solely to fund Huntington s GME program; and

(B) 2.5% of the investment portfolio of the Trust (to be defined in the Definitive Documents) measured at the end of each fiscal year (starting with the first full fiscal year after the Closing), which must be used solely to fund Huntington Capital Plan items designated by the Trust or other Huntington programs designated by the Trust.

4. Governance

The Parties would provide for their boards of directors and membership to be as follows:

4.1 Huntington Board. The board of directors of Huntington (the **Huntington Board**) would consist of not less than thirteen and not more than twenty-eight directors, as follows: two Cedars-Sinai Directors, five Trust Directors, two Physician Directors and the balance of Community Directors.

(a) **Cedars-Sinai Directors**" would consist of the Chief Executive Officer and the Chief Financial Officer of Cedars-Sinai, who will serve ex officio with vote pursuant to Section 5220(f) of the California Corporations Code (herein, "**ex officio**"). Cedars-Sinai would identify the Cedars-Sinai Directors by name prior to execution and delivery of the Affiliation Agreement (**Signing**), and the Cedars-Sinai Directors would be listed in the applicable Definitive Document. A vacancy in the position of a Cedars-Sinai Director would be filled by the person occupying the position of Chief Executive Officer or Chief Financial Officer, as applicable, of Cedars-Sinai.

(b) **Physician Directors**" will consist of the president of the medical staff and the immediate past president of the medical staff of Huntington, who serve ex officio.

(c) **Trust Directors**" would consist of the trustees of the Trust, who would continue to serve ex officio.

(d) **Community Directors**" would consist of individuals nominated by the Huntington Board subject to election by Cedars-Sinai. Huntington would propose the initial Community Directors prior to Signing, and the Community Directors would be listed in the applicable Definitive Document. A vacancy in the position of a Community Director would be filled by nomination of the Huntington Board subject to election by Cedars-Sinai.

(e) Any executive committee of the Huntington Board would include a proportionate number of Cedars-Sinai Directors, Community Directors and Trust Directors.

4.2 Cedars-Sinai Board. The board of directors of Cedars-Sinai (the **Cedars-Sinai Board**) would, upon consummation of the Proposed Transaction, consist of not less than twelve and not more than eighteen directors, three of whom (the **Rose Directors**) would be nominated by Huntington, which is the same number of directors as are currently nominated by Torrance Health Association, a California nonprofit public benefit corporation ("**THA**).

(a) Huntington would propose the initial Rose Directors prior to Closing.

(b) A vacancy in the position of a Rose Director would be filled by nomination of Huntington and election by the Cedars-Sinai Board.

(c) If the size of the Cedars-Sinai Board is decreased, then the number of Rose Directors would decrease to the same extent as the number of directors nominated by THA (the "**THA Directors**") is decreased, and if the size of the Cedars-Sinai Board is increased, and as a result the number of THA directors is increased, then the number of Rose Directors would be increased to the same extent as the number of THA Directors, provided that in all events at least 51% of the members of the Cedars-Sinai Board will be Cedars-Sinai Directors.

(d) If an executive committee of the Cedars-Sinai Board is created by the Cedars-Sinai Board, it would include at least one Rose Director and at least one THA Director.

4.3 Director Parity.

(a) Huntington Board Director Parity. Each director on the Huntington Board would have the same rights and responsibilities as all other directors serving on the Huntington Board, except to the extent that any action of the Huntington Board requires the affirmative vote of a majority of the Trust Directors as described in Section 4.5 of this LOI. Additionally, each director on the executive committee of the Huntington Board would have the same rights and responsibilities as all other directors serving on the executive committee.

(b) Cedars-Sinai Board Director Parity. Each director on the Cedars-Sinai Board would have the same rights and responsibilities as all other directors serving on the Cedars-Sinai Board. Additionally, each director on the executive committee of the Cedars-Sinai Board would have the same rights and responsibilities as all other directors serving on the executive committee.

4.4 Role of Huntington Board.

(a) General. The Huntington Board would continue as a fiduciary board. The business and affairs of Huntington would be managed under the direction of the Huntington Board, except to the extent provided in Section 4.5 of this LOI. Without limiting the foregoing, the Huntington Board would continue to be responsible for the oversight, development and implementation of quality assessment, performance improvement and patient safety programs for the Hospital, which would utilize the quality resources of Cedars-Sinai to assist with such oversight, development and implementation of quality-related matters and programs. The Definitive Documents would provide for Huntington to notify Cedars-Sinai of any significant quality or safety risk events and to confer with Cedars-Sinai regarding the development and implementation of a corrective action response plan for such events. The Definitive Documents would provide for Cedars-Sinai and Huntington to use their commercially reasonable efforts to cause the Hospital and the medical staffs of Cedar-Sinai hospital affiliates to enter into appropriate peer review sharing agreements in compliance with applicable law as soon as reasonably possible after Closing.

(b) Strategic Plans. Huntington management periodically would develop Huntington s strategic plans and present them to the Huntington Board. In developing strategic plans, Huntington management may consult with management of Cedars-Sinai. The Huntington Board would have the authority to review the strategic plans and determine whether to approve and recommend them to Cedars-Sinai. Cedars-Sinai, in its capacity as sole member of Huntington, would have the final authority to approve the strategic plans. Cedars-Sinai would not use its approval authority to create an annual "de novo" approval process for the Huntington Capital Plan or the EHR Project and would not withhold approval of any portion of the Huntington Capital Plan or the EHR Project within the Commitment Period without good cause.

(c) Budgets. Each year Huntington management would develop Huntington s annual operating and capital budgets and present them to the Huntington Board. In developing budgets, Huntington management may consult with management of Cedars-Sinai. The Huntington Board would have the authority to review the annual budgets and determine whether to approve and recommend them to Cedars-Sinai. Cedars-Sinai, in its capacity as sole member of Huntington, would have the final authority to approve the annual budgets. Cedars-Sinai would not use its approval authority to create an annual "de novo" approval process for the Huntington Capital Plan or the EHR Project and would not withhold approval of any portion of the Huntington Capital Plan or the EHR Project within the Commitment Period without good cause. Cedars-Sinai may make determinations about Huntington's incurrence of debt to fund any portion of Huntington's budgets.

4.5 Reserved and Joint Approval Rights.

(a) Member Reserved Rights. Cedars-Sinai, in its capacity as the sole member of Huntington, would have the unilateral right (except as expressly noted below in this Section 4.5(a)) to take the following actions with respect to Huntington and any subsidiaries of Huntington:

(i) Appointment and removal, with or without cause, of the chief executive officer of Huntington (the **Huntington CEO**), subject to Section 4.5(b)(iii) of this LOI.

(ii) Incurrence of indebtedness (other than the entry into any capital lease or equipment lease valued in the aggregate under $5,000,0000, and other than accounts payable incurred in the ordinary course of business).

(iii) Formation of an obligated group for credit purposes that includes Huntington along with one or more other Cedars-Sinai hospital subsidiaries.

(iv) Entrance into any material settlement or consent decree with a government agency or third party on behalf of Huntington.

(v) Any change of the legal form of the Huntington entity if such change is part of an an event that is subject to Section 4.6 of this LOI.

(vi) Any transaction or series of related transactions involving a change in control of Huntington (a **Change in Control**), including a change in the membership of Huntington such that Cedars-Sinai is no longer the sole and controlling member of Huntington; a transaction pursuant to which a majority of the directors on the Huntington Board is replaced or any person or group of persons has the right to replace a majority of the directors on the Huntington Board; and any merger, consolidation or reorganization of Huntington, or other transaction, resulting in a change in control of Huntington, or a sale, transfer, or other disposition of all or substantially all of the assets of Huntington, which Change in Control would be subject to Section 4.6 of this LOI.

(vii) The closure of the Hospital, which closure would be subject to Section 4.6 of this LOI.

(viii) Dissolution of Huntington if such dissolution is part of a Change in Control that would be subject to Section 4.6 of this LOI.

(ix) Removal of individuals who serve as Community Directors and Cedars-Sinai Directors from the Huntington Board either with or without cause.

(x) Sale of any real property owned by Huntington, subject to Section 4.5(c)(i) of this LOI.

(xi) Sale, transfer or other disposition of all or substantially all of the assets owned by Huntington that are used exclusively for the operation of Huntington s affiliated physician network if such sale, transfer or other disposition constitutes an entirely internal reorganization by Cedars-Sinai of Cedars-Sinai s entire affiliated physician enterprise within the Southern California region in which all such assets remain owned by controlled affiliates of Cedars-Sinai (a **Physician Network Reorg**).

(xii) Sale, transfer, or other disposition of assets of Huntington that have an aggregate value exceeding 2% of the net revenue of the selling, transferring or disposing entity for the entity s immediately preceding fiscal year if such sale, transfer or other disposition is not part of a Change in Control that would be subject to Section 4.6 of this LOI.

(b) 5-Year Qualified Member Reserved Rights. Cedars-Sinai, in its capacity as the sole member of Huntington, may take or make any of the following actions or decisions with respect to Huntington or any of Huntington's subsidiaries, which, during the first five years following the Closing (the **5-Year Transition Period**), would also require the approval of the Huntington Board (which Huntington Board approval would require the affirmative vote of the Huntington Board and a majority of the Trust Directors):

(i) Adoption, repeal, amendment, modification or restatement of the articles of incorporation or bylaws of Huntington or any of its subsidiaries.

(ii) Any action or decision that would change the size or composition of the Huntington Board.

(iii) Approval of the successor to the person serving as the Huntington CEO as of the Closing (the **Huntington Incumbent CEO**) if the Huntington Incumbent CEO for any reason ceases to occupy the office of Huntington CEO during the 5-Year Transition Period.

(c) 10-Year Qualified Member Reserved Rights. Cedars-Sinai, in its capacity as the sole member of Huntington, may take or make the following actions or decisions with respect to Huntington or any of Huntington's subsidiaries, which, during the first ten years following the Closing (the **10-Year Transition Period**), would also require the approval of the Huntington Board (which Huntington Board approval would require the affirmative vote of the Huntington Board and a majority of the Trust Directors):

(i) Sale of any real property owned by Huntington if such sale is not part of a Change in Control that would be subject to Section 4.6 of this LOI.

(d) Joint Approval Rights without Trust Directors. The following actions or decisions with respect to Huntington or any of its subsidiaries would require the approval of both Cedars-Sinai, in its capacity as the sole member of Huntington, and the Huntington Board:

(i) Approval of an expenditure by Huntington that is not set forth in an approved budget and exceeds $5,000,000.

(ii) Approval of the community benefit plan of Huntington.

(e) Joint Approval Rights, including Trust Directors. The following actions or decisions with respect to Huntington or any of its subsidiaries would require the approval of both Cedars-Sinai, in its capacity as the sole member of Huntington, and the Huntington Board (which Huntington Board approval, during and beyond the 10-Year Transition Period, would require the affirmative vote of the Huntington Board and a majority of the Trust Directors):

(i) Any change to the mission, vision or values of Huntington.

(ii) Any change to the name of Huntington or the Hospital.

(iii) Any change of the legal form of the Huntington entity if such change is not part of a Change in Control that would be subject to Section 4.6 of this LOI.

(iv) Dissolution of Huntington if such dissolution is not part of a Change in Control that would be subject to Section 4.6 of this LOI.

(v) Any action that results in Huntington or the Hospital not being owned and operated by a tax-exempt organization under Section 501(c)(3) of the Code which is also a public charity under Section 509(a) of the Code or which otherwise jeopardizes the tax exempt status of the Trust.

(vi) Sale, transfer or other disposition of all or substantially all of the assets owned by Huntington that are used exclusively for the operation of Huntington s affiliated physician network, provided that such sale, transfer or disposition is not part of a Physician Network Reorg.

(vii) The sale, transfer, or other disposition of assets of Huntington that have an aggregate value exceeding 2% of the net revenue of the selling, transferring or disposing entity for the entity s immediately preceding fiscal year if such sale, transfer or other disposition is not part of a Change in Control that would be subject to Section 4.6 of this LOI.

(f) Approval Rights of the Trust. Notwithstanding anything to the contrary, any action or decision that would change the voting rights of Trust Directors would require the approval of the Trust (acting by a majority of its trustees then in office).

4.6 Change in Control, Closure or Change to Tax-Exempt Status of Huntington. In the event that Cedars-Sinai causes any of the following events to occur, the Huntington Board (excluding any directors appointed by Cedars-Sinai) would have the right to terminate Cedars-Sinai s membership in Huntington and cause Huntington or the Trust to assume the assets and liabilities of Huntington on terms to be agreed upon in the Definitive Documents (notwithstanding any other reserved powers of Cedars-Sinai described herein):

(a) Any transaction or series of related transactions involving a Change in Control.

(b) The closure of the Hospital.

(c) Any action that results in Huntington or the Hospital not being owned and operated by a tax-exempt organization under Section 501(c)(3) of the Code which is also a public charity under Section 509(a) of the Code or which otherwise jeopardizes the tax exempt status of the Trust.

5. Financial Commitments

5.1 Consideration. The aggregate consideration to be delivered by Cedars-Sinai would be comprised of each of the following:

(a) The Funding Commitment described in Section 5.2 of this LOI.

(b) The EHR Project described in Section 5.3 of this LOI.

(c) The In-Kind Services described in Section 5.4 of this LOI.

(d) The Release described in Section 5.5 of this LOI.

5.2 Funding Commitment. Cedars-Sinai would commit to the following:

(a) Cedars-Sinai would accept the Huntington strategic capital plan totaling $560,000,000 for the period between 2021 and 2029 as identified in the capital expenditure plan attached hereto as Exhibit 5.2 (the "**Huntington Capital Plan**"). The Huntington Capital Plan would be incorporated by reference into the Definitive Documents on the understanding that it would be fulfilled in accordance with the plans and timeline set forth in the Huntington Capital Plan (the **Commitment Period**).

(b) Cedars-Sinai would commit $300,000,000 throughout the Commitment Period (the **Funding Commitment**") to support the Huntington Capital Plan. Cedars-Sinai would determine the appropriate source of funds for the Funding Commitment, including debt, intercompany loans from Cedars-Sinai and/or other sources, provided that Huntington would first use its unrestricted cash on hand in excess of 90 days to fund the Huntington Capital Plan (with the understanding that Cedars-Sinai would coordinate the additional funding when Huntington reasonably anticipates that Huntington's expenditures to fund the Huntington Capital Plan will cause Huntington s cash on hand to be reduced to 90 days or less). For purposes of Section 5 of this LOI, Huntington's cash on hand will exclude all cash transferred

from the Trust to Huntington. Annual amounts and types of spending would be decided pursuant to the process for approving annual budgets described in Section 4.4(c) of this LOI.

(c) The Parties acknowledge that Cedars-Sinai may invest more capital into Huntington's operations than the Funding Commitment described in this Section 5.2. The Funding Commitment is intended to be the minimum amount of investment by Cedars-Sinai during the Commitment Period, but certain business and strategic considerations could result in Cedars-Sinai deciding, in its sole discretion, to invest more than the Funding Commitment into Huntington.

5.3 EHR Project. In addition to the Huntington Capital Plan, Cedars-Sinai would, immediately upon the Closing, begin to implement an enterprise-wide IT strategy at Huntington (collectively, the **EHR Project**) as described in this Section 5.3. The EHR Project would include: (i) establishing an integrated (rather than interfaced) EHR system with Epic Systems Corporation (**Epic**) to extend the Cedars-Sinai instance of Epic to Huntington that would consist of completing the core phases 0 5 attached hereto as Exhibit 5.3(a) (the "**EHR Core Phases**") (pending further discussions with Huntington to occur at the appropriate time during the due diligence period to better define the scope, timing and implementation expectations for the EHR Project), and (ii) extending to Huntington Cedars-Sinai's enterprise license to use Epic software that would permit Huntington to sublicense the Epic system modules set forth on Exhibit 5.3(b) attached hereto.

(a) The EHR Project would be overseen and directed by the EHR governance, management structure and operating model set forth on Exhibit 5.3(c) attached hereto (the "**EHR Project Committee**). Cedars-Sinai would oversee the EHR Project Committee and would commit to providing the resources necessary and appropriate for its oversight of the EHR Project Committee.

(b) Cedars-Sinai would complete implementation of the EHR Project based on a timeline and implementation plan for the EHR Project established by the EHR Project Committee, which timeline and implementation plan may be updated or amended from time to time in the reasonable discretion of the EHR Project Committee. Huntington will make available appropriate Huntington staff to assist Cedars-Sinai and otherwise reasonably cooperate with Cedars-Sinai in completing the implementation of the EHR Project.

(c) Cedars-Sinai would commit to fund all capital costs necessary to complete the EHR Project (the **EHR Project Capital Costs**), separate and apart from the Funding Commitment. Annual amounts and types of spending on EHR Project Capital Costs would be decided pursuant to the process for approving annual budgets described in Section 4.4(c) of this LOI. Cedars-Sinai and Huntington would consider the extent to which Huntington's accumulated level of surplus cash on hand could reasonably be made available for the EHR Project Capital Costs without affecting the funds available to Huntington for the Huntington Capital Plan or the Funding Commitment. Subject to the foregoing, Cedars-Sinai would determine the appropriate source of funds for the EHR Project Capital Costs, including debt, intercompany loans from Cedars-Sinai and/or other sources.

5.4 In-Kind Services. At no cost to Huntington, Cedars-Sinai would provide: (a) significant support from personnel from Cedars-Sinai's Information Technology team to assist Huntington in executing the elements of the Huntington Capital Plan related to the Master Facility Plan and IT Infrastructure, with such support to be further described in the Definitive Documents, (b) support from other Cedar-Sinai personnel to assist Huntington in executing the elements of the Huntington Capital Plan related to physician network development, ambulatory network strategy, and other related projects, with such support to be further described in the Definitive Documents, and (c) support in other areas where Cedars-Sinai has both scale and capability advantages to support Huntington s strategic initiatives (the **In-Kind Services**).

5.5 Release of the Trust. At the Closing, Cedars-Sinai will cause the Trust to be fully released from all of its obligations in connection with Huntington s bond indebtedness and related contractual obligations (the **Release**), subject to commercially reasonable cooperation of the Trust and Huntington to accomplish the Release.

5.6 Allocation of Costs. During the Commitment Period, Cedars-Sinai would not charge Huntington or allocate to Huntington any costs for Cedars-Sinai overhead, management fees or other centralized expenses except to the extent allocated among Cedars-Sinai hospital affiliates based on their pro-rata share of operating expenses relative to the other hospital affiliates.

6. Hospital Commitments

For the applicable periods of time required by the Attorney General of the State of California (the **Attorney General**) in the Attorney General s conditional approval of the Proposed Transaction (the **AG Approval**), as further described in Section 10.4 of this LOI, Cedars-Sinai would and cause Huntington to comply with the conditions of the AG Approval, including each of the following:

6.1 Huntington will operate and maintain the Hospital as a licensed general acute care hospital, including to the extent that Huntington is able to meet the requirements of applicable accreditation agencies, maintaining each of the following with the same types and levels of services as currently provided:

(a) Level II Trauma Center
(b) Level III Neonatal Intensive Care Unit
(c) Comprehensive Stroke Center
(d) STEMI Receiving Center
(e) Advanced Cardiology and Cardiovascular Surgery Programs
(f) Advanced Robotic Surgery
(g) Orthopedic Service Line
(h) Oncology Service Line
(i) Neurology Service Line
(j) GME programs
(k) Senior Care Network

6.2 Huntington will be certified to participate in the Medi-Cal program at the Hospital.

6.3 Huntington will be certified to participate in the Medicare program by maintaining a Medicare provider number.

6.4 The Hospital will be operated under a name that prominently includes “Huntington,” provided that after the Closing, Huntington will identify itself in all material respects as an affiliate of Cedars-Sinai, pursuant to branding guidelines mutually agreed upon by the Parties in good faith within 180 days after the Closing.

6.5 Huntington will honor restrictions imposed by donors on gifts to the Hospital.

6.6 Neither Cedars-Sinai nor any of its affiliates would (a) sell, lease, exchange, option, convey, manage, or otherwise dispose of the Hospital or (b) transfer control, responsibility, management, or governance of the Hospital, or in each case allow any such transaction to occur, without the prior approval of the Attorney General.

6.7 Huntington will use commercially reasonable efforts to maintain Magnet Status with substantially the same types and levels of services as currently provided.

7. Charity Care and Community Benefit

7.1 Charity Care. Cedars-Sinai would ensure, and Huntington will cooperate with Cedars-Sinai in ensuring, that Huntington continues to provide charity care at such levels as required by the Attorney General. The term charity care is used as defined by the Attorney General.

7.2 Community Benefit. Cedars-Sinai would ensure, and Huntington will cooperate with Cedars-Sinai in ensuring, that Huntington continues to provide community benefit at such levels as required by the Attorney General. The term community benefit is used as defined by the Attorney General.

8. Physicians

8.1 Huntington Medical Staff. Cedars-Sinai would permit Huntington to retain a separate, independent medical staff accountable to the Huntington Board and allow Huntington to retain the Medical Staff Bylaws of the Hospital.

8.2 Changes to Status. Cedars-Sinai would not require or take any action as a condition of or in connection with the Closing that would change any officers or committee chairs of the medical staff of the Hospital or alter the membership status and clinical privileges that any Medical Staff member had immediately prior to the Closing. The Parties agree that such status may be changed only after the Closing Date and only in accordance with the provisions of the Medical Staff Bylaws and applicable laws.

9. Employees

Cedars-Sinai agrees that effective as of Closing, all employees of Huntington would remain employees of Huntington immediately after the Closing. Cedars-Sinai would not take or require Huntington to take any action in connection with the Closing that would trigger application of the WARN Act or its state equivalent to Huntington. After Closing, to the extent that the Parties agree to consolidate any Huntington employee welfare and benefit plans, paid time off, vacation, or any other employee benefit programs ("**Employee Benefit Programs**") with any Cedars-Sinai or Cedars-Sinai subsidiary Employee Benefit Programs, the Parties agree that employees of Huntington would receive full credit for their years of service to Huntington under such Employee Benefit Programs, subject to applicable law and the terms of any applicable plan document.

10. Definitive Documents

10.1 Preparation of Definitive Documents. The Parties will instruct their respective counsel to prepare the Definitive Documents and deliver them to each other as soon as possible after the Effective Date, consistent with the timeline in Section 12. Initial drafts of the Affiliation Agreement will be prepared by Cedars-Sinai's counsel to allow for consistency with the prior affiliation agreement to which Cedars-Sinai and THA are parties. Amended articles of incorporation of Huntington and amended bylaws of Huntington will be prepared by Huntington s counsel, after taking into account a form of bylaws that counsel for Cedars-Sinai will provide which is based on the bylaws of Cedars-Sinai's other affiliate hospitals. Amended bylaws of Cedars-Sinai will be prepared by Cedars-Sinai s counsel.

10.2 Certain Provisions Regarding Bylaws. The amended articles of incorporation and bylaws of Huntington will contain provisions on exculpation and indemnification no less favorable to the indemnitees than the existing articles of incorporation and bylaws of Huntington. The amended articles of incorporation and bylaws of Cedars-Sinai will contain protective provisions to preserve certain terms, as applicable, described in this LOI unless Cedars-Sinai obtains the prior written consent of the Huntington Board.

10.3 Terms of Affiliation Agreement. Terms of the Affiliation Agreement will include the provisions described in this LOI and the following:

(a) The Parties will obtain all necessary corporate and Trust approvals prior to Signing. The Parties will cooperate to obtain all necessary third-party consents to leases and contracts of Huntington and all approvals necessary to maintain government authorizations and provider numbers of Huntington as soon as possible after Signing.

(b) Cedars-Sinai will not take any action that would result in Huntington maintaining directors and officers, errors and omissions, professional liability, general liability and other insurance coverage at levels lower than those currently maintained by Huntington or with terms no less favorable for the insureds than the policies maintained by Huntington immediately prior to Closing, for at least six years after Closing.

(c) Cedars-Sinai, on the one hand, and Huntington and the Trust, on the other hand, will make mutual representations and warranties to each other, covering due organization, authority, enforceability, no conflicts, 501(c)(3) status and brokers for the Proposed Transaction, and other representations and warranties that are usual and customary in transactions of this nature, with knowledge and other customary qualifications and limitations and mutually agreeable materiality thresholds. The knowledge of each Party will be limited to the actual knowledge of its executive leadership team. All representations and warranties will be qualified by disclosure schedules delivered by each Party to the others prior to Signing and updated prior to Closing.

(d) Each Party will confirm that the Party has, as of Signing, completed all of its due diligence necessary for the Party to enter into the Affiliation Agreement and complete the Closing. Each Party will provide full non-reliance provisions, agreeing that the other Parties representations and warranties set forth in the Affiliation Agreement, together with bring down certificates delivered at Closing, constitute the sole and exclusive representations and warranties made by or on behalf of any of the Parties in connection with the Affiliation Agreement or the Proposed Transactions. Each Party will disclaim any other representations and warranties, express or implied, and waive any claim for reliance on any other representations or warranties.

(e) All representations and warranties by or on behalf of Huntington will expire at Closing. From and after Closing, no Cedars-Sinai Party will have any rights against anyone relating to representations or warranties by Huntington.

(f) Huntington will continue to provide meeting space and administrative support that are reasonably necessary to support the Trust after Closing.

10.4 Notice to Attorney General. Huntington will be responsible for delivering written notice to the Attorney General pursuant to Section 999.5 of the California Code of Regulations. Cedars-Sinai and Huntington will use their respective commercially reasonable efforts to obtain the AG Approval, including participating in any required Attorney General or public meetings. Each Party will notify the others of communications from the Attorney General relating to such notice or approval. Cedars-Sinai and the Trust each acknowledge and agree that they will need to comply, and after Closing cause Huntington to comply, with the terms of the AG Approval.

10.5 HSR Compliance. To the extent required by law, each Party will file or cause to be filed with the applicable government agency any notifications and reports required to be filed by its ultimate parent entity under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended (the **HSR Act**), with respect to the Proposed Transaction; respond on a timely basis to any requests for additional information by any such agency; keep the other Parties promptly apprised of any communications with,

and inquiries or requests for information from, such agency; and furnish the other with such necessary information and reasonable assistance as the other Parties and their respective representatives may reasonably request in connection with their preparation of necessary filings, registrations or submissions of information to any such agency. Each Party will take such action as required to resolve without delay any objections any such agency may have to the Proposed Transaction.

10.6 Access to Information. From and after the Closing, (a) the Trust will have full access to information and to directors, officers and employees of Huntington relating to Huntington or the subject matter of any of the terms of the Affiliation Agreement, (b) Cedars-Sinai and Huntington will deliver to the Trust copies of the Affiliation Agreement and other Definitive Documents, (c) Huntington will deliver to Cedars-Sinai and the Trust the AG Approval, and (d) each Party will deliver to the other Parties copies of all communications with the Attorney General received by such Party relating to the Proposed Transaction, the Affiliation Agreement or the AG Approval.

11. Conditions

11.1 Conditions to Signing

(a) Negotiation of the Definitive Documents.

(b) Necessary corporate and Trust authorizations of the adoption and approval of the amendments and restatements of the articles of incorporation and bylaws described in this LOI and of the execution, delivery and performance of the other Definitive Documents.

11.2 Conditions to Closing

(a) AG Approval, with conditions comparable to other recent nonprofit hospital change-in-control transactions.

(b) Such court approval as determined necessary or appropriate by the Trust upon its petition.

(c) Expiration or termination of the applicable waiting period under the HSR Act.

(d) Receipt of other consents, approvals and authorizations of third parties that the Parties mutually agree are necessary to obtain prior to the Closing and are sufficiently material to justify as conditions to the Closing.

(e) No law or order in effect prohibiting the Closing.

(f) No breach by the other Party of its representations and warranties in the Affiliation Agreement that is reasonably expected to constitute a material adverse change of such Party.

(g) Compliance by the other Parties with their covenants in the Affiliation Agreement in all material respects if such Parties are required to perform such covenants prior to the Closing (subject to notice and cure).

12. Timeline

The Parties will use their respective commercially reasonable efforts to reach Signing on the following timeline:

(a) Within 20 days after the Effective Date:	Cedars-Sinai to deliver to Huntington the initial draft of the amended bylaws of Cedars-Sinai and a proposed Affiliation Agreement,

	Huntington to deliver to Cedars-Sinai the initial drafts of the amended articles of incorporation of Huntington and amended bylaws of Huntington
(b) Within 30 days after receipt of initial drafts from Cedars-Sinai:	Huntington to deliver to Cedars-Sinai a complete markup of the Affiliation Agreement, Cedars-Sinai to deliver to Huntington a complete markup of amended articles of incorporation of Huntington and amended bylaws of Huntington
(c) Within 90 days after the Effective Date:	Each Party to notify the other that it has completed due diligence necessary for Signing and the Parties to finalize Definitive Documents
(d) Within 110 days after the Effective Date:	Cedars-Sinai Board, Huntington Board, and any other corporate action to approve the Proposed Transaction and Definitive Documents, Trust approval of Transaction and Definitive Documents
(e) Within 10 days after all the approvals described in (d) above have been obtained:	Signing

13. Binding Provisions

For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties, intending legally to be bound, hereby agree as follows:

13.1 Exclusivity. During the Exclusivity Period defined below, Huntington and its affiliates will not directly or indirectly engage in a Proposed Transaction with anyone but Cedars-Sinai; solicit, initiate, or encourage the submission of any proposal from any person relating to any transaction similar to or adversely affecting the ability of Huntington to engage in the Proposed Transaction with Cedars-Sinai, including any merger, sale or similar transaction; participate in any negotiations regarding or furnish to any other person any non-public information with respect to any such proposal; encourage any effort by any person to do any of the foregoing; approve, endorse or recommend any such proposal with any other parties; enter into any letter of intent or similar document or any contract or commitment with any other parties relating to any such proposal; or permit any of their respective directors, officers, employees or representatives to do any of the foregoing. **Exclusivity Period** means the period beginning on the Effective Date and ending on the earliest of the following dates:

(a) Immediately by Huntington upon written notice to Cedars-Sinai if Cedars-Sinai at any time proposes any change to any term of the Proposed Transaction that, taken alone or collectively, has the effect of decreasing any of the amounts described in Section 5 of this LOI.

(b) Immediately by Huntington upon written notice to Cedars-Sinai if Cedars-Sinai at any time proposes any change to any term of the Proposed Transaction that is set forth in this LOI if, taken alone or collectively, such change adversely affects Huntington in any material respect.

(c) Immediately by Cedars-Sinai upon written notice to Huntington if Huntington at any time proposes any change to any term of the Proposed Transaction that, taken alone or collectively, has the effect of increasing any of the amounts described in Section 5 of this LOI.

(d) Immediately by Cedars-Sinai upon written notice to Huntington if Huntington at any time proposes any change to any term of the Proposed Transaction that is set forth in this LOI if, taken alone or collectively, such change adversely affects Cedars-Sinai in any material respect.

(e) By written notice from Huntington to Cedars-Sinai if by 5:00 P.M. Pacific Time on the day indicated in Section 12(c) of this LOI Huntington has not received a letter from an authorized representative of Cedars-Sinai stating that Cedars-Sinai has completed all of its due diligence investigation necessary to enter into the Affiliation Agreement and complete the Closing.

(f) At 5:00 P.M. Pacific Time on September 30, 2020.

(g) Immediately upon termination of this LOI.

13.2 Solicitation Restrictions. During the Exclusivity Period, Cedars-Sinai and its affiliates (the "**Cedars-Sinai Parties**") will not directly or indirectly engage in a Competing Transaction (defined below); solicit, initiate, or encourage the submission of any proposal from any person relating to a Competing Transaction; participate in any negotiations regarding or furnish to any other person any non-public information with respect to a Competing Transaction; encourage any effort by any person to do any of the foregoing; approve, endorse or recommend any Competing Transaction with any other parties; enter into any letter of intent or similar document or any contract or commitment with any other parties relating to any Competing Transaction; or permit any of their respective directors, officers, employees or representatives to do any of the foregoing. In addition, during the Exclusivity Period, no Cedars-Sinai Party will directly or indirectly solicit, initiate, or encourage any physician on the Medical Staff of Huntington to move the physician s practices from Huntington; or permit any of their respective directors, officers, employees or representatives to do any of the foregoing; provided that nothing in this LOI generally or this Section 13.2 specifically shall prohibit any Cedars-Sinai Party from (a) hiring a physician who applies to an advertisement placed in the ordinary course, (b) granting or renewing any physician's medical staff membership or privileges to practice medicine at any Cedars-Sinai hospital or other facility that maintains an organized medical staff, or (c) engaging any physician to provide call coverage services in such physician's medical specialty at any Cedars-Sinai hospital. "Competing Transaction means a transaction that is directly or indirectly related to or dependent upon the Proposed Transaction, upon which the Proposed Transaction would be dependent, that would make the Proposed Transaction impractical or unfeasible or that is a change in control transaction with a hospital in the service area of Huntington described in Exhibit 13.2.

13.3 NDAs Remain in Effect. Huntington and Cedars-Sinai will be and remain bound by those two certain Nondisclosure Agreements dated July 2, 2019 between Cedars-Sinai and Huntington (the **NDA**). The terms and existence of this LOI are Confidential Information (as defined in the NDA).

13.4 Press Releases. No Party will issue any press release or public statement regarding the Proposed Transaction without the consent of the other Parties as to the timing, content, and circulation/audience thereof, unless, upon written advice of counsel, disclosure is required by law, provided that the disclosing Party uses commercially reasonable efforts to consult with the other Parties with respect to the text thereof.

13.5 Due Diligence.

(a) Huntington will, subject to the terms of the NDA, provide reasonable access to information, documents, books and records and facilities in its care, custody or control so that Cedars-

Sinai and their representatives can evaluate, negotiate and implement the Proposed Transaction. Cedars-Sinai agrees not to contact any director, officer, supplier, customer, physician or employee of Huntington in connection with Cedars-Sinai s due diligence investigation without the prior written approval of Huntington.

(b) Cedars-Sinai will, subject to the terms of the NDA, provide reasonable access to information, documents and books and records in their care, custody or control so that Huntington and its representatives can evaluate, negotiate and implement the Proposed Transaction. Huntington agrees not to contact any director, officer, supplier, customer, physician or employee of Cedars-Sinai and its affiliates in connection with Huntington s due diligence investigation without the prior written approval of Cedars-Sinai.

(c) The Trust will provide reasonable access to information, documents and books and records in its care, custody or control so that Cedars-Sinai and its representatives can evaluate, negotiate and implement the Proposed Transaction. The Trust agrees not to contact any director, officer, supplier, customer, physician or employee of Cedars-Sinai and its affiliates in connection with the Trust's due diligence investigation without the prior written approval of Cedars-Sinai.

13.6 Authority. Each Party confirms that it has all necessary corporate or Trust power and authority to enter into and to perform its respective obligations under this LOI.

13.7 Each Party to Bear Own Costs. The Parties will be responsible for and bear all of their own costs and expenses (including any broker s or finder s fees) incurred in connection with the Proposed Transaction, including expenses of their representatives, incurred at any time in connection with pursuing or consummating the Proposed Transaction.

13.8 Termination. The term of this LOI began on the Effective Date. This LOI may be terminated by any Party upon 30 days prior written notice to the other Parties. Termination of this LOI will not affect the liability of a Party for a breach prior to termination. Upon termination, the Parties will have no further obligations hereunder, except as stated in this Section 13, which will survive termination in accordance with its terms.

13.9 Non-Binding Nature of LOI. Neither this LOI nor any past or future communications, course of conduct, action or failure to act will constitute an obligation or commitment to enter into any Definitive Documents or give any person any rights or claims against another in the event that any person for any reason terminates negotiations to effect the Proposed Transaction. All obligations or commitments to proceed with the Proposed Transaction will be contained only in the Definitive Documents, and none of the Parties will have any obligation to consummate any transaction with each other unless and until Definitive Documents have been executed and delivered by all Parties thereto. For purposes of this LOI, the term Definitive Documents does not include this LOI, any letter of intent, term sheet or other preliminary agreement. Notwithstanding the preceding, the terms of Section 13 are binding on each Party and such Party s successors and assigns and will survive any termination or expiration of this LOI.

13.10 Governing Law and Rules of Interpretation. This LOI will be governed by and construed in accordance with the internal laws of the State of California. The language used in this LOI will be deemed to be the language chosen by the Parties to express their mutual agreement, and this LOI will not be deemed to have been prepared by any single Party hereto. The Parties waive the application of any law providing that ambiguities in an agreement or other document will be construed against the Party drafting such agreement or document. The words include and including and variations thereof are not terms of limitation, but rather will be deemed to be followed by the words without limitation. This LOI and the NDA contain the entire agreement of the Parties concerning the matters addressed herein. No modification of this LOI or waiver of its terms and conditions will be binding upon any Parties hereto,

unless approved in writing signed by the Parties to be bound thereby. This LOI may be executed in counterparts and by electronic means.

Signature lines are on the next page.

Signature Page to Letter of Intent

CEDARS-SINAI:

CEDARS-SINAI HEALTH SYSTEM

REDACTED

By:
Title: Chief Executive Officer

HUNTINGTON:

PASADENA HOSPITAL ASSOCIATION, LTD.
D/B/A HUNTINGTON HOSPITAL

REDACTED

By:
Title: Chief Executive Officer

TRUST:

REDACTED

Jayne Studenmund, TRUSTEE OF THE COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

REDACTED

Armando L. Gonzalez, TRUSTEE OF THE COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

REDACTED

Michelle Quinones Chinn, TRUSTEE OF THE COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST

Exhibit A

Goals

(a) Enhance Huntington s ability to fulfill its mission and vision

(b) Develop a compatible culture with Cedars-Sinai, with a focus on collaboration and a commitment to quality and community

(c) Recognize Huntington s commitment to and relationship with its community as key foundational assets to be maintained and built upon

(d) Develop the leading clinically integrated healthcare delivery platform in Huntington s service area

(e) Enhance the relationship with Huntington s medical provider community

(f) Commit to the wellness of Huntington s service area

(g) Balance the current economic realities of the greater Los Angeles area

(h) Enable Huntington to continue and enhance its ambulatory growth strategy

(i) Support investment in the ambulatory resources necessary to provide value-based care

(j) Position Huntington to be a leader in a value-based care environment with specific competencies, including the ability to enter into risk-based payment arrangements, coordinate care effectively, perform sophisticated data analytics and provide broad access to care

(k) Implement an enterprise-wide IT strategy, including EHR, ambulatory population health management and wellness, and revenue cycle management

(l) Provide the resources necessary to support the development of a full service MSO and offer competitive employment and quasi-employment options to our medical community

(m) Consider strategic and economic realities, balancing the possible effects on Huntington s current partnerships and relationships

(n) Maintain and enhance Huntington s current relationship with DaVita Healthcare Partners, now part of OptumCare

(o) Support the full spectrum of the clinical services Huntington offers to the community, particularly in areas of cardiology and oncology

(p) Commit to clinical quality

(q) Demonstrate alignment with Huntington s focus upon excellence in nursing and its medical staff

(r) Continue Huntington s existing commitment to research and education

(s) Provide financial strength and stability to support the combined capital needs of Huntington and Cedars-Sinai

(t) Ensure ongoing commitment to Huntington s relationship with the community as well as its existing mission, including a meaningful role in governance for the Huntington board and the Trust

(u) Demonstrate that the affiliation with Huntington is a strategic priority for Cedars-Sinai

(v) Successfully execute an affiliation strategy

Exhibit 1.6

Cedars-Sinai Medical Center

Cedars-Sinai Medical Care Foundation

CFHS Holdings, Inc., dba Cedars-Sinai Marina del Rey Hospital

Torrance Health Association, Inc.

Torrance Memorial Medical Center

Torrance Memorial Medical Center Health Care Foundation

Exhibit 5.2

Huntington Capital Plan

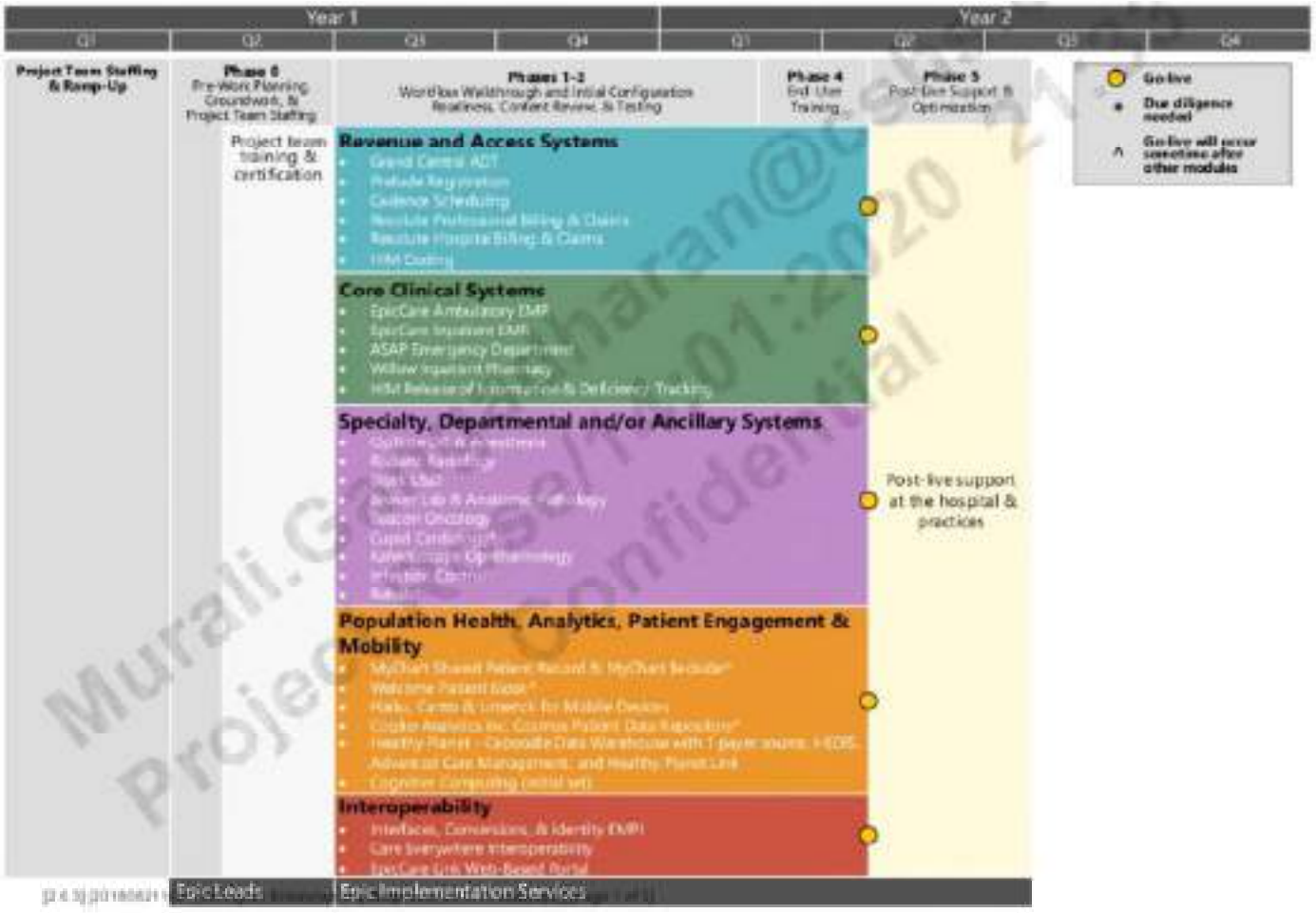
Huntington Hospital & Affiliates 2021 - 2029 Capital Expenditure Plan

		2021	2022	2023	2024	2025	2026	2027	2028	2029	Total *(rounded)*
(a)	Routine	15,758	16,230	16,717	17,219	17,736	18,267	18,815	19,379	19,960	**160,000**
(b)	IT Strategic/Infrastructure/Masterplan	14,762	12,106	12,923	11,982	13,992	11,901	14,961	12,070	12,070	**117,000**
(c)	FMP Non-Compliance Projects	31,352	7,000	-	-	-	-	-	-	-	**38,000**
(d)	Major Capital Projects	23,882	15,594	6,594	594	594	-	-	-	-	**47,000**
(e) *= (a) + (b) + (c) + (d)*	**Total PHA & Affiliate CapEx** *(rounded)*	**86,000**	**51,000**	**36,000**	**30,000**	**32,000**	**30,000**	**34,000**	**31,000**	**32,000**	**362,000**
(f)	Additional CapEx Estimated Needs	-	4,406	13,406	19,406	19,406	20,000	20,000	20,000	20,000	**137,000**
(g)	Unallocated Strategic/Physician Integration	3,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	**43,000**
(h)	Total Additions - CSC HASC	1,308	1,311	1,303	1,280	1,279	1,281	1,278	1,278	1,278	**12,000**
(i)	Total Additions - HHP	656	656	656	656	656	656	656	656	656	**6,000**
(j) *= (e) + (f) + (g) + (h) + (i)*	**Total Non-Specifically Defined Strategic Capital** *(rounded)*	**5,000**	**11,000**	**20,000**	**26,000**	**26,000**	**27,000**	**27,000**	**27,000**	**27,000**	**198,000**
(e) + (j)	**Total PHA & Affiliates Proposed Capital** *(rounded)*	**91,000**	**62,000**	**56,000**	**56,000**	**58,000**	**57,000**	**61,000**	**58,000**	**59,000**	**560,000**

($ in 000's)

Exhibit 5.3(a)

EHR Core Phases



Phase 0 Month 1 Deliverables:

- Identify all core project team members and operational readiness owners.
- Finalize Epic license and hosting agreements.
- Finalize Epic hosting agreement.
- Designate a block of private IP addresses for your Hosting Infrastructure.

Phase 0 Month 2 Deliverables:

- Finalize go-live date, application scoping, and key organizational scoping.
- Send project team members to training at Epic and complete certification.
- Complete contracting for all Tier 1 third parties from the Third Party Checklist.
- Create executive and specialty governance committees that are empowered to quickly make decisions.
- Gather legacy CDM and charging data.
- Perform gap analysis of supplies in materials management system to what will be documented in Epic.
- Complete role analysis for training.
- Complete facility structure analysis, mapping physical departments to Epic departments.

Out of Scope for Implementation (not included in the implementation estimates)

- Bones Orthopaedics
- Behavioral Health
- Wisdom General Dentistry*
- EpicCare Dialysis*
- Willow Ambulatory Pharmacy*
- Willow Inpatient Inventory Supply Tracking*
- Cupid Cardiology (extended functionality)*
- Home Care (inc. Home Health & Hospice)*
- HIM Chart Tracking
- CM/CRM Customer Service Support
- Nurse Triage
- Lumens Endoscopy*
- Social Care*
- Genomics*
- EpicCare Fertility*
- Long-Term Care*
- Healthy Planet – Additional payer sources

Exhibit 5.3(b)

Modules To Be Provided Under Cedars-Sinai's Epic Enterprise License

1. Core Clinical

1.1 EpicCare Inpatient Clinical System

(a) Including EDR, EHR, Order Entry / CPOE, Clinical Documentation, MAR, Interdisciplinary Care Plans, Clinical Pathways, Infection Control. Clinical Case Management, Willow Inpatient Pharmacy, Inventory Supply Tracking, Rover, ICU, HIM Deficiency Tracking, HIM Release of Information, ASAP Emergency Department, and EpicCare for Hospital Outpatient Services

1.2 EpicCare Ambulatory EHR

1.3 Healthy Planet Population Health

(a) Including Healthy Patient Link, Advanced Care Management, and HEDIS Quality Measures

2. Specialty & Ancillary

2.1 Beacon Oncology

2.2 Beaker Clinical and Anatomic Pathology

2.3 Behavioral Health

2.4 Cupid Cardiology (Including ACC-NCDR Registry Module)

2.5 EpicCare for Home Care (Including Home Health and Hospice)

2.6 EpicCare Link

2.7 Dialysis

2.8 Bones Orthopaedics

2.9 EpicCare Fertility

2.10 Kaleidoscope General Ophthalmology

2.11 Lumens Endoscopy

2.12 Long-Term Care

2.13 Base Genomics

2.14 OpTime Operating Room Management and Anesthesia

2.15 Radiant Radiology

2.16 EpicCare Rehab

2.17 Secure Chat

2.18 Social Care

2.19 Stork OB / Labor & Delivery

2.20 Urgent Care

2.21 Willow Ambulatory Pharmacy & Inventory Supply Tracking

2.22 Wisdom General Dentistry

3. Revenue Cycle and Patient Access

3.1 Resolute Hospital Billing

(a) Including Hospital Coding, HIM Clinical Documentation Improvement, Patient Estimates, Charge Reconciliation, and Denial & Variance, and Self-Pay & Contract Management

3.2 Resolute Professional Billing

(a) Including Prelude Ambulatory Registration, Patient Estimates, Charge Reconciliation, and Denial & Variance, Self-Pay and Contract Management

3.3 Cadence Enterprise Scheduling

3.4 Grand Central & Prelude Registration

3.5 Financial Assistance

3.6 Transfer Center

3.7 CRM Call Management

3.8 Nurse Triage

4. Analytics and Enterprise Foundation

4.1 Cogito Analytics

(a) Including Clarity and Analyst Reporting Package, Reporting Workbench, Radar Executive Information Desktop

4.2 Caboodle Data Warehouse and SlicerDicer

4.3 Haiku for Smartphones / Canto for Tablets / Limerick for Apple Watch

4.4 Identify Embedded Master Person Index

4.5 Charge Router

4.6 Push Notifications

4.7 Bridges EDI Developer s License

4.8 Interface Starter Set

4.9 Epic Cognitive Computing Platform

4.10 Care Everywhere (Including Carequality Exchange)

5. Other Items

5.1 MyChart Shared Patient Record

5.2 Lucy Personal Health Record

5.3 MyChart Virtual Care

5.4 Healthy Planet

5.5 MyChart Bedside

5.6 Welcome Patient Kiosk

5.7 Epic Cognitive Computing

5.8 Cosmos

5.9 Advanced Care Management

5.10 HEDIS Quality Measures

5.11 Cognitive Computing Models

5.12 Cognitive Computing Developer Platform

5.13 Cognitive Cloud Services

5.14 34 Interface Units

Exhibit 5.3(c)

EHR Program Level Governance and Management Structure

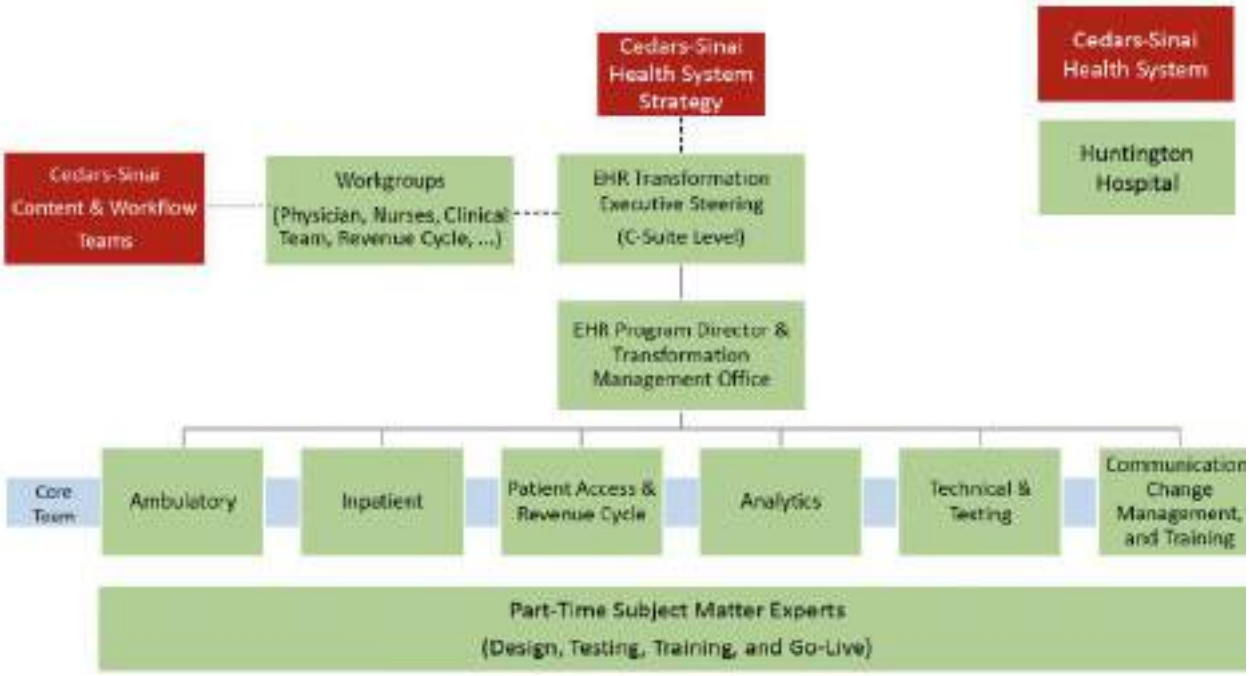


Exhibit 8-J

Project Rose Funding Commitment Discussion

KaufmanHall

Exceptional Partners. Exceptional Performance.

Funding Commitment Discussion

April 2020

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Original Capital Plan Exhibit

		2021	2022	2023	2024	2025	2026	2027	2028	2029	Total *(rounded)*
(a)	Routine	15,758	16,230	16,717	17,219	17,736	18,267	18,815	19,379	19,960	**160,000**
(b)	IT Strategic/Infrastructure/Masterplan	14,762	12,106	12,923	11,982	13,992	11,901	14,961	12,070	12,070	**117,000**
(c)	FMP Non-Compliance Projects	31,352	7,000	-	-	-	-	-	-	-	**38,000**
(d)	Major Capital Projects	23,882	15,594	6,594	594	594	-	-	-	-	**47,000**
(e) *= (a) + (b) + (c) + (d)*	**Total PHA & Affiliate CapEx** *(rounded)*	**86,000**	**51,000**	**36,000**	**30,000**	**32,000**	**30,000**	**34,000**	**31,000**	**32,000**	**362,000**
(f)	Additional CapEx Estimated Needs	-	4,406	13,406	19,406	19,406	20,000	20,000	20,000	20,000	**137,000**
(g)	Unallocated Strategic/Physician Integration	3,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	**43,000**
(h)	Total Additions - CSC HASC	1,308	1,311	1,303	1,280	1,279	1,281	1,278	1,278	1,278	**12,000**
(i)	Total Additions - HHP	656	656	656	656	656	656	656	656	656	**6,000**
(j) *= (f) + (g) + (h) + (i)*	**Total Non-Specifically Defined Strategic Capital** *(rounded)*	**5,000**	**11,000**	**20,000**	**26,000**	**26,000**	**27,000**	**27,000**	**27,000**	**27,000**	**198,000**
(e) + (j)	**Total PHA & Affiliates Proposed Capital** *(rounded)*	**91,000**	**62,000**	**56,000**	**56,000**	**58,000**	**57,000**	**61,000**	**58,000**	**59,000**	**560,000**

($ in 000's)

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Overview

Goals:

- Adhere to the dollar framework agreed to in the LOI
- Create a more committed budgeting process for routine capital
- Ensure completion of pre-identified capital projects initiatives
- Afford flexibility for future strategic capital budgeting

Proposal:

- **Routine Capital**
  - Pre-commitment of a maximum annual routine capital budget for the nine years of the commitment period: e.g. $30.5 million per annum
  - Any request for routine capital in excess of this amount to be subject to Cedars approval
- **FMP Non-Compliance & Major Capital Projects**
  - Same list and dollars as previously shared (attached as Appendix)
  - Pre-approval of these projects subject to an aggregate budget for these items of $85 million (same dollars as previously shared)
  - Any increase in aggregate budget over $85 million to be subject to Cedars approval
  - If projects can be completed for less than the aggregate budget of $85 million, then savings available to be allocated to routine or strategic capital budgets post 2023
- **Strategic Capital**
  - To be mutually identified and agreed by Huntington and Cedars with a target of $100 million 2021 to 2025 and $100 million 2026 to 2029

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Proposed Capital Commitment Exhibit

	2021 - 2023	Total *(rounded)*
FMP Non-Compliance & Major Capital Projects Budget	85,000	**85,000**

Notes
Cedars approves the specific list of FMP Non-Compliance & Major Capital Projects up to an aggregate amount of $85 million by the end of 2023. If pre-specified FMP Non-Compliance & Major Capital Projects are completed for an aggregate total of less than $85 million, the balance of the FMP Non-Compliance & Major Capital Projects budget is then reallocated to increase either the Routine Capital Budget or the Strategic Capital Budget and will be spent by the end of 2025.

	2021	2022	2023	2024	2025	2026	2027	2028	2029	Total *(rounded)*
Routine Capital Budget	30,500	30,500	30,500	30,500	30,500	30,500	30,500	30,500	30,500	**275,000**

Notes
Routine capital budget up to $30.5 million in any fiscal year. In any fiscal year. Huntington may request routine capital spending in excess of $30.5 million and such request must be approved by Cedars.

	2021 - 2025	2026 - 2029	Total *(rounded)*
Strategic Capital Budget	100,000	100,000	**200,000**

Notes
Funding of strategic capital will be mutually determined by Cedars and Huntington with strategic capital spending targets of $100 million from 2021-2025 and $100 million from 2026-2029.

Huntington Strategic Capital Plan Total *(rounded)*	**560,000**

($ in 000's)

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Bridge to Prior Capital Plan Exhibit

FMP Non-Compliance & Major Capital Projects Budget

Collapsed into aggregate total to be spent from 2021-2023 rather than annual amounts

	2021 - 2023	Total *(rounded)*
Revised	85,000	**85,000**

	2021	2022	2023	2024	2025	2026	2027	2028	2029	Total *(rounded)*
Original	55,200	22,600	6,600	600	600	-	-	-	-	**86,000**

Routine Capital Budget

Converted to consistent annual amount of $30.5 million

	2021	2022	2023	2024	2025	2026	2027	2028	2029	Total *(rounded)*
Revised	30,500	30,500	30,500	30,500	30,500	30,500	30,500	30,500	30,500	**275,000**

	2021	2022	2023	2024	2025	2026	2027	2028	2029	Total *(rounded)*
Original	30,500	28,300	29,600	29,200	31,700	30,200	33,800	31,400	32,000	**277,000**

Strategic Capital Budget

Collapsed into two periods of $100 million each rather than annual amounts

	2021 - 2025	2026 - 2029	Total *(rounded)*
Revised	100,000	100,000	**200,000**

	2021	2022	2023	2024	2025	2026	2027	2028	2029	Total *(rounded)*
Original	5,000	11,400	20,400	26,300	26,300	26,900	26,900	26,900	26,900	**197,000**

Huntington Strategic Capital Plan Total *(rounded)*	*Revised*	**560,000**
Huntington Strategic Capital Plan Total *(rounded)*	*Original*	**560,000**

Totals remain consistent

($ in 000's)

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Appendix

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

List of FMP Non-Compliance & Major Capital Projects

	2021	2022	2023	2024	2025	Total
FMP Non-Compliance	**31,352**	**7,000**	**-**	**-**	**-**	**38,352**
Major Capital	**23,882**	**15,594**	**6,594**	**594**	**594**	**47,258**
COU Relocation	*500*	-	-	-	-	*500*
CSPD Masterplan	*12,879*	*3,000*	-	-	-	*15,879*
High Level Disinfection	-	-	-	-	-	-
Unit 35 Relocation	*4,534*	-	-	-	-	*4,534*
IT Relocation	*900*	-	-	-	-	*900*
Campus Space Reuse	-	-	-	-	-	-
Clinical Lab HVAC Upgrade (Regulatory)	*875*	-	-	-	-	*875*
CT Scan Upgrade	*800*	-	-	-	-	*800*
Rad Fluoroscopy 7&8	*500*	-	-	-	-	*500*
Pharmacy IV Clean Room	-	-	-	-	-	-
Pathology Lab Upgrade	*300*	-	-	-	-	*300*
Surgery Department Associated Services Upgrade	*2,000*	*12000*	*6000*	-	-	*20,000*
Intuitive Robotics	*594*	*594*	*594*	*594*	*594*	*2970*
Total	**55,234**	**22,594**	**6,594**	**594**	**594**	**85,610**

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Qualifications, Assumptions and Limiting Conditions (v.12.08.06):

This Report is not intended for general circulation or publication, nor is it to be used, reproduced, quoted or distributed for any purpose other than those that may be set forth herein without the prior written consent of Kaufman, Hall & Associates, LLC. ("Kaufman Hall").

All information, analysis and conclusions contained in this Report are provided "as-is/where-is" and "with all faults and defects". Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified by Kaufman Hall. No warranty is given as to the accuracy of such information. Public information and industry and statistical data, including without limitation, data are from sources Kaufman Hall deems to be reliable; however, neither Kaufman Hall nor any third party sourced, make any representation or warranty to you, whether express or implied, or arising by trade usage, course of dealing, or otherwise. This disclaimer includes, without limitation, any implied warranties of merchantability or fitness for a particular purpose (whether in respect of the data or the accuracy, timeliness or completeness of any information or conclusions contained in or obtained from, through, or in connection with this report), any warranties of non-infringement or any implied indemnities.

The findings contained in this report may contain predictions based on current data and historical trends. Any such predictions are subject to inherent risks and uncertainties. In particular, actual results could be impacted by future events which cannot be predicted or controlled, including, without limitation, changes in business strategies, the development of future products and services, changes in market and industry conditions, the outcome of contingencies, changes in management, changes in law or regulations. Kaufman Hall accepts no responsibility for actual results or future events.

The opinions expressed in this report are valid only for the purpose stated herein and as of the date of this report.

All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the client.

In no event will Kaufman Hall or any third party sourced by Kaufman Hall be liable to you for damages of any type arising out of the delivery or use of this Report or any of the data contained herein, whether known or unknown, foreseeable or unforeseeable.

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

KaufmanHall

Exceptional Partners. Exceptional Performance.

CHICAGO, IL | PORTLAND, OR | LOS ANGELES, CA | FT. COLLINS, CO | SKOKIE, IL

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Exhibit 8-K

Project Rose Debt Consolidation Discussion

KaufmanHall

Exceptional Partners. Exceptional Performance.

Preliminary Huntington Hospital Debt Consolidation

Pasadena, CA | May 2020

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Overview

- The Trust has proposed, and Cedars has agreed, that a requirement of the affiliation transaction is that the Trust will be released from its obligation on the Hospital's Master Trust Indenture

- In order to maintain the Hospital's access to the capital markets, the Trust's obligation will need to be replaced by some form of credit support from Cedars

- There are a variety of options to achieve this credit support, each presenting a different set of considerations and costs

- Cedars has proposed that the parties explore these options and define the preferred approach prior to signing the Affiliation Agreement

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Overview

- For the purpose of this analysis, Huntington's debt falls into the following categories:
  1. Public bonds:
     - Series 2018, $99.7M outstanding, 4% - 5% coupons, final maturity July 1, 2048, callable July 1, 2028
     - Series 2014B, $145.2M outstanding, 4% - 5% coupons, final maturity July 1, 2044, callable July 1, 2024
  2. The Private Placement (Original Holder: Deutsche Bank):
     - Series 2014, $50M outstanding, 5% coupon, final maturity July 1, 2044, callable July 1, 2024
     - We learned this week that Deutsche has sold the bonds: not yet known who the holder or holders are
  3. The Revolving lines of Credit:
     - Still being negotiated, but expected to be:
     - $80MM Wells Fargo
     - $100MM Union Bank
     - 1-year facilities
- All of the debt described above is issued pursuant to the Master Trust Indenture
- The solution to be adopted together with Cedars must address all pieces of the debt simultaneously
- We cannot remove the Trust from one category of debt and leave it in place on another

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Lines Of Credit

- **The Revolving lines of Credit:**
  - **Still being negotiated, but expected to be:**
    - **$80MM Wells Fargo**
    - **$100MM Union Bank**
    - **1-year facilities**

- This is the most straightforward category to restructure – the lines are cancellable at any time, without cost
- At any time, including at closing, Huntington could **either** pay off the lines,

  or

  Depending on Cedars' and Huntington's joint view of liquidity needs, Cedars could issue a guaranty to the banks

  or

  Negotiate a credit substitution replacing the Trust obligation with a form of guaranty from Cedars

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

The Public Bonds

- Public bonds:
  - **Series 2018, $99.7M outstanding, 4% - 5% coupons, final maturity July 1, 2048, callable July 1, 2028**
  - **Series 2014B, $145.2M outstanding, 4% - 5% coupons, final maturity July 1, 2044, callable July 1, 2024**
- Options for restructuring on this category of debt include:
  1. Defeasing with cash
  2. Refinancing with new public debt based on Cedar's credit support
  3. Refinancing with a bridge loan, probably bank debt, as an interim step to an eventual public debt issue
  4. Leaving the bonds in place but substituting Cedars for the Trust as the co-obligor or guarantor on the bonds

- **Options 1, 2 and 3 all involve purchasing defeasance escrows, just financing the funding of the escrow differently – we estimate defeasance "costs" today at:**
  - Series 2014B: $28M
  - Series 2018: $32M

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

The Public Bonds

- **Option 1** seems unattractive in terms of the impact on the system's liquidity, given the size of the debt
- **Option 2** presents timing questions:
  - Tax law would allow for a tax-exempt refinancing either within 6 months of the closing of the affiliation or no sooner than 2028
  - Is the Trust prepared to consider remaining in place as Obligor for 6 months? Until 2028?
  - However, a taxable financing could be undertaken at anytime. In today's market, there is very little spread between a taxable and a tax-exempt issue for a credit such as Cedars'. This creates much more flexibility in the timeline
  - The timeline should recognize that arranging a public issue, whether tax-exempt or taxable, is time consuming, could take several months to execute and is probably not feasible to process within the time between signing and closing
- **Option 3**, a bridge loan from a bank, would be far quicker to arrange and would provide a flexible bridge between closing and a future public debt issuance. Any subsequent tax-exempt financing would not be subject to the 6 months limitation in Option 2

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

The Public Bonds

- Because the public bonds are not callable until 2024 and 2028, **Options 1 , 2 and 3** would involve funding an escrow sufficient to pay debt service on the bonds until the call dates and to pay the full redemption price of the bonds on their call dates
- Given the historic low returns on treasury securities in today's market, the cost of this escrow is high relative to the par amount of the bonds
- Timing and cost could be mitigated by **Option 4**: substituting credit support from Cedars for the Trust Obligation
- Huntington's Indentures appear to offer two routes to achieve this: same result, different indenture provisions
    1. The Trust withdraws from the Huntington Obligated Group, and simultaneously, Cedars either issues a guaranty to the Bond Trustee or joins the Huntington Obligated Group
    2. Huntington utilizes the Note substitution language in its Master Trust Indenture: exchanging the existing Trust obligation for a Cedars obligation
- The options involve compliance with different debt coverage tests. Preliminarily, we believe Huntington can comply with each. Both will need to be confirmed and validated with Cedars
- Both options will, in practice, require that the rating agencies affirm to the bondholders that the credit rating on the bonds has not been impaired
- This could be done at any time, including at closing

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

The Private Placement (formerly held by Deutsche Bank)

- **The Private Placement:**
  - **Series 2014, $50M outstanding, 5% coupon, final maturity July 1, 2044, callable July 1, 2024**
- Recall that the plan of finance must remove the Trust from **ALL** categories of debt so we must address Deutsche Bank as well as the Public Bonds
- All refinancing options described for the Public Bonds apply to the Private Placement
- We estimate that the defeasance cost today at approximately $10M in today's market
- However, unlike the Public bonds, Private Placement documentation does **NOT** permit any unilateral credit substitution methodology
- The Trust may only be removed from its obligation on these bonds by either funding the defeasance escrow **OR** negotiating a credit substitution with the holder(s)
- Cedars' credit rating should be attractive to the holders, but we cannot be certain they will agree until we negotiate with them
  - If the bonds are now held by multiple owners, negotiation will be complicated
  - It is possible they will try to negotiate for a fee representing some portion of the $10M escrow cost

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Indemnification Solution

- If the negotiation with the holders of the Private Placement is unsuccessful, then we could require that these bonds be defeased at the closing of the Affiliation, incurring the cost of the escrow (estimated at $10M today)

- If either Huntington, the Trust or Cedars believes that this is too high a cost to pay for the release of the obligation, then the Trust could consider proposing to Cedars that the Trust is prepared to stay in place as Obligor on the Master Trust Indenture, in return for an indemnification from Cedars-Sinai Medical Center for full reimbursement of any claim made on the Trust pursuant to the Obligation

- The Trust will need to decide how long it is willing to sit in that position: until the call dates on the Bonds? Or some earlier date?

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Conclusion

- Assuming we confirm our compliance with credit substitution, we can achieve a credit substitution on the Public Bonds, and this should be achievable at closing if that remains the goal of the Trust
- Credit substitution is only achievable on the Private Placement via negotiation with the holders. This negotiation has been complicated by the sale of the bonds by Deutsche Bank
- A path forward to removing the Trust obligation at closing could take the form:
  1. Effect a credit substitution on the Public bonds
  2. Attempt to negotiate a credit substitution with the Private Placement holder(s). If that is unsuccessful, then defease the Private Placement, accepting the $10 Million cost of that escrow

OR

- The Trust could accept remaining in place as Obligor on the Huntington bonds and rely on an indemnification from Cedars-Sinai Medical Center in the event of any claims being made on the Obligation

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Recommended Next Steps

1. Affirm Trust's preferred position regarding timing of obligation release

2. Confirm compliance with credit substitution ratios

3. Confirm cost of defeasance escrow for both public bonds and Deutsche Bank private placement

4. Convene meeting with Huntington and Cedars finance teams, bond counsel and Kaufman Hall to review options described and agree path forward

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Qualifications, Assumptions and Limiting Conditions (v.12.08.06):

This Report is not intended for general circulation or publication, nor is it to be used, reproduced, quoted or distributed for any purpose other than those that may be set forth herein without the prior written consent of Kaufman, Hall & Associates, LLC. ("Kaufman Hall").

All information, analysis and conclusions contained in this Report are provided "as-is/where-is" and "with all faults and defects". Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified by Kaufman Hall. No warranty is given as to the accuracy of such information. Public information and industry and statistical data, including without limitation, data are from sources Kaufman Hall deems to be reliable; however, neither Kaufman Hall nor any third party sourced, make any representation or warranty to you, whether express or implied, or arising by trade usage, course of dealing, or otherwise. This disclaimer includes, without limitation, any implied warranties of merchantability or fitness for a particular purpose (whether in respect of the data or the accuracy, timeliness or completeness of any information or conclusions contained in or obtained from, through, or in connection with this report), any warranties of non-infringement or any implied indemnities.

The findings contained in this report may contain predictions based on current data and historical trends. Any such predictions are subject to inherent risks and uncertainties. In particular, actual results could be impacted by future events which cannot be predicted or controlled, including, without limitation, changes in business strategies, the development of future products and services, changes in market and industry conditions, the outcome of contingencies, changes in management, changes in law or regulations. Kaufman Hall accepts no responsibility for actual results or future events.

The opinions expressed in this report are valid only for the purpose stated herein and as of the date of this report.

All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the client.

In no event will Kaufman Hall or any third party sourced by Kaufman Hall be liable to you for damages of any type arising out of the delivery or use of this Report or any of the data contained herein, whether known or unknown, foreseeable or unforeseeable.

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Exhibit 8-L

Project Rose Materials

CONFIDENTIAL – NOT FOR DISTRIBUTION – INTERNAL USE ONLY

KaufmanHall

Exceptional Partners. Exceptional Performance.

Project Rose:
1. Review of Updated Financials
2. Comparison of Affiliation Agreement terms to LOI

Pasadena, CA | June 19, 2020

CONFIDENTIAL

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Updated Cedars Financials

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Cedars-Sinai
Long Range Financial Plan FY21 – FY25
Project Rose Submission

May 2020

Cedars Sinai

Assumptions

Revenue

- Volume Increase – 0.5% annually (after return in FY 22)
- Reimbursement Rate Increase – Approximately 1.5%annually

Expense

- Inflation Rate – 3.0% to 4.0%
- Annual Operating Efficiency of $50M
- Wage – 3%
- Drugs – 4%
- All Others – 1% to 3%

Capital

- MDRH Rebuild
- Approximately $300M annually for Base Construction, EIS, and Equipment
- Strategic Commitments included

Debt Issuance $800M in FY22

Financial Projections

(in millions)

	FY2021 Budget	FY2022 Projected	FY2023 Projected	FY2024 Projected	FY2025 Projected
Revenue	$ 4,305	$ 4,531	$ 4,645	$ 4,764	$ 4,886
Expense	4,177	4,292	4,404	4,536	4,669
Operating Income (Loss)	**$ 128**	**$ 239**	**$ 241**	**$ 228**	**$ 217**
Cash - Beginning Balance	$ 2,691	$ 2,724	$ 3,492	$ 3,437	$ 3,388
Operating Income	128	239	241	228	217
Depreciation	199	211	238	279	315
Investment Income (3% of Total Investment)	97	98	121	120	118
Capital Spend - Base	(231)	(315)	(291)	(317)	(312)
Capital Spend - Strategic	(110)	(215)	(315)	(308)	(229)
Other Investments (Start up)	(50)	(50)	(50)	(50)	(50)
New Debt	-	800	-	-	-
Cash - Ending Balance	**$ 2,724**	**$ 3,492**	**$ 3,437**	**$ 3,388**	**$ 3,447**
Endowments	$ 548	$ 548	$ 548	$ 548	$ 548
Total Cash and Investments	**$ 3,272**	**$ 3,272**	**$ 4,040**	**$ 3,985**	**$ 3,936**
Days Cash on Hand	250	312	301	290	289

Comparing the LOI to the Affiliation Agreement

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Orientation

- The Letter of Intent is a comprised of a combination of both terms and principles for the affiliation
- The Affiliation Agreement converts those principles into binding terms and conditions
- Typical in any affiliation, there are natural variations in term and conditions during the negotiation process as the Letter of Intent is translated into the Affiliation Agreement
- The following slides examine each component of the Letter of Intent as presented to the Board on March 6th by noting any variations to the corresponding provisions in the Affiliation Agreement and Bylaws

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

EHR Commitment

Key Term	EHR Commitment (Section 5.3)	
	Letter of Intent	**Affiliation Agreement**
	• Epic EHR • Cedars has deployed or has the license to deploy all modules to meet HH needs - Deployment prioritization to be determined by EHR Project Committee overseen by CS • Implementation timeline to be established by EHR Project Committee	• Agreed to all "core modules", as identified by Huntington, to be deployed at Huntington as part of the initial implementation • Certain additional modules may be implemented subject to further discussion by and approval of the EHR Project Committee • Cedars will commence work on the EHR project as soon as reasonably practicable after closing • The EHR Project will be fully completed no later than the 3rd anniversary of the closing date unless otherwise mutually agreed by Cedars and Huntington

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Capital Commitment

Key Term	Capital Commitment (Section 5.1 & 5.2)	
	Letter of Intent	**Affiliation Agreement**
	• Accept Huntington Hospital Capital Plan totaling $560M • Commitment Period 2021-2029 • $300M of the $560M funded by Cedars, after use of Huntington Hospital unrestricted cash down to 90 days' cash on hand • Cedars to determine the appropriate source of the $300M commitment • May invest beyond commitment at Cedars' sole discretion	• Within the $560M Huntington Hospital Capital Plan, specified pre-approval for $85M designated for FMP Non-Compliance and Major Capital projects • Development and funding of remaining Huntington Hospital Capital Plan subject to annual budgeting and approval process by both Huntington and Cedars' boards • Huntington Hospital days cash on hand threshold for Cedars' $300M funding commitment revised from 90 days cash on hand in LOI to 60 days cash on hand in Affiliation Agreement

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Capital Commitment *(continued)*

Huntington Capital Plan	**2021 – 2029**	$560M

How is Capital Plan funded?

First Source of Funds	Huntington cash flow & Huntington unrestricted cash on hand **> 60 days**

What if first source of funds is insufficient?

Next Source of Funds	Balance of capital plan up to **$300M** to be funded by debt and/or cash from Cedars

Shortfall Risk	***Exists if Huntington cash flow & unrestricted cash is insufficient to fund at least $260M of the Capital Plan over aggregate 9 year period***

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Capital Commitment *(continued)*

Pre-Approved Capital Projects Totaling $85 Million

	2021	2022	2023	2024	2025	Total
FMP Non-Compliance	**31,352**	**7,000**	**-**	**-**	**-**	**38,352**
Operating Room Build Out and Renovation	*31,352*	*7,000*	*-*	*-*	*-*	*38,352*
Major Capital	**23,882**	**15,594**	**6,594**	**594**	**594**	**47,258**
COU Relocation	*500*	*-*	*-*	*-*	*-*	*500*
CSPD Masterplan	*12,879*	*3,000*	*-*	*-*	*-*	*15,879*
Unit 35 Relocation	*4,534*	*-*	*-*	*-*	*-*	*4,534*
IT Relocation	*900*	*-*	*-*	*-*	*-*	*900*
Clinical Lab HVAC Upgrade (Regulatory)	*875*	*-*	*-*	*-*	*-*	*875*
CT Scan Upgrade	*800*	*-*	*-*	*-*	*-*	*800*
Rad Fluoroscopy 7&8	*500*	*-*	*-*	*-*	*-*	*500*
Pathology Lab Upgrade	*300*	*-*	*-*	*-*	*-*	*300*
Surgery Department Associated Services Upgrade	*2,000*	*12000*	*6000*	*-*	*-*	*20,000*
Intuitive Robotics	*594*	*594*	*594*	*594*	*594*	*2,970*
Total	**55,234**	**22,594**	**6,594**	**594**	**594**	**85,610**

($ in 000's)

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Debt Co-Obligation

Key Term	Debt Co-Obligation (Section 5.5)
Letter of Intent	**Affiliation Agreement / Reimbursement Agreement**

• Trust to be released from debt obligations at Closing	• Due to significant identified costs to defease the existing debt obligations (defeasance cost approximated at nearly $70M) and complications of potential restructuring alternatives, the Trust will remain a co-obligor on the debt until no later than the current call dates of the bonds
	  - 2024 for Series 2014 ($50M) & 2014B ($145M)
	  - 2028 for Series 2018 ($100M)
	• The Trust and Cedars-Sinai Medical Center will execute a Reimbursement Agreement that in effect transfers any claim under the MTI from the Trust to Cedars-Sinai Medical Center
	• Reimbursement Agreement currently under negotiation
	• Huntington Hospital will terminate the existing lines of credit at or prior to closing

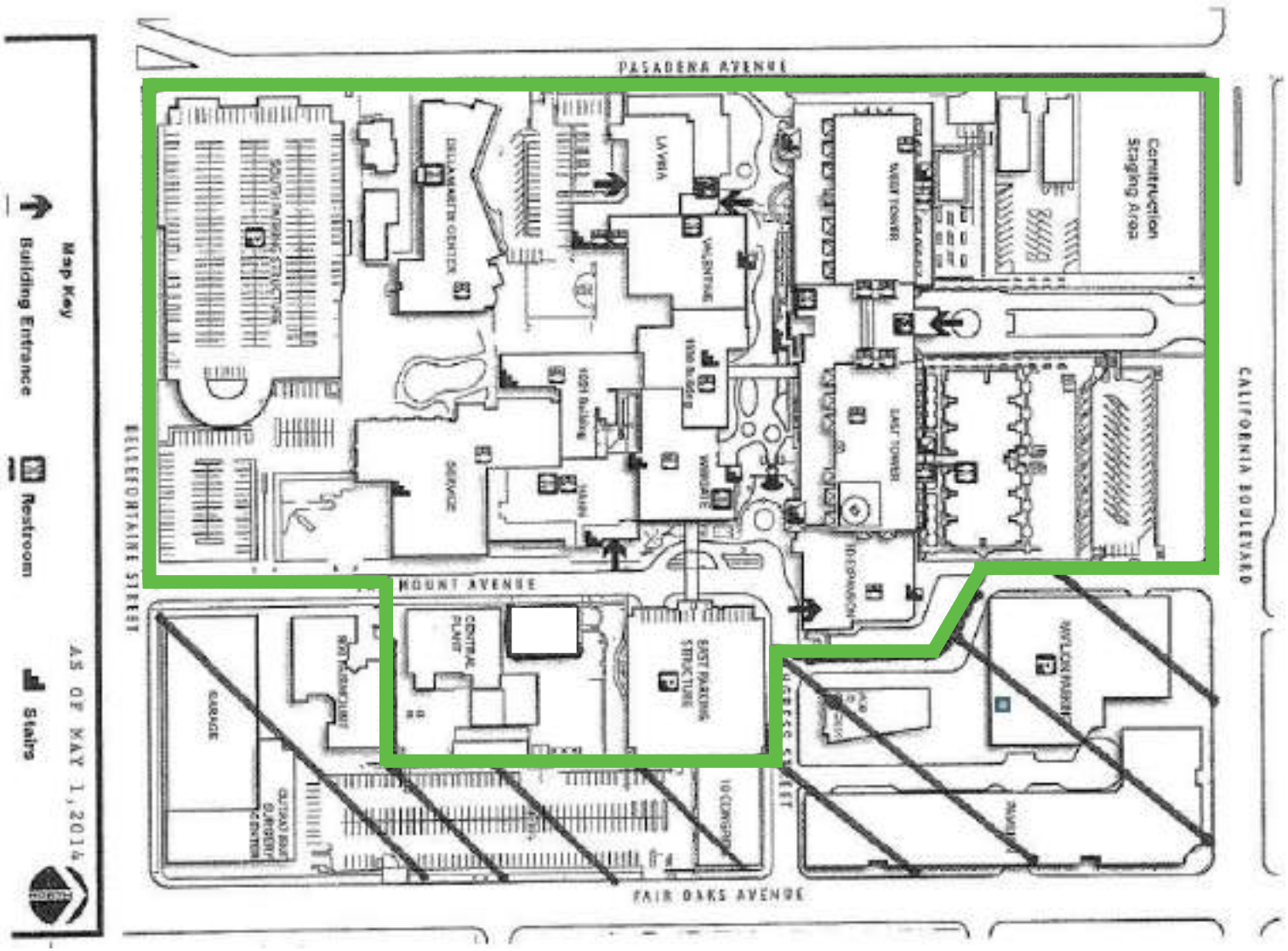
CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Land Assets

Key Term	Land Assets (Section 3.3)
Letter of Intent	**Affiliation Agreement**
• Trust to transfer the Hospital Real Property to Huntington Hospital at closing • Trust to retain ownership of all other assets of the Trust	• Trust to gift the Hospital Real Property to Huntington Hospital prior to closing • Final description of the land to be gifted currently awaiting a lot line adjustment on a specific parcel • Intent is to gift land currently being used by Huntington Hospital on the main hospital campus

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Map Of Land To Be Gifted



CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Required Ongoing Distributions

Key Term	Required Ongoing Distributions (Section 3.3)	
	Letter of Intent	**Affiliation Agreement**
	• During the Commitment Period, Trust would make annual distributions to Huntington Hospital equal to the sum of: - $5.3M for FY 2021 (increased by 2.5% per annum in future years), which must be used solely to fund HH's GME program - 2.5% of the Trust's investment portfolio measured at the end of each fiscal year, which must be used solely to fund the Capital Plan or other Huntington programs designated by the Trust	• Specific to the annual transfer of 2.5% of the Trust's investment portfolio, the specified use of that transfer is subject designation from the Trust **and** approval by the Board of Directors of Huntington Hospital • Trust's investment portfolio is specifically defined as the Trust Securities Portfolio including only cash and marketable securities (i.e. excludes land assets and other investments with minimum hold periods of >6 months) • Trust distributions to occur no more frequently than monthly

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Governance

Key Term	Huntington Hospital Board (Section 4.1)

Letter of Intent

- All current directors would remain on the Huntington Hospital Board; in addition, 2 Cedars directors would be added to the Huntington Hospital Board
- Immediately after Closing, the composition of the HH Board would be:
  - 2 Cedars directors (Cedars CEO and CFO, ex-officio)
  - 5 Trust directors, ex-officio
  - At least 2 Physician directors (the HH President of Medical Staff and the immediate past president of HH Medical staff, ex-officio)
  - Community directors nominated by HH, subject to approval by Cedars
- Board composition is subject to change after the initial 5 year period according to the reserved powers
- Any executive committee of the Huntington Hospital Board would include a proportional number of Cedars directors, Community directors and Trust directors

Bylaws

- The number of physician directors on the Huntington Hospital Board was revised from 2 Physician directors to 3 Physician directors to reflect that Huntington Hospital bylaws allow the following on the Huntington Board:
  - President of the Medical Staff
  - Immediate Past President of the Medical Staff
  - Predecessor to the Immediate Past President of the Medical Staff
- All existing Huntington Emeritus directors will continue to serve on the Huntington Hospital Board
- The President of Huntington Hospital to serve ex-officio on the Huntington Board
- A proportionate 10 person executive committee would consist of:
  - 1 Cedars director
  - 3 Trust directors
  - 1 Huntington CEO ex-officio
  - 1 Physician director
  - 4 Community directors

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Governance *(continued)*

Key Term	Parent Board (Section 4.2)	
	Letter of Intent	**Bylaws**
	• The Cedars-Sinai Health System Board will consist of no less than 12 and up to 18 directors, including: - 3 Huntington directors nominated by Huntington Hospital and elected by Cedars - 3 Torrance directors nominated by Torrance and elected by Cedars • If the size of the Cedars-Sinai Health System Board is increased or decreased, the number of Huntington directors would be increased/decreased the same as Torrance	• The initial Cedars-Sinai Health System Board will consist of 15 directors, including 3 Huntington directors and 3 Torrance directors • Huntington and Torrance shall have the right to nominate at least 10% of the Cedars-Sinai Health System Board; however, if the size of the Cedars-Sinai Health System Board increases, the number of Huntington directors may differ from Torrance • In addition, Torrance has the "founder" right to approve any change to the Cedars-Sinai Health System bylaws that would result in Cedars-Sinai Medical Center and Torrance not having the right to nominate at least a majority of the total number of CSHS directors • At all times, at least 1 representative from Huntington Hospital will be on the Cedars-Sinai Health System Board

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Governance Matrix

HH Action	HH Board	HH Board, including 3/5 of Trust Directors	CS as Member	Trust Vote	Withdrawal Right
Business and affairs of HH, except to the extent of items listed below, and subject to the provisions of the Affiliation Agreement and the Bylaws	• Approve				
Periodic strategic plans (other than Capital Plan)	• Approve and Recommend		• Approve		
Annual operating and capital budgets	• Approve and Recommend		• Approve		
Removal of the CEO	• Approve		• Approve • Unilateral		
Borrowed indebtedness (except leases under $5M)	• Approve		• Approve • Unilateral		
Including HH in an obligated group	• Approve		• Approve • Unilateral		
~~Material~~ Settlement or consent decree (except for non-gov't settlements; no reputational effect on CSHS)	• Approve		• Approve • Unilateral		
Change of the legal form of HH	• Approve		• Approve • Unilateral		• Yes
Change in Control	• Approve		• Approve • Unilateral		• Yes

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Governance Matrix *(continued)*

HH Action	HH Board	HH Board, including 3/5 of Trust Directors	CS as Member	Trust Vote	Withdrawal Right
Closure, sale, lease, transfer, exchange, disposition or change in use, of the Hospital	• Approve		• Approve • Unilateral		• Yes
Dissolution	• Approve		• Approve • Unilateral		• Yes
Removal of Community Directors from HH Board	• Approve		• Approve • Unilateral		
Sale of HH real property (except for the 10-year rule below)	• Approve		• Approve • Unilateral		
Internal reorganization of physician network assets	• Approve		• Approve • Unilateral		
Sale of assets with value exceeding 2% of net revenue (except as part of a Change in Control)	• Approve		• Approve • Unilateral		
Amendment of articles or bylaws	• Approve	• For 5 years, Approve	• Approve • After 5 years, Unilateral		
Any action or decision that would change the size or composition of the HH Board.	• Approve	• For 5 years, Approve	• Approve • After 5 years, Unilateral		
Approval of successor to the person serving as the CEO as of the Closing	• Approve	• For 5 years, Approve	• Approve • After 5 years, Unilateral		
Sale of HH real property (except as part of a Change in Control)	• Approve	• For 10 years, Approve	• Approve • After 10 years, Unilateral		

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Governance Matrix *(continued)*

HH Action	HH Board	HH Board, including 3/5 of Trust Directors	CS as Member	Trust Vote	Withdrawal Right
Unbudgeted expenditures over $5M	• Approve		• Approve		
Loans in excess of 2% of net assets (except for intercompany transfers)	• Approve		• Approve		
Community benefit plan	• Approve		• Approve		
Change to mission, vision or values	• Approve	• Approve	• Approve		
Change to HH name	• Approve	• Approve	• Approve		
Change to legal form of HH entity (except as part of a Change in Control)	• Approve	• Approve	• Approve		
Dissolution (except as part of a Change in Control)	• Approve	• Approve	• Approve		
Any action that jeopardizes the tax-exempt status of the Trust	• Approve	• Approve	• Approve		• Yes
Sale of HH physician network assets (except an internal reorganization)	• Approve	• Approve	• Approve		
Sale of assets with value exceeding 2% of net revenue (except as part of a Change in Control)	• Approve	• Approve	• Approve		
Any action that would change the voting rights of Trust Directors				• Approve	

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Hospital Commitments

Key Term	Operational Commitments (Section 6.1)	
	Letter of Intent	**Affiliation Agreement**

	• Comply with conditions required for AG Approval
	• Operate and maintain Hospital as a licensed general acute care hospital
	• Maintain identified services and programs
	  - Level II Trauma Center
	  - Level III Neonatal Intensive Care Unit
	  - Comprehensive Stroke Center
	  - STEMI Receiving Center
	  - Advanced Cardiology and Cardiovascular Surgery
	  - Advanced Robotic Surgery
	  - Orthopedic Service Line
	  - Oncology Service Line
	  - Neurology Service Line
	  - GME programs
	  - Senior Care Network
	  - Magnet
	• Continue certification to participate in Medi-Cal and Medicare programs
		• The list of identified services services was expanded to include Women's Health Services and End of Life Services

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Hospital Commitments *(continued)*

Key Term	Brand (Section 6.4)
Letter of Intent	**Affiliation Agreement**
• Hospital will be operated under a name that prominently includes "Huntington" • In all material respects, HH will identify as an affiliate of Cedars-Sinai	• No change to branding approach • Branding guidelines will be mutually agreed upon within 180 days from closing

Key Term	Charity Care and Community Benefit (Section 7)
Letter of Intent	**Affiliation Agreement**
• Charity Care to be provided at level commensurate with that required by AG • Community Benefit to be provided at level commensurate with that required by AG	• No change

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Physicians and Employees

Key Term	Physicians (Section 8)	
	Letter of Intent	**Affiliation Agreement**
	• Huntington to maintain separate, independent medical staff accountable to the Huntington Hospital Board • Retain medical staff bylaws • All officer and committee chairs of the medical staff will retain the same positions • Membership status and clinical privileges to remain unchanged	• No change

Key Term	Employees (Section 9)	
	Letter of Intent	**Affiliation Agreement**
	• All of Huntington Hospital employees to remain employed immediately after Closing • Employees to receive credit for years of service and benefit eligibility if benefit plans are consolidated	• No change

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Trust as a Party To The Agreement

Key Term	Trust as a Party
Letter of Intent	**Affiliation Agreement**
• Trust as a party for the duration of the Affiliation Agreement	• Trust shall cease to be a party to the Affiliation Agreement as of that date that is the later of: - 5th anniversary from closing - Completion of FMP-Non Compliance and Major Capital Projects budget - Full release of the Trust from claims under the MTI

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Certainty of Closing

Category	
Certainty of Closing	
Observations	• MAC Definition + NOT for effects of COVID-19 or other pandemics + NOT for failure—in and of itself—to meet revenue, earnings or other projections + NOT for conditions disclosed at signing + NOT for general business, industry or economic conditions • Closing Conditions include + MAC standard applies to state of representations and warranties at closing + Representations qualified by actual knowledge, materiality and four-year lookback - Diligence and partial 10b-5 representations (open-ended) - Amendments to Imaging Center JV Agreements - Government consents - Third-party consents

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Partnership Committee Recommendation

-- discussion --

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Qualifications, Assumptions and Limiting Conditions (v.12.08.06):

This Report is not intended for general circulation or publication, nor is it to be used, reproduced, quoted or distributed for any purpose other than those that may be set forth herein without the prior written consent of Kaufman, Hall & Associates, LLC. ("Kaufman Hall").

All information, analysis and conclusions contained in this Report are provided "as-is/where-is" and "with all faults and defects". Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified by Kaufman Hall. No warranty is given as to the accuracy of such information. Public information and industry and statistical data, including without limitation, data are from sources Kaufman Hall deems to be reliable; however, neither Kaufman Hall nor any third party sourced, make any representation or warranty to you, whether express or implied, or arising by trade usage, course of dealing, or otherwise. This disclaimer includes, without limitation, any implied warranties of merchantability or fitness for a particular purpose (whether in respect of the data or the accuracy, timeliness or completeness of any information or conclusions contained in or obtained from, through, or in connection with this report), any warranties of non-infringement or any implied indemnities.

The findings contained in this report may contain predictions based on current data and historical trends. Any such predictions are subject to inherent risks and uncertainties. In particular, actual results could be impacted by future events which cannot be predicted or controlled, including, without limitation, changes in business strategies, the development of future products and services, changes in market and industry conditions, the outcome of contingencies, changes in management, changes in law or regulations. Kaufman Hall accepts no responsibility for actual results or future events.

The opinions expressed in this report are valid only for the purpose stated herein and as of the date of this report.

All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the client.

In no event will Kaufman Hall or any third party sourced by Kaufman Hall be liable to you for damages of any type arising out of the delivery or use of this Report or any of the data contained herein, whether known or unknown, foreseeable or unforeseeable.

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

KaufmanHall

Exceptional Partners. Exceptional Performance.

CHICAGO, IL | PORTLAND, OR | LOS ANGELES, CA | FT. COLLINS, CO | SKOKIE, IL

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Exhibit 8-M

Project Rose: Board Meeting Pre-Read Summary

CONFIDENTIAL – NOT FOR DISTRIBUTION – INTERNAL USE ONLY

Huntington Hospital

KaufmanHall

Exceptional Partners. Exceptional Performance.

Project Rose: Board Meeting PRE-READ SUMMAY

Pasadena, CA | July 14, 2020

CONFIDENTIAL

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Summary of Affiliation Documents

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

EHR Commitment

reflects changes from the LOI

EHR Platform | Capital

Key Term	EHR Commitment	
	Letter of Intent	**Affiliation Agreement**
	• Epic EHR • Cedars has deployed or has the license to deploy all modules to meet Huntington Hospital needs - Deployment prioritization to be determined by EHR Project Committee overseen by Cedars-Sinai • Implementation timeline to be established by EHR Project Committee	• Agreed to all "core modules", pre-specified by Huntington, to be deployed at Huntington as part of the initial implementation • Certain additional modules may be implemented subject to further discussion by and approval of the EHR Project Committee • Cedars-Sinai will commence work on the EHR project as soon as reasonably practicable after closing • The EHR Project will be fully completed no later than the 3rd anniversary of the closing date unless otherwise mutually agreed by Cedars and Huntington

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Capital Commitment

reflects changes from the LOI



Key Term	Capital Commitment	
	Letter of Intent	**Affiliation Agreement**
	• Accept Huntington Hospital Capital Plan totaling $560M • Commitment Period 2021-2029 • $300M of the $560M funded by Cedars, after use of Huntington Hospital unrestricted cash down to 90 days' cash on hand • Cedars to determine the appropriate source of the $300M commitment • May invest beyond commitment at Cedars' sole discretion	• Accept Huntington Hospital Capital Plan totaling $560M, including pre-approval for $85M designated for FMP Non-Compliance and Major Capital projects • Development and funding of remaining Huntington Hospital Capital Plan subject to annual budgeting and approval process by both Huntington and Cedars' boards • Huntington Hospital days cash on hand threshold for Cedars' $300M funding commitment revised from 90 days cash on hand in LOI to 60 days cash on hand in Affiliation Agreement

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Capital Commitment *(continued)*

reflects changes from the LOI

Capital

Huntington Capital Plan	**2021 – 2029**	$560M

How is Capital Plan funded?

First Source of Funds	Huntington cash flow & Huntington unrestricted cash on hand **> 60 days**

What if first source of funds is insufficient?

Next Source of Funds	Balance of capital plan up to **$300M** to be funded by debt and/or cash from Cedars

Shortfall Risk	***Exists if Huntington cash flow & unrestricted cash is insufficient to fund at least $260M of the Capital Plan over aggregate 9 year period***

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Debt Co-Obligation

reflects changes from the LOI

Capital

Governance & the Trust

Key Term	Debt Co-Obligation
Letter of Intent	**Affiliation Agreement / Reimbursement Agreement**
• Trust to be released from debt obligations at Closing	• Due to significant identified costs to defease the existing debt obligations (approximately $70M) and complications of potential restructuring alternatives, the Trust will remain a co-obligor on the debt until no later than the current call dates of the bonds - 2024 for Series 2014 ($50M) & 2014B ($145M) - 2028 for Series 2018 ($100M) • The Trust and Cedars-Sinai Medical Center will execute a Reimbursement Agreement that in effect transfers any claim under the MTI from the Trust to Cedars-Sinai Medical Center • Huntington Hospital will terminate the existing lines of credit at or prior to closing

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Trust Contributions

reflects changes from the LOI

Governance & the Trust

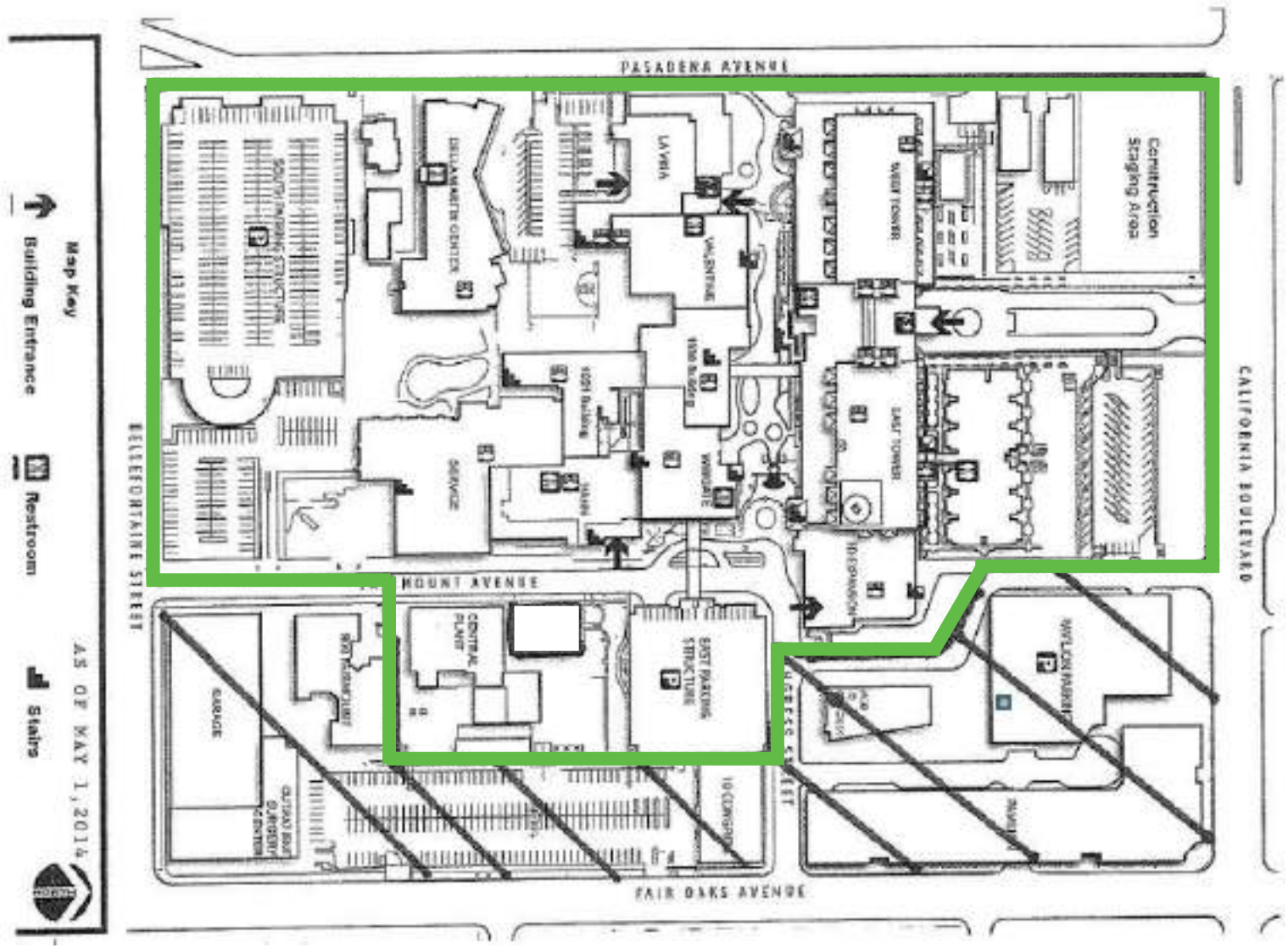
Key Term	Land Assets	
	Letter of Intent	**Affiliation Agreement**
	• Trust to transfer the Hospital Real Property to Huntington Hospital at closing • Trust to retain ownership of all other assets of the Trust	• Trust to gift main hospital campus to Huntington Hospital prior to closing (see map on the following slide) • Real estate transfer is subject to the completion of lot line adjustments that are currently underway

Key Term	Required Ongoing Distributions	
	Letter of Intent	**Affiliation Agreement**
	• During the Commitment Period, Trust would make annual distributions to Huntington equal to the sum of: - $5.3M for FY 2021 (increased by 2.5% per annum in future years), which must be used solely to fund Huntington Hospital's GME program - 2.5% of the Trust's investment portfolio measured at the end of each fiscal year, which must be used solely to fund the Capital Plan or other Huntington programs designated by the Trust	• Specific to the annual transfer of 2.5% of the Trust's investment portfolio, the specified use of that transfer is subject designation from the Trust **and** approval by the Board of Directors of Huntington Hospital • Trust's investment portfolio is defined as the Trust Securities Portfolio including only cash and marketable securities (i.e. excludes land assets and other investments with minimum hold periods of >6 months) • Trust distributions no more frequently than monthly

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Governance & the Trust

Map Of Land To Be Gifted



CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Governance

reflects changes from the LOI

Governance & the Trust

Key Term	Huntington Hospital Board

Letter of Intent

- All current directors would remain on the Huntington Hospital Board; in addition, 2 Cedars directors would be added to the Huntington Hospital Board
- Immediately after Closing, the composition of the Huntington Hospital Board would be:
  - 2 Cedars directors (Cedars CEO and CFO, ex-officio)
  - 5 Trust directors, ex-officio
  - At least 2 Physician directors (the Huntington Hospital President of Medical Staff and the immediate past president of Huntington Hospital Medical staff, ex-officio)
  - Community directors nominated by Huntington Hospital, subject to approval by Cedars
- Board composition is subject to change after the initial 5 year period according to the reserved powers
- Any executive committee of the Huntington Hospital Board would include a proportional number of Cedars directors, Community directors and Trust directors

Amended Bylaws

- Physician directors revised from 2 to 3 and will include:
  - President of the Medical Staff
  - Immediate Past President of Medical Staff
  - Predecessor to Immediate Past President of Medical Staff
- All existing Huntington Emeritus directors are grandfathered and will continue to serve as voting members on the Huntington Hospital Board
- Age limit for Community directors of 80 years of age and allow for completion of current terms for existing board members; does not apply to Emeritus Board Members
- The President of Huntington Hospital to serve ex-officio on the Huntington Board
- The 10 person executive committee would consist of:
  - 1 Cedars director
  - 3 Trust directors
  - 1 President of Huntington Hospital
  - 1 Physician director
  - 4 Community directors
- Community directors may serve 3 consecutive 4-year terms; unless special circumstances

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Governance *(continued)*

reflects changes from the LOI

Governance & the Trust

Key Term	Cedars-Sinai Health System Board	
	Letter of Intent	**Amended Bylaws**
	• The Cedars-Sinai Health System Board will consist of no less than 12 and up to 18 directors, including: - 3 Huntington directors nominated by Huntington Hospital and elected by Cedars - 3 Torrance directors nominated by Torrance and elected by Cedars • If the size of the Cedars-Sinai Health System Board is increased or decreased, the number of Huntington directors would be increased/decreased the same as Torrance	• The initial Cedars-Sinai Health System Board will consist of 15 directors, including 3 Huntington directors and 3 Torrance directors • Each of Huntington and Torrance has the right to nominate at least 10% of the Cedars-Sinai Health System Board; however, if the size of the Cedars-Sinai Health System Board increases, the number of Huntington directors may differ from Torrance • In addition, Torrance has the "founder" right to approve any change to the Cedars-Sinai Health System bylaws that would result in Cedars-Sinai Medical Center and Torrance not having the right to nominate at least a majority of the total number of CSHS directors • At all times, at least 1 representative from Huntington Hospital will be on the Cedars-Sinai Health System Board

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Governance Matrix

reflects changes from the LOI

Governance & the Trust

	Huntington Hospital Board			Cedars-Sinai as Member	
Steps to Achieve Huntington Hospital Action	**Approval Right**	**Special Approval Right (including 3 of 5 Trust Directors)**	**Can Recommend to CS Board**	**Approval Right**	**Unilateral Right**
Huntington Hospital Action					
Business and affairs of HH, except to the extent of items listed below, and subject to the provisions of the Affiliation Agreement and the Bylaws	✓				
Periodic strategic plans (other than Capital Plan)	✓			✓	
Annual operating and capital budgets	✓			✓	
Appointment and Removal of CEO (other than approval of successor to incumbent CEO during the first 5 years after Closing)			✓		✓
Approval of successor to the person serving as the CEO as of the Closing		✓ *(for 5 years)*	✓ *(after 5 years)*	✓ *(for 5 years)*	✓ *(after 5 years)*

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Governance Matrix *(continued)*

reflects changes from the LOI

Governance & the Trust

	Huntington Hospital Board			Cedars-Sinai as Member	
Steps to Achieve Huntington Hospital Action	**Approval Right**	**Special Approval Right (including 3 of 5 Trust Directors)**	**Can Recommend to CS Board**	**Approval Right**	**Unilateral Right**
Huntington Hospital Action					
Borrowed indebtedness (except leases under $5M)			✓		✓
Including HH in an obligated group			✓		✓
~~Material~~ Settlement or consent decree (except for non-gov't settlements; no reputational effect on CSHS)			✓		✓
Change of the legal form of HH			✓		✓
Change in Control of HH			✓		✓

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Governance Matrix *(continued)*

reflects changes from the LOI

Governance & the Trust

	Huntington Hospital Board			Cedars-Sinai as Member	
Steps to Achieve Huntington Hospital Action	**Approval Right**	**Special Approval Right (including 3 of 5 Trust Directors)**	**Can Recommend to CS Board**	**Approval Right**	**Unilateral Right**
Huntington Hospital Action					
Closure, sale, lease, transfer, exchange, disposition or change in use, of HH			✓		✓
Dissolution			✓		✓
Removal of Community Directors from HH Board			✓		✓
Sale of HH real property (except for the 10-year rule below)			✓		✓
Sale of HH real property (except as part of a Change in Control)		✓ *(for 10 years)*	✓ *(after 10 years)*	✓ *(for 10 years)*	✓ *(after 10 years)*

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Governance Matrix *(continued)*

reflects changes from the LOI

Governance & the Trust

	Huntington Hospital Board			Cedars-Sinai as Member	
Steps to Achieve Huntington Hospital Action	**Approval Right**	**Special Approval Right (including 3 of 5 Trust Directors)**	**Can Recommend to CS Board**	**Approval Right**	**Unilateral Right**
Huntington Hospital Action					
Internal reorganization of physician network assets			✓		✓
Sale of HH physician network assets (except an internal reorganization)		✓		✓	
Sale of assets with value exceeding 2% of net revenue (except as part of a Change in Control)			✓		✓
Sale of assets with value exceeding 2% of net revenue (except as part of a Change in Control)		✓		✓	
Amendment of articles or bylaws		✓ *(for 5 years)*	✓ *(for 5 years)*	✓ *(for 5 years)*	✓ *(after 5 years)*

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Governance Matrix *(continued)*

reflects changes from the LOI

Governance & the Trust

Steps to Achieve Huntington Hospital Action	Huntington Hospital Board: Approval Right	Huntington Hospital Board: Special Approval Right (including 3 of 5 Trust Directors)	Huntington Hospital Board: Can Recommend to CS Board	Cedars-Sinai as Member: Approval Right	Cedars-Sinai as Member: Unilateral Right
Huntington Hospital Action					
Any action or decision that would change the size or composition of the HH Board.		✓ *(for 5 years)*	✓ *(for 5 years)*	✓ *(for 5 years)*	✓ *(after 5 years)*
Unbudgeted expenditures over $5M	✓			✓	
Loans in excess of 2% of net assets (except for intercompany transfers)	✓			✓	
Community benefit plan	✓			✓	
Change to mission, vision or values		✓		✓	

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Governance Matrix *(continued)*

reflects changes from the LOI

Governance & the Trust

	Huntington Hospital Board			Cedars-Sinai as Member	
Steps to Achieve Huntington Hospital Action	**Approval Right**	**Special Approval Right (including 3 of 5 Trust Directors)**	**Can Recommend to CS Board**	**Approval Right**	**Unilateral Right**
Huntington Hospital Action					
Change to HH name		✓		✓	
Change to legal form of HH entity (except as part of a Change in Control)		✓		✓	
Dissolution (except as part of a Change in Control)		✓		✓	
Any action that jeopardizes the tax-exempt status of the Trust		✓		✓	
Any action that would change the voting rights of Trust Directors	*requires vote from the Trust only*				

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Hospital Commitments

reflects changes from the LOI

Clinical Programs & Services | Other Commitments

Key Term	Operational Commitments	
	Letter of Intent	**Affiliation Agreement**

	• Comply with conditions required for AG Approval
	• Operate and maintain Hospital as a licensed general acute care hospital
	• Maintain identified services and programs
	  - Level II Trauma Center
	  - Level III Neonatal Intensive Care Unit
	  - Comprehensive Stroke Center
	  - STEMI Receiving Center
	  - Advanced Cardiology and Cardiovascular Surgery
	  - Advanced Robotic Surgery
	  - Orthopedic Service Line
	  - Oncology Service Line
	  - Neurology Service Line
	  - GME programs
	  - Senior Care Network
	  - Magnet
	• Continue certification to participate in Medi-Cal and Medicare programs
		• The list of identified services was expanded to include Women's Health Services and End of Life Services

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Hospital Commitments *(continued)*

reflects changes from the LOI

Community Perception & Brand | Other Commitments

Key Term	Brand
Letter of Intent	**Affiliation Agreement**
• Hospital will be operated under a name that prominently includes “Huntington” • In all material respects, Huntington Hospital will identify as an affiliate of Cedars-Sinai	• No change to branding approach • Branding guidelines will be mutually agreed upon within 180 days from closing

Key Term	Charity Care and Community Benefit
Letter of Intent	**Affiliation Agreement**
• Charity Care to be provided at level commensurate with that required by AG • Community Benefit to be provided at level commensurate with that required by AG	• No change

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Physicians and Employees

reflects changes from the LOI


Physician Integration


Other Commitments

Key Term	Physicians	
	Letter of Intent	**Affiliation Agreement**
	• Huntington to maintain separate, independent medical staff accountable to the Huntington Hospital Board • Retain medical staff bylaws • All officer and committee chairs of the medical staff will retain the same positions • Membership status and clinical privileges to remain unchanged	• No change

Key Term	Employees	
	Letter of Intent	**Affiliation Agreement**
	• All of Huntington Hospital employees to remain employed immediately after Closing • Employees to receive credit for years of service and benefit eligibility if benefit plans are consolidated	• No change

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Trust as a Party To The Agreement

reflects changes from the LOI

Governance & the Trust

Key Term	Trust as a Party	
	Letter of Intent	**Affiliation Agreement**
	• Trust as a party for the duration of the Affiliation Agreement	• Trust shall cease to be a party to the Affiliation Agreement as of that date that is the later of: - 5th anniversary from closing - Completion of FMP-Non Compliance and Major Capital Projects budget - Full release of the Trust from the Huntington Master Trust Indenture

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Unwind Events

reflects changes from the LOI

Governance & the Trust

Key Term	Unwind Events	
	Letter of Intent	**Affiliation Agreement**
	• The Huntington Hospital Board (excluding any directors appointed by Cedars-Sinai) would have the right to terminate Cedars-Sinai's membership in Huntington and cause Huntington or the Trust to assume the assets and liabilities of Huntington (terms TBD) in the event that Cedars-Sinai causes any of the following events to occur: - Any transaction or series of related transactions involving a Change in Control - Closure of Huntington Hospital - Any action that results in Huntington or the Hospital not being owned and operated by a tax-exempt organization or which otherwise jeopardizes the tax exempt status of the Trust	• Unwind Events include the following: - Law/regulation renders the affiliation illegal - Closure or sale of Huntington Hospital - Change of tax-exempt status of Huntington Hospital • Cedars must notify Huntington Hospital if an Unwind Event is caused by Cedars. Huntington then has the right, but not the obligation, to pursue unwind • Mechanics of an unwind include: - 30 day notice period whereby Huntington must notify Cedars of intent to unwind - Huntington and Cedars mutually agree and work towards actions to effectuate unwind - In exchange for fair market value compensation, Huntington may require Cedars to provide management services for period of time post-unwind - Two-way payments between Huntington and Cedars for owed expenses and investments

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Certainty of Closing



Category	
Certainty of Closing	
Observations	• MAC Definition + NOT for effects of COVID-19 or other pandemics + NOT for failure—in and of itself—to meet revenue, earnings or other projections + NOT for conditions disclosed at signing + NOT for general business, industry or economic conditions • Closing Conditions include + MAC standard applies to state of representations and warranties at closing + Representations qualified by actual knowledge, materiality and four-year lookback - Diligence and partial 10b-5 representations (open-ended) - Amendments to Imaging Center JV Agreements - Government consents - Third-party consents

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Conditions to Closing

Mutual

- California AG approval
- Trust Court Approval
- Hart-Scott-Rodino
- No law, order or material action prohibiting closing
- Government approvals
- Third-party consents

Cedars-Sinai

- Huntington and Trust representations and warranties remain true and correct, except as reasonably expected to constitute a material adverse change of Huntington Hospital
- Performance of Huntington Hospital and Trust covenants in all material respects
- No Huntington Hospital Material Adverse Change since signing
- Gift of the Hospital Land to Huntington Hospital
- Amendments to Huntington Hospital imaging center JV agreements

Huntington & the Trust

- Cedars-Sinai representations and warranties remain true and correct, except as reasonably expected to constitute a material adverse change of Cedars-Sinai
- Cedars-Sinai has performed all covenants and agreements under the Affiliation Agreement in all material respects
- Cedars-Sinai has not experienced a Material Adverse Change since signing
- Title policy has been issued for the Huntington Hospital Hospital Land
- Reimbursement Agreement remains in full force without modification

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Huntington Hospital Capital Plan

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Capital Commitment *(continued)*

Huntington Strategic Capital Plan Totaling $560 Million

	2021 - 2023	Total *(rounded)*
FMP Non-Compliance & Major Capital Projects Budget	85,000	**85,000**

	2021	2022	2023	2024	2025	2026	2027	2028	2029	Total *(rounded)*
Routine Capital Budget	30,500	30,500	30,500	30,500	30,500	30,500	30,500	30,500	30,500	**275,000**

	2021 - 2025	2026 - 2029	Total *(rounded)*
Strategic Capital Budget	100,000	100,000	**200,000**

Total Proposed Capital *(rounded)*	**560,000**

($ in 000's)

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Capital Commitment *(continued)*

Capital

Pre-Approved Capital Projects Totaling $85 Million

	2021	2022	2023	2024	2025	Total
FMP Non-Compliance	**31,352**	**7,000**	**-**	**-**	**-**	**38,352**
Operating Room Build Out and Renovation	*31,352*	*7,000*	*-*	*-*	*-*	*38,352*
Major Capital	**23,882**	**15,594**	**6,594**	**594**	**594**	**47,258**
COU Relocation	*500*	*-*	*-*	*-*	*-*	*500*
CSPD Masterplan	*12,879*	*3,000*	*-*	*-*	*-*	*15,879*
Unit 35 Relocation	*4,534*	*-*	*-*	*-*	*-*	*4,534*
IT Relocation	*900*	*-*	*-*	*-*	*-*	*900*
Clinical Lab HVAC Upgrade (Regulatory)	*875*	*-*	*-*	*-*	*-*	*875*
CT Scan Upgrade	*800*	*-*	*-*	*-*	*-*	*800*
Rad Fluoroscopy 7&8	*500*	*-*	*-*	*-*	*-*	*500*
Pathology Lab Upgrade	*300*	*-*	*-*	*-*	*-*	*300*
Surgery Department Associated Services Upgrade	*2,000*	*12000*	*6000*	*-*	*-*	*20,000*
Intuitive Robotics	*594*	*594*	*594*	*594*	*594*	*2,970*
Total	**55,234**	**22,594**	**6,594**	**594**	**594**	**85,610**

($ in 000's)

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Qualifications, Assumptions and Limiting Conditions (v.12.08.06):

This Report is not intended for general circulation or publication, nor is it to be used, reproduced, quoted or distributed for any purpose other than those that may be set forth herein without the prior written consent of Kaufman, Hall & Associates, LLC. ("Kaufman Hall").

All information, analysis and conclusions contained in this Report are provided "as-is/where-is" and "with all faults and defects". Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified by Kaufman Hall. No warranty is given as to the accuracy of such information. Public information and industry and statistical data, including without limitation, data are from sources Kaufman Hall deems to be reliable; however, neither Kaufman Hall nor any third party sourced, make any representation or warranty to you, whether express or implied, or arising by trade usage, course of dealing, or otherwise. This disclaimer includes, without limitation, any implied warranties of merchantability or fitness for a particular purpose (whether in respect of the data or the accuracy, timeliness or completeness of any information or conclusions contained in or obtained from, through, or in connection with this report), any warranties of non-infringement or any implied indemnities.

The findings contained in this report may contain predictions based on current data and historical trends. Any such predictions are subject to inherent risks and uncertainties. In particular, actual results could be impacted by future events which cannot be predicted or controlled, including, without limitation, changes in business strategies, the development of future products and services, changes in market and industry conditions, the outcome of contingencies, changes in management, changes in law or regulations. Kaufman Hall accepts no responsibility for actual results or future events.

The opinions expressed in this report are valid only for the purpose stated herein and as of the date of this report.

All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the client.

In no event will Kaufman Hall or any third party sourced by Kaufman Hall be liable to you for damages of any type arising out of the delivery or use of this Report or any of the data contained herein, whether known or unknown, foreseeable or unforeseeable.

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

KaufmanHall

Exceptional Partners. Exceptional Performance.

CHICAGO, IL | PORTLAND, OR | LOS ANGELES, CA | FT. COLLINS, CO | SKOKIE, IL

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Exhibit 8-N

Project Rose: Board Meeting Materials

CONFIDENTIAL – NOT FOR DISTRIBUTION – INTERNAL USE ONLY

Huntington Hospital

KaufmanHall

Exceptional Partners. Exceptional Performance.

Project Rose: Board Meeting

Pasadena, CA | July 14, 2020

CONFIDENTIAL

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

July 14th Special Board Meeting Agenda

1. Review of agenda and purpose of the meeting

   PURPOSE OF MEETING: vote potential affiliation with Cedars-Sinai

   ~10 minutes

2. Revisiting the Rose Process
   ~10 minutes

3. Context Setting
   ~10 minutes

4. Presentation of Affiliation Documents
   ~60 minutes

5. Partnership Committee Recommendation
   ~15 minutes

6. Board Deliberation and Vote

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Huntington Hospital Board Participation in the Rose Process

Rose Committee Participants	Partnership Committee	Trustees	Ad Hoc Committee Participants
• Wayne Brandt*	• Ron Havner	• Wayne Brandt	• Louise Bryson, Chair
• Louise Bryson	• Paul Johnson*	• Michelle Chino	• Liz Olson, Co-chair
• Michelle Chino*	• David Kirchheimer	• Armando Gonzalez	• Bill Bogaard
• Armando Gonzalez*	• Chris Mitchell	• Paul Johnson	• Michelle Chino*
• Chris Hedley, MD	• Jaynie Studenmund*	• Jaynie Studenmund	• Ellen Lee
• Scott Jenkins			• Brandon Lew
• Paul Johnson*			• Simon Li
• Chris Mitchell			• Kathy Podley
• Paul Ouyang**			• Jaynie Studenmund*
• Jaynie Studenmund*			• Debbie Williams

**Denotes Trustee*
***Consulted on an advisory basis on Rose Committee activities*

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Key Board Meetings

- **Huntington Hospital**

  2019

  - April 25th: Initial Rose Committee process update and review of healthcare trends
  - May 29th: Presentation of Rose Committee findings and vote to formally explore strategic partnership alternatives
  - November 7th: Presentation of Indications of Interest and vote to discontinue discussions with Providence and continue discussions with Cedars-Sinai, City of Hope and USC Keck

  2020

  - January 23rd: Project Rose process update
  - February 10th: Presentation of qualitative partnership evaluation
  - March 6th: Presentation of Letters of Intent and vote to enter exclusive discussions with Cedars-Sinai
  - July 2nd: Governance information session
  - July 14th: Presentation of affiliation documents and affiliation vote

- **Cedars-Sinai Medical Center**
  - June 29th: Affiliation vote

- **Cedars-Sinai Health System**
  - July 13th: Affiliation vote

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Confidentiality and Fiduciary Duties

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Revisiting the Rose Process

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Revisiting the Rose Process: 2019

Feb-May



STRATEGIC OPTIONS EVALUATION

Huntington Hospital establishes the Rose Committee to evaluate strategic alternatives for the future of Huntington Hospital

May



BOARD MEETING AND VOTE

Huntington Hospital Board votes to explore strategic partnership alternatives with potential health system partners

June



CIP DEVELOPMENT

Development of Confidential Information Presentation for distribution to potential health system partners

July



RFP DISTRIBUTED TO PARTIES

Partnership RFP and Confidential Information Presentation distributed

Sept



RFP RESPONSES RECEIVED

Received and reviewed RFP responses from potential partners

Oct



RFP FOLLOW-UP QUESTIONS AND RESPONSES

Clarifying follow-up questions distributed to each potential partner – responses received and reviewed

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Revisiting the Rose Process: 2019-2020

Nov



Huntington Hospital Board votes to continue partnership process with select finalists

Dec



Form Letter of Intent ("LOI") distributed to finalists

Jan-Feb



Refinement and negotiation of initial LOIs resulting in submission of final LOI from finalists

March



Huntington Hospital votes to enter into the negotiated LOI with Cedars-Sinai Health System

Mar - July



Two-way confirmatory due diligence and development and negotiation of affiliation documents

Today



CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Recap of Activity Since the March 6th Special Board Meeting

Activity	Timing
Affiliation Agreement & Reimbursement Agreement ***Purpose:*** *Translate the LOI into binding documents to formalize the affiliation through drafting of Affiliation Agreement and negotiating sessions*	• Affiliation Agreement: **Completed** • Reimbursement Agreement: **Completed**
Huntington Bylaws and Articles of Incorporation ***Purpose:*** *Amend to reflect Cedars-Sinai Health System as Sole Corporate Member of Huntington and incorporate terms and conditions of the affiliation*	• **Completed**
Cedars-Sinai Health System Bylaws ***Purpose:*** *Amend to accommodate Huntington Hospital entry into the system and incorporate relevant terms and conditions of the affiliation*	• **Completed**
Due Diligence ***Purpose:*** *provide information necessary for Cedars-Sinai to conduct thorough review of Huntington Hospital and review of similar information provided by Cedars-Sinai*	• **In progress**

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Context Setting

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Context

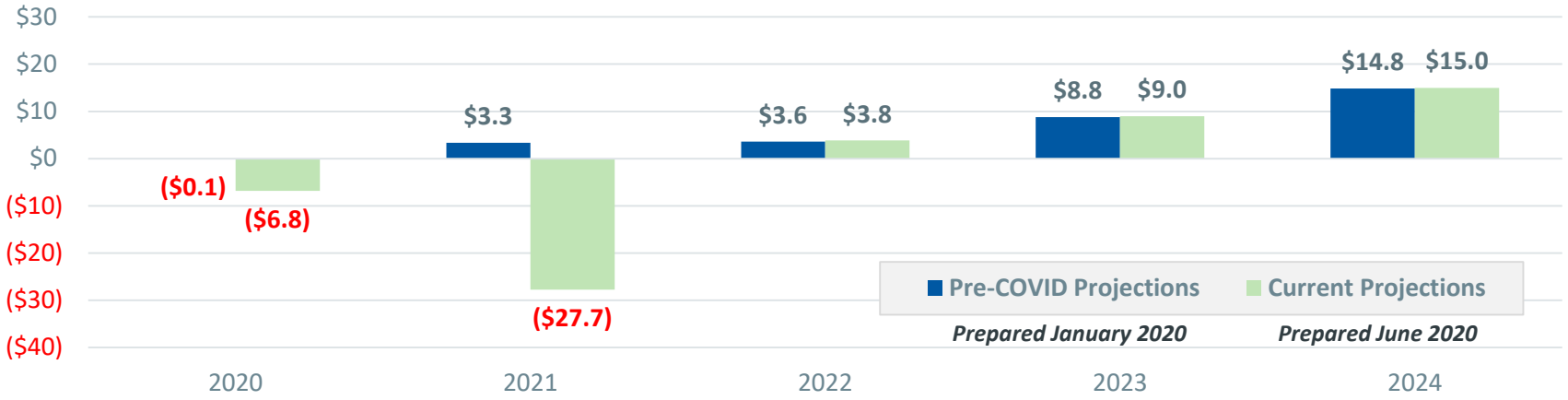
- COVID-19 has impacted hospital operations nationwide
  - Steep volume and revenue declines drove record-poor margin performance
  - Significant uncertainty around future impacts of COVID-19 remains
- These impacts have significantly affected hospital M&A as well
  - Citing COVID impacts as the primary reason, several transactions have been delayed or canceled across the country
  - Many non-public transactions have been delayed as well
- Since April 1st, the rating agencies have taken a collective total of 110 rating, outlook, and CreditWatch actions on 91 different not-for-profit hospitals -- 102 of these actions were negative in nature(1)
- Huntington Hospital's financial projections reflecting COVID-19 impacts indicate operating loses and a reduced ability to fund the strategic capital plan
- Cedars-Sinai's financial projections indicate balance sheet strength and a greater ability to weather reduced and/or uneven operating performance
- **The original strategic rationale to affiliate with Cedars has only been affirmed by impacts on the healthcare industry**

Source: (1) Moody's, S&P and Fitch as of June 26, 2020

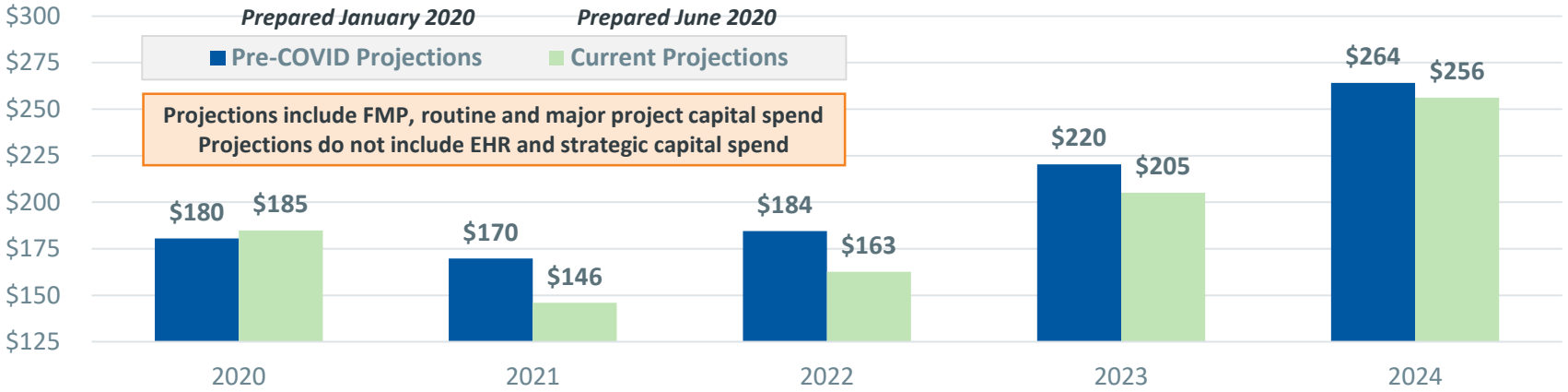
CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Huntington Hospital Financial Projections

OPERATING INCOME



UNRESTRICTED CASH & EQUIVALENTS



Source: Huntington Hospital

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Financial Projections (as of June 2020)

(in millions)

Current Cedars-Sinai Health System (CS+THA)	FY19 Audit	FY20 Projected	FY2021 Budgeted	FY2022 Projected	FY2023 Projected	FY2024 Projected	FY2025 Projected
Revenue	$ 5,111	$ 5,173	$ 5,291	$ 5,453	$ 5,598	$ 5,749	$ 5,908
Expense	4,708	4,932	5,176	5,208	5,353	5,520	5,693
Operating Income (Loss)	**$ 403**	**$ 241**	**$ 115**	**$ 245**	**$ 245**	**$ 229**	**$ 215**
Operating Margin		**4.7%**	**2.2%**	**4.5%**	**4.4%**	**4.0%**	**3.6%**
Cash - Beginning Balance	$ 2,754	$ 3,050	$ 3,156	$ 3,147	$ 3,905	$ 3,824	$ 3,744
Operating Income	403	241	115	245	245	229	215
Depreciation	240	236	237	253	282	324	363
Investment Income (3% of Total Investment)	150	107	100	116	139	133	131
Capital Spend - Base	(417)	(393)	(268)	(344)	(315)	(341)	(336)
Capital Spend - Strategic	-	-	(110)	(215)	(315)	(308)	(229)
Other Investments (Start up)	(37)	(43)	(36)	(50)	(50)	(50)	(50)
Debt Proceeds (Repayment)	(43)	(42)	(47)	753	(68)	(68)	(69)
Unrestricted Cash	**$ 3,050**	**$ 3,156**	**$ 3,147**	**$ 3,905**	**$ 3,823**	**$ 3,743**	**$ 3,769**
Total Debt			$ 1,349	$ 2,102	$ 2,034	$ 1,966	$ 1,897
Cash to Debt			**274.1%**	**211.9%**	**215.0%**	**218.4%**	**227.7%**
Days Cash on Hand Unrestricted	249	245	233	288	275	263	258
Endowments		$ 550	$ 667	$ 786	$ 910	$ 1,037	$ 1,169

Huntington Has Completed Reverse Due Diligence of Cedars-Sinai

As part of the reverse due diligence process, Huntington completed a review of key organizational and operational areas to the satisfaction of the Huntington Management Team

Organizational/ Governance	*Finance*	*Medical Staff & Residency*
Information Technology	*Legal*	*Quality*
Compliance	*Human Resources*	*Community Benefit & Philanthropy*

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Presentation of the Affiliation Documents

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Executive Summary: Key Themes Of The Affiliation Documents

Change in Control	• Governance by member system • Governance by board
Financial Benefits	• New EHR • Strategic capital plan support • Prospect for future debt restructuring
Certainty of Closing	• Probability affiliation will close • "Outs" between signing and closing
Stewardship	• Healthcare services to the community • Stakeholders: patients, physicians/medical staff, employees
Changing Relationship with the Trust	• Role of the Huntington Board • Gift of Hospital land to Huntington Hospital • Cash distributions to Huntington Hospital • Release of Trust from Huntington Hospital debt

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Summary of Key Terms: Huntington Articles and Bylaws

Key Term	Huntington Hospital Articles of Incorporation and Bylaws
Membership	• Cedar-Sinai Health System will be sole corporate member of Huntington Hospital
Member Approval Rights	• As sole member of Huntington Hospital, Cedars-Sinai Health system will have certain approvals rights and unilateral rights with respect to actions of Huntington Hospital
Role of Huntington Hospital Board	• Huntington Hospital Board will continue to be a fiduciary board • Some decisions will be subject to member approval rights above
Composition of Huntington Hospital Board	• Immediately after Closing, the composition of the 28-director Huntington Hospital Board would be: – 2 Cedars directors (Cedars CEO and CFO, ex-officio) – 5 Trust directors, ex-officio – 3 Physician directors (the Huntington Hospital President of Medical Staff the two preceding presidents of Huntington Hospital Medical staff, ex-officio) – Community directors nominated by Huntington Hospital, subject to approval by Cedars • 2 current voting Emeritus directors will be Included in the initial Community directors
Huntington Hospital Board Executive Committee	• The 10 person executive committee would consist of: – 1 Cedars director – 3 Trust directors – 1 President of Huntington Hospital – 1 Physician director – 4 Community directors

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Summary of Key Terms: Cedars-Sinai Bylaws

reflects changes from the LOI

Key Term	Cedars-Sinai Health System Bylaws
Huntington Hospital Representation on Cedars-Sinai Health System Board	• Cedars-Sinai Health System Board (currently not less than 12 and up to 18 directors) would include 3 Huntington directors nominated by Huntington Hospital and elected by Cedars-Sinai
Minimum Representation of Huntington Hospital on Cedars-Sinai Health System Board	• Huntington Hospital has the right to nominate at least 10% of the Cedars-Sinai Health System Board ***(LOI contemplated representation consistent with Torrance – initial representation will be consistent but potential for differences over time as Torrance has "founder" status)*** • At all times, at least 1 representative from Huntington Hospital will be on the Cedars-Sinai Health System Board

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Summary of Key Terms: Affiliation Agreement

reflects changes from the LOI

Key Term		Affiliation Agreement
Membership		• CSHS becomes the sole member of Huntington • CSHS creates board positions for Huntington
Financial Terms	**EHR Project**	• All "core modules" of Cedars' Epic EHR, pre-specified by Huntington, to be deployed at Huntington as part of the initial implementation • Cedars-Sinai will commence work on the EHR project as soon as reasonably practicable after closing • To be fully completed no later than the 3rd anniversary of the closing ***(new vs. LOI)***
	Huntington Hospital Capital Plan	• Accept Huntington Hospital Capital Plan totaling $560M (2021-2029), including pre-approval for $85M designated for FMP Non-Compliance and Major Capital projects • Up to $300M of the $560M to be funded by Cedars, after use of Huntington Hospital unrestricted cash down to 60 days' cash on hand ***(90 days' in LOI)*** • Development and funding of remaining Huntington Hospital Capital Plan subject to annual budgeting and approval process
	Financial Obligations of Huntington Hospital as part of Cedars-Sinai	• Huntington responsible for proportional share of Cedars-Sinai Health System "system-level" operating expenses • Huntington Hospital responsible for proportional share of Cedars-Sinai Health System "system-level" capital expenditures after initial 9 year period

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Funding of Huntington Hospital Capital Plan

Huntington Capital Plan	**2021 – 2029**	$560M

How is Capital Plan funded?

First Source of Funds	Huntington cash flow & Huntington unrestricted cash on hand **> 60 days**

What if first source of funds is insufficient?

Next Source of Funds	Balance of capital plan up to **$300M** to be funded by debt and/or cash from Cedars

Shortfall Risk	***Exists if Huntington cash flow & unrestricted cash is insufficient to fund at least $260M of the Capital Plan over aggregate 9 year period***

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Summary of Key Terms: Affiliation Agreement *(continued)*

Key Term	Affiliation Agreement
Representations and Warranties	• Huntington and Cedars-Sinai Health System make similar representations to each other • **Exception**: Huntington makes Due Diligence and 10b-5 representations to Cedars-Sinai
Pre-Closing Requirements	• Must operate in the ordinary course, except changes required to respond to COVID • Huntington and Cedars-Sinai Health System are required to tell each other about certain changes • HSR filing • AG notice • Trust court petition • Trust gift of hospital land to Huntington Hospital
Termination Before Closing	• Events that may cause a termination before closing include: – Third party challenge to the transactions – Major breaches – Failure to satisfy conditions by 3/31/2021
Conditions to Closing	• HSR clearance • AG approval • Court approval • Compliance with representations and warranties – no Material Adverse Change

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Summary of Key Terms: Affiliation Agreement *(continued)*

Key Term	Affiliation Agreement
Protections for Huntington Hospital and the Trust	• Representations made by Huntington and the Trust expire at closing • No representations outside of the Affiliation Agreement • Limited remedies – No monetary damages – Pre-closing: terminate or compel closing – Post-closing: compel performance • Release of claims • Protection of Directors & Officers
Post-Closing Agreements	• Commitments from Cedars-Sinai Health System to maintain community healthcare services and Charity Care and Community Benefit programs • Protection of Huntington employees • Protection of Huntington medical staff • Limited rights to unwind the affiliation
Provisions Specific to the Trust	• Gift of hospital land from Trust to Huntington Hospital • Trust to make ongoing cash distributions to Huntington Hospital Including: – Funding of GME – 2.5% of market value of Trust's securities portfolio • Trust shall cease to be a party to the Affiliation Agreement at the later of: – 5th anniversary from closing – Completion of FMP-Non Compliance and Major Capital Projects budget – Full release of the Trust from Huntington debt obligations

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Summary of Key Terms: Reimbursement Agreement

reflects changes from the LOI

Key Term	Affiliation Agreement
Trust Co-Obligation on Huntington Hospital Debt	• Trust will remain a co-obligor under the Huntington Hospital Master Trust Indenture ***(LOI contemplated release of Trust at closing)***
Release of Trust Co-Obligation	• Cedars-Sinai Medical Center and Cedars-Sinai Health System agree to cause the Trust to be released from the Huntington Hospital Master Trust Indenture by: – 2024 (partial release) – 2028 (full release)
Protections For Trust Prior to Release of Co-Obligation	• Cedars-Sinai Medical Center will protect the Trust from liabilities under the Master Trust Indenture

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Next Steps and Conditions to Closing

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Critical Next Steps

Activity
• Seek regulatory approval (Hart-Scott-Rodino and AG filings) • Seek court approval • Seek other third party approvals • Closing

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Conduct of Business Between Signing and Closing

Do's

- Complete notice and approval processes with California AG and under Hart-Scott-Rodino
- Obtain required third-party consents under Huntington Hospital agreements
- Supplement/amend the Huntington Hospital and Trust Disclosure Schedules reasonably promptly to keep such information timely, complete and accurate
- Carry on Huntington Hospital operations in the ordinary course consistent with past practice*
- Preserve organization's assets, present business organizations and goodwill*
- Make available to Cedars-Sinai the unaudited internal consolidated monthly balance sheet and statement of operations of Huntington Hospital
- Continue to provide Cedars-Sinai with reasonable access to Huntington Hospital and Trust diligence materials and updates to disclosure schedules
- Complete all other actions required to close

Don'ts

- Engage in a member substitution transaction or other change in control transaction with anyone but Cedars-Sinai Health System
- Enter into or materially change the terms of any employment agreement with any Huntington Entity employee
- Increase the compensation, bonus or benefits of any Huntington Entity employee, except in the ordinary course of business*
- Terminate, amend or otherwise modify any Huntington Employee Benefit Program in any material respect, except for amendments required to comply with Laws*
- Begin integration activities in violation of the antitrust guidelines

***These requirements are subject to a categorical carveout permitting each party to make such changes to its operations as such party deems necessary or appropriate to respond to COVID-19 (including complying with government orders or advisories and any conduct or suspension of any of the Huntington Operations)**

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Partnership Committee Recommendation

-- discussion --

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Board Deliberations and Vote

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

Qualifications, Assumptions and Limiting Conditions (v.12.08.06):

This Report is not intended for general circulation or publication, nor is it to be used, reproduced, quoted or distributed for any purpose other than those that may be set forth herein without the prior written consent of Kaufman, Hall & Associates, LLC. ("Kaufman Hall").

All information, analysis and conclusions contained in this Report are provided "as-is/where-is" and "with all faults and defects". Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified by Kaufman Hall. No warranty is given as to the accuracy of such information. Public information and industry and statistical data, including without limitation, data are from sources Kaufman Hall deems to be reliable; however, neither Kaufman Hall nor any third party sourced, make any representation or warranty to you, whether express or implied, or arising by trade usage, course of dealing, or otherwise. This disclaimer includes, without limitation, any implied warranties of merchantability or fitness for a particular purpose (whether in respect of the data or the accuracy, timeliness or completeness of any information or conclusions contained in or obtained from, through, or in connection with this report), any warranties of non-infringement or any implied indemnities.

The findings contained in this report may contain predictions based on current data and historical trends. Any such predictions are subject to inherent risks and uncertainties. In particular, actual results could be impacted by future events which cannot be predicted or controlled, including, without limitation, changes in business strategies, the development of future products and services, changes in market and industry conditions, the outcome of contingencies, changes in management, changes in law or regulations. Kaufman Hall accepts no responsibility for actual results or future events.

The opinions expressed in this report are valid only for the purpose stated herein and as of the date of this report.

All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the client.

In no event will Kaufman Hall or any third party sourced by Kaufman Hall be liable to you for damages of any type arising out of the delivery or use of this Report or any of the data contained herein, whether known or unknown, foreseeable or unforeseeable.

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

KaufmanHall

Exceptional Partners. Exceptional Performance.

CHICAGO, IL | PORTLAND, OR | LOS ANGELES, CA | FT. COLLINS, CO | SKOKIE, IL

CONFIDENTIAL – ©2020 Kaufman, Hall & Associates, LLC. All rights reserved.

AMENDED AND RESTATED

ARTICLES OF INCORPORATION

OF

PASADENA HOSPITAL ASSOCIATION, LTD.

~~ALLEN W. MATHIES, JR. and STEPHEN A. RALPH~~The undersigned certify ~~that~~as follows:

(1) They are the President and the ~~Assistant~~ Secretary, respectively, of PASADENA HOSPITAL ASSOCIATION, LTD., a California nonprofit public benefit corporation (the "Corporation").

(2) The Articles of Incorporation of this Corporation are amended and restated to read as follows:

I

The name of this Corporation is PASADENA HOSPITAL ASSOCIATION, LTD.

II

This ~~corporation~~Corporation is a nonprofit public benefit corporation and is not organized for the private gain of any person. It is organized under the Nonprofit Public Benefit Corporation Law for charitable purposes.

III

~~The objects and purposes for which this Corporation are formed are to establish, maintain, and carry on within the County of Los Angeles, State of California, a hospital for the sick and injured, and for that purpose:~~

~~(1) To purchase, lease or otherwise acquire, to own, hold, receive, take, use, enjoy and improve, to mortgage, pledge, or otherwise encumber or hypothecate, to sell, assign, transfer, grant, alien or otherwise dispose of, and to invest in real and personal property.~~

~~(2) To build, erect, construct, alter, repair, renew, remove, rebuild, reconstruct, equip, maintain and operate such~~

~~buildings and other structures as may be proper, necessary or convenient for the purposes and objects herein recited; to erect and maintain a dispensary, branch hospitals, and a training school for nurses.~~

~~(3) To enter into cooperative or affiliation agreements with other healthcare providers.~~

~~(4) To borrow money, to incur indebtedness and to secure the same by deed of trust or mortgage upon the real property of the corporation in any manner and amount authorized by law; to evidence such indebtedness by bonds, notes, debentures, or other appropriate instruments; to execute mortgages, deeds of trust, or pledges of and upon the whole or any part of the real and personal property of this corporation for the purpose of securing the payment of such indebtedness.~~

~~(5) To receive property by devise or bequest, subject to the laws regulating the transfer of property by will.~~

~~(6) To act as trustee under any trust incidental to the principal objects of the corporation, and to receive, hold, administer, and expend funds and property subject to such trust.~~

~~(7) To convey all or any portion of the corporate property in trust to carry out the objects of this corporation as the Board of Directors may deem advisable; to receive endowments and to invest the same.~~

~~(8) To do each and every thing necessary, appropriate or adopted to carry into effect any and all of the foregoing purposes and powers, or to attain any one or more of the objects herein enumerated.IV~~

(1) ~~A.~~ This ~~corporation~~Corporation is ~~organize~~organized and operated exclusively for charitable purposes within the meaning of Internal Revenue Code~~,~~ Section ~~531~~501(c)(3). Any other provision of these Articles of Incorporation notwithstanding, this ~~corporation~~Corporation shall not carry on any activities not permitted to be carried on (i) by a corporation exempt from ~~Federal Income Tax~~federal income taxation under Internal Revenue Code~~,~~ Section 501(c)(3) or (ii) by a corporation contributions to which are deductible pursuant to Internal Revenue Code~~,~~ Section 170(c)(2).

(2) ~~B.~~ No part of the net earnings or assets of this ~~corporation~~Corporation shall ever inure to the benefit of any director or officer of this ~~corporation or to any private individual who is a member of this corporation~~Corporation or to the benefit of any private individual whatsoever (except that reasonable compensation may be paid for services rendered to or for the ~~corporation affecting one or more of its purposes).~~ Corporation).

(3) No substantial part of the activities of the ~~corporation~~Corporation shall consist of carrying on propaganda or otherwise attempting to influence legislation (except to the extent that such activities can be carried on without a loss of tax-exempt status under Internal Revenue Code~~,~~ Section 501(h)), and the ~~corporation~~Corporation shall not participate or intervene in (including the publication or distribution or statements) any political campaign on behalf of any candidate~~:~~ for public office.

IV~~V~~

The property of this Corporation is irrevocably dedicated to charitable purposes. Upon the winding-up or dissolution of this Corporation, after paying or adequately providing for the debts and obligations of the Corporation, any remaining assets of this Corporation shall be distributed for use in furtherance of the purposes of this Corporation, as set forth above in these Articles of Incorporation, to one or more nonprofit funds, foundations or corporations, each of which is then in existence and each of which is organized and operated exclusively for charitable purposes and each of which is qualified as an exempt organization under Internal Revenue Code~~, section~~ Section 501(c)(3).

V ~~VI~~

The number of Directors of this Corporation shall be as set forth in the Bylaws of the Corporation (the "Bylaws"), and the Bylaws may provide that the number

of Directors of this Corporation shall be not less than a stated minimum nor more than a stated maximum with the exact number of Directors to be fixed, within the ~~limited~~limit specified, by approval of the Board of Directors of this Corporation in the manner provided in the Bylaws.

VI

The sole member of the Corporation (as defined in Section 5056(a) of the California Corporations Code) is Cedars-Sinai Health System, a California nonprofit public benefit corporation. The rights of Cedars-Sinai Health System as sole member of the Corporation shall be as fixed in the Bylaws.

VII

~~Amendment of the Articles of Incorporation of this Corporation shall require the approval of a majority of the Directors of this corporation and the approval of a majority of the Directors of this Corporation and the approval of a majority of those persons who are Trustees of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST under Article NINETEENTH of the Last Will and Testament of Henry E. Huntington.VIII~~

~~This Corporation shall have no members.~~The authorization or authorizations required to amend, restate or repeal these Articles of Incorporation are set forth in the Bylaws.

VIII~~IX~~

In accordance with the provisions of Section 9913 of the California Corporations Code, this Corporation elects to be governed by all the provisions of the California Nonprofit Public Benefit Corporation Law not otherwise applicable to this Corporation under Sections 9910-9927, inclusive, of the California Corporations Code.

(3) ~~(1) This~~As of the date of the adoption of the foregoing amendment and restatement of these Articles of Incorporation, this Corporation has no members.

~~(4)~~ ~~(2)~~ The foregoing amendment and restatement of ~~this Corporation's~~these Articles of Incorporation has been duly approved by ~~its~~the Corporation's Board of Directors and the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST.

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this Certificate are true and correct of our own knowledge and that this Declaration was executed on ~~April 28, 1993~~[●] at Pasadena, California.

~~ALLEN W. MATHIES, JR~~
LORI J. MORGAN M.D., President

~~STEPHEN A. RALPH,~~
~~Assistant~~
[●], Secretary

Document comparison by Workshare 9.5 on Thursday, July 02, 2020 5:20:45 PM

Input:	
Document 1 ID	file://C:\Users\noyek\AppData\Local\Temp\Workshare\wmtemp3ca8\Rose - PHA A&R Articles2.docx
Description	Rose - PHA A&R Articles2
Document 2 ID	file://C:\Users\noyek\AppData\Local\Temp\Workshare\wmtemp3ca8\Rose - PHA A&R Articles3.docx
Description	Rose - PHA A&R Articles3
Rendering set	Standard

Legend:	
Insertion	
~~Deletion~~	
~~Moved from~~	
Moved to	
Style change	
Format change	
~~Moved deletion~~	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
	Count
Insertions	41
Deletions	50
Moved from	0
Moved to	0
Style change	0
Format changed	0
Total changes	91

AMENDED AND RESTATED BYLAWS

OF

PASADENA HOSPITAL ASSOCIATION, LTD.

TABLE OF CONTENTS

~~October 2014~~

Page

ARTICLE I PURPOSES 1

ARTICLE II MEMBERSHIP 1

Section 2.1 Membership 1
Section 2.2 Reserved Powers of Member. 1

ARTICLE III BOARD OF DIRECTORS 5

Section 3.1 General Powers 5
Section 3.2 Specific Powers 6
Section 3.3 Number of Directors 7
Section 3.4 Community Director Election and Term of Office 7
Section 3.5 Vacancies 8
Section 3.6 Compensation 9
Section 3.7 Resignation or Removal of a Director. 9
Section 3.8 Indemnification of Directors, Officers, Employees and Agents 9
Section 3.9 Restriction on Interested Persons as Directors 10
Section 3.10 Board Observers 10

ARTICLE IV MEETINGS OF THE BOARD OF DIRECTORS 11

Section 4.1 Annual Meeting 11
Section 4.2 Regular Meetings 11
Section 4.3 Special Meetings 11
Section 4.4 Notice of Meetings 11
Section 4.5 Quorum and Actions 12
Section 4.6 Place of Meetings 12
Section 4.7 Attendance 12
Section 4.8 Action Without Meeting 12
Section 4.9 Adjournment of Meetings 13

ARTICLE V OFFICERS 13

Section 5.1 Officers 13
Section 5.2 Election of Officers 13
Section 5.3 Term of Office 13
Section 5.4 Removal 13
Section 5.5 Vacancies 13
Section 5.6 Chair Pro Tempore 14
Section 5.7 Secretary Pro Tempore 14
Section 5.8 Treasurer Pro Tempore 14

ARTICLE VI DUTIES OF THE OFFICERS 14

Section 6.1 Duties 14
Section 6.2 Chair of the Board 14
Section 6.3 Vice Chair of the Board 14
Section 6.4 President 14
Section 6.5 Secretary 15
Section 6.6 Assistant Secretary 15
Section 6.7 Treasurer 15
Section 6.8 Assistant Treasurer 15
Section 6.9 Execution of Checks 16

ARTICLE VII COMMITTEES 16

Section 7.1 Committees 16
Section 7.2 Appointment of Committees 16
Section 7.3 Executive Committee 16
Section 7.4 Reports of Committees 17
Section 7.5 Term of Office 17
Section 7.6 Vacancies 17
Section 7.7 Meetings; Quorum 17
Section 7.8 Expenditures 17

ARTICLE VIII MEDICAL STAFF 17

Section 8.1 Organization and Appointments. 17
Section 8.2 Medical Care and Its Evaluation. 18
Section 8.3 Medical and Dental Staff Bylaws 18

ARTICLE IX AMENDMENTS 18

Section 9.1 Procedure 18
Section 9.2 Review 19

ARTICLE X AUXILIARY ORGANIZATIONS 19

ARTICLE XI CORPORATE SEAL 19

ARTICLE XII MISCELLANEOUS 19

Section 12.1 Voting Shares 19
Section 12.2 Checks, Drafts, Etc 19
Section 12.3 Execution of Contracts 19
Section 12.4 Conflict of Interest 20
Section 12.5 Confidentiality 20
Section 12.6 Records and Annual Report 20
Section 12.7 Fiscal Year 20

INDEX OF DEFINED TERMS

Affiliation Agreement	1	Hospital	1
Board of Directors	1	Incumbent President	3
Cedars-Sinai Directors	7	Law	1
Change in Control	5	Member's Bylaws	1
Community Directors	7	Physician Directors	7
Corporation	1	Physician Network Reorganization	3
Director	6	Retirement Age	8
Emeritus Directors	7	Special Board Approval	5
ex officio	7	Subsidiary	5
Executive Committee	16	Ten-Year Transition Period	3
Executive Officers	13	Trust	1
Five-Year Transition Period	3	Trust Directors	7

AMENDED AND RESTATED BYLAWS

OF

PASADENA HOSPITAL ASSOCIATION, LTD.

ARTICLE I
~~PURPOSE~~
PURPOSES

The ~~purpose~~purposes of ~~the~~ Pasadena Hospital Association, Ltd., a California nonprofit public benefit corporation (~~the "Association" or~~ the "**Corporation**") ~~is~~, are to operate ~~a hospital for the sick and injured, namely the Collis P. and Howard Huntington Memorial Hospital (~~an acute care hospital and provide or participate in other healthcare services within the County of Los Angeles, State of California (the "**Hospital**") in accordance with the wishes expressed in the Will of Henry E. Huntington and the provisions of the Collis P. and Howard Huntington Memorial Hospital Trust (the "**Trust**") established by said Will~~. ~~The Association~~ and related activities, consistent with the purposes set forth in the Articles of Incorporation of the Corporation. The Corporation shall operate the Hospital as a charitable, community ~~not-for-profit~~nonprofit general hospital.

ARTICLE II
~~NO MEMBERS~~
MEMBERSHIP

~~The Association shall have no members as defined in Section 5056 of the California Corporations Code and any action which would otherwise require a vote of members under the law shall only require a vote of the Directors.~~

Section 2.1 Membership. This Corporation shall have one member within the meaning of Section 5056 of the California Nonprofit Corporation Law (the "**Law**"), namely, Cedars-Sinai Health System, a California nonprofit public benefit corporation (the "**Member**"). Except as provided in these Bylaws and as is not inconsistent with the Law, the Member shall have and be entitled to exercise fully all rights and privileges of a member of a nonprofit public benefit corporation under the Law and under all other applicable laws. All actions of the Member with respect to this Corporation must be taken consistent and in compliance with the terms of the Amended and Restated Bylaws of Cedars-Sinai Health System, dated [●], as such are amended or restated from time to time (the "**Member's Bylaws**") and consistent with that certain Affiliation Agreement dated [July 15, 2020] between the Member and this Corporation, as such is amended or restated from time to time (the "**Affiliation Agreement**").

Section 2.2 Reserved Powers of Member.

(a) Member Reserved Rights. The Member has exclusive power to take any of the following actions with respect to the Corporation or any of its Subsidiaries without the need

to obtain the approval of the Board of Directors of the Corporation (the "**Board of Directors**"), and no attempted exercise of any such powers by anyone other than the Member shall be valid or of any force or effect whatsoever:

(i) Approval of the strategic plans, capital budgets and operating budgets of this Corporation and its Subsidiaries, (A) taking into account the recommendation of the Board of Directors and (B) subject to Section 14.4 of the Affiliation Agreement.

(ii) Appointment and removal, with or without cause, of the President of the Corporation, subject to Section 2.2(b)(iii).

(iii) Incurrence of indebtedness by the Corporation or any of its Subsidiaries (other than the entry into any capital lease or equipment lease valued in the aggregate under Five Million Dollars ($5,000,0000), and other than accounts payable incurred in the ordinary course of business).

(iv) Formation of an obligated group for credit purposes that includes, without limitation, the Corporation and the Member.

(v) Entrance into any settlement or consent decree with a government authority or any other third party on behalf of the Corporation or any of its Subsidiaries except for settlements with non-government authorities that are related to claims arising in the ordinary course of the business of the Corporation or any of its Subsidiaries and which are not reasonably anticipated to have an adverse effect on the reputation of the Member, the Corporation or any of the Corporation's Subsidiaries.

(vi) Any change of the legal form of the Corporation or any of its Subsidiaries if such change is part of a Change in Control.

(vii) Any transaction or series of related transactions involving a Change in Control of the Corporation or any of its Subsidiaries.

(viii) The closure, sale, lease, transfer, exchange, disposition or change in use of all or substantially all of the assets of the Hospital.

(ix) Dissolution of the Corporation or any of its Subsidiaries if such dissolution is part of a Change in Control.

(x) Election of individuals to serve as Community Directors in accordance with the nomination and election process set forth in these Bylaws.

(xi) Removal of individuals who serve as Community Directors from the Board of Directors either with or without cause.

(xii) Sale of any real property owned by the Corporation or any of its Subsidiaries, subject to Section 2.2(c)(i).

(xiii) Sale, transfer or other disposition of all or substantially all of the assets owned by the Corporation or any of its Subsidiaries that are used exclusively for the operation of the Corporation's affiliated physician network if such sale, transfer or other disposition constitutes an entirely internal reorganization by the Member of the Member's entire affiliated physician enterprise within the Southern California region in which all such assets remain owned by controlled affiliates of the Member (a "**Physician Network Reorganization**").

(xiv) Sale, transfer, or other disposition of assets of the Corporation or any of its Subsidiaries that have an aggregate value exceeding two percent (2%) of the net revenue of the selling, transferring or disposing entity for the entity's immediately preceding fiscal year if such sale, transfer or other disposition is part of a Change in Control.

(xv) Select the independent auditor that will serve as auditor for the Member, the Corporation and its Subsidiaries.

(b) Five-Year Qualified Member Reserved Rights. Except as otherwise set forth in this Section 2.2, the Member has exclusive power to take any of the following actions without the need to obtain the approval of the Board of Directors, and no attempted exercise of any such powers by anyone other than the Member shall be valid or of any force or effect whatsoever; *provided that*, during the period from the effective date of these Bylaws through [●] (the "**Five-Year Transition Period**"), the following actions shall also require Special Board Approval (as defined in Section 2.2(h)(i)):

(i) Adoption, repeal, amendment, modification or restatement of the articles of incorporation, bylaws or other governing documents, as applicable, of the Corporation or any of its Subsidiaries.

(ii) Any action or decision that would change the size or composition of the Board of Directors, including the number of Cedars-Sinai Directors, Trust Directors, Physician Directors or Community Directors.

(iii) Approval of the successor to the person serving as the President of the Corporation as of the effective date of these Bylaws (the "**Incumbent President**") if the Incumbent President for any reason ceases to occupy the office of President of the Corporation during the Five-Year Transition Period.

(c) 10-Year Qualified Member Reserved Rights. Except as otherwise set forth in this Section 2.2, the Member has exclusive power to take any of the following actions without the need to obtain the approval of the Board of Directors, and no attempted exercise of any such powers by anyone other than the Member shall be valid or of any force or effect whatsoever; *provided that*, during the period from the effective date of these Bylaws through [●] (the "**Ten-Year Transition Period**"), the following actions shall also require Special Board Approval:

(i) Sale of any real property owned by the Corporation or any of its Subsidiaries if such sale is not part of a Change in Control.

(d) Approvals by Member and Board. Each of the following actions or decisions with respect to the Corporation or any of its Subsidiaries requires both the approval of the Member and the approval of the Board of Directors:

(i) Approval of an expenditure by the Corporation or any of its Subsidiaries that is not set forth in an approved budget and exceeds Five Million Dollars ($5,000,000).

(ii) Approval of the community benefit plan of the Corporation or any of its Subsidiaries.

(iii) Lending of money by the Corporation or any of its Subsidiaries in amounts that exceed two percent (2%) of the lending entity's net assets, except for intercompany transfers made by Huntington to its Subsidiaries in the ordinary course of business.

(e) Approval by Member and Special Board Approval. Each of the following actions or decisions with respect to the Corporation or any of its Subsidiaries requires both the approval of the Member and Special Board Approval:

(i) Any change to the mission, vision or values of the Corporation or any of its Subsidiaries.

(ii) Any change to the name of the Corporation or the Hospital.

(iii) Any change of the legal form of the Corporation or any of its Subsidiaries if such change is not part of a Change in Control.

(iv) Dissolution of the Corporation if such dissolution is not part of a Change in Control.

(v) Any action that results in the Corporation or the Hospital not being owned and operated by a tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code of 1986 (as amended, the "**Code**") which is also a public charity under Section 509(a) of the Code or which otherwise jeopardizes the tax exempt status of the Trust.

(vi) Sale, transfer or other disposition of all or substantially all of the assets owned by the Corporation or any of its Subsidiaries that are used exclusively for the operation of the Corporation's affiliated physician network, *provided that* such sale, transfer or disposition is not part of a Physician Network Reorganization.

(vii) The sale, transfer or other disposition of assets of the Corporation or any of its Subsidiaries that have an aggregate value exceeding two percent (2%) of the net revenue of the selling, transferring or disposing entity for the entity's immediately preceding fiscal year if such sale, transfer or other disposition is not part of a Change in Control.

(f) Approval Rights of the Trust. Notwithstanding anything to the contrary, approval of the Trust (acting by majority of its trustees then in office) shall be required for any

action or decision that would change the requirement that at least a majority of the Trust Directors vote in favor of any Special Board Approval, as described in Section 2.2(h)(ii).

(g) Scope of the Member's Rights and Approvals over Subsidiaries. Notwithstanding anything in this Section 2.2 that may be construed to the contrary, any right of the Member to take action with respect to, or approve an action taken by or with respect to, a Subsidiary of the Corporation as set forth in this Section 2.2 may only be exercised by the Member if the Corporation possesses the right to take or approve such action, pursuant to the Subsidiary's organizational documents, at the time the Member desires to exercise its right over the Subsidiary. Additionally, the Member shall consider the recommendation of the Corporation prior to the Member taking any action described in this Section 2.2 with respect to, or approving any action described in this Section 2.2 taken by or with respect to, a Subsidiary of the Corporation.

(h) Definitions. For the purposes of these Bylaws:

(i) "**Change in Control**" means the following with respect to the Corporation or any of its Subsidiaries: (A) any transaction or series of related transactions of an entity (including, without limitation, merger or consolidation, sale, transfer or other disposition of equity, amendment to the articles of incorporation or bylaws or other applicable governing documents of such entity or other contract or arrangement) that results in another entity becoming the beneficial owner of more than fifty percent (50%) of the voting ownership interests of such entity, (B) the sale, lease, transfer, exchange, disposition or change in use of all or substantially all of the property and assets of an entity, (C) the substitution of a new corporate member or members that transfers the control of, responsibility for, or governance of the entity; or (D) a joint venture, management arrangement or similar transaction by an entity with another entity that results in the other entity becoming the owner, operator or manager of all or substantially all of the assets of the entity.

(ii) "**Special Board Approval**" means either (A) the affirmative vote of a majority of the Directors who are present at a duly held meeting of the Board of Directors, provided that such affirmative vote must include a majority of the Trust Directors in office, or (B) the unanimous written consent of the Board of Directors in accordance with Section 4.8.

(iii) "**Subsidiary**" means an entity that, directly or indirectly through one or more intermediaries, is controlled by the Corporation. For purposes of this definition, "control" means the power or possession of the power, direct or indirect, to direct or cause the direction of the management and policies of an entity, whether through the ownership of securities, election or appointment of directors, by contract or otherwise. Without limiting the generality of the foregoing, "Subsidiary" includes those entities of which the Corporation is a corporate member and those entities in which the Corporation owns at least fifty-one percent (51%) of the voting securities.

ARTICLE III
~~DIRECTORS~~
BOARD OF DIRECTORS

~~Section 1. Number, Designation and Qualification. The~~

Section 3.1 General Powers. Subject to the provisions of Sections 5110 – 6910 of the California Corporations Code and the provisions in the Affiliation Agreement and these Bylaws relating to action that may be taken by, or that require the approval of, the Member, the activities and affairs of the ~~Association shall be conducted and all corporate powers shall be exercised, subject to this Article III of these Bylaws, by or under the direction of a Board of Directors of not less than thirteen and not more than thirty Directors, with the exact number of Directors to be fixed by approval of the Board within such range as set forth in these Bylaws. Five of the persons who are Directors of the Association shall be those persons who from time to time are serving as the Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust (a or the "Trustee" or the "Trustees"). As soon as a Director who is also such a Trustee ceases to be a Trustee of the Collis P. and Howard Huntington Memorial Trust he or she shall, by that fact, cease to be a member of the Board of Directors of the Association unless he subsequently becomes elected a Director as described below in Section 2. Any person who is serving as Director because he is a Trustee of the Collis P. and Howard Huntington Memorial Hospital Trust may not be removed without the written consent of a majority of the persons who are Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust. The President of the Medical Staff of the Hospital and the President of the Association shall each also serve as a Director with full voting rights. In addition, the President-elect of the Medical Staff of the Hospital shall be an invited guest at each board meeting but shall have no vote, shall not be a member of the Board of Directors and shall leave the meeting when requested by the Chairman of the Board.~~

~~Section 2. Election and Term of Office. Each Director who is a Trustee of the Collis P. and Howard Huntington Memorial Hospital Trust shall serve as a Director while and for as long as he is a Trustee. The person who is from time-to-time President of the Medical Staff of the Hospital shall serve as a member of the Board of Directors with full voting rights while he is President of the Medical Staff and for two additional two-year terms, such additional terms commencing at the time such person ceases to serve as President of the Medical Staff of the Hospital. Except as to a Director who is a Trustee of the Collis P. and Howard Huntington Memorial Hospital Trust and the Director who is the President of the Medical Staff of the Hospital and a Director who has been elected President or Director Emeritus, all other Directors shall be elected by the Board of Directors and shall serve a term of three years commencing with the date of their election; such elected Directors maybe elected to succeed themselves for one additional three year term or for an indefinite appointment if any of them becomes a Trustee of the Collis P. and Howard Huntington Memorial Hospital Trust during his tenure as a Director.~~

~~From time to time, at the discretion of the Board of Directors, an individual may be elected to a term of less than three years. After serving two consecutive three-year terms, each such elected Director shall not be eligible for reelection and shall not serve as a Director of the Association for a period of at least one year. Following a one year absence from the Board of Directors, each such elected Director will again be eligible for election to the Board of Directors of the Association.~~Corporation shall be conducted and all the corporate powers shall be exercised by or under the direction of the Board of Directors. The Board of Directors may delegate the management of the Corporation to any person or persons, management company or committee however composed, *provided that* the affairs of the Corporation shall be managed and all corporate powers shall be exercised under the ultimate direction of the Board of Directors and the Member to the extent provided in Sections 5110 – 6910 of the California Corporations Code, the Affiliation Agreement or these Bylaws. The powers and responsibilities of the Board of Directors shall include:

(a) To nominate individuals to be appointed by the Member to the Board of Directors in accordance with the nomination process set forth in these Bylaws.

(b) To nominate and recommend to the Member representatives of this Corporation to be appointed to the board of directors of the Member.

(c) To recommend to the Member for approval, the strategic plans, capital budgets and operating budgets of this Corporation and its Subsidiaries, taking into account the recommendation of the President of the Corporation.

(d) To prescribe such duties for the officers, agents and employees of this Corporation as are not inconsistent with these Bylaws or applicable laws, and to require from them security for faithful performance.

(e) To provide input on the addition of a new entity as an "Affiliated Hospital Organization" as such term is defined in the Member's Bylaws.

(f) To provide input to the Member on any proposed action to establish or consummate a transaction that results in a Change in Control of the Member.

(g) To provide input on any proposed change in the name of the Member.

(h) To do and perform every act whatsoever not inconsistent with these Bylaws that may pertain to the office of director, or that may legally or properly be done by a board of directors.

Section 3.2 Specific Powers. Subject to the terms of the Affiliation Agreement, and notwithstanding the Member reserved rights set forth in Section 2.2, the Board of Directors shall have the right to terminate the membership of the Member in the event that any of the following events occur, each as defined in the Affiliation Agreement: (i) a Closure or Sale of Hospital Unwind Event; (ii) a Tax-Exempt Status Unwind Event; or (iii) an Illegality Unwind Event. Any such termination of the Member shall be subject to full compliance with Section 5341 of the California Corporations Code and the terms of the Affiliation Agreement.

Section 3.3 Number of Directors. Unless changed by an amendment to these Bylaws, the authorized range for the number of individuals on the Board of Directors (each a "**Director**") is not less than thirteen (13) and not more than twenty-eight (28). The authorized number of Directors at the effective time of these Bylaws is twenty-eight (28). At all times, the Board of Directors will be constituted as follows (except that a position described below may remain vacant until the vacancy is filled under Section 3.5):

(a) Cedars-Sinai Directors. Two (2) of the Directors are the Member's Chief Executive Officer and the Member's Chief Financial Officer (the "**Cedars-Sinai Directors**"), who will serve ex officio with vote pursuant to Section 5220(f) of the California Corporations Code ("**ex officio**").

(b) Trust Directors. Five (5) of the Directors are the trustees of the Trust (the "**Trust Directors**"), who will serve ex officio.

(c) Physician Directors. Three (3) of the Directors are the president of the medical staff of the Hospital, the immediate past president of the medical staff of the Hospital and the predecessor of the immediate past president of the medical staff of the Hospital (the "**Physician Directors**"), who will serve ex officio.

(d) Community Directors. Eighteen (18) of the Directors (the "**Community Directors**") will consist of the following:

(i) the President of the Corporation, who will serve ex officio;

(ii) each Emeritus Director so long as such Emeritus Director remains in office; and

(iii) the remainder of the Community Directors shall be individuals nominated by the Board of Directors subject to election by the Member, as further set forth in Section 3.4(a).

(e) ~~From time to time, and in the exercise of its sole discretion, the Board of Directors shall have the authority to designate one or more individuals, upon the vote of a majority of the Directors then in office, as Director or President Emeritus. Such Director shall be appointed from among current or former Directors or officers whom the Board shall determine have rendered extraordinary service to the Corporation, shall serve six (6) year terms and not be subject to any term limits. A Director or President Emeritus shall serve as a Director, be considered in the authorized number of Directors, and have the right to attend meetings of~~

~~Directors, shall count for the purposes of establishing a quorum and shall have the right to vote. Similarly, the Board of Directors shall have the authority to designate one or more individuals, upon the vote of a majority of the Directors then in office, as non-voting Directors. Such nonvoting Directors shall receive notices of meetings of the Board, but shall not count for the purposes of establishing a quorum and shall not have the right to vote at meetings of the Board of Directors.~~Emeritus Directors. At the effective time of these Bylaws, three of the Community Directors are individuals who were elected as Directors in recognition of their years of service to the Corporation (each, an "**Emeritus Director**"). Each Emeritus Director has a six (6) year term and may be reelected for additional six (6) year terms. A vacancy in the position of an Emeritus Director will not be filled by an Emeritus Director described in Section 3.3(d)(ii), but will be filled by a Community Director described in Section 3.3(d)(iii) pursuant to the process for filling vacancies for Community Directors described in Section 3.5(d).

~~Notwithstanding the foregoing, if a Director is elected for an initial term that commences on a date other than January 1, such Director's initial term shall expire as of a subsequent January 1, as follows:~~

~~1. If the initial term commences after January 1 but before July 1, the Director's initial term shall expire three years following the January 1 preceding the term commencement.~~

~~2. If the initial term commences on or after July 1 but before January 1, the Director's initial term shall expire four years following the January 1 preceding the term commencement.~~

Section 3.4 Community Director Election and Term of Office.

(a) Election of Community Directors. At each annual meeting of the Board of Directors (or at a special meeting of the Board of Directors if an annual meeting is not held) the Board of Directors shall select a list of nominees to fill offices of Community Directors (including Emeritus Directors) whose terms will expire as of the end of the applicable year and such other vacancies which have not been previously filled, subject to the discretion of the Member to retain vacancies for Community Directors. Each Director shall be afforded a reasonable means to present candidates for nomination by the Board of Directors. The nominees receiving a majority vote at such meeting of the Board of Directors shall be declared officially nominated by the Corporation, and the Secretary of the Corporation shall immediately send notice of the list of nominees to the Member for election at the next annual meeting of the Member. If, at such annual meeting of the Member, the Member fails to elect any of the individuals nominated by the Corporation, the Corporation shall promptly propose alternative nominees for election by the Member. The process set forth in the foregoing sentence shall continue until such time as the Member has elected individuals to fill the offices of all Community Directors with expiring terms.

(b) Community Director Terms. Except for Emeritus Directors, each Community Director will hold a specific numbered position. Each position will have a term of four (4) years. The terms shall be staggered so that the terms of approximately one-third (1/3) of the authorized number of Community Directors expire each year. Community Directors may be

elected to serve for no more than three (3) successive four (4) year terms; *provided that* exceptions to the three-term limitation may be granted by resolution duly adopted by the Board of Directors.

(c) Community Director Age Limit. No person eighty (80) years of age or older shall be eligible for election, reelection, appointment or reappointment as a Community Director.

Section 3.5 ~~Section 3.~~ Vacancies~~. Vacancies in the Board of Directors shall:~~.

(a) A vacancy in the ~~case~~position of a Cedars-Sinai Director ~~who is also a Trustee, be filled by the successor Trustee appointed in accordance with the terms of the Collis P. and Howard Huntington Memorial Hospital Trust;~~shall be filled by the person occupying the position of Chief Executive Officer or Chief Financial Officer, as applicable, of the Member.

(b) A vacancy in the position of a Physician Director shall be filled, in the case of the ex officio position reserved for the President of the Medical Staff ~~serving pursuant to the provisions above, be filled~~, by the person who is appointed the new President of the Medical Staff; in the case of the ex officio position reserved for the immediate past President of the Medical Staff, by the person who was the immediate past President of the Medical Staff; and in the case of the ex officio position reserved for the predecessor to the immediate past President of the Medical Staff, by the person who was the predecessor to the immediate past President of the Medical Staff.

(c) ~~in the case of the President of the Association serving pursuant to the provisions above, be filled by the appointment of a new President:~~A vacancy in the position of a Trust Director shall be filled by the successor trustee appointed by the Trust.

(d) ~~in the case of the past President of the Medical Staff serving two additional two-year terms pursuant to the provisions above, be filled by a member of the Medical Staff recommended by the President of the Medical Staff and elected by the affirmative vote of a majority of the Directors then in office; and~~A vacancy in the position of a Community Director who is the President of the Corporation shall be filled by the person who is appointed the new President of the Corporation. Subject to the Member's right to leave vacancies for Community Directors unfilled as set forth in Section 3.4(a), all other vacancies in the position of a Community Director, including vacancies in the position of an Emeritus Director, shall be filled as follows:

~~(e) in the case of all other vacancies, be filled by the affirmative vote of a majority of the Directors then in office.~~

(i) The Board of Directors shall nominate a Community Director to fill any such vacancy, and the nominee shall then be nominated for election to the Board of Directors by the Member. Each Community Director so elected shall hold office for the balance of the term of the vacated position.

(ii) A Community Director vacancy shall be deemed to exist (1) in case of the death, resignation or removal of any Community Director, (2) if the authorized number of Community Directors is increased, (3) if the Member's board of directors fails, at any meeting at which any Community Director is elected, to elect the full authorized number of Community Directors to be elected at that meeting, (4) if no nomination is made pursuant to these Bylaws to fill any Community Director position to be elected at that meeting, or (5) when a Community Director who was a compensated officer of this Corporation at the beginning of such Community Director's initial or re-election term, as applicable, is no longer a compensated officer of this corporation.

(iii) In the event that Community Director vacancies are created by an increase in the authorized number of Community Directors, the new Community Directors shall be appointed for staggered terms so that the terms of approximately one-third (1/3) of the authorized number of Community Directors expire each year. No reduction of the authorized number of Community Directors shall have the effect of removing any Community Director prior to the expiration of such Director's term; *provided that* the foregoing shall not in any way limit the Member's right to remove a Community Director with or without cause pursuant to Section 2.2(a)(xi).

Section 3.6 ~~Section 4.~~ Compensation. ~~The~~ Directors shall ~~serve as such without~~not receive any compensation~~, but performance of his duties as a Director may be considered as part of the duties for which the President of the Association receives compensation as such.~~ for their services as Directors; *provided that* Directors may be reimbursed for any expenses actually incurred in connection with the performance of their duties as Directors if the same be authorized by the Board of Directors. Except as otherwise precluded by law, nothing herein shall be construed to preclude any Director from serving the Corporation in any other capacity as an officer, agent, employee or otherwise, and receiving compensation therefor.

Section 3.7 ~~Section 5.~~ Resignation or Removal of a Director.

(a) Any Director may resign ~~his office~~ as a Director by a writing delivered to the Board of Directors. ~~Upon such resignation such Director's term as a Director shall end. No~~Such resignation will be deemed effective upon delivery unless the notice specifies a later time of effectiveness. Notwithstanding the foregoing, no Director may resign without providing proper notice to the Attorney General, if such resignation would leave the Corporation ~~would be left~~ without a duly elected Director in charge of its affairs.

(b) The Board of Directors may declare vacant the office of a Community Director who has been declared of unsound mind by a final order of court, or convicted of a felony, or been found by a final order or judgment of any court to have breached any duty under Article 3 (Sections 5230 – 5239) of the ~~California Nonprofit Public Benefit Corporation~~ Law.

~~Section 6. Records and Annual Report. The Association shall keep adequate and correct books and records of account and minutes of the proceedings of its Board of Directors and committees of the Board of Directors. The Board of Directors shall cause an annual report to~~

be sent to all Directors of the Association not later than 120 days after the close of the Corporation's fiscal year. Such report shall contain in appropriate detail the following:

(a) The assets and liabilities, including the trust funds, of the Association as of the end of the fiscal year.

(b) The principal changes in assets and liabilities, including trust funds, during the fiscal year.

(c) The revenue or receipts of the Association, both unrestricted and restricted to particular purposes, for the fiscal year.A Community Director may be removed from office by the Member for any reason in accordance with the Member's Bylaws, taking into consideration any input of the Board of Directors.

(d) The expenses or disbursements of the Association, for both general and restricted purposes, during the fiscal year.

(e) Any information required by Section 6322 of the California Corporations Code.

Any financial statements presented as part of the above-described report shall be prepared in accordance with generally accepted accounting principles and be audited by an independent certified public accountant in conformity with generally accepted auditing standards.

Section 3.8 Section 7. Indemnification of Directors, Officers, Employees and Agents.

(a) As to the Board of Directors, Executive Officers (as defined belowin Section 5.1) and the members of any standing committee of the Board of Directors (as defined in Article VIII, Section 3 of these Bylaws), the Association, the Corporation shall, and as to all other agents the AssociationCorporation may, to the maximum extent permitted by the California Nonprofit Corporation Law, indemnify each of its agents against expenses, judgments, fines, settlements and other amounts actually and reasonably incurred in connection with any proceeding arising by reason of the fact that any such person is or was an agent of the AssociationCorporation. For purposes of this Article III, Section 7,3.8, an "agent" of the Corporation includes any person who is or was a director, officer, employee or other agent of the Corporation or is or was serving at the request of the corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise; or was a director, officer, employee or agent of the predecessor corporation, of the AssociationCorporation, or of another enterprise at the request of such predecessor corporation. For the purposes of this Article III, "Executive Officers" shall mean the officers defined in the first sentence of Article VI, Section 1.

(b) As to the Board of Directors, Executive Officers and the members of any standing committee of the Board of Directors (as defined in Article VIII, Section 3 of these

~~Bylaws), the Association~~, the Corporation shall, and as to all other agents the ~~Association~~Corporation may, to the extent permitted by law, advance expenses incurred or to be incurred by an agent in connection with any proceeding arising by reason of the fact that such person was or is an agent of the ~~Association~~Corporation, provided such advance is authorized by the Board of Directors and permitted by law.

(c) The Board of Directors may adopt a resolution authorizing the purchase and maintenance of insurance on behalf of any agent of the ~~Association~~Corporation against any liability which may be asserted against or incurred by the agent in such capacity or arising out of the agent's status as such, whether or not this Corporation would have the power to indemnify the agent against that liability under the provisions of this ~~Article III,~~ Section ~~7.~~3.8.

(d) This ~~Article III,~~ Section ~~7~~3.8 does not apply to any proceeding against any trustee, investment manager or other fiduciary of an employee benefit plan in such person's capacity as such, even though such person may also be an agent of the Corporation as defined in subsection (a) of this Section ~~7.~~3.8. The Corporation shall have power to indemnify such trustee, investment manager or other fiduciary to the extent permitted by subsection (f) of Section 5140 of the ~~California Nonprofit Corporation~~ Law.

(e) The indemnification provided by this ~~Article III,~~ Section ~~7 of these Bylaws~~3.8 shall not be deemed exclusive of any rights to which those seeking indemnification may be entitled under any agreement, vote of disinterested directors, or otherwise, both as to action in ~~his or her~~their official capacity while holding such office, and shall continue as to a person who has ceased to be a director, officer~~,~~ or employee and agent, and shall inure to the benefit of the heirs, executors and administrators of such person.

Section 3.9 ~~Section 8.~~ Restriction on Interested Persons as Directors. No more than ~~49~~forty-nine percent (49%) of the persons serving on the Board of Directors may be interested persons. An interested person is (a) any person compensated by the ~~Association~~Corporation for services rendered to it within the previous twelve (12) months, whether as a full-time or part-time employee, independent contractor, or otherwise, excluding any reasonable compensation paid to a Director as Director; and (b) any brother, sister, ancestor, descendant, spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, or father-in-law of such person. However, any violation of the provisions of this section shall not affect the validity or enforceability or any transaction entered into by the ~~Association~~Corporation.

Section 3.10 Board Observers. Each of the President-elect of the Medical Staff of the Hospital and (subject to approval by the Board of Directors) an individual nominated by Huntington Medical Research Institutes may be an invited guest at each meeting of the Board of Directors but shall have no vote, shall not be a Director and shall leave the meeting when requested by the Chair of the Board or the President.

ARTICLE IV

MEETINGS OF THE BOARD OF DIRECTORS

Section 4.1 ~~Section 1.~~ Annual Meeting. The annual meeting of the Board of Directors shall be held in conjunction with the regular monthly meeting in December of each year~~. The~~ or as otherwise determined by the Board of Directors. The Executive Officers of the Board of Directors for the coming year shall be elected at the annual meeting.

Section 4.2 ~~Section 2.~~ Regular Meetings. The Board of Directors shall hold a regular meeting on the fourth Thursday of each month at 4:00 p.m., or on such other day and time as may be fixed by resolution of the Board of Directors, at the Huntington ~~Memorial~~ Hospital, 300 West California Boulevard, Pasadena, California.

Section 4.3 ~~Section 3.~~ Special Meetings. Special meetings may be called by the ~~Chairman~~Chair of the Board or Secretary at any time, and must be called at the written request of three (3) Directors. In the absence of the ~~Chairman~~Chair of the Board, the Vice ~~Chairman~~Chair of the Board may call special meetings.

Section 4.4 ~~Section 4.~~ Notice of Meetings.

(a) The Secretary shall give notice of the time and place of the annual meeting and special meetings to each Director upon at least four (4) calendar days' notice given by first-class mail or at least forty-eight (48) hours' notice delivered personally or by telephone, including a voice messaging system or other system or technology designed to record and communicate messages, or by "electronic transmission by the Corporation" (as defined below).

(b) Any such notice shall be addressed or delivered to each Director at such Director's address as is shown upon the records of the ~~Association~~Corporation or as may have been given to the ~~corporation~~Corporation by the Director for purposes of notice, or if such address is not shown on such records or is not readily ascertainable, at the place in which the meetings of the Directors are regularly held. Notice by mail shall be deemed to have been given at the time a written notice is deposited in the United States mail, postage prepaid. Any other written notice shall be deemed to have been given at the time it is personally delivered to the recipient or is delivered to a common carrier for transmission or actually transmitted by the person giving the notice by electronic means, to the recipient. Oral notice shall be deemed to have been given at the time it is communicated, in person or by telephone, including a voice messaging system or other system or technology designed to record and communicate messages, telegraph, facsimile, electronic mail, or other electronic means, to the recipient or to a person at the office of the recipient who the person giving notice has reason to believe will promptly communicate it to the recipient. The recital by the Secretary in the minutes that due notice was given shall be sufficient evidence of that fact. No notice of the regular monthly meetings shall be required.

(c) For purposes of these Bylaws, "electronic transmission by the Corporation" means a communication (a) delivered by facsimile telecommunication or electronic mail when directed to the facsimile number or electronic mail address, respectively, for that

recipient on record with the Corporation, (b) to a recipient who has provided an unrevoked consent to the use of those means of transmission for communications under or pursuant to the California Corporations Code, and (c) that creates a record that is capable of retention, retrieval, and review, and that may thereafter be rendered into clearly legible tangible form.

Section 4.5 ~~Section 5.~~ Quorum and Actions.

(a) At all meetings of the Board of Directors, ten (10) Directors ~~at any one meeting~~ shall constitute a quorum ~~and any action of the Board at any meeting shall require a majority vote of the Directors present at the meeting; provided, however, that (subject to the sections of the California Corporations Code set forth in California Corporations Code, Section 5151(e) to the extent they are applicable) the affirmative vote of a majority of the Directors who are Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust shall be necessary for the transaction of any business; and provided further,~~; *provided that* a quorum shall not be less than two-fifths (2/5) of the total number of Directors ~~authorized~~then in ~~these Bylaws~~office, or less than two, whichever is larger, unless the number of Directors authorized in these Bylaws is one, in which case one Director constitutes a quorum.

(b) An act or decision done or made by a majority of the Directors present at a meeting duly held at which a quorum is present is the act of the Board of Directors, except for those acts or decisions that also require Member approval or Special Board Approval under Section 2.2.

(c) Members of the Board of Directors may participate in a meeting through use of a conference telephone, electronic video screen communication or similar communications equipment so long as all Directors participating in the meeting are able to hear one another. Participation in a meeting as permitted in the preceding sentence constitutes presence in person at such meeting of the person or persons so participating if the following apply:

(d) ~~(a)~~ Each member participating in the meeting can communicate with all of the other members concurrently.

(e) ~~(b)~~ Each member is provided the means of participating in all matters before the Board, including the capacity to propose, or to interpose an objection, to a specific action to be taken by the Corporation.

Section 4.6 ~~Section 6.~~ Place of Meetings. All meetings of Directors shall be held in the County of Los Angeles, California, unless the Directors shall otherwise designate or approve.

Section 4.7 ~~Section 7.~~ Attendance. All Directors shall be expected to attend all duly called meetings of the Board of Directors. Attendance at no less than fifty percent (50%) of all duly called meetings shall be necessary for ~~each Director, not a Trustee of the Collis P. and Howard Huntington Memorial Hospital Trust, to maintain membership on the Board of Directors (actual attendance records will be reviewed by the Governance Committee)~~a non-ex officio Director to remain a Director; *provided, however, that*, for purposes of computing a Director's percentage of attendance, there shall be excluded (both from the numerator and from the denominator) any meeting which such Director fails to attend for good cause, as determined by

the affirmative vote of ~~a majority~~the Board of ~~those~~ Directors ~~who are Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust~~.

Section 4.8 ~~Section 8.~~ Action Without Meeting. Any action required or permitted to be taken by the Board of Directors may be taken without a meeting if all members of the Board of Directors shall individually or collectively consent in writing to such action, *provided, however, that* the consent of any Director who has a material financial interest in a transaction to which the corporation is a party and who is an "interested director" as defined in section 5233 of the California Corporations Code, or who is a "common director" as described in Section 5234 of the California Corporations Code, shall not be required for approval of that transaction where the facts giving rise to the exception are established in advance of the execution of, and are set forth in, the written consent or consents. Such consent or consents shall be filed with the minutes of the proceedings of the Board of Directors and shall have the same force and effect as a unanimous vote of such Directors.

Section 4.9 ~~Section 9.~~ Adjournment of Meetings. A majority of the Board of Directors present, whether or not a quorum is present, may adjourn any meeting to another time and place. If the meeting is adjourned for more than twenty-four (24) hours, notice of any adjournment to another time and place shall be given prior to the time of the adjourned meeting to the Directors who are not present at the time of the adjournment.

ARTICLE V
~~POWERS OF DIRECTORS~~

~~Section 1. Powers. The powers of the Directors shall be:~~

~~**(a)** To conduct, manage and control the affairs and business of the Association.~~

~~**(b)** To make rules and regulations not inconsistent with the laws of the State of California and to adopt and amend Bylaws for the Association for the guidance of its officers and employees in the management of its affairs.~~

~~**(c)** To incur indebtedness and cause its notes to be executed as evidence thereof, and to secure the payment thereof by mortgage, pledge, assignment or otherwise.~~

~~**(d)** From time to time by resolution adopted by a majority of the number of the Directors then in office provided that a quorum is present (but subject to the provisions of Article V, Section 5 of these Bylaws), to appoint committees to exercise the authority of the Board of Directors between meetings of the Board of Directors, and to delegate to said committees such of their powers as they deem appropriate; provided that all members of~~

~~any such committee which has the power to exercise the authority of the Board shall be members of the Board of Directors of the Association and that any such committee which has such power shall consist of two or more Directors; and provided further than no committee shall have authority as to any of the following:~~

~~(1) The filing of vacancies on the Board or in any committee which has the authority of the Board;~~

~~(2) The fixing of compensation of the directors for serving on the Board or on any committee.~~

~~(3) The amendment or repeal of bylaws or the adoption of new bylaws;~~

~~(4) The amendment or repeal of any resolution of the Board which by its expressed terms is not so amendable or repealable;~~

~~(5) The appointment of committees of the Board or the members thereof;~~

~~(6) The approval of any self-dealing transaction within the meaning of Section 5233 of the California Corporations Code, except as provided in paragraph (3) of subdivision (d) of that Section 5233.~~**~~ARTICLE VI~~**

OFFICERS

Section 5.1 ~~Section 1.~~ Officers. The officers of the Corporation shall consist of a ~~Chairman~~Chair of the Board, a Vice ~~Chairman~~Chair of the Board, a President, one or more additional Vice Presidents, a Secretary, one or more Assistant Secretaries, a Treasurer, and one or more Assistant Treasurers, one of whom serves as the Chief Financial Officer for the ~~Association~~Corporation (collectively, the "**Executive Officers**"). Neither the Secretary, Treasurer nor the Assistant Treasurer who serves as the Chief Financial Officer may serve concurrently as President or ~~Chairman~~Chair of the Board.

Section 5.2 ~~Section 2. Term~~Election of ~~Office~~Officers. The officers of the Corporation, except for the President, shall be elected by the Board of Directors at the annual meeting ~~and~~. The President shall be appointed by the Member, subject to Section 2.2(b)(iii).

Section 5.3 Term of Office. The officers of the Corporation shall hold office for one (1) year ~~and~~ until their successors are chosen and qualified or until such officer is removed or resigns. The term of office of an officer shall begin immediately after such officer's election.

Section 5.4 Removal. The officers of the Corporation, except for the President, may be removed with or without cause by the Board of Directors at any meeting of the Board of Directors. The President may be removed with or without cause by the Member.

Section 5.5 ~~Section 3. Vacancies. Vacancies may be filled for the unexpired term at any regular meeting of the Board of Directors, or at any special meeting called for that purpose.~~Vacancies.

(a) Should a vacancy occur in any office except for the office of President, the Board of Directors may fill the vacancy for the unexpired term at any meeting of the Board of Directors, and the Board of Directors may delegate the powers and duties of such office to any officer or to any Director until such time as a successor for such office has been elected.

(b) Should a vacancy occur in the office of President, the Member shall fill the vacancy for the unexpired term (subject to Section 2.2(b)(iii)), and the Member may delegate the powers and duties of the President to any officer or to any Director until such time as a successor President has been appointed by the Member.

Section 5.6 ~~Section 4. Chairman~~Chair Pro Tempore. In the absence of the ~~Chairman~~Chair and Vice ~~Chairman~~Chair of the Board, or in the event of their inability to act, the Board of Directors may elect a ~~Chairman~~Chair Pro Tempore who shall act as such ~~Chairman~~Chair of the Board during such absence or inability to act.

Section 5.7 ~~Section 5.~~ Secretary Pro Tempore. In the absence of the Secretary and Assistant Secretary, or in the event of their inability to act, the Board of Directors may elect a Secretary Pro Tempore who shall act as such Secretary during such absence or inability to act.

Section 5.8 ~~Section 6.~~ Treasurer Pro Tempore. In the absence of the Treasurer and Assistant Treasurer, or in the event of their inability to act, the Board of Directors may elect a Treasurer Pro Tempore who shall act as such Treasurer during such absence or inability to act.

ARTICLE VI~~ARTICLE VII~~

DUTIES OF THE OFFICERS

Section 6.1 ~~Section 1.~~ Duties. The ~~respective~~Executive Officers shall exercise the usual functions of such ~~Officers~~officers, together with such powers and duties as may from time to time be designated or assigned to them.

Section 6.2 ~~Section 2. Chairman~~Chair of the Board. The ~~Chairman~~Chair of the Board shall be a member of the Board of Directors and shall:

(a) have general direction of the affairs of the Board of Directors ~~of the Association~~ and shall preside at all meetings of the Directors;

(b) sign all corporate instruments in writing, required by law to be signed by such officer and not others, except as directed by resolution of the Board of Directors;

(c) perform such other duties from time to time as directed or authorized by the Board of Directors; and

(d) act as the representative of the Board of Directors in relationships with the President regarding administration of the Hospital.

Section 6.3 ~~Section 3.~~ Vice ~~Chairman~~Chair of the Board. There shall be a Vice ~~Chairman who is a member~~Chair of the Board ~~of Directors~~who is a Director. If at any time the ~~Chairman~~Chair of the Board shall for any reason be unable to perform the duties of ~~his~~such office, or any of them, the Vice ~~Chairman~~Chair of the Board shall perform such duties, and when so acting shall have the power and authority of the ~~Chairman~~Chair of the Board.

Section 6.4 ~~Section 4.~~ President. The President shall be the Chief Executive Officer of the ~~Association~~Corporation. In accordance with the objectives and policies of the ~~Association~~Corporation as established by the Board of Directors, the President shall have full authority and responsibility for the management and operation of Hospital and shall report regularly to the Board of Directors concerning the performance of Hospital. The President shall provide leadership and administrative staff support for the development and execution of objectives, policies, plans and programs adopted by the Board of Directors; coordinate and direct the administration and management of the Hospital through the delegation of authority and management to such one or more other Vice Presidents as the President may designate; ensure competency of the staff; coordinate the continuing planning and long -range development of the Hospital; and provide appropriate continuing administrative support to the Board of Directors, its committees and officers and to the ~~Medical Staff~~medical staff of the Hospital and its committees and officers to ensure appropriate policy and program development and control. In the temporary absence of the President, one of the Vice Presidents will be designated by the President to act on behalf of the President.

Section 6.5 ~~Section 5.~~ Secretary. The Secretary:

(a) shall notify or cause the notification of the Directors of all meetings of the Board of Directors as required by these Bylaws~~,~~ and shall keep or cause to be kept the minutes of all meetings of Directors;

(b) shall sign, as Secretary, all corporate instruments in writing required by law to be signed by such officer and no others, except as directed by resolution of the Board of Directors; and

(c) shall perform such other duties from time to time as directed or authorized by resolution of the Board of Directors.

Section 6.6 ~~Section 6.~~ Assistant Secretary. The Assistant Secretary shall assist the Secretary in ~~his~~the Secretary's general duties, and in the absence of the Secretary shall perform all the duties of said office.

Section 6.7 ~~Section 7.~~ Treasurer. The Treasurer shall perform such duties from time to time as directed or authorized by the Board of Directors.

Section 6.8 ~~Section 8.~~ Assistant Treasurer. The Assistant Treasurer who serves as the Chief Financial Officer, excepting such functions that are by these ~~bylaws~~Bylaws or by the Board of Directors assigned to another, shall exercise the usual functions of that office ~~arid~~and any

other duties that are from time to time prescribed by the Board of Directors. In this regard, and not in any way limiting the description of functions in the preceding sentence, the Chief Financial Officer shall:

(a) keep and maintain, or cause to be kept and maintained, adequate and correct accounts of the properties and business transactions of the ~~Association~~Corporation, including accounts of its assets, liabilities, receipts, disbursements, gains and losses;

(b) cause to be deposited all moneys and other valuables in the name and to the credit of the ~~Association~~Corporation in such depositories as may be designated by the Board of Directors;

(c) disburse or cause to be disbursed the funds of the ~~Association~~Corporation as shall be ordered by the Board of Directors;

(d) render or cause to be rendered to the Chair of the Board and the Board of Directors, whenever they shall request it, an accounting of all transactions as Chief Financial Officer and of the financial condition of the ~~Association;~~Corporation;

(e) submit an annual report as required by ~~Article III,~~ Section ~~6~~12.6 hereof; and

(f) have such other powers and perform such other duties as may be prescribed by the Board of Directors or these Bylaws.

Section 6.9 ~~Section 9.~~ Execution of Checks. All checks, warrants, bills, notes and/or contracts of the ~~Association~~Corporation shall be executed for and on behalf of the ~~Association~~Corporation as provided from time to time by resolution of the Board of Directors.

ARTICLE VII~~ARTICLE VIII~~

COMMITTEES

Section 7.1 ~~Section 1.~~ Committees. The Board of Directors shall determine the number of its committees and their functions~~. The basic purpose of committees is to assist the Board of Directors and thereby better enable the Board to achieve the purpose of the Hospital in serving the community and providing patient care.~~, including any standing committees. A committee that consists exclusively of Directors shall, to the extent provided in a resolution of the Board of Directors or in these Bylaws, have the authority of the Board of Directors, except with respect to powers reserved to the Board of Directors pursuant to Section 5212(c) of the Law. In furtherance of the foregoing, a committee that does not consist exclusively of Directors shall not have any delegated authority of, or ability to make decisions on behalf of, the Board of Directors.

Section 7.2 ~~Section 2.~~ Appointment of Committees. The ~~Chairman~~chair and the members of each committee shall be appointed by the ~~Chairman~~Chair of the Board at the annual meeting, and shall be confirmed by the Board of Directors. Removals or replacements of

committee members may be made in the same manner as original appointments at any regular meeting of the Board of Directors.

~~Section 3. Standing Committees. Standing committees shall consist of, but not be limited to, the following:~~

~~(a) The Community Benefits~~

Section 7.3 Executive Committee. There shall be an executive committee of the Board of Directors (the "**Executive Committee**") consisting only of Directors and consisting of a proportionate number of Cedars-Sinai Directors, Community Directors and Trust Directors. An Executive Committee consisting of one (1) Cedars-Sinai Director, three (3) Trust Directors, one (1) Physician Director, the President of the Corporation and four (4) Community Directors is considered proportionate. Except as otherwise prohibited by law, the Board of Directors, by written resolution, may delegate to the Executive Committee any of the powers and authority of the Board of Directors in the management of the business and affairs of this Corporation, *provided that* the designation of the Executive Committee and the delegation of authority to it shall not operate to relieve the Board of Directors or any Director of any responsibility imposed by law, by the Corporation's Articles of Incorporation or by these Bylaws. The Executive Committee shall have only those powers specifically delegated to it by written resolution of the Board of Directors. The Executive Committee shall establish rules and regulations for its meetings and meet at such times and places as shall be fixed by the Chair of the Board; *provided that* a reasonable notice as required by law shall be given of all meetings of the Executive Committee, and no act of the Executive Committee shall be valid unless approved by the vote of a majority of the members of the Executive Committee present at a meeting at which a quorum is then present; *provided further that* the dissenting opinion of any member of the Executive Committee may be reported to the Board of Directors. The Executive Committee shall keep regular minutes of its proceedings and report the same to the Board of Directors from time to time as the Board of Directors may require. A quorum of the members of the Executive Committee may adjourn any meeting thereof to meet again at a stated day and hour; *provided that* in the absence of a quorum a majority of the Executive Committee members present at any meeting of the Executive Committee may adjourn until the time fixed for the next meeting of the Executive Committee. The Executive Committee shall oversee ~~community outreach activities in conjunction with the community needs biannual plan as mandated by the State of California.~~

~~(b) The Building Committee shall be responsible for reviewing all building projects, including plans and costs. The committee shall make recommendations to the Board of Directors concerning all building projects.~~

~~(c) The Finance Committee shall meet regularly to review the financial affairs of the Association and shall annually review the audit report. The committee shall review monthly and annual financial statements, including budget and equipment schedules and shall make recommendations to the Board of Directors.~~

~~**(d)** The Investment Committee shall meet regularly and will be responsible for administering, reviewing, monitoring and recommending to the Board of Directors a program for the investment of funds of the Association.~~

~~**(e)** The Audit and Compliance Committee shall be responsible for advising and making recommendations to the Board of Directors based on this committee's oversight of the Association's financial reporting process on behalf of the Board, review of the audit program and reports for the Association, and oversight of the Association's Ethics Program, Compliance Program activities and conflict of interest policy. The committee shall make yearly recommendations to the Board concerning the appointment of the auditing firm, the scope of the audit, and approval of all fees for audit and, whenever necessary, termination of the auditors.~~

~~**(f)** The Strategy Committee shall be responsible for developing the strategic plan of Hospital and shall provide oversight of the implementation of the strategic plan which shall include but not be limited to clinical programs, business plans and strategic alliances.~~

~~**(g)** The Compensation Committee shall be responsible to the Board of Directors for overall administration of the compensation programs of the Association, including recommending to the Board of Directors a compensation philosophy and strategy for Executive Management, monitoring competitive compensation levels and practices in comparable organizations in Southern California, providing oversight of benefit programs for Executive Management and for employees of the Association, and establishing and approving salary ranges, increases and annual incentive objectives and awards for Executive Management of the Hospital. While the Board of Directors may grant the authority to the Compensation Committee for establishing executive salaries and awarding incentive payment, the committee will report to the full board the actual salaries and incentives paid.~~

~~**(h)** The Interdisciplinary Practice Committee shall be responsible for overseeing the Board's responsibilities related to Allied Health Professionals.~~

~~**(i)** The Governance Committee shall be responsible for developing and monitoring a set of clear accountabilities and expectations for the Board of Directors. The committee shall also establish and maintain policies for recruitment, orientation, continuing education and evaluation of board members, with the objective of enhancing the overall~~

~~effectiveness of the Board as a whole. The Governance Committee will also serve as the nominating committee for the nomination of officers and persons eligible to serve on the Board of Directors. Additionally, the committee will ensure there is appropriate succession planning for key board and management positions.~~

~~(j) The Quality Committee shall be responsible for advising and making recommendations to the Board of Directors based on this committee's monitoring of all patient safety and quality of care activities within the institution.~~

~~(k) The Special Medical Staff Approval Committee shall be comprised of not less than 2 board members (and only of board members) and be responsible for reviewing recommendations from the Medical Staff with respect to policies and procedures, applicants for membership or privileges and taking action to the maximum extent permitted by law with respect to such recommendations in those months when the Board is not meeting.~~

~~(l) The Philanthropy Committee shall be responsible for oversight of the hospital's fundraising efforts and, specifically, the overall direction of its philanthropic efforts.~~the preparation and modification of long-term strategic and development plans and an annual implementation plan for the Corporation and its Subsidiaries. The Executive Committee may establish such subcommittees as it deems appropriate, which subcommittees shall have such duties and responsibilities as are delegated to them by written resolution of the Executive Committee.

Section 7.4 ~~Section 4.~~ Reports of Committees. Whenever requested by the Board of Directors, each committee shall make a report, oral or written.

Section 7.5 ~~Section 5.~~ Term of Office. The ~~Chair, Vice Chair~~chair, vice chair and each member of each standing committee shall serve until the next annual election of committee members by the Board of Directors and until ~~his or her~~such person's successor is appointed or until such committee is sooner terminated, or until such person is removed, resigns, or otherwise ceases to qualify as a chair or member, as the case may be, of the committee. Chairs, ~~Vice Chairs~~vice chairs and members of special committees shall serve for the life of the committee unless they resign or are sooner removed, replaced~~,~~ or cease to qualify as a ~~Chair~~chair or member, as the case may be, of such committee.

Section 7.6 ~~Section 6.~~ Vacancies. Vacancies on any committee may be filled for the unexpired portion of the term in the same manner as provided in the case of original appointment.

Section 7.7 ~~Section 7.~~ Meetings; Quorum. Each committee shall meet as often as necessary to perform its duties, at such times and places as directed by its ~~Chair~~chair or by the Board of Directors. A majority of the members of a committee shall constitute a quorum of such committee. The chair of each committee shall preside at such committee's meetings; in the absence of the chair, the vice chair will preside at such meetings. Each committee shall keep accurate minutes of its meetings, the chair designating a secretary of the committee for this purpose, and shall, make periodic reports and recommendations to the Board of Directors. Except as otherwise provided in this Article ~~VIII~~VII, meetings of committees shall be governed by, and held and taken in accordance with the following provisions of Article ~~IV~~VI, with such changes in the context therein as are necessary to substitute the committee and its members for the Board of Directors and its members: Section ~~2~~4.2 (Regular Meetings), Section ~~3~~4.3 (Special Meetings), Section ~~4~~4.4 (Notice of Meetings), Section ~~5~~4.5 (Quorum and Actions), Section ~~6~~4.6 (Place of Meetings), Section ~~8~~4.8 (Action Without Meeting), and Section ~~9~~4.9 (Adjournment of Meetings).

Section 7.8 ~~Section 8.~~ Expenditures. Any expenditure of corporation funds by a committee shall require prior approval of the Board of Directors.

ARTICLE VIII~~ARTICLE IX~~

MEDICAL STAFF

Section 8.1 ~~Section 1.~~ Organization and Appointments.

(a) The Board of Directors shall require the physicians, dentists and podiatrists granted practice privileges in the Hospital to organize into a medical and dental staff under Medical and Dental Staff Bylaws approved by the Board of Directors. The Board of Directors shall consider recommendations of the Medical and Dental Staff and appoint to the Medical and Dental Staff physicians, dentists and podiatrists who meet the qualifications for membership as set forth in the Bylaws of the Medical and Dental Staff. Each member of the Medical and Dental Staff shall have appropriate authority and responsibility for the care of ~~his~~their patients subject to such limitations as are contained in these Bylaws and in the Bylaws, rules and regulations for the Medical and Dental Staff and subject, further, to any limitations attached to ~~his~~their appointment.

(b) Rules regarding applications for appointment, term of appointment, renewal of privileges, reduction, suspension or termination of staff membership, or other appropriate rules for the governing of the Medical Staff, shall be contained in Medical Staff Bylaws as approved from time to time by the Board of Directors, which approval shall not be unreasonably withheld.

(c) A physician or dentist in a medical-administrative position, who holds a concurrent appointment on the Medical and Dental Staff, shall not have ~~his~~such physician or dentist's Medical Staff privileges terminated without the same due process provisions as are available to any other member of the Medical and Dental Staff, unless otherwise provided in the terms of a formal agreement covering the individual's engagement.

Section 8.2 ~~Section 2.~~ Medical Care and Its Evaluation.

(a) The Medical and Dental Staff shall conduct a continuing review and appraisal of the quality of professional care rendered in the Hospital~~,~~ and shall report such activities and their results to the Board of Directors.

(b) The Medical and Dental Staff shall make recommendations to the Board of Directors concerning (1) appointments, reappointments, and alterations of staff status, (2) granting of clinical privileges, (3) disciplinary actions, (4) all matters relating to professional competency, and (5) such specific matters as may be referred to it by the Board of Directors.

Section 8.3 ~~Section 3.~~ Medical and Dental Staff Bylaws. There shall be bylaws, rules and regulations for the Medical and Dental Staff setting forth its organization and government and which shall include a mechanism for review of decisions affecting the privileges of members which provides for the exercise of due process. Proposed bylaws, rules and regulations may be recommended by the Medical and Dental Staff, but only those approved by the Board of Directors shall become effective, which approval shall not be unreasonably withheld. Neither the Medical Staff nor the Board of Directors may unilaterally amend the Medical Staff Bylaws or Rules and Regulations.

ARTICLE IX~~ARTICLE X~~

AMENDMENTS

Section 9.1 ~~Section 1. Procedure. These Bylaws may be amended or repealed, or new Bylaws may be adopted, at any meeting of the Board of Directors, by the affirmative vote of a majority of all Directors then in office, provided that the notice of the meeting shall contain the language of the amendment or new Bylaws or the fact of such rescission; or these Bylaws may be amended or repealed, or new Bylaws adopted, without a meeting, by the written consent of all the Directors then in office; provided however, that these Bylaws may not be amended or repealed nor may new Bylaws be adopted, except upon, the affirmative vote of a majority of the Directors who are Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust.~~Procedure. Any amendment, restatement, repeal or replacement of these Bylaws must be adopted in accordance with Section 2.2.

Section 9.2 ~~Section 2.~~ Review. ~~The~~These Bylaws~~ of the Pasadena Hospital Association, Ltd.,~~ shall be reviewed periodically by a committee appointed by the ~~Chairman~~Chair of the Board of Directors with the observations and results of the review reported to the Board of Directors at a regular meeting.

ARTICLE X~~ARTICLE XI~~

AUXILIARY ORGANIZATIONS

There may be established from time to time auxiliary volunteer organizations such as guilds, leagues and women's auxiliaries whose purpose is to assist the Hospital in obtaining its goals through volunteer service, fund raising, public relations and public information programs. All auxiliary organizations associated with the Hospital shall have bylaws which delineate the purpose and functions of the auxiliary organization and such bylaws shall be approved by the

Board of Directors ~~of~~and the ~~Association~~Member. These Bylaws and the Articles of Incorporation of the ~~Association~~Corporation shall prevail and govern over the documents and actions of such ~~adjunct~~auxiliary organizations. To the extent required by the Board of Directors or the President of the Corporation, auxiliary and associated organizations shall provide periodic financial reports to the ~~Association~~Corporation and be carried under a fidelity bond if they handle any funds.

ARTICLE XI~~ARTICLE XII~~

CORPORATE SEAL

~~Section 1. Seal.~~ The corporate seal of the corporation shall be the impression of a circular disc, with the following inscription upon the circumference thereof, to wit: "PASADENA HOSPITAL ASSN., LTD., a corporation" and within the last mentioned inscription, the word "SEAL".

ARTICLE XII~~ARTICLE XIII~~

MISCELLANEOUS

Section 12.1 ~~Section 1.~~ Voting Shares. The ~~Association~~Corporation may vote any and all shares held by it in any other corporation by such officer, agent or proxy as the Board of Directors or President of the Corporation may appoint, or in default of any such appointment, by ~~its~~the Chair of the Board or by ~~its~~the Vice Chair of the Board, and, in such case, such officers, or any of them, may likewise appoint a proxy to vote said shares.

Section 12.2 ~~Section 2.~~ Checks, Drafts, Etc. All checks, drafts or other orders for payment of money, notes or other evidence of indebtedness issued in the name of or payable to the ~~corporation~~Corporation, and any and all securities owned or held by the ~~Association~~Corporation requiring signature for the transfer, shall be signed or endorsed by such person or persons and in such manner as, from time to time, shall be determined by a resolution of the Board of Directors.

Section 12.3 ~~Section 3.~~ Execution of Contracts. ~~The~~Except as otherwise provided in these Bylaws, the Board of Directors or the President~~, except as in these Bylaws otherwise provided,~~ of the Corporation may authorize any officer or officers, agent or agents, to enter into any contract or execute any instrument in the name of and on behalf of the ~~Association~~Corporation, and such authority may be general or confined to specific instances and unless so authorized by the Board of Directors or the President of the Corporation, no officer, agent or employee shall have any power or authority to bind the ~~Association~~Corporation by any contract or engagement or to pledge its credit or to render it liable for any purpose or in any amount.

Section 12.4 ~~Section 4.~~ Conflict of Interest. The Board of Directors shall enforce a policy on conflicts of interest and self-dealing that requires a disclosure by all ~~directors~~Directors and officers of the ~~Association~~Corporation and other persons in a position to influence corporate decisions of actual and potential conflicts of interest and that will assure that no person holding

such a position will be permitted to vote on any issue, motion or resolution that directly or indirectly inures to ~~his or her~~such individual's benefit financially or with respect to which ~~he or she~~such individual shall have any other conflict of interest, except that such individual may be counted in order to qualify a quorum, and, except as the ~~board~~Board of Directors may otherwise direct, may participate in a discussion of such an issue, motion, or resolution if ~~he or she~~such individual first discloses the nature of ~~his or her~~the individual's own interest.

Section 12.5 Confidentiality~~Section 5. Appropriation of Business Opportunity and Confidential Information~~.

~~(a) No director or officer of the Association may appropriate or divert to others any opportunity for profit in connection with a transaction in which it is known or could be anticipated that the Association is or would be interested. Such opportunities include but are not limited to, acquisition of real or personal property, appointment of suppliers, or design or development of new products, services or areas of business related to the corporation's present or planned services or service areas.~~**~~(b)~~** ~~Each director~~ Each Director or officer of the ~~Association~~Corporation with access to confidential information regarding the ~~corporation~~Corporation or the ~~Association~~Corporation's business is expected to hold such information in confidence and to refrain from either using such information for personal gain or disclosing it unnecessarily outside the scope of the ~~director~~Director's or officer's duty with respect to the ~~corporation~~Corporation or the Member.

Section 12.6 Records and Annual Report. The Corporation shall keep adequate and correct books and records of account and minutes of the proceedings of its Board of Directors and committees of the Board of Directors. The Board of Directors shall cause an annual report to be sent to all Directors of the Corporation not later than one hundred twenty (120) days after the close of the Corporation's fiscal year. Such report shall contain in appropriate detail the following:

(a) The assets and liabilities, including the trust funds, of the Corporation as of the end of the fiscal year.

(b) The principal changes in assets and liabilities, including trust funds, during the fiscal year.

(c) The revenue or receipts of the Corporation, both unrestricted and restricted to particular purposes, for the fiscal year.

(d) The expenses or disbursements of the Corporation, for both general and restricted purposes, during the fiscal year.

(e) Any information required by Section 6322 of the California Corporations Code.

Any financial statements presented as part of the above-described report shall be prepared in accordance with generally accepted accounting principles and be audited by an independent certified public accountant in conformity with generally accepted auditing standards.

Section 12.7 ~~Section 6.~~ Fiscal Year. The fiscal or business year of the ~~Association~~Corporation shall be ~~the calendar year.~~as determined by approval of the Board of Directors.

CERTIFICATE

I, ~~Lois Starke Matthews~~_____, the Secretary of Pasadena Hospital Association, Ltd., a California nonprofit public benefit corporation, do hereby certify that the Bylaws attached hereto constitute the Bylaws of said corporation as adopted by its Board of Directors on the ~~23~~____ day of ~~October, 2014.~~_____, ____.

By: ____
~~Lois Starke Matthews~~

Document comparison by Workshare 9.5 on Monday, June 29, 2020 12:11:14 PM

Input:	
Document 1 ID	file://C:\Users\noyek\AppData\Local\Temp\Workshare\wmtemp36bc\PHA Bylaws (compiled).docx
Description	PHA Bylaws (compiled)
Document 2 ID	file://C:\Users\noyek\AppData\Local\Temp\Workshare\wmtemp36bc\Rose - PHA A&R Bylaws2.docx
Description	Rose - PHA A&R Bylaws2
Rendering set	Standard

Legend:	
Insertion	
~~Deletion~~	
~~Moved from~~	
Moved to	
Style change	
Format change	
~~Moved deletion~~	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
	Count
Insertions	583
Deletions	273
Moved from	18
Moved to	18
Style change	0
Format changed	0
Total changes	892

AMENDED AND RESTATED ARTICLES OF INCORPORATION

OF

CEDARS-SINAI HEALTH SYSTEM

THE UNDERSIGNED CERTIFY THAT:

1. ~~1.~~ They are the President and Secretary, respectively, of Cedars-Sinai Health System, a California nonprofit public benefit corporation (this "Corporation").

2. ~~2.~~ The Articles of Incorporation of this Corporation are amended and restated to read as follows:

~~ARTICLE I~~

ARTICLE I

The name of this corporation is CEDARS-SINAI HEALTH SYSTEM.

~~ARTICLE II~~

ARTICLE II

A. ~~A.~~ This corporation is a nonprofit public benefit corporation and is not organized for the private gain of any person. It is organized under the Nonprofit Public Benefit Corporation Law for charitable purposes.

B. ~~B.~~ This corporation is organized and operated exclusively for charitable, scientific and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended , or the corresponding provision of any future United States internal revenue law (the "Code"). Specifically, this corporation shall be organized, and at all times operated, exclusively for the benefit of, to perform the functions of, or to carry out the purposes of, and to support: (i) Cedars-Sinai Medical Center, a California nonprofit public benefit corporation; ~~and~~ (ii) Torrance Memorial Medical Center, a California nonprofit public benefit corporation; and (iii) Pasadena Hospital Association, Ltd., a California nonprofit public benefit corporation doing business as Huntington Hospital (collectively, the "Named ~~Member~~Affiliate Hospital Organizations"), which are nonprofit health care organizations organized for the purpose of establishing, maintaining, sponsoring and promoting

activities relating to the improvement of human health and well-being, though only as long as that Named ~~Member~~Affiliate Hospital Organization is exempt from Federal income taxation under Section 501(c)(3) of the Code and classified as other than a private foundation pursuant to Section 509(a)(1) or 509(a)(2) of the Code. In support and in furtherance of the charitable purposes of the Named ~~Member~~Affiliate Hospital Organizations, the corporation may: (i) establish, maintain, sponsor and promote activities relating to the improvement of human health and the provision of care to the sick, injured or disabled; (ii) establish, maintain, sponsor and promote educational and research programs relating to the promotion of health and the provision of care to the sick, injured or disabled; (iii) coordinate, sponsor, promote and advance programs and activities designed and carried on to improve the physical, psychological and emotional health and welfare of persons living in and around the territory which it serves; (iv) provide management support and direction to those specified nonprofit corporations that this corporation was organized to support; (v) evaluate, develop and implement long-range health care objectives, strategies, plans, and alternative health care delivery systems, in furtherance of the purposes of this corporation and the purposes of those nonprofit health care organizations that this corporation was organized to support; (vi) otherwise function as a functionally integrated parent organization of the Named ~~Member~~Affiliate Hospital Organizations, within the meaning of the applicable regulations promulgated under the Code; and (vii) carry out such other acts and undertake such other activities as may be necessary, appropriate or desirable in furtherance of or in connection with the conduct, promotion or attainment of the foregoing purposes, provided that none of such activities shall be undertaken that would cause this corporation to lose its status as an organization described in Section ~~501~~501(c)(3) of the Code, or as a supporting organization within the meaning of Section 509(a)(3) of the Code.~~ARTICLE III~~

ARTICLE III

A. ~~A.~~ No substantial part of the activities of this corporation shall consist of carrying on propaganda, or otherwise attempting to influence legislation, and this corporation shall not participate or intervene in any political campaign (including the publishing or distribution of statements) on behalf of or in opposition to any candidate for public office.

B. ~~B.~~ Notwithstanding any other provision of these articles, this corporation shall not, except to an insubstantial degree, engage in any activities or exercise any powers that are not in furtherance of the purposes of this corporation as stated herein, and this corporation shall not carry on any other activities not permitted to be carried on: (i) by a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (ii) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

~~ARTICLE IV~~

ARTICLE IV~~A.~~

A. This corporation shall not have members.

B. ~~B.~~ The powers of this corporation shall be exercised, its properties controlled, and its affairs conducted by the corporation~~'~~'s board of directors as provided in the bylaws of this corporation.

~~ARTICLE V~~

ARTICLE V

A. ~~A.~~ The property of this corporation is irrevocably dedicated to charitable purposes. No part of the net income or assets of this corporation shall ever inure to the benefit of any director or officer thereof, or to the benefit of any other private person.

B. ~~B.~~ Upon the dissolution or winding up of this corporation, its assets remaining after payment, or provision for payment, of all debts and liabilities of this corporation shall be distributed to the Named ~~Member~~Affiliate Hospital Organizations. If, at the time of the dissolution or winding up of this corporation, the Named ~~Member~~Affiliate Hospital Organizations are not organizations which are organized and operated exclusively for charitable purposes which at such time have established their tax-exempt status under Section 501(~~0~~c)(3) of the Code, then upon the dissolution or winding up of this corporation, its assets remaining after payment, or provision for payment, of all debts and liabilities of this corporation shall be distributed to an organization which is organized and operated exclusively for charitable

purposes which at such time has established its tax-exempt status under Section 501(c)(3) of the Code.

ARTICLE VI

These Amended and Restated Articles of Incorporation may only be amended or restated as provided in the Bylaws of this corporation.

3. ~~3.~~ The foregoing Amended and Restated Articles of Incorporation of this Corporation have been duly approved by the required vote of the board of directors of this Corporation.

4. ~~4.~~ The Corporation has no members.

5. ~~5.~~ The foregoing Amended and Restated Articles of Incorporation of this Corporation shall be effective as of ~~February 1, 2018.~~[_____, 20__].

[Remainder of page intentionally left blank]

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this certificate are true and correct of our knowledge:

~~Dated: January 31,2018~~

~~Thomas M. Priselac, President~~

~~Edward Prunchunas, Secretary~~

Dated: [_____, 20__]

_____
Thomas M. Priselac, President

_____
Greg Geiger, Secretary

Document comparison by Workshare 9.5 on Thursday, July 02, 2020 6:06:57 PM

Input:	
Document 1 ID	file://C:\Users\noyek\AppData\Local\Temp\Workshare\wmtemp3ca8\CSHS Current Articles.docx
Description	CSHS Current Articles
Document 2 ID	file://C:\Users\noyek\AppData\Local\Temp\Workshare\wmtemp3ca8\Rose - CSHS A&R Articles.docx
Description	Rose - CSHS A&R Articles
Rendering set	Standard

Legend:	
Insertion	
~~Deletion~~	
~~Moved from~~	
Moved to	
Style change	
Format change	
~~Moved deletion~~	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
	Count
Insertions	47
Deletions	38
Moved from	0
Moved to	0
Style change	0
Format changed	0
Total changes	85

AMENDED AND RESTATED BYLAWS

OF

CEDARS-SINAI HEALTH SYSTEM

TABLE OF CONTENTS

Page

ARTICLE I HEALTH SYSTEM PARENT ENTITY 1

Section 1.1 Corporate Name; Preamble 1
Section 1.2 Purposes 1
Section 1.3 Location 1
Section 1.4 Members 1

ARTICLE II BOARD OF DIRECTORS ~~1~~2

Section 2.1 Powers ~~1~~2
Section 2.2 Numbers 4
Section 2.3 Qualifications of Directors 5
Section 2.4 Term of Office 5
Section 2.5 Election of Directors 5
Section 2.6 Vacancies 6
Section 2.7 Board Orientation 6
Section 2.8 Quorum of Board of Directors; Adjournment 6
Section 2.9 Annual Meeting of the Board ~~6~~7
Section 2.10 Regular Meetings of the Board ~~6~~7
Section 2.11 Special Meetings of the Board ~~6~~7
Section 2.12 Written Notice of Meetings 7
Section 2.13 Failure to Attend Meetings ~~7~~8
Section 2.14 Telephonic Meetings ~~7~~8
Section 2.15 Action by Written Consent ~~7~~8
Section 2.16 Retirement from Board Membership 8
Section 2.17 Conflict of Interest Policies 8
Section 2.18 Emergency Powers ~~8~~9

ARTICLE III MEETINGS OF THE BOARD 10

Section 3.1 Annual Meetings of the Board 10
Section 3.2 Vote 10

ARTICLE IV OFFICERS OF HEALTH SYSTEM PARENT ENTITY 10

Section 4.1 Enumeration of Officers 10
Section 4.2 Election of Officers 10
Section 4.3 Removal, Appointment and Term ~~10~~11
Section 4.4 Powers and Duties of Officers 11
Section 4.5 Compensation of Employees ~~13~~14

ARTICLE V BOARD COMMITTEES ~~13~~14

Section 5.1 Creation of Committees; Function ~~13~~14
Section 5.2 Board Committees 14
Section 5.3 Vacancies in Board Committees; Removal 14

TABLE OF CONTENTS
(continued)

Page

Section 5.4 ~~Audit and Finance Committee~~ ~~14~~
~~Section 5.5 Quality Committee~~ ~~14~~
~~Section 5.6~~ Written Consent 14

ARTICLE VI FISCAL PROVISIONS ~~14~~15

Section 6.1 Fiscal Year ~~14~~15
Section 6.2 Withdrawal of Funds ~~14~~15
Section 6.3 Deposit of Securities ~~14~~15
Section 6.4 Transfer of Securities 15
Section 6.5 Financial Records 15
Section 6.6 Inspection 15
Section 6.7 No Proprietary Interest 15

ARTICLE VII INDEMNIFICATION ~~15~~16

Section 7.1 Indemnity of Officers and Directors ~~15~~16
Section 7.2 Employees and Agents 16
Section 7.3 Insurance 16

ARTICLE VIII AMENDMENT AND REPEAL OF BYLAWS ~~16~~17

Section 8.1 General Provisions ~~16~~17

CERTIFICATE OF SECRETARY ~~17~~18

AMENDED AND RESTATED BYLAWS

OF

CEDARS-SINAI HEALTH SYSTEM

ARTICLE I
Health System Parent Entity

Section 1.1 Corporate Name; Preamble. The name of the corporation shall be Cedars-Sinai Health System (the "Health System Parent Entity"). The Health System Parent Entity is a nonprofit public benefit corporation organized and existing under the laws of the State of California. These Amended and Restated Bylaws of the Health System Parent Entity ("Bylaws") are adopted as of ~~February 1, 2018~~[_____, 20__] (the "Effective Date") for the purpose of providing for the governance of the Health System Parent Entity.

Section 1.2 Purposes. The Health System Parent Entity's purposes shall at all times be as set forth in the Articles of Incorporation of the Health System Parent Entity (the "Articles of Incorporation"), which provide that the Health System Parent Entity shall be organized, and at all times operated, exclusively for the benefit of, to perform the functions of, or to carry out the purposes of, and to support certain specified nonprofit health care organizations organized for the purpose of establishing, maintaining, sponsoring and promoting activities relating to the improvement of human health and well-being including the provision of clinical health care services, engaging in community benefit activities and undertaking health care research and professional education, which organizations are exempt from Federal income taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or the corresponding provision of any future United States Internal Revenue law (the "Code") and which are exempt from classification as a private foundation pursuant to Section 509(a)(1) or 509(a)(2) of the Code. The named organizations set forth in the Articles of Incorporation as of the Effective Date are: (i) Cedars-Sinai Medical Center, a California nonprofit public benefit corporation ("CSMC"), ~~and~~ (ii) Torrance Memorial Medical Center, a California nonprofit public benefit corporation ("TMMC"), and (iii) Pasadena Hospital Association, Ltd., a California nonprofit public benefit corporation doing business as Huntington Hospital ("Huntington"). Torrance Health Association, Inc., a California nonprofit public benefit corporation ("THA"), is the sole corporate member of TMMC. CSMC, THA and ~~THA~~Huntington shall be referred to herein as the "~~Member~~Affiliate Hospital Organizations".

Section 1.3 Location. The principal office of the Health System Parent Entity shall be located at 8700 Beverly Boulevard, Suite #2622, Los Angeles, CA 90048. The Health System Parent Entity may also have offices at such other locations both within and without of the State of California as the Board of Directors may from time to time determine or as the business of the Health System Parent Entity may require.

Section 1.4 Members. The Health System Parent Entity shall have no members.

ARTICLE II
Board of Directors

Section 2.1 Powers.

(a) General Powers of the Board. The powers of the Health System Parent Entity shall be exercised, its property controlled, and its affairs conducted by the Board of Directors. Additionally, the Board of Directors shall exercise those powers reserved to the Health System Parent Entity as identified in the governing documents of the ~~Member~~Affiliate Hospital Organizations.

(b) Approval of Certain Actions by Board. The following actions shall only be taken by the Health System Parent Entity upon affirmative vote of a majority of the Board of Directors:

(i) Establish or consummate a transaction that results in a Change of Control (as defined below) of the Health System Parent Entity;

(ii) Adopt, repeal, modify, amend or restate the Health System Parent Entity's Articles of Incorporation or Bylaws;

(iii) Remove individuals from the Board of Directors of the Health System Parent Entity with or without cause;

(iv) Elect to voluntarily dissolve the Health System Parent Entity;

(v) Change the name of the Health System Parent Entity;

(vi) Establish the mission, vision and values of the Health System Parent Entity, or make any change thereto;

(vii) Change the corporate structure of the Health System Parent Entity if such change would affect the Health System Parent Entity's status as an exempt organization under Section 501(c)(3) of the Code;

(viii) Add a new entity as ~~a Member~~an Affiliate Hospital Organization;

(ix) Elect individuals to the Board of Directors who are nominated in accordance with Section 2.5;

(x) Elect, renew or remove the Health System Parent Entity CEO;

(xi) Approve the Health System Parent Entity's strategic plans, capital budgets and operating budgets;

(xii) Adopt a charity care policy for the Health System Parent Entity or make any change or modification thereto;

(xiii) Select the independent auditor that will serve as auditor for the Health System Parent Entity and the ~~Member~~Affiliate Hospital Organizations and their Affiliates; and

(xiv) Form an obligated group amongst the Health System Parent Entity and the ~~Member Organizations, subject to the terms of that certain Affiliation Agreement entered into by and between the Health System Parent Entity and THA dated June 5, 2017 (as amended, the "Affiliation Agreement")~~Affiliate Hospital Organizations.

For the purposes of these Bylaws, "Change of Control" means: (a) any transaction or series of related transactions of an entity (including, without limitation, merger or consolidation, sale, transfer or other disposition of equity, amendment to the articles of incorporation or bylaws or other applicable governing documents of such entity or other contract or arrangement) that results in another entity becoming the beneficial owner of more than fifty percent (50%) of the voting ownership interests of such entity, (b) the sale, lease, transfer, exchange, disposition or change in use of all or substantially all of the property and assets of an entity, (c) the substitution of a new corporate member or members that transfers the control of, responsibility for, or governance of the entity; or (d) a joint venture, management arrangement or similar transaction by an entity with another entity that results in the other entity becoming the owner, operator or manager of all or substantially all of the assets of the entity.

For purposes of these Bylaws, an "Affiliate" of ~~a Member~~an Affiliate Hospital Organization means an entity that, directly or indirectly through one or more intermediaries, is controlled by the ~~Member~~Affiliate Hospital Organization. For purposes of this definition, "control" means the power or possession of the power, direct or indirect, to direct or cause the direction of the management and policies of an entity, whether through the ownership of securities, election or appointment of directors, by contract or otherwise. Without limiting the generality of the foregoing, "Affiliate" shall include those entities of which ~~a Member~~an Affiliate Hospital Organization is a corporate member and those entities in which ~~a Member~~an Affiliate Hospital Organization own at least fifty-one percent (51%) of the voting securities.

(c) Approval of Certain Actions of ~~a Member~~an Affiliate Hospital Organization. The following actions shall only be taken by the Health System Parent Entity with respect to ~~a Member~~an Affiliate Hospital Organization upon affirmative vote of a majority of the Board of Directors, subject to the approval rights set forth in ~~a Member~~an Affiliate Hospital Organization's organizational documents:

(i) Adopt, repeal, modify, amend or restate the ~~Articles of Incorporation, Bylaws~~articles of incorporation, bylaws or other governing documents, as applicable, of ~~a Member~~an Affiliate Hospital Organization or any of its Affiliates~~, subject to the terms of the Affiliation Agreement~~;

(ii) Elect individuals to the Board of Directors of ~~a Member~~an Affiliate Hospital Organization in accordance with the nomination and election process set forth in the ~~Member~~Affiliate Hospital Organization's Bylaws;

(iii) Transfer non-cash assets from ~~a Member~~an Affiliate Hospital Organization or any of its Affiliates to the Health System Parent Entity~~, subject to the terms of the Affiliation Agreement~~;

(iv) Remove individuals from the Board of Directors of the ~~Member~~Affiliate Hospital Organization with or without cause;

(v) Establish or consummate a transaction that results in a Change of Control of ~~a Member~~an Affiliate Hospital Organization or any of its Affiliates;

(vi) Change the mission, vision and values of the ~~Member~~Affiliate Hospital Organization or any of its Affiliates;

(vii) Change the corporate structure of the ~~Member~~Affiliate Hospital Organization or any of its Affiliates if such change would affect the ~~Member~~Affiliate Hospital Organization's or its Affiliate's status as an exempt organization under Section 501(c)(3) of the Code;

(viii) Elect to voluntarily dissolve the ~~Member~~Affiliate Hospital Organization or any of its Affiliates;

(ix) Change the name of the ~~Member~~Affiliate Hospital Organization or a licensed hospital owned and operated by the ~~Member~~Affiliate Hospital Organization or any of its Affiliates;

(x) Sell any real property owned by ~~a Member~~an Affiliate Hospital Organization or any of its Affiliates;

(xi) Approve ~~a Member~~an Affiliate Hospital Organization's strategic plans, capital budgets and operating budgets; and

(xii) Approve the incurrence of debt or lending of money in material amounts by the ~~Member~~Affiliate Hospital Organization or any of its Affiliates~~, as described in the Affiliation Agreement;~~.

Section 2.2 Numbers. The Board of Directors shall consist of not less than twelve (12) persons and no more than eighteen (18) persons. The exact number of authorized Directors shall be fixed from time to time, within said range, by resolution of the Board of Directors. As of the Effective Date, the Board shall consist of ~~twelve~~fifteen (~~12~~15) Directors, including President/Chief Executive Officer ("CEO"), who shall serve as an ex-officio voting member, and ~~eleven~~fourteen (~~11~~14) additional Directors, eight (8) of whom shall be nominated by CSMC (the "CSMC Directors"), three (3) of whom shall be nominated by THA (the "THA Directors"), and three (3) of whom shall be nominated by ~~THA~~Huntington (the "~~THA~~Huntington Directors").

(a) CSMC, THA and ~~THA~~Huntington Representatives. At all times: (i) at least one (1) member of the Board of Directors shall be a director or officer of CSMC, ~~and~~ (ii) at

least one (1) member of the Board of Directors shall be a director or officer of THA, and (iii) at least one (1) member of the Board of Directors shall be a director or officer of Huntington.

(b) Notwithstanding any change that may occur in the future to the number of Directors and/or composition of the Board, CSMC shall at all times have the right to nominate at least a majority of the total number of Directors serving on the Board at any given time.

(c) Notwithstanding any increase that may occur in the future to the number of Directors and/or composition of the Board, THA shall at all times have the right to: (i) nominate at least ten percent (10%) of the total number of Directors serving on the Board at any given time, and (ii) approve any change to these Bylaws that results in CSMC and THA, in the aggregate, not having the right to nominate at least a majority of the total number of Directors serving on the Board at any given time. ~~Additionally, the number of THA Directors shall not be less than three (3) unless the Articles of Incorporation and Bylaws of the Health System Parent Entity are amended to include an entity in addition to CSMC and THA as a Member Organization.~~

(d) Notwithstanding any increase that may occur in the future to the number of Directors and/or composition of the Board, Huntington shall at all times have the right to nominate at least ten percent (10%) of the total number of Directors serving on the Board at any given time.

Section 2.3 Qualifications of Directors. Members of the Board of Directors ("Directors") shall be individuals who have demonstrated leadership, civic interest and community involvement; have exhibited an awareness of and interest in the provision of health care services, educational or research activities; and have the ability to contribute to the appropriate governance of the Health System Parent Entity. Additionally, the individual Directors should at all times have complementary and diverse skill sets, backgrounds and experiences to contribute to Board effectiveness.

Section 2.4 Term of Office. At each annual meeting of the Board, Directors shall be elected to fill the expiring terms of office and any other vacancies on the Board which have not been previously filled. Vacancies on the Board may remain unfilled at the discretion of the Board; provided, however, the Board shall not leave a vacancy unfilled if doing so would result in the Board being comprised of fewer Directors than as of the Effective Date. Except as expressly set forth herein, persons elected as Directors at each annual meeting of the Board may be elected to serve for a one (1) or two (2) year term. As used in these Bylaws, the expression "year" means the period from the annual meeting of the Board at which a Director is elected to the next succeeding annual meeting of the Board. The exceptions to this provision relate to the CEO, who shall serve as a member of the Board of Directors as long as he or she holds office.

Section 2.5 Election of Directors. At least fifteen (15) days before each annual meeting of the Board of the Health System Parent Entity: (i) CSMC shall select a list of nominees to fill the offices of the CSMC Directors whose terms will expire and such other vacancies of CSMC Directors which have not been previously filled, subject to the discretion of the Board to retain vacancies, ~~and~~ (ii) THA shall select a list of nominees to fill the offices of the THA Directors whose terms will expire and such other vacancies of THA Directors which

have not been previously filled, subject to the discretion of the Board to retain vacancies, and (iii) Huntington shall select a list of nominees to fill the offices of the Huntington Directors whose terms will expire and such other vacancies of Huntington Directors which have not been previously filled, subject to the discretion of the Board to retain vacancies. Notwithstanding the foregoing, the Board may not: (i) retain a vacancy of a THA Director without the approval of THA, ~~or~~ (ii) retain a vacancy of a CSMC Director without the approval of CSMC~~. CSMC and THA~~, or (iii) retain a vacancy of a Huntington Director without the approval of Huntington. CSMC, THA and Huntington shall file with the Secretary of the Health System Parent Entity a written list of such nominees. At least three (3) business days before the date of such meeting, the Secretary shall send notice of the names of the nominees to each member of the Board of Directors. The term "business days" means Monday through Friday, unless one of those days is a legal holiday as defined under California law.

(a) Nomination a Prerequisite to Election. No person shall be eligible for election as a Director at an annual meeting of the Board unless he or she has been nominated by CSMC, THA or ~~THA~~Huntington, as applicable, in the manner provided for in this Section 2.5, except that at any time before the annual meeting of the Board, if by reason of the death, declination or incapacity of any nominee, the number of nominees remaining is less than the number of Directors to be elected, nominations to supply such deficiency may be made by CSMC, THA or ~~THA~~Huntington, as applicable, at, or any time before, the annual meeting.

(b) Vote Required for Election. The nominees receiving a majority vote at such annual meeting of the Board shall be declared elected. If, at the annual meeting of the Board, the Board fails to elect any of the individuals nominated by CSMC ~~or THA, CSMC and/or THA, as applicable,~~, then the Health System Parent Entity shall promptly notify CSMC, CSMC shall promptly propose alternative nominees for election by the Board, and thereafter a special meeting of the Board shall promptly be called for the purpose of voting on the election of such alternative nominees. If, at the annual meeting of the Board, the Board fails to elect any of the individuals nominated by THA, then the Health System Parent Entity shall promptly notify THA, THA shall promptly propose alternative nominees for election by the Board, and thereafter a special meeting of the Board shall promptly be called for the purpose of voting on the election of such alternative nominees. If, at the annual meeting of the Board, the Board fails to elect any of the individuals nominated by Huntington, then the Health System Parent Entity shall promptly notify Huntington, Huntington shall promptly propose alternative nominees for election by the Board, and thereafter a special meeting of the Board shall promptly be called for the purpose of voting on the election of such alternative nominees. The process set forth in the foregoing sentence shall continue until such time as the Board has elected individuals to fill the offices of all Directors with expiring terms.

Section 2.6 Vacancies. Vacancies occurring in the Board of Directors from time to time shall be filled in accordance with Section 2.5. Each Director elected to fill a vacancy shall hold office for the unexpired term of such Director's predecessor.

Section 2.7 Board Orientation. The Board will require each newly elected member of the Board of Directors to participate in an orientation program designed to enhance that Director's understanding of the Director's new responsibilities.

Section 2.8 Quorum of Board of Directors; Adjournment.

(a) A majority of the actual number of Directors shall constitute a quorum for any meeting of the Board, provided that at least seven (7) CSMC Directors are in attendance at such meeting.

(b) If a quorum is not present at any meeting of the Board, such meeting may be adjourned from time to time until a quorum shall be obtained. Each such adjournment, and the reason therefore, shall be recorded in the minutes of the Health System Parent Entity.

(c) Every act or decision done or made by a majority of the Directors present at a meeting duly held at which a quorum is present shall be regarded as the act of the Board of Directors, unless a greater or different number be required by law, by the Articles of Incorporation, or by another provision of these Bylaws.

(d) A majority of the Directors present, whether or not a quorum is present, may adjourn any meeting to another time and place. If the meeting is adjourned to a different calendar date, notice of an adjournment to another time and place shall be given prior to the time of the adjourned meeting to the Directors who were not present at the time of the adjournment in accordance with the notice procedure set forth in Section 2.12.

Section 2.9 Annual Meeting of the Board. An annual meeting of the incumbent Board of Directors shall be held as provided by Section 3.1 for the election of Directors for the succeeding year. At this meeting, in addition to any other business of the Health System Parent Entity, the officers of the Health System Parent Entity shall be elected.

Section 2.10 Regular Meetings of the Board. In addition to the annual meeting of the Board of Directors, the Board of Directors shall hold at least three (3) regular meetings of the Board of Directors per year at the time and place fixed by the Board of Directors.

Section 2.11 Special Meetings of the Board. On call of either the Chairperson of the Board of Directors or ~~one-third (1~~two-thirds (2/3) of the members of the Board of Directors then in office, a special meeting of the Board may be held at a time and place designated in the call.

Section 2.12 Written Notice of Meetings. The Secretary shall give notice of each regular or special meeting to each member of the Board of Directors by any of the following means:

(a) In person at least forty-eight (48) hours prior to the time designated for the holding of the meeting;

(b) Electronically directed to the electronic address of a Director as set forth in the books and records of the Health System Parent Entity, sent at least forty-eight (48) hours prior to the time designated for the holding of the meeting; or

(c) By written notice directed to the address of the Director as it appears on the books and records of the Health System Parent Entity and deposited in the United States mail

in the County of Los Angeles at least four (4) calendar days prior to the time designated for the holding of the meeting.

(d) Any notice of a special meeting of the Board of Directors shall specify the primary purpose therefor.

(e) Any Director shall be deemed to have waived the requirement of a formal notice of a meeting of the Board of Directors when he or she:

(i) Does so in writing either before, at or after the meeting;

(ii) Participates in or attends such meeting; or

(iii) Ratifies or approves in writing such action (and such assent is recorded in the minutes).

Section 2.13 Failure to Attend Meetings. The Board of Directors may declare vacant the office of a Director who does not attend annually at least fifty percent (50%) of the regular meetings of the Board or any committee of the Board to which such individual has been duly elected or appointed, held in the respective calendar year, or grant any Director a leave of absence for any period of time upon the affirmative vote of a majority of the remaining Directors.

Section 2.14 Telephonic Meetings. Directors are encouraged to attend meetings in person. In certain circumstances, with the approval of the Chairperson of the Board and, if applicable, the Chairperson of the relevant Board Committee, members of the Board or members of any such Board Committee may participate in meetings through the use of conference telephone or similar communications equipment, so long as all members participating in such meeting can hear one another. Participation in a meeting by these means constitutes presence in person at such meeting.

Section 2.15 Action by Written Consent. Except as otherwise provided in these Bylaws, any action required or permitted to be taken by the Board of Directors under any provision of law or by these Bylaws may be taken without a meeting if all members of the Board shall individually or collectively consent in writing to such action. Such written consent shall be filed with the Board minutes. Such action by written consent shall have the same force and effect as a unanimous vote of the Board of Directors. Any certificate or other document filed under this Section which relates to an action so taken shall state that the action was taken by unanimous written consent of the Board of Directors without a meeting, and that the Bylaws authorize the Directors to so act, and such statement shall be prima facie evidence of such authority.

Section 2.16 Retirement from Board Membership. Except as otherwise provided in this Article II, individuals shall be eligible to serve as members of the Board of Directors until the annual meeting of the Board next succeeding such individual's seventy-second (72nd) birthday. For purposes of these Bylaws, the retirement age for Board members shall be as set forth in this Section 2.16. Members of the Board of Directors who reach retirement age during the first year of election to a two (2) year term shall serve as a member of the Board only until the annual Board meeting next succeeding such individual's retirement age and not beyond that date.

Section 2.17 Conflict of Interest Policies. The Board shall establish and adopt for the Health System Parent Entity policies and procedures for determining when an actual or potential conflict of interest exists, addressing all such conflicts of interest, and ensuring appropriate remedies for failure to comply with said policies. All members of the Board shall annually complete an accurate Conflict of Interest Questionnaire consistent with the Health System Parent Entity's Conflict of Interest Policy from time to time in effect. Any Board member who fails to return the required Conflict of Interest Questionnaire within sixty (60) days of the date it is sent to such Board member may be removed from Board membership. Individuals who are not members of the Board but who are otherwise required to return a complete and accurate Conflict of Interest Questionnaire as "Covered Individuals" under the Board-approved Conflict of Interest policies shall be removed by the Board of Directors from Board Committees, research responsibilities or key administrative positions (as the case may be) for failure to return the Conflict of Interest Questionnaire within sixty (60) days of the date it is sent to such Covered Individual, subject to the provisions of the relevant policies. Nothing contained herein shall alter the requirement that conflicts of interest be disclosed in writing more frequently than annually should one arise between the dates that the annual Conflict of Interest Questionnaire is required to be completed.

Section 2.18 Emergency Powers.

(a) "Emergency" is defined as any of the following events or circumstances as a result of which, and only so long as, a quorum of the Board of Directors cannot be readily convened for action:

(i) A natural catastrophe, including, but not limited to, a hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought, or regardless of cause, any fire, flood, or explosion;

(ii) An attack on the State of California or the nation by an enemy of the United States of America, or upon receipt by the State of California of a warning from the federal government indicating that an enemy attack is probable or imminent;

(iii) An act of terrorism or other man-made disaster that results in extraordinary levels of casualties or damage or disruption severely affecting the infrastructure, environment, economy, government functions, or population, including, but not limited to, mass evacuations.

(iv) A state of emergency proclaimed by the Governor of the State of California or by the President of the United States of America which impacts the Cedars-Sinai Health System, its property, officers or activities or its surroundings.

(b) In anticipation of or during an Emergency, the Board of Directors may take either or both of the following actions necessary to conduct the Health System Parent Entity's ordinary business operations and affairs:

(i) Modify lines of succession to accommodate the incapacity of any director, officer, employee, or agent resulting from the Emergency.

(ii) Relocate the principal office, designate alternative principal offices or regional offices, or authorize the officers to do so.

(c) During an Emergency, the Board of Directors may give notice to a Director in any practicable manner under the circumstances, including but not limited to, by publication and radio, when notice of a meeting of the Board of Directors cannot be given to that Director in the manner otherwise prescribed by these Bylaws.

(d) In the event of an Emergency, a quorum of the Board shall be reduced to a minimum number of seven (7) Directors, provided that at least four (4) CSMC Directors are in attendance at such meeting. Notwithstanding Section 2.8(c), every act or decision done or made by the Board at a Board meeting that is held during an Emergency shall require the affirmative vote of all of the CSMC Directors in attendance at such Board meeting.

(e) Notwithstanding anything in these Bylaws to the contrary, the Board of Directors may not, in anticipation of or during an Emergency, take any action that is not in the Health System Parent Entity's ordinary course of business, unless the required vote of the Board of Directors was obtained prior to the Emergency.

(f) Those Directors representing a quorum of the Board during an Emergency shall use their best efforts to report what actions they have taken during the Emergency to the full Board within a reasonable time period after the Emergency has ended.

(g) Any actions taken in good faith in anticipation of or during an Emergency under this Section 2.18 shall bind the Health System Parent Entity and may not be used to impose liability on a director, officer, employee or agent of the Health System Parent Entity.

(h) All other provisions of these Bylaws consistent with the provisions in this Section 2.18 shall remain in full force and effect during the Emergency. The provisions of this Section 2.18 shall cease to apply once the Emergency has been reasonably deemed ended.

ARTICLE III
Meetings of the Board

Section 3.1 Annual Meetings of the Board. The annual meeting of the Board of Directors shall be held at such place and time as may be determined by the Board.

Section 3.2 Vote. Each member of the Board of Directors shall have one (1) vote in any action voted upon by the Board or a Board Committee to which such member is appointed. Votes may be cast only by members in attendance at a meeting except as provided in Sections 2.14 and 2.15. Votes may not be cast by proxy.

ARTICLE IV
Officers of Health System Parent Entity

Section 4.1 Enumeration of Officers. The officers of the Health System Parent Entity shall be: Chairperson of the Board of Directors (the "Chairperson"), Vice-Chairperson of the Board of Directors (the "Vice Chairperson"), the CEO, Treasurer, Secretary, and such other officers as may be elected or appointed in accordance with Sections 4.2 and 4.3, as the case may be.

Section 4.2 Election of Officers.

(a) Election to these offices of the Chairperson, Vice-Chairperson, CEO, Treasurer and Secretary shall occur at the annual meeting of the Board by a majority vote of the ~~Board~~total number of Directors then in office. A vacancy in the offices of the Chairperson, Vice-Chairperson, CEO, Treasurer and Secretary may be filled prior to the next annual meeting of the Health System Parent Entity by majority vote of the total number of Directors then in office at the next succeeding regular meeting of the Board of the Health System Parent Entity.

(b) The term of office for all persons elected at the annual meeting shall commence at the conclusion of such meeting.

Section 4.3 Removal, Appointment and Term.

(a) The Board of Directors shall have the authority to remove officers and to promote persons to officer positions from time to time during the year; provided, however, the CEO shall have the authority to appoint an individual to any office except those offices specifically referred to in Section 4.2.

(b) The CEO shall be elected to serve for a term of three (3) years. There shall be no restriction on the number of terms that the CEO may serve.

(c) The Chairperson shall be elected to serve for a term of three (3) years. No person shall serve as Chairperson for more than one (1) term.

(d) The Vice-Chairperson shall be elected to serve for a term of one (1) year. No person shall serve as Vice-Chairperson for more than three (3) consecutive terms

(e) The Secretary shall be elected to serve for a term of one (1) year. No person shall serve as Secretary for more than three (3) consecutive terms.

(f) The Treasurer shall be elected to serve for a term of one (1) year. There shall be no restriction on the number of terms that the Treasurer may serve.

(g) Notwithstanding the limitations of Section 2.4, each of the officers referenced in this Section 4.1 may complete the term of that office, even if completion of the term results in Board membership extending beyond such individual's Board retirement age as set forth in Section 2.16 (provided that all individuals must be elected prior to reaching their Section 2.16 retirement age). The respective limitations on the term of office set forth in Sections 4.3(b), 4.3(c), 4.3(d), 4.3(e) and 4.3(f) shall not include that part of an officer's tenure to

the extent that such officer was elected to fill the unexpired term of office for his or her predecessor.

(h) It is not the intention of the Health System Parent Entity to provide that election to any officer position necessarily presumes that such officer is then in line to succeed to any other officer position, including, but not limited to, Chairperson of the Board of Directors.

Section 4.4 Powers and Duties of Officers.

(a) The Chairperson shall:

(i) preside at all meetings of the Board of Directors;

(ii) periodically review and evaluate the performance of the CEO in the discharge of that office's responsibilities, and have the authority to direct the CEO in the execution of the policies and programs established from time to time by the Board of Directors;

(iii) exercise the powers and duties accorded to the Chairperson pursuant to these Bylaws;

(iv) exercise such other powers and duties requested from time to time by the Board of Directors;

(v) be an ex officio member of all Board Committees; and

(vi) serve as the liaison between the Board of Directors and all of the Board Committees, and in this regard the Chairpersons of all such Board Committees periodically and promptly shall report to the Chairperson all decisions, recommendations and proposed actions of their respective Board Committees.

(b) The Vice Chairperson of the Board of Directors shall:

(i) assist the Chairperson in carrying out the duties and responsibilities of the Chairperson;

(ii) act in place of the Chairperson when requested by the Chairperson;

(iii) serve as the Chairperson of the Board of Directors in the event the Chairperson retires, resigns or is otherwise incapable, unable or unwilling to complete the elected term until a new Chairperson is elected by the Board of Directors; and

(iv) perform such other duties as the Board of Directors may from time to time designate.

In the event the Vice Chairperson of the Board of Directors becomes the Chairperson under circumstances set forth in subsection (b)(iii), such individual shall serve as the Chairperson of the Board of Directors until the next annual meeting of the Board. At such meeting, the individual who has completed the year as Chairperson of the Board shall be eligible for nomination and election to a new three (3) year term as Chairperson of the Board in a manner consistent with these Bylaws. Notwithstanding anything else to the contrary set forth in the Bylaws, a Vice Chairperson who succeeds to the office of Chairperson of the Board shall serve as the Chairperson regardless of such individual's age upon the date of succession provided that an individual who has reached the Section 2.16 retirement age shall not be eligible for election to a subsequent term.

(c) The CEO shall:

(i) be the chief executive officer of the Health System Parent Entity and by reason of that office be deemed to be an elected member of the Board of Directors and be counted as a member of the Board for all purposes;

(ii) act as the representative of the Board of Directors in all matters pertaining to the administration of the business and the affairs of the Health System Parent Entity;

(iii) execute the policies of the Board of Directors in managing the Health System Parent Entity's business and affairs;

(iv) participate in the formulation of policies and the development, coordination and execution of corporate programs; and

(v) be responsible to the Board of Directors;

(d) The Treasurer shall be the Chief Financial Officer of the Health System Parent Entity (unless otherwise determined by vote of the Board) and shall:

(i) supervise the collecting, receipt, deposit and distribution of all funds of the Health System Parent Entity as directed by the Board of Directors;

(ii) cause to be kept regular books of account financial records of the Health System Parent Entity and account for the Treasurer's actions and of the financial condition of the Health System Parent Entity as the Board of Directors requires from time to time; and

(iii) perform such other duties as are assigned the Treasurer from time to time by the Board of Directors.

(e) The Secretary shall, or shall cause the appropriate officers to:

(i) keep full and complete minutes of the meetings of the Board of Directors and Board Committees, and when notice of a meeting is required by law or by these Bylaws give notice of each such meeting;

(ii) keep at the principal office of the Health System Parent Entity records containing the name and address of each member of the Board of Directors and the Board Committee members and record the date of election of such member, the duration of that membership, and the date on which the membership ceased;

(iii) keep the seal of the Health System Parent Entity and affix it to all instruments executed by the Health System Parent Entity when required;

(iv) keep at the principal office of the Health System Parent Entity a book in which the Secretary shall record all Bylaws of the Health System Parent Entity as amended to date which Bylaws and amendments shall be reviewed annually, revised as necessary, and dated to indicate the time of last review;

(v) maintain custody of and keep the books of account and other records of the Health System Parent Entity except such books or records which are in the custody of the Treasurer; and

(vi) generally perform such other duties as are assigned to the Secretary from time to time by the Board of Directors.

Section 4.5 Compensation of Employees. Compensation may be paid by the Health System Parent Entity to officers who are also employees of the Health System Parent Entity in such amounts as are determined from time to time by the Board of Directors.

ARTICLE V
Board Committees

Section 5.1 Creation of Committees; Function. The Chairperson of the Board of Directors shall appoint the members and the Chairpersons of the standing committees duly constituted by the Board (the "Board Committees"). Except for Board Committees delegated to act on behalf of the Board by specific Board resolutions, Board Committees of the Board shall act by making recommendations to the Board. Each Board Committee with delegated authority shall be comprised solely of persons who are members of the Board provided that individuals serving as non-voting advisors may also be asked to routinely attend such meetings. Each Board Committee shall be chaired and co-chaired solely by members of the Board. Board Committees shall not otherwise establish policy for the Health System Parent Entity or act on behalf of the Board except pursuant to a specific resolution adopted by the Board.

Section 5.2 Board Committees. The Health System Parent Entity ~~shall have the following~~, by approval of the Board of Directors, may from time to time establish standing Board Committees~~: Audit and Finance~~, including an Executive Committee, Audit and Finance Committee, Quality Committee~~,~~ and/or such other committees as the Board of Directors shall ~~designate~~approve. The term of each standing Board Committee shall terminate at the discretion of the Board. If after the Effective Date the Health System Parent Entity establishes an Executive Committee, such Executive Committee shall at all times include at least one (1) THA Director and at least one (1) Huntington Director.

Section 5.3 Vacancies in Board Committees; Removal. Vacancies in any Board Committee shall be filled by appointment by the Chairperson of the Board of Directors. Board Committee members may be removed from a standing Board Committee by the Chairperson of the Board of Directors.

~~Section 5.4 Audit and Finance Committee. The roles and purposes of the Audit and Finance Committee shall be defined by the Board of Directors of the Health System Parent Entity and at a minimum shall include those responsibilities required under applicable law.~~

~~Section 5.5 Quality Committee. The roles and purposes of the Quality Committee shall be defined by the Board of Directors of the Health System Parent Entity. In general, the Quality Committee shall serve to oversee and support the respective quality initiatives, overall quality of care, and maintenance of accreditation and licensure undertaken by each Member Organization and their Affiliates.~~

Section 5.4 ~~Section 5.6~~ Written Consent. Except as otherwise provided in these Bylaws, any action required or permitted to be taken by any Board Committee under any provision of law or by these Bylaws may be taken without a meeting if all members of the Board Committee shall individually or collectively consent in writing to such action. Such written consent or consents shall be filed with the minutes of the proceedings of the applicable committee. Such action by written consent shall have the same force and effect as a unanimous vote of the Board Committee. Any certificate or other document filed under this Section which relates to an action so taken shall state that the action was taken by unanimous written consent of the Board Committee without a meeting, and that the Bylaws authorize the Board Committees to so act, and such statement shall be prima facie evidence of such authority.

ARTICLE VI
Fiscal Provisions

Section 6.1 Fiscal Year. The fiscal year of the Health System Parent Entity shall be fixed by the Board of Directors.

Section 6.2 Withdrawal of Funds. Funds of the Health System Parent Entity on deposit with any bank or other financial institution shall be subject to withdrawal on the signatures of such persons as are determined from time to time by resolution of the Board of Directors.

Section 6.3 Deposit of Securities. Securities of the Health System Parent Entity held by any custodian approved by the Board shall be subject to withdrawal by such persons (not less than two) as are determined from time to time by resolution of the Board of Directors.

Section 6.4 Transfer of Securities. Any two (2) or more persons designated by the Board of Directors by appropriate resolution shall have authority to execute such forms of transfer and assignment as are customary to effect transfer of shares or other securities in the name of the Health System Parent Entity.

Section 6.5 Financial Records. The books and accounts of the Health System Parent Entity shall be kept in accordance with approved accounting procedures and shall be audited annually by independent auditors selected by the Board of Directors.

Section 6.6 Inspection. Subject to applicable law, every member of the Board of Directors shall have the absolute right at any reasonable time to inspect the books, records, documents of every kind, and physical properties of the Health System Parent Entity, provided reasonable advance notice of such inspection is given to the Chairperson of the Board or the CEO. Upon receipt, the Chairperson and the CEO shall then consult regarding the nature of the particular request and to make suitable arrangements. Subject to applicable law, the right of inspection includes the right to copy and make extracts of documents.

Section 6.7 No Proprietary Interest. By virtue of being a member of the Board, no individual shall have any proprietary interest whatsoever in or to the assets of the Health System Parent Entity; there shall be no distribution of gains, profits or dividends to any members of the Board; and no income, increments or other pecuniary or proprietary gain, benefit or advance of any kind arising from or growing out of the assets of the Health System Parent Entity or its operations and activities shall in any way inure to, go to or vest in any member of the Board. Nothing herein contained shall prevent payment of compensation, by affirmative vote of the Board, to any director or officer for services rendered to the Health System Parent Entity provided any such payment is not prohibited by law.

ARTICLE VII
Indemnification

Section 7.1 Indemnity of Officers and Directors. Every person who serves, or has in the past served, as a director or officer of the Health System Parent Entity, and every person who serves, or has in the past served, at the written request of the Health System Parent Entity (or at its oral request subsequently confirmed in writing) as a director or officer of the Health System Parent Entity, except as otherwise provided by law, shall be indemnified to the full extent permitted by law and held harmless by the Health System Parent Entity from and against any loss, cost, liability or expense that may be imposed on or incurred by such individual in connection with or resulting from any claim, action, suit or proceeding, civil or criminal, in which he or she may become a party or otherwise involved because of his or her being or having been a director or officer of the Health System Parent Entity, whether or not he has this relationship when the loss, cost, liability or expense was imposed or incurred. The phrase "loss, cost, liability or expense" shall include all expenses incurred in defense of the claim, action, suit or proceeding and the amounts of judgments, fines or penalties levied or rendered against the indemnified person, provided that, except as otherwise provided by law, no person shall be entitled to indemnity under this section unless he or she was acting in good faith and within the scope of his or her employment or authority and for a purpose that he or she reasonably believed to be in the Health System Parent Entity's best interests. Payments authorized under this Section shall include amounts paid and expenses incurred in settling the claim, action, suit or proceeding, whether actually begun or only threatened. Expenses incurred with respect to a claim, action, suit or proceeding indemnified against under this section may be advanced by the Health System Parent Entity before final disposition of the matter on receipt of an undertaking by or on behalf of the recipient to repay this amount if it is ultimately determined that he or she is not entitled to

indemnification. This undertaking shall be satisfactory in form and amount to the Board of Directors. This right of indemnification shall not affect any other rights to which any person may otherwise be entitled by law or contract.

Section 7.2 Employees and Agents. The Health System Parent Entity may indemnify any employee or agent of the Health System Parent Entity to the maximum extent permitted by law as approved by majority vote of the ~~Board~~total number of Directors then in office.

Section 7.3 Insurance. Except as prohibited by law, the Board of Directors may (but shall not be required to) adopt a resolution authorizing the purchase and maintenance of insurance on behalf of the Health System Parent Entity and any Director, officer, employee or other agent of the Health System Parent Entity, against any liability asserted against or incurred by such person in such capacity or arising out of such person's status as such, whether or not the Health System Parent Entity would have the power to indemnify such person against the liability under the provisions of this Article VII. The Directors shall receive advance notice of any action by the Health System Parent Entity to eliminate or substantially reduce Directors and officers insurance coverage.

ARTICLE VIII
Amendment and Repeal of Bylaws

Section 8.1 General Provisions. These Bylaws or any of them may be repealed or amended or new or additional Bylaws may be adopted at a duly held meeting by the affirmative vote of a majority of the ~~actual~~total number of ~~members of the Board of~~ Directors then in office, or by unanimous written consent in accordance with Section ~~2.15; provided, however: (i) any amendment or repeal of Section 2.2(c) of these Bylaws, or (ii) any amendment or repeal of any reference to the Affiliation Agreement in these Bylaws,~~2.15. Notwithstanding the foregoing: (i) any change to the rights, preferences, privileges, powers or restrictions provided for the benefit of THA (by amendment, restatement or repeal of these Bylaws or the Articles of Incorporation or by merger, consolidation, conversion or otherwise) set forth in Section 2.2(c), Section 2.5, Section 5.2 or Section 8.1 of these Bylaws shall require the prior written approval of THA, and (ii) any change to the rights, preferences, privileges, powers or restrictions provided for the benefit of Huntington (by amendment, restatement or repeal of these Bylaws or the Articles of Incorporation or by merger, consolidation, conversion or otherwise) set forth in Section 2.2(d), Section 2.5, Section 5.2 or Section 8.1 of these Bylaws shall require the prior written approval of Huntington. Notice of the proposed repeal, amendment, or adoption of new or additional Bylaws must be included in the notice calling the meeting to consider such proposal.

Section 8.2

CERTIFICATE OF SECRETARY

I, the undersigned, do hereby certify:

(1) That I am the duly elected and acting Secretary of Cedars-Sinai Health System, a California nonprofit public benefit corporation; and

(2) That the foregoing Bylaws constitute true and accurate Bylaws adopted by the action of the Board of Directors on ~~January 29, 2018.~~[_____, 20__].

CEDARS-SINAI HEALTH SYSTEM,
a California nonprofit public benefit corporation

~~January 31, 2018~~
Date

By: _____
~~Edward Prunchunas~~Greg Geiger
Secretary

(SEAL)

~~DM_US 80111069-6.044248.0530~~

Document comparison by Workshare 9.5 on Thursday, July 02, 2020 3:59:14 PM

Input:	
Document 1 ID	file://C:\Users\noyek\AppData\Local\Temp\Workshare\wmtemp3ca8\CSHS - AMENDED AND RESTATED BYLAWS - to take effect at closing.DOCX
Description	CSHS - AMENDED AND RESTATED BYLAWS - to take effect at closing
Document 2 ID	file://C:\Users\noyek\AppData\Local\Temp\Workshare\wmtemp3ca8\Rose - CSHS A&R Bylaws.docx
Description	Rose - CSHS A&R Bylaws
Rendering set	Standard

Legend:	
Insertion	
~~Deletion~~	
~~Moved from~~	
Moved to	
Style change	
Format change	
~~Moved deletion~~	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
	Count
Insertions	112
Deletions	95
Moved from	1
Moved to	1
Style change	0
Format changed	0

Total changes	209

Exhibit 8-O

PHA Board Resolutions Approving Affiliation

PASADENA HOSPITAL ASSOCIATION, LTD.

RESOLUTIONS OF THE BOARD OF DIRECTORS

July 14, 2020

WHEREAS, Pasadena Hospital Association, Ltd., doing business as Huntington Hospital (the "Corporation"), is a California nonprofit public benefit corporation that is recognized as exempt from federal income tax under Section 501(a) of the Internal Revenue Code of 1986 (as amended, the "Code") as an organization described in Section 501(c)(3) of the Code.

WHEREAS, the Corporation has been engaged in its charitable mission of delivering healthcare services to communities in Pasadena and the San Gabriel Valley for over 125 years, with the support of the Collis P. and Howard Huntington Memorial Hospital Trust (the "Trust").

WHEREAS, considering the importance of preserving and strengthening the quality and scope of services and the charity care and community benefits that the Corporation provides to the communities it serves and the propriety of identifying additional sources for the Corporation's current and anticipated capital needs, and in recognition of the long history of the Corporation and the hospital, the Board of Directors of the Corporation (the "Board"), with the advice of legal counsel to the Corporation, and after review and consideration of the duties of directors and management of the Corporation in connection with a potential transaction that could include a change of control of the Corporation, in late 2018 the Board authorized the formation of a committee (the "Rose Committee") to explore alternatives for the Corporation to consider.

WHEREAS, the Rose Committee engaged in a months-long process to explore alternatives, interviewed and selected Kaufman, Hall & Associates, LLC to assist the Rose Committee and undertook an evaluation of the priorities of the Corporation to assess the Corporation's alternatives, including mission, culture, clinical programs and services, physician alignment, ambulatory strategies, value-based care capabilities, IT resources, financial resources, and strategic alignment, as well as effects on the community governance of the Corporation and its relationship with the Trust.

WHEREAS, at the conclusion of this process in April 2019, the Rose Committee, with the guidance of Kaufman Hall, presented the findings of the Rose Committee to the Board and after deliberations the Board determined that it would be in the best interests of the Corporation and in furtherance of the charitable purposes it services to pursue a process designed to generate interest in an affiliation transaction in which the Corporation could join a health system that best meets the Corporation's priorities and authorized the reconstitution of the Rose Committee as the "Partnership Committee," adjusted the membership of the Partnership Committee to consist solely of directors, including directors who are also trustees of the Trust, and granted broad authority to the Partnership Committee, with the guidance and advice of Kaufman Hall and legal counsel for the Corporation, to explore strategic alternatives for the Corporation and the hospital, including the possibility of the Corporation becoming affiliated with a charitable health system with a

mission and values consistent with those of the Corporation (the "Potential Transaction"), and to report or make recommendations to the Board concerning the findings of the Partnership Committee.

WHEREAS, the Partnership Committee adopted and implemented protocols concerning compliance with California Health and Safety Code 1260.1, including prohibiting communications concerning the Potential Transaction to directors of the Corporation from members of management who may receive compensation from an acquiring party in a transaction with the Corporation.

WHEREAS, after April 2019, the Partnership Committee, with guidance and advice from its financial advisers and legal counsel, explored strategic alternatives for the Corporation, including identifying charitable health systems (the "Interested Parties") whose missions, values and operations provided a reasonable basis to believe that an affiliation with one of the systems could help the Corporation meet its objectives; entering into nondisclosure agreements with the Interested Parties; engaging in confidential discussions with the Interested Parties; soliciting and receiving nonbinding initial indications of interest from multiple Interested Parties; evaluating the initial indications for the Board; narrowing the field of Interested Parties based on their initial indications, after input and direction from the Board; two-way due diligence with the Interested Parties, including visiting each other's facilities; soliciting and receiving letters of intent from multiple Interested Parties; and negotiating the terms of the letters of intent with each Interested Party.

WHEREAS, at a meeting of the Board in February 2020 with no members of management participating, the Partnership Committee presented its qualitative assessment of each Interested Party based on campus tours and confidential meetings with directors and executives of each Interested Party measured against the criteria developed by the Rose Committee, but the Partnership Committee did not reach conclusions or make recommendations at that meeting, pending the outcome of negotiations concerning the letters of intent.

WHEREAS, after the February 2020 Board meeting, negotiations of the letters of intent continued, and one of the Interested Parties withdrew from the process.

WHEREAS, at a meeting of the Board duly held in March 2020 with no members of management participating, the Board, after presentations by the financial and legal advisers to the Corporation and due deliberation, determined that the Potential Transaction in which Cedars-Sinai Health System, a California nonprofit public benefit corporation that is recognized as exempt from federal income tax under Section 501(a) of the Code ("CSHS"), would become the sole member of the Corporation, commit to install a new electronic health record system, support the 9-year strategic capital plan of the Corporation and preserve key community healthcare programs, among other things, on substantially the terms in the letter of intent negotiated with CSHS and presented to the Board (collectively, the "Cedars Affiliation"), was in the best interests of the Corporation and in furtherance of its charitable purposes and authorized the Partnership Committee to negotiate agreements to implement the Cedars Affiliation.

WHEREAS, the letter of intent was signed by the Corporation and CSHS as of March 6, 2020, and a public announcement was issued on March 9, 2020.

WHEREAS, since March 2020, representatives of the Corporation have engaged in negotiations with representatives of CSHS, conducted due diligence of CSHS and its affiliates and facilitated due diligence of the Corporation and its affiliates by CSHS.

WHEREAS, the Board has received and reviewed substantially final versions of an affiliation agreement (the "Affiliation Agreement") between the Corporation and the Trust, on the one hand, and CSHS, on the other hand; amended and restated articles of incorporation of the Corporation (the "Amended Articles"); amended and restated bylaws of the Corporation (the "Amended Bylaws"); amended and restated bylaws of CSHS; a reimbursement agreement between Cedars-Sinai Medical Center, a California nonprofit public benefit corporation whose sole member is CSHS ("CSMC"), CSHS and the Trust, providing, among other things, for the Trust to remain obligated under the master indenture governing indebtedness of the Corporation, for CSHS and CSMC to cause the Trust to be released from its obligations under the master indenture within 3-7 years after the closing of the Cedars Affiliation and for CSMC to hold the Trust harmless from obligations under the master indenture; and the exhibits and schedules to these agreements and other documents and agreements to implement the Cedars Affiliation (collectively, and as they may be revised or amended in accordance with these resolutions, the "Transaction Documents").

WHEREAS, the Board has reviewed the Transaction Documents as they have been negotiated to date and summaries of the material terms of the Transaction Documents; the Board has had full opportunity to ask questions of the Partnership Committee and the financial and legal advisers to the Corporation and consider their responses; the Board has reviewed updates on the condition, financial and otherwise, of the Corporation and considered the viability of the Corporation and the hospital continuing on a standalone basis; and the Board engaged in deliberations regarding the strategic alternatives of the Corporation, including the possibilities of continuing on a standalone basis or proceeding with CSHS and the Cedars Affiliation.

NOW, THEREFORE, it is hereby resolved as follows:

APPROVAL OF CEDARS AFFILIATION

1. Based on the belief of the Board, after consultation and discussion with members of the Partnership Committee and advisers to the Corporation, consideration of the strategic alternatives of the Corporation, receipt and review of the documents described in these resolutions and due deliberation, that the Cedars Affiliation on substantially the terms described in the Affiliate Agreement and the Transaction Documents would further the charitable purposes of the Corporation and be in the best interests of the Corporation and the communities it serves, the Cedars Affiliation is hereby approved, ratified and confirmed in all respects.

2. The execution, delivery and performance by the Corporation of the Affiliation Agreement and each of the other Transaction Documents (as any such agreements or documents may be revised or amended in accordance with these resolutions) to which the Corporation is a party are hereby approved, ratified and confirmed in all respects.

AMENDMENT TO ARTICLES OF INCORPORATION

3. The amendments to Articles of Incorporation of the Corporation in substantially the form of the Amended Articles and the amendments reflected therein (as such amendments may be revised or amended in accordance with these resolutions) are hereby adopted and approved by the Board pursuant to California Corporations Code § 5812(a) and (b)(3) (it being recognized that, prior to the effectiveness of such amendments, the Corporation has no members and the existing Articles of Incorporation do not require approval by any person but the Board for an amendment to the Articles of Incorporation); *provided, however*, that implementation of such amendments (including their filing with the Secretary of State of the State of California) is subject to the satisfaction or waiver of all conditions to closing under the terms of the Affiliation Agreement.

AMENDMENT TO BYLAWS

4. The amendments to the Bylaws of the Corporation in substantially the form of the Amended Bylaws (as such amendments may be revised or amended in accordance with these resolutions) are hereby adopted and approved by the Board pursuant to California Corporations Code § 5150 (it being recognized that, prior to the effectiveness of such amendments, the Corporation has no members and the existing Articles of Incorporation and Bylaws do not require approval by any person but the Board for an amendment to the Bylaws); *provided, however*, that implementation of such amendments is subject to the satisfaction or waiver of all conditions to closing under the terms of the Affiliation Agreement and the contemporaneous implementation of the amendments to the Articles of Incorporation.

AUTHORIZED REPRESENTATIVES

5. The following individuals (the "Authorized Representatives"), or any one or more of them, will have the authority and discretion on behalf of the Corporation to negotiate, make or approve such changes to the Transaction Documents and such other related documents as such Authorized Representative deems necessary, advisable or appropriate, without further resolution or documentation thereof by the Board, as conclusively indicated by execution and delivery thereof by one or more of such Authorized Representatives (or one or more of their delegates) on behalf of the Corporation or by adoption of resolutions to that effect by one or more of Authorized Representatives:

Name	Title
Ronald Havner	Director, Partnership Committee
Paul Johnson	Director, Partnership Committee
David Kirchheimer	Director, Partnership Committee
Chris Mitchell	Director, Partnership Committee
Jaynie Studenmund	Chair, Director, Partnership Committee

6. Each Authorized Representative acting singly is hereby authorized, empowered and directed, in the name of and on behalf of the Corporation, to take or cause to be taken any and all further actions (including the filing of the Amended Articles with the Secretary of State of the State of California) and to execute, file and deliver (and to direct any officers of the Corporation to execute, file and deliver) on behalf of the Corporation such agreements and instruments as any Authorized Representative deems necessary, desirable, advisable or appropriate (as conclusively evidenced by the taking of such actions or the execution and delivery of such agreements or instruments) to permit the Corporation to complete the Cedars Affiliation, generally in accordance with the terms of the Transaction Documents, as they may be revised or amended in accordance with these resolutions.

7. The omission from these resolutions of any agreement or other arrangement contemplated by any of the agreements or instruments described in the foregoing resolutions or any action to be taken in accordance with any requirements of any of the agreements or instruments described in the foregoing resolutions will in no manner derogate from the authority of the Authorized Representatives to take all actions necessary, desirable, advisable or appropriate to consummate, effectuate, carry out or further the transactions contemplated by and the intent and purposes of the foregoing resolutions.

RATIFICATION

8. All actions previously taken by the members of the Partnership Committee, management of the Corporation, the Authorized Representatives, and their respective delegates and advisers, with respect to the Cedars Affiliation, the documents contemplated hereby and thereby, and the consummation of the transactions therein, which have been disclosed to the Board in accordance with these resolutions and which otherwise are consistent with and in furtherance of the intent and purposes of these resolutions, are hereby ratified, confirmed, and approved in all respects.

CERTIFICATE OF ADOPTION

The undersigned certifies that the undersigned is the Chair of the Board of the Corporation; that the foregoing is a true and correct copy of resolutions duly adopted by the Corporation at a meeting of the Board of Directors of the Corporation following appropriate notice; that the passage of the resolutions was in all respects legal; and that the resolutions are in full force and effect as of this date.

Dated as of the 14th day of July, 2020.

REDACTED

Jayne Studenmund
Chair, Board of Directors

#9

Title 11, California Code of Regulations, § 999.5(d)(2)(E)

Joint Venture Transactions

The proposed transaction is not a joint venture.

Title 11, California Code of Regulations, § 999.5(d)(3)

INUREMENT AND SELF-DEALING

#10

Title 11, California Code of Regulations, § 999.5(d)(3)(A)

Copies of any documents or writings of any kind that relate or refer to any personal financial benefit that a proposed affiliation between applicant and the transferee would confer on any officer, director, employee, doctor, medical group or other entity affiliated with applicant or any family member of any such person as identified in Corporations Code section 5227(b)(2)

Pursuant to the Affiliation Agreement, Cedars-Sinai will become the sole member of PHA, with PHA retaining all of its assets and liabilities. These assets and liabilities include contractual arrangements PHA has in place with officers, employees, doctors, and medical groups to provide administrative, professional and coverage services to PHA, arrangements which PHA does not intend the Affiliation to disrupt. For more information in this regard, see the response to Section 999.5(d)(5)(F).

The PHA Board has adopted retention arrangements following the process to establish the rebuttable presumption of reasonableness under Section 4958 of the Internal Revenue Code and Treasury Regulations Sections 53.4958. Additional information about these arrangements is being submitted under separate cover to the California Attorney General as a confidential document in accordance with Section 999.5(c)(3).

#11

Title 11, California Code of Regulations, § 999.5(d)(3)(B)

The identity of each and every officer, trustee or director of applicant (or any family member of such persons as identified in Corporations Code section 5227(b)(2)) or any affiliate of applicant who or which has any personal financial interest in any company, firm, partnership, or business entity (other than salary and directors/trustees' fees) currently doing business with applicant, any affiliate of applicant, or the transferee or any affiliate of the transferee

Arrangements responsive to this Section 999.5(d)(3)(B) are as follows:

- Harry Bowles, a director of PHA, is a member of Pacific Valley Medical Group, which owns one share in Huntington Ambulatory Surgical Center, LLC. Huntington Ambulatory Surgical Center is a California limited liability company in which PHA holds a 99.82% interest.

- Wayne Brandt, a director of PHA, is employed at Wells Fargo, which provides PHA with certain banking services.

- Reed Gardiner, a director of PHA, is a retired partner from PricewaterhouseCoopers and, in that capacity, receives a semi-fixed percentage of its future profits. PricewaterhouseCoopers has provided services to Huntington and the Trust and provides services to Cedars-Sinai affiliates from time to time.

- Allen Mathies Jr., M.D., a director of PHA, is an independent contractor of Congress Services Corporation, a California business corporation wholly owned by PHA.

- Lori Morgan, M.D., the Chief Executive Officer of PHA, and her spouse Henry Outzen, are borrowers under that certain Secured Promissory Note, dated June 26, 2018, as amended by the first amendment dated May 2020, and Security Agreement, dated June 26, 2018, with Huntington. This loan was provided for purposes of providing financing for the purchase of Dr. Morgan's principal residence in order to secure her services, and is secured by the residence.

- Lori Morgan, M.D., the Chief Executive Officer of PHA, serves as the sole shareholder of Huntington Aligned Medical Group, Inc., a professional medical corporation of PHA providing certain professional services to The Huntington Medical Foundation dba Huntington Health Physicians ("HHP"), a California nonprofit corporation qualified with the Internal Revenue Services as a Section 501(c)(3) public charity and exempt from state licensure under Section 1206(l) of the California Health and Safety Code. HHP is controlled nonprofit subsidiary of PHA.

- Kelly Silver, a current manager at PHA, has a sister-in-law who is an Associate Vice President at Vizient, a group purchasing organization in which PHA participates.

#12

Title 11, California Code of Regulations, § 999.5(d)(3)(C)

A statement describing how the board of directors of the nonprofit corporations involved in the transaction are complying with the provisions of Health and Safety Code sections 1260 and 1260.1

As further described in response to Section 999.5(d)(1)(C), the PHA Board formed the Partnership Committee to explore strategic alternatives, engage in confidential discussions with interested parties, conduct due diligence, and negotiate letters of intent, all of which ultimately resulted in the PHA Board identifying Cedars-Sinai and its health system as the best partner and approving PHA moving forward with this proposed Affiliation.

The PHA Board members who participated in negotiating the Affiliation Agreement have not received and will not receive, directly or indirectly, any salary, stipend, compensation or other form of remuneration from Cedars-Sinai, directly or indirectly, following the closing of the proposed transaction. Accordingly, none of the PHA Board members listed in Section 999.5(d)(3)(B) of this Notice who will receive, directly or indirectly, any salary, stipend, compensation or other form of remuneration from Cedars-Sinai following the closing of the proposed transaction participated in negotiating the Affiliation Agreement.

For purposes of ensuring compliance with California Health and Safety Code section 1260 and 1260.1, PHA's President and Chief Executive Officer resigned from the PHA Board, and the Partnership Committee adopted and implemented compliance protocols, which included prohibiting communications to the Partnership Committee from members of management who could be in a position to receive compensation from the other party to a transaction with PHA. In addition, no members of management participated in the March 6, 2020 meeting, at which the PHA Board approved moving forward with the proposed Affiliation with Cedars-Sinai, and no members of management participated in the July 14, 2020 meeting, in which the PHA Board approved the Affiliation Agreement, amendments to the articles of incorporation and bylaws of PHA and other definitive transaction documents. In making this decision, the Board received and relied upon the information and counsel of its volunteer directors and the members of the Partnership Committee, together with PHA's financial and legal advisors.

Throughout the process culminating in the signing of the Affiliation Agreement, PHA has maintained an appropriate firewall between members of management who may receive compensation from Cedars-Sinai or PHA following the Closing of the Affiliation and directors on the PHA Board. The PHA Board has continued to rely on its financial and legal advisors to guide this process and has not substantially relied on any information from members of management who may work for Cedars-Sinai or PHA in the future, except for factual information about PHA and Huntington Hospital.

Title 11, California Code of Regulations, § 999.5(d)(4)

CHARITABLE USE OF ASSETS

#13

Title 11, California Code of Regulations, § 999.5(d)(4)(A)

Applicant's articles of incorporation and all amendments thereto and current bylaws, any charitable trust restrictions, and any other information necessary to define the charitable trust purpose of the Applicant's assets

1. Attached to this Section 999.5(d)(4)(A) as **Exhibit 13-A** is a copy of PHA's Articles of Incorporation and all amendments.

2. Attached to this Section 999.5(d)(4)(A) as **Exhibit 13-B** is a copy of PHA's current Bylaws.

3. Attached to this Section 999.5(d)(4)(A) as **Exhibit 13-C** is a copy of the last will and testament and court orders establishing the Trust.

Exhibit 13-A

PHA's Articles of Incorporation

A431817

State of California

OFFICE OF THE SECRETARY OF STATE

CORPORATION DIVISION

I, *MARCH FONG EU*, Secretary of State of the State of California, hereby certify:

That the annexed transcript has been compared with the corporate record on file in this office, of which it purports to be a copy, and that same is full, true and correct.

IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California this

MAY 7 1995

March Fong Eu

Secretary of State

A431817

ENDORSED
FILED
In the office of the Secretary of State
of the State of California

MAY 6 1993

MARCH FONG EU, Secretary of State

RESTATED ARTICLES OF INCORPORATION

OF

PASADENA HOSPITAL ASSOCIATION, LTD.

ALLEN W. MATHIES, JR. and STEPHEN A. RALPH certify that:

(1) They are the President and the Assistant Secretary, respectively, of PASADENA HOSPITAL ASSOCIATION, LTD., a California nonprofit public benefit corporation.

(2) The Articles of Incorporation of this Corporation are amended and restated to read as follows:

I

The name of this Corporation is PASADENA HOSPITAL ASSOCIATION, LTD.

II

This corporation is a nonprofit public benefit corporation and is not organized for the private gain of any person. It is organized under the Nonprofit Public Benefit Corporation Law for charitable purposes.

III

The objects and purposes for which this Corporation are formed are to establish, maintain, and carry on within the County of Los Angeles, State of California, a hospital for the sick and injured, and for that purpose:

(1) To purchase, lease or otherwise acquire, to own, hold, receive, take, use, enjoy and improve, to mortgage, pledge, or otherwise encumber or hypothecate, to sell, assign, transfer, grant, alien or otherwise dispose of, and to invest in real and personal property.

(2) To build, erect, construct, alter, repair, renew, remove, rebuild, reconstruct, equip, maintain and operate such buildings and other structures as may be proper, necessary or convenient for the purposes and objects herein recited; to erect and maintain a dispensary, branch hospitals, and a training school for nurses.

(3) To enter into cooperative or affiliation agreements with other healthcare providers.

(4) To borrow money, to incur indebtedness and to secure the same by deed of trust or mortgage upon the real property of the corporation in any manner and amount authorized by law; to evidence such indebtedness by

bonds, notes, debentures, or other appropriate instruments; to execute mortgages, deeds of trust, or pledges of and upon the whole or any part of the real and personal property of this corporation for the purpose of securing the payment of such indebtedness.

(5) To receive property by devise or bequest, subject to the laws regulating the transfer of property by will.

(6) To act as trustee under any trust incidental to the principal objects of the corporation, and to receive, hold, administer, and expend funds and property subject to such trust.

(7) To convey all or any portion of the corporate property in trust to carry out the objects of this corporation as the Board of Directors may deem advisable; to receive endowments and to invest the same.

(8) To do each and every thing necessary, appropriate or adopted to carry into effect any and all of the foregoing purposes and powers, or to attain any one or more of the objects herein enumerated.

IV

A. This corporation is organized and operated exclusively for charitable purposes within the meaning of Internal Revenue Code, Section 501(c)(3). Any other provision of these Articles of Incorporation notwithstanding, this corporation shall not carry on any activities not permitted to be carried on (i) by a corporation exempt from Federal Income Tax under Internal Revenue Code, Section 501(c)(3) or (ii) by a corporation contributions to which are deductible pursuant to Internal Revenue Code, Section 170(c)(2).

B. No part of the net earnings or assets of this corporation shall ever inure to the benefit of any director or officer of this corporation or to any private individual who is a member of this corporation or to the benefit of any private individual whatsoever (except that reasonable compensation may be paid for services rendered to or for the corporation affecting one or more of its purposes). No substantial part of the activities of the corporation shall consist of carrying on propaganda or otherwise attempting to influence legislation (except to the extent that such activities can be carried on without a loss of tax-exempt status under Internal Revenue Code, Section 501(h)), and the corporation shall not participate or intervene in (including the publication or

distribution or statements) any political campaign on behalf of any candidate for public office.

V

The property of this Corporation is irrevocably dedicated to charitable purposes. Upon the winding-up or dissolution of this Corporation, after paying or adequately providing for the debts and obligations of the Corporation, any remaining assets of this Corporation shall be distributed for use in furtherance of the purposes of this Corporation, as set forth above in these Articles of Incorporation, to one or more nonprofit funds, foundations or corporations, each of which is then in existence and each of which is organized and operated exclusively for charitable purposes and each of which is qualified as an exempt organization under Internal Revenue Code, Section 501(c)(3).

VI

The number of Directors of this Corporation shall be as set forth in the Bylaws and the Bylaws may provide that the number of Directors of this Corporation shall be not less than a stated minimum nor more than a stated maximum with the exact number of Directors to be fixed, within the limited specified, by approval of the Board of Directors in the manner provided in the Bylaws.

VII

Amendment of the Articles of Incorporation of this Corporation shall require the approval of a majority of the Directors of this Corporation and the approval of a majority of the Directors of this Corporation and the approval of a majority of those persons who are Trustees of the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST under Article NINETEENTH of the Last Will and Testament of Henry E. Huntington.

VIII

This Corporation shall have no members.

IX

In accordance with the provisions of Section 9913 of the California Corporations Code, this Corporation elects to be governed by all the provisions of the California Nonprofit Public Benefit Corporation Law not otherwise applicable to this Corporation under Sections 9910-9927, inclusive, of the California Corporations Code.

(3) This Corporation has no members.

(4) The foregoing amendment and restatement of this Corporation's Articles of Incorporation has been duly approved by its Board of Directors and the COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL TRUST.

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this certificate are true and correct of our own knowledge and that this Declaration was executed on April 29, 1993 at Pasadena, California.

REDACTED

ALLEN W. MATHIES, JR., President

REDACTED

STEPHEN A. RALPH,
Assistant Secretary

EDMUND G. BROWN JR.
SECRETARY OF STATE

State of California

Office of the
Secretary of State
SACRAMENTO

I, EDMUND G. BROWN JR., *Secretary of State of the State of California, hereby certify:*

That on the 2nd *day of* March, 19 1892 "Pasadena Hospital Association", now:

PASADENA HOSPITAL ASSOCIATION, LTD.

became incorporated under the laws of the State of California by filing its Articles of Incorporation in this office and that said Articles of Incorporation were duly recorded.

That no record exists in this office of a certificate of winding up and dissolution of said corporation nor of a court decree or order declaring dissolution thereof, nor of a merger or consolidation which terminated its existence, that said corporation's corporate powers, rights and privileges are not suspended of record in this office; and

That according to the records of this office, the said corporation is duly organized, subsisting, and in good standing, and is authorized to exercise all its corporate powers, rights and privileges and to transact business in the State of California.

IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California this 6th *day of* November, 1974

Edmund G. Brown Jr.
Secretary of State



DEPARTMENT OF STATE

ARTICLES OF INCORPORATION

OF THE

PASADENA HOSPITAL ASSOCIATION

RECEIVED

Sales Tax Unit

KNOW ALL MEN BY THESE PRESENTS, That we, the undersigned, citizens and residents of the State of California, do hereby associate ourselves together, under the laws of the State of California, to become incorporated under the laws of the State of California, a private corporation, and we do hereby certify that the purposes of the said corporation shall be PASADENA HOSPITAL ASSOCIATION.

SECOND: That the principal place where the business of said corporation is to be conducted is the City of Pasadena, Los Angeles County, California.

THIRD: That the term for which said corporation is to exist is fifty years, from and after the date of its incorporation.

FIFTH: That the number of the directors of said corporation shall be seven and the names and residences of the directors who are appointed for the first year, and to serve until the election of such officers, and their qualifications, are as follows, to-wit:

NAMES	RESIDENCES
JOHN W. GOODYEAR	PASADENA, CALIFORNIA
F.E. GROSS	" "
A.P. ANDERSON	" "
E.P. HOLT	" "
V.S.C. LOFT	" "
GEO. F. KREISMAN	" "
F.F. EBELL	" "

That on the eighteenth day of February A.D.1892, in Meadow City County of Los Angeles, in said State of California, an election was held for Director, that a majority of the members of said Association were present and [illegible] that the report thereof was that the Directors [illegible] were declared duly elected.

In witness whereof, we have hereunto set our hands and [illegible]

[illegible]

Attest [illegible]

Secretary

[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]

STATE OF CALIFORNIA)
COUNTY OF LOS ANGELES,)

On this [illegible] before me, [illegible] and [illegible] duly sworn, [illegible] and each for himself and not one for the other did depose and say that they were the officers [illegible] the foregoing Directors above mentioned; that said Articles were duly [illegible] the time and place of said [illegible] the result thereof [illegible] above and [illegible]

[illegible]

Directors

Subscribed and sworn to before me,
this 19th day of February [illegible]

[illegible]

Notary Public

STATE OF CALIFORNIA,)
COUNTY OF LOS ANGELES,)

On this [illegible] day of [illegible], in the year [illegible] before me [illegible] a Notary Public in and for said County and State, residing therein, duly commissioned and sworn, personally appeared [illegible] known to me to be [illegible] whose name [illegible] subscribed to the within instrument, and acknowledged to me that [illegible] executed the same.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal, at my office in said Los Angeles County, the day and year first above written.

(SEAL)

[illegible]

Notary Public

Exhibit 13-B

PHA's Bylaws

HUNTINGTON MEMORIAL HOSPITAL

ADMINISTRATIVE POLICY & PROCEDURE

SUBJECT: BYLAWS OF PASADENA HOSPITAL ASSOCIATION	POLICY NO: 004	PAGE 1 of 32
AUTHORIZED APPROVAL: REDACTED	EFFECTIVE DATE: 09/26/2019	SUPERCEDES/REPLACES 03/28/2019

PURPOSE:

To establish the governing bylaws of Pasadena Hospital Association, LTD, dba Huntington Memorial Hospital

POLICY:

(see attached)

APPROVALS:

Huntington Memorial Hospital Board of Directors

AMENDMENT NO. 2

TO

BYLAWS

OF

PASADENA HOSPITAL ASSOCIATION, LTD.

The Board of Directors of Pasadena Hospital Association, Ltd., a California nonprofit public benefit corporation doing business as Huntington Hospital (the "Association"), acting pursuant to Section 5150 of the California Corporations Code and Article X, Section 1 of the Bylaws of the Association dated as October 23, 2014 (as amended July 23, 2015, the "Bylaws), adopts the following amendments to Article III, Section 2 of the Bylaws:

Section 2. Election and Term of Office. Each Director who is a Trustee of the Collis P. and Howard Huntington Memorial Hospital Trust shall serve as a Director while and for as long as he is a Trustee. The person who is from time-to-time President of the Medical Staff of the Hospital shall serve as a member of the Board of Directors with full voting rights while he is President of the Medical Staff and for two additional two-year terms, such additional terms commencing at the time such person ceases to serve as President of the Medical Staff of the Hospital. ~~The person who is from time-to-time President of the Association shall serve as a member of the Board of Directors with full voting rights while and for so long as he or she is President.~~ Except as to a Director who is a Trustee of the Collis P. and Howard Huntington Memorial Hospital Trust and the Director who is the President of the Medical Staff of the Hospital ~~and the Director who is the President of the Association~~ and a Director who has been elected President or Director Emeritus, all other Directors shall be elected by the Board of Directors and shall serve a term of three years commencing with the date of their election; such elected Directors maybe elected to succeed themselves for one additional three year term or for an indefinite appointment if any of them becomes a Trustee of the Collis P. and Howard Huntington Memorial Hospital Trust during his tenure as a Director. From time to time, at the discretion of the Board of Directors, an individual may be elected to a term of less than three years. After serving two consecutive three-year terms, each such elected Director shall not be eligible for reelection and shall not serve as a Director of the Association for a period of at least one year. Following a one year absence from the Board of Directors, each such elected Director will again be eligible for election to the Board of Directors of the Association.

[Signature Page Follows]

I certify that I am the duly elected and acting Chair of the Association; that this Amendment No. 2 to the Bylaws of the Association was adopted by the Board of Directors on the 26 day of September, 2019; and that this Amendment No 2 to the Bylaws has not been further amended or modified since that date.

Executed on the 26 day of September, 2019, at Pasadena, California.

Chair of the Association:

REDACTED

Signature

Jaynie Studenmund
Print Name

RESOLUTION OF THE BOARD OF DIRECTORS OF

PASADENA HOSPITAL ASSOCIATION, LTD. d/b/a/ HUNTINGTON HOSPITAL

(Bylaw Amendment)

WHEREAS, it is in the best interest of Pasadena Hospital Association, Ltd. d/b/a/ Huntington Hospital ("Hospital") to be able occasionally to elect a Director for a term commencing on a date other than January 1;

WHEREAS, the Hospital prefers to coordinate Director terms so that they all expire as of January 1;

WHEREAS, in those cases when an initial term commences between July 1 and January 1, the Hospital desires the Director to have an initial term that exceeds the current three year limit;

NOW, THEREFORE, BE IT RESOLVED THAT:

Article III, Section 2 ("Election and Term of Office") is hereby revised by adding the following at its conclusion:

> "Notwithstanding the foregoing, if a Director is elected for an initial term that commences on a date other than January 1, such Director's initial term shall expire as of a subsequent January 1, as follows:
>
> > "1. If the initial term commences after January 1 but before July 1, the Director's initial term shall expire three years following the January 1 preceding the term commencement.
> >
> > "2. If the initial term commences on or after July 1 but before January 1, the Director's initial term shall expire four years following the January 1 preceding the term commencement."

CERTIFICATE OF SECRETARY

I, Michelle Chino, being the Secretary of Pasadena Hospital Association, Ltd., d/b/a Huntington Hospital, hereby certify that the foregoing resolution was adopted at a meeting of the Board of Directors of said corporation duly and validly held in Pasadena, California, on March 28, 2019, at which a quorum of said Board of Directors was present and voted in favor of said resolution; that no action has been taken to rescind or amend said resolution and that it is now in full force and effect as of the present date shown below.

IN WITNESS WHEREOF, I have hereunto affixed my signature.

REDACTED

Michelle Chino
Secretary, Board of Directors



PASADENA HOSPITAL ASSOCIATION, LTD

Memorialization of Bylaw Amendment

RESOLVED: that Article III, Section 1 ("DIRECTORS-Number, Designation and Qualification") of the Pasadena Hospital Association, Ltd. Bylaws is revised to increase the maximum number of Directors from twenty-five to thirty.

I, Wayne Brandt, being the Secretary of Pasadena Hospital Association, Ltd., d.b.a. Huntington Hospital, hereby certify that the foregoing resolution was adopted at a meeting of the Board of Directors of said corporation duly and validly held in Pasadena, California, on December 14, 2017, at which a quorum of said Board of Directors was present and voted in favor of said resolution; that no action has been taken to rescind or amend said resolution and that it is now in full force and effect as of the present date shown below.

IN WITNESS WHEREOF, I have hereunto affixed my signature on this 25th day of January, 2018.

REDACTED

Wayne Brandt
Secretary, Board of Directors

RESOLUTIONS OF THE BOARD OF DIRECTORS OF
PASADENA HOSPITAL ASSOCIATION, LTD.

(Bylaw Amendment)

WHEREAS, individuals who are not members of the Board of Directors of this corporation (the "Board") are asked to serve on standing Board committees, whereat important work of the Board is conducted and recommendations for the Board are developed;

WHEREAS, the Bylaws of this corporation provide different indemnification rights for Directors and Executive Officers when compared to the rights provided to other agents of the corporation, such as committee members who are not Board members; and

WHEREAS, this Board believes it to be in the best interests of the corporation to provide committee members who are not Board members with the same indemnification rights as Board members and desires to amend Article III of the Bylaws to so provide them with the same indemnification rights

NOW THEREFORE BE IT RESOLVED that:

(a) The first sentence of Article III, Section 7(a) of the Bylaws shall be amended to read as follows:

As to the Board of Directors, Executive Officers (as defined below) and the members of any standing committee of the Board of Directors (as defined in Article VIII, Section 3 of these Bylaws), the Association shall, and as to all other agents the Association may, to the maximum extent permitted by the California Nonprofit Corporation Law, indemnify each of its agents against expenses, judgments, fines, settlements and other amounts actually and reasonably incurred in connection with any proceeding arising by reason of the fact that any such person is or was an agent of the Association.

(b) Article III, Section 7(b) of the Bylaws shall be amended to read as follows.

As to the Board of Directors, Executive Officers and the members of any standing committee of the Board of Directors (as defined in Article VIII, Section 3 of these Bylaws), the Association shall, and as to all other agents the Association may, to the extent permitted by law, advance expenses incurred or to incurred by an agent in connection with any proceeding arising by reason of the fact that such person was or is an agent of the Association, provided such advance is authorized by the Board of Directors and permitted by law.

RESOLVED FURTHER that the officers this Corporation do any and all things and to execute and deliver any and all certificates and documents which they may deem necessary or advisable in order to effectuate the foregoing Bylaw amendments.

IN WITNESS WHEREOF, I have hereunto affixed my signature and the Seal of said corporation on this twenty-third day of July, 2015.



REDACTED

Stephen A. Ralph
President and Chief Executive Officer

BYLAWS OF

PASADENA HOSPITAL ASSOCIATION, LTD.

October 2014

BYLAWS OF

PASADENA HOSPITAL ASSOCIATION, LTD.

ARTICLE I

PURPOSE

The purpose of the Pasadena Hospital Association, Ltd. (the "Association" or the "Corporation") is to operate a hospital for the sick and injured, namely the Collis P. and Howard Huntington Memorial Hospital ("Hospital") in accordance with the wishes expressed in the Will of Henry E. Huntington and the provisions of the Collis P. and Howard Huntington Memorial Hospital Trust established by said Will. The Association shall operate the Hospital as a charitable, community not-for-profit general hospital.

ARTICLE II

NO MEMBERS

The Association shall have no members as defined in Section 5056 of the California Corporations Code and any action which would otherwise require a vote of members under the law shall only require a vote of the Directors.

ARTICLE III

DIRECTORS

Section 1. Number, Designation and Qualification. The activities and affairs of the Association shall be conducted and all corporate powers shall be exercised, subject to this Article III of these Bylaws, by or under the direction of a Board of Directors of not less than thirteen and not more than twenty-five Directors, with the exact number of Directors to be fixed by approval of the Board within such range as set forth in these Bylaws. Five of the persons who are Directors of the Association shall be those persons who from time to time are serving as the Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust (a or the "Trustee" or the "Trustees"). As soon as a Director who is also such a Trustee ceases to be a Trustee of the Collis P. and Howard Huntington Memorial Trust he or she shall, by that fact, cease to be a

member of the Board of Directors of the Association unless he subsequently becomes elected a Director as described below in Section 2. Any person who is serving as Director because he is a Trustee of the Collis P. and Howard Huntington Memorial Hospital Trust may not be removed without the written consent of a majority of the persons who are Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust. The President of the Medical Staff of the Hospital and the President of the Association shall each also serve as a Director with full voting rights. In addition, the President-elect of the Medical Staff of the Hospital shall be an invited guest at each board meeting but shall have no vote, shall not be a member of the Board of Directors and shall leave the meeting when requested by the Chairman of the Board.

Section 2. Election and Term of Office. Each Director who is a Trustee of the Collis P. and Howard Huntington Memorial Hospital Trust shall serve as a Director while and for as long as he is a Trustee. The person who is from time-to-time President of the Medical Staff of the Hospital shall serve as a member of the Board of Directors with full voting rights while he is President of the Medical Staff and for two additional two-year terms, such additional terms commencing at the time such person ceases to serve as President of the Medical Staff of the Hospital. The person who is from time-to-time President of the Association shall serve as a member of the Board of Directors with full voting rights while and for so long as he or she is President. Except as to a Director who is a Trustee of the Collis P. and Howard Huntington Memorial Hospital Trust and the Director who is the President of the Medical Staff of the Hospital and the Director who is the President of the Association and a Director who has been elected President or Director Emeritus, all other Directors shall be elected by the Board of Directors and shall serve a term of three years commencing with the date of their election; such elected Directors maybe elected to succeed themselves for one additional three year term or for an indefinite appointment if any of them becomes a Trustee of the Collis P. and Howard Huntington Memorial Hospital Trust during his tenure as a Director. From time to time, at the discretion of the Board of Directors, an individual may be elected to a term of less than three years. After serving two consecutive three year terms, each such elected Director shall not be eligible for reelection and shall not serve as a Director of the Association for a period of at least one year. Following a one year absence from the Board of Directors, each such elected Director will again be eligible for election to the Board of Directors of the Association.

From time to time, and in the exercise of its sole discretion, the Board of Directors shall have the authority to designate one or more individuals, upon the vote of a majority of the Directors then in office, as Director or President Emeritus. Such Director shall be appointed from among current or former Directors or officers whom the Board shall determine have rendered extraordinary service to the Corporation, shall serve six (6) year terms and not be subject to any term limits. A Director or President Emeritus shall serve as a Director, be considered in the authorized number of Directors, and have the right to attend meetings of Directors, shall count for the purposes of establishing a quorum and shall have the right to vote. Similarly, the Board of Directors shall have the authority to designate one or more individuals, upon the vote of a majority of the Directors then in office, as non-voting Directors. Such nonvoting Directors shall receive notices of meetings of the Board, but shall not count for the purposes of establishing a quorum and shall not have the right to vote at meetings of the Board of Directors.

Section 3. Vacancies. Vacancies in the Board of Directors shall:

(a) in the case of a Director who is also a Trustee, be filled by the successor Trustee appointed in accordance with the terms of the Collis P. and Howard Huntington Memorial Hospital Trust;

(b) in the case of the President of the Medical Staff serving pursuant to the provisions above, be filled by the person who is appointed the new President of the Medical Staff;

(c) in the case of the President of the Association serving pursuant to the provisions above, be filled by the appointment of a new President;

(d) in the case of the past President of the Medical Staff serving two additional two-year terms pursuant to the provisions above, be filled by a member of the Medical Staff recommended by the President of the Medical Staff and elected by the affirmative vote of a majority of the Directors then in office; and

(e) in the case of all other vacancies, be filled by the affirmative vote of a majority of the Directors then in office.

Section 4. Compensation. The Directors shall serve as such without compensation, but performance of his duties as a Director may be considered as part of the duties for which the President of the Association receives compensation as such. Directors may be reimbursed for expenses actually incurred in connection with the performance of their duties as Directors.

Section 5. Resignation or Removal of a Director.

(a) Any Director may resign his office as Director by a writing delivered to the Board of Directors. Upon such resignation such Director's term as a Director shall end. No Director may resign without providing proper notice to the Attorney General, if the Corporation would be left without a duly elected Director in charge of its affairs.

(b) The Board of Directors may declare vacant the office of a Director who has been declared of unsound mind by a final order of court, or convicted of a felony, or been found by a final order or judgment of any court to have breached any duty under Article 3 (Sections 5230 -5239) of the California Nonprofit Public Benefit Corporation Law.

Section 6. Records and Annual Report. The Association shall keep adequate and correct books and records of account and minutes of the proceedings of its Board of Directors and committees of the Board of Directors. The Board of Directors shall cause an annual report to be sent to all Directors of the Association not later than 120 days after the close of the Corporation's fiscal year. Such report shall contain in appropriate detail the following:

(a) The assets and liabilities, including the trust funds, of the Association as of the end of the fiscal year.

(b) The principal changes in assets and liabilities, including trust funds, during the fiscal year.

(c) The revenue or receipts of the Association, both unrestricted and restricted to particular purposes, for the fiscal year.

(d) The expenses or disbursements of the Association, for both general and restricted purposes, during the fiscal year.

(e) Any information required by Section 6322 of the California Corporations Code.

Any financial statements presented as part of the above-described report shall be prepared in accordance with generally accepted accounting principles and be audited by an independent certified public accountant in conformity with generally accepted auditing standards.

Section 7. Indemnification of Directors, Officers, Employees and Agents.

(a) As to the Board of Directors and Executive Officers (as defined below) the Association shall, and as to all other agents the Corporation may, to the maximum extent permitted by the California Nonprofit Corporation Law, indemnify each of its agents against expenses, judgments, fines, settlements and other amounts actually and reasonably incurred in connection with any proceeding arising by reason of the fact that any such person is or was an agent of the Association. For purposes of this Article III, Section 7, an "agent" of the Corporation includes any person who is or was a director, officer, employee or other agent of the Corporation or is or was serving at the request of the corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise; or was a director, officer, employee or agent of the predecessor corporation, of the Association, or of another enterprise at the request of such predecessor corporation. For the purposes of this Article III, "Executive Officers" shall mean the officers defined in the first sentence of Article VI, Section 1.

(b) As to the Board of Directors and Executive Officers the Association shall, and as to all other agents the corporation may, to the extent permitted by

law, advance expenses incurred or to be incurred by an agent in connection with any proceeding arising by reason of the fact that such person was or is an agent of the Corporation, provided such advance is authorized by the Board of Directors and permitted by law.

(c) The Board of Directors may adopt a resolution authorizing the purchase and maintenance of insurance on behalf of any agent of the Association against any liability which may be asserted against or incurred by the agent in such capacity or arising out of the agent's status as such, whether or not this Corporation would have the power to indemnify the agent against that liability under the provisions of this Article III, Section 7.

(d) This Article III, Section 7 does not apply to any proceeding against any trustee, investment manager or other fiduciary of an employee benefit plan in such person's capacity as such, even though such person may also be an agent of the Corporation as defined in subsection (a) of this Section 7. The Corporation shall have power to indemnify such trustee, investment manager or other fiduciary to the extent permitted by subsection (f) of Section 5140 of the California Nonprofit Corporation Law.

(e) The indemnification provided by this Article III, Section 7 of these Bylaws shall not be deemed exclusive of any rights to which those seeking indemnification may be entitled under any agreement, vote of disinterested directors, or otherwise, both as to action in his or her official capacity while holding such office, and shall continue as to a person who has ceased to be a director, officer, or employee and agent, and shall inure to the benefit of the heirs, executors and administrators of such person.

Section 8. Restriction on Interested Persons as Directors. No more than 49 percent of the persons serving on the Board of Directors may be interested persons. An interested person is (a) any person compensated by the Association for services rendered to it within the previous 12 months, whether as a full-time or part-time employee, independent contractor, or otherwise, excluding any reasonable compensation paid to a Director as Director; and (b) any brother, sister,

ancestor, descendant, spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, or father-in-law of such person. However, any violation of the provisions of this section shall not affect the validity or enforceability or any transaction entered into by the Association.

ARTICLE IV

MEETINGS

Section 1. Annual Meeting. The annual meeting of the Board of Directors shall be held in conjunction with the regular monthly meeting in December of each year. The Officers of the Board of Directors for the coming year shall be elected at the annual meeting.

Section 2. Regular Meetings. The Board of Directors shall hold a regular meeting on the fourth Thursday of each month at 4:00 p.m., or on such other day and time as may be fixed by resolution of the Board of Directors, at the Huntington Memorial Hospital, 300 West California Boulevard, Pasadena, California.

Section 3. Special Meetings. Special meetings may be called by the Chairman or Secretary at any time, and must be called at the written request of three Directors. In the absence of the Chairman, the Vice Chairman may call special meetings.

Section 4. Notice of Meetings. The Secretary shall give notice of the time and place of the annual meeting and special meetings to each Director upon at least four (4) calendar days' notice given by first-class mail or at least forty-eight (48) hours' notice delivered personally or by telephone, including a voice messaging system or other system or technology designed to record and communicate messages, or by "electronic transmission by the Corporation" (as defined below). Any such notice shall be addressed or delivered to each Director at such Director's address as is shown upon the records of the Association or as may have been given to the corporation by the Director for purposes of notice, or if such address is not shown on such records or is not readily ascertainable, at the place in which the meetings of the Directors are regularly held. Notice by mail shall be deemed to have been given at the time a written notice is deposited in the United States mail, postage prepaid. Any other written notice shall be deemed to have been given at the time it is personally delivered to the recipient or is delivered to a common carrier for transmission or actually transmitted by the person giving the notice by

electronic means, to the recipient. Oral notice shall be deemed to have been given at the time it is communicated, in person or by telephone, including a voice messaging system or other system or technology designed to record and communicate messages, telegraph, facsimile, electronic mail, or other electronic means, to the recipient or to a person at the office of the recipient who the person giving notice has reason to believe will promptly communicate it to the recipient. The recital by the Secretary in the minutes that due notice was given shall be sufficient evidence of that fact. No notice of the regular monthly meetings shall be required.

For purposes of these Bylaws, "electronic transmission by the Corporation" means a communication (a) delivered by facsimile telecommunication or electronic mail when directed to the facsimile number or electronic mail address, respectively, for that recipient on record with the Corporation, (b) to a recipient who has provided an unrevoked consent to the use of those means of transmission for communications under or pursuant to the California Corporations Code, and (c) that creates a record that is capable of retention, retrieval, and review, and that may thereafter be rendered into clearly legible tangible form.

Section 5. Quorum and Actions. At all meetings of the Board of Directors, ten Directors at any one meeting shall constitute a quorum and any action of the Board at any meeting shall require a majority vote of the Directors present at the meeting; provided, however, that (subject to the sections of the California Corporations Code set forth in California Corporations Code, Section 5151(c) to the extent they are applicable) the affirmative vote of a majority of the Directors who are Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust shall be necessary for the transaction of any business; and provided further, that a quorum shall not be less than two-fifths of the number of Directors authorized in these Bylaws, or less than two, whichever is larger, unless the number of Directors authorized in these Bylaws is one, in which case one Director constitutes a quorum.

Members of the Board of Directors may participate in a meeting through use of a conference telephone, electronic video screen communication or similar communications equipment so long as all Directors participating in the meeting are able to hear one another. Participation in a meeting as permitted in the preceding sentence constitutes presence in person at such meeting of the person or persons so participating if the following apply:

(i) Each member participating in the meeting can communicate with all of the other members concurrently

(ii) Each member is provided the means of participating in all matters before the Board, including the capacity to propose, or to interpose an objection, to a specific action to be taken by the Corporation.

Section 6. Place of Meetings. All meetings of Directors shall be held in the County of Los Angeles, California, unless the Directors shall otherwise designate or approve.

Section 7. Attendance. All Directors shall be expected to attend all duly called meetings of the Board of Directors. Attendance at no less than 50% of all duly called meetings shall be necessary for each Director, not a Trustee of the Collis P. and Howard Huntington Memorial Hospital Trust, to maintain membership on the Board of Directors (actual attendance records will be reviewed by the Governance Committee); provided, however, that, for purposes of computing a Director's percentage of attendance, there shall be excluded (both from the numerator and from the denominator) any meeting which such Director fails to attend for good cause, as determined by the affirmative vote of a majority of those Directors who are Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust

Section 8. Action Without Meeting. Any action required or permitted to be taken by the Board may be taken without a meeting if all members of the Board shall individually or collectively consent in writing to such action, provided, however that the consent of any Director who has a material financial interest in a transaction to which the corporation is a party and who is an "interested director" as defined in section 5233 of the California Corporations Code, or who is a "common director" as described in Section 5234 of the California Corporations Code, shall not be required for approval of that transaction where the facts giving rise to the exception are established in advance of the execution of, and are set forth in, the written consent or consents. Such consent or consents shall be filed with the minutes of the proceedings of the Board of Directors and shall have the same force and effect as a unanimous vote of such Directors.

Section 9. Adjournment of Meetings. A majority of the Board of Directors present, whether or not a quorum is present, may adjourn any meeting to another time and place. If the

meeting is adjourned for more than 24 hours, notice of any adjournment to another time and place shall be given prior to the time of the adjourned meeting to the Directors who are not present at the time of the adjournment.

ARTICLE V

POWERS OF DIRECTORS

Section 1. Powers. The powers of the Directors shall be:

(a) To conduct, manage and control the affairs and business of the Association.

(b) To make rules and regulations not inconsistent with the laws of the State of California and to adopt and amend Bylaws for the Association for the guidance of its officers and employees in the management of its affairs.

(c) To incur indebtedness and cause its notes to be executed as evidence thereof, and to secure the payment thereof by mortgage, pledge, assignment or otherwise.

(d) From time to time by resolution adopted by a majority of the number of the Directors then in office provided that a quorum is present (but subject to the provisions of Article V, Section 5 of these Bylaws), to appoint committees to exercise the authority of the Board of Directors between meetings of the Board of Directors, and to delegate to said committees such of their powers as they deem appropriate; provided that all members of any such committee which has the power to exercise the authority of the Board shall be members of the Board of Directors of the Association and that any such committee which has such power shall consist of two or more Directors; and provided further that no committee shall have authority as to any of the following:

(1) The filing of vacancies on the Board or in any committee which has the authority of the Board;

(2) The fixing of compensation of the directors for serving on the Board or on any committee.

(3) The amendment or repeal of bylaws or the adoption of new bylaws;

(4) The amendment or repeal of any resolution of the Board which by its expressed terms is not so amendable or repealable;

(5) The appointment of committees of the Board or the members thereof;

(6) The approval of any self-dealing transaction within the meaning of Section 5233 of the California Corporations Code, except as provided in paragraph (3) of subdivision (d) of that Section 5233.

ARTICLE VI

OFFICERS

Section 1. Officers. The officers shall consist of a Chairman of the Board, a Vice Chairman of the Board, a President, one or more additional Vice Presidents, a Secretary, one or more Assistant Secretaries, a Treasurer, and one or more Assistant Treasurers, one of whom serves as the Chief Financial Officer for the Association. Neither the Secretary, Treasurer nor the Assistant Treasurer who serves as the Chief Financial Officer may serve concurrently as President or Chairman of the Board.

Section 2. Term of Office. The officers shall be elected by the Board of Directors at the annual meeting and shall hold office for one year and until their successors are chosen and qualified. The term of office shall begin immediately after election.

Section 3. Vacancies. Vacancies may be filled for the unexpired term at any regular meeting of the Board of Directors, or at any special meeting called for that purpose.

Section 4. Chairman Pro Tempore. In the absence of the Chairman and Vice Chairman, or in the event of their inability to act, the Board of Directors may elect a Chairman Pro Tempore who shall act as such Chairman during such absence or inability to act.

Section 5. Secretary Pro Tempore. In the absence of the Secretary and Assistant Secretary, or in the event of their inability to act, the Board of Directors may elect a Secretary Pro Tempore who shall act as such Secretary during such absence or inability to act.

Section 6. Treasurer Pro Tempore. In the absence of the Treasurer and Assistant Treasurer, or in the event of their inability to act, the Board of Directors may elect a Treasurer Pro Tempore who shall act as such Treasurer during such absence or inability to act.

ARTICLE VII

DUTIES OF THE OFFICERS

Section 1. Duties. The respective Officers shall exercise the usual functions of such Officers, together with such powers and duties as may from time to time be designated or assigned to them.

Section 2. Chairman of the Board. The Chairman shall be a member of the Board of Directors and shall:

(a) have general direction of the affairs of the Board of Directors of the Association and shall preside at all meetings of the Directors;

(b) sign all corporate instruments in writing, required by law to be signed by such officer and not others, except as directed by resolution of the Board of Directors;

(c) perform such other duties from time to time as directed or authorized by the Board of Directors; and

(d) act as the representative of the Board of Directors in relationships with the President regarding administration of the Hospital.

Section 3. Vice Chairman of the Board. There shall be a Vice Chairman who is a member of the Board of Directors. If at any time the Chairman shall for any reason be unable to perform the duties of his office, or any of them, the Vice Chairman shall perform such duties, and when so acting shall have the power and authority of the Chairman.

Section 4. President. The President shall be the Chief Executive Officer of the Association. In accordance with the objectives and policies of the Association as established by the Board of Directors the President shall have full authority and responsibility for the management and operation of Hospital and shall report regularly to the Board of Directors concerning the performance of Hospital. The President shall provide leadership and administrative staff support for the development and execution of objectives, policies, plans and programs adopted by the Board of Directors; coordinate and direct the administration and management of the Hospital through the delegation of authority and management to such one or more other Vice Presidents as the President may designate; ensure competency of the staff; coordinate the continuing planning and long range development of the Hospital; and provide appropriate continuing administrative support to the Board of Directors, its committees and officers and to the Medical Staff and its committees and officers to ensure appropriate policy and program development and control. In the temporary absence of the President, one of the Vice Presidents will be designated by the President to act on behalf of the President.

Section 5. Secretary. The Secretary:

(a) shall notify or cause the notification of the Directors of all meetings of the Board of Directors as required by these Bylaws, and shall keep or cause to be kept the minutes of all meetings of Directors;

(b) shall sign, as Secretary, all corporate instruments in writing required by law to be signed by such officer and no others, except as directed by resolution of the Board of Directors; and

(c) shall perform such other duties from time to time as directed or authorized by resolution of the Board of Directors.

Section 6. Assistant Secretary. The Assistant Secretary shall assist the Secretary in his general duties and in the absence of the Secretary shall perform all the duties of said office.

Section 7. Treasurer. The Treasurer shall perform such duties from time to time as directed or authorized by the Board of Directors.

Section 8. Assistant Treasurer. The Assistant Treasurer who serves as the Chief Financial Officer, excepting such functions that are by these bylaws or by the Board of Directors assigned to another, shall exercise the usual functions of that office and any other duties that are from time to time prescribed by the Board of Directors. In this regard, and not in any way limiting the description of functions in the preceding sentence, the Chief Financial Officer shall:

(a) keep and maintain, or cause to be kept and maintained, adequate and correct accounts of the properties and business transactions of the Association, including accounts of its assets, liabilities, receipts, disbursements, gains and losses;

(b) cause to be deposited all moneys and other valuables in the name and to the credit of the Association in such depositories as may be designated by the Board of Directors;

(c) disburse or cause to be disbursed the funds of the Association as shall be ordered by the Board of Directors;

(d) render or cause to be rendered to the Chair of the Board and the Board of Directors, whenever they shall request it, an accounting of all transactions as Chief Financial Officer and of the financial condition of the Association;

(e) submit an annual report as required by Article III, Section 6 hereof; and

(f) have such other powers and perform such other duties as may be prescribed by the Board of Directors or these Bylaws.

Section 9. Execution of Checks. All checks, warrants, bills, notes and/or contracts of the Association shall be executed for and on behalf of the Association as provided from time to time by resolution of the Board of Directors.

ARTICLE VIII

COMMITTEES

Section 1. Committees. The Board of Directors shall determine the number of its committees and their functions. The basic purpose of committees is to assist the Board of Directors and thereby better enable the Board to achieve the purpose of the Hospital in serving the community and providing patient care.

Section 2. Appointment of Committees. The Chairman and the members of each committee shall be appointed by the Chairman of the Board at the annual meeting, and shall be confirmed by the Board of Directors. Removals or replacements of committee members may be made in the same manner as original appointments at any regular meeting of the Board of Directors.

Section 3. Standing Committees. Standing committees shall consist of, but not be limited to, the following:

(1) The Community Benefits Committee shall oversee community outreach activities in conjunction with the community needs biannual plan as mandated by the State of California.

(2) The Building Committee shall be responsible for reviewing all building projects, including plans and costs. The committee shall make recommendations to the Board of Directors concerning all building projects

(3) The Finance Committee shall meet regularly to review the financial affairs of the Association and shall annually review the audit report. The committee shall review monthly and annual

financial statements, including budget and equipment schedules and shall make recommendations to the Board of Directors.

(4) The Investment Committee shall meet regularly and will be responsible for administering, reviewing, monitoring and recommending to the Board of Directors a program for the investment of funds of the Association.

(5) The Audit and Compliance Committee shall be responsible for advising and making recommendations to the Board of Directors based on this committee's oversight of the Association's financial reporting process on behalf of the Board, review of the audit program and reports for the Association, and oversight of the Association's Ethics Program, Compliance Program activities and conflict of interest policy. The committee shall make yearly recommendations to the Board concerning the appointment of the auditing firm, the scope of the audit, and approval of all fees for audit and, whenever necessary, termination of the auditors.

(6) The Strategy Committee shall be responsible for developing the strategic plan of Hospital and shall provide oversight of the implementation of the strategic plan which shall include but not be limited to clinical programs, business plans and strategic alliances.

(7) The Compensation Committee shall be responsible to the Board of Directors for overall administration of the compensation programs of the Association, including recommending to the Board of Directors a compensation philosophy and strategy for Executive Management, monitoring competitive compensation levels and practices in comparable organizations in Southern California, providing oversight of benefit programs for Executive Management and for employees of the Association, and establishing and approving salary ranges, increases and annual

incentive objectives and awards for Executive Management of the Hospital. While the Board of Directors may grant the authority to the Compensation Committee for establishing executive salaries and awarding incentive payment, the committee will report to the full board the actual salaries and incentives paid.

(8) The Interdisciplinary Practice Committee shall be responsible for overseeing the Board's responsibilities related to Allied Health Professionals

(9) The Governance Committee shall be responsible for developing and monitoring a set of clear accountabilities and expectations for the Board of Directors. The committee shall also establish and maintain policies for recruitment, orientation, continuing education and evaluation of board members, with the objective of enhancing the overall effectiveness of the Board as a whole. The Governance Committee will also serve as the nominating committee for the nomination of officers and persons eligible to serve on the Board of Directors. Additionally, the committee will ensure there is appropriate succession planning for key board and management positions.

(10) The Quality Committee shall be responsible for advising and making recommendations to the Board of Directors based on this committee's monitoring of all patient safety and quality of care activities within the institution

(11) The Special Medical Staff Approval Committee shall be comprised of not less than 2 board members (and only of board members) and be responsible for reviewing recommendations from the Medical Staff with respect to policies and procedures, applicants for membership or privileges and taking action to the maximum extent

permitted by law with respect to such recommendations in those months when the Board is not meeting.

(12) The Philanthropy Committee shall be responsible for oversight of the hospital's fundraising efforts and, specifically, the overall direction of its philanthropic efforts.

Section 4. Reports of Committees. Whenever requested by the Board of Directors, each committee shall make a report, oral or written.

Section 5 Term of Office. The Chair, Vice Chair and each member of each standing committee shall serve until the next annual election of committee members by the Board of Directors and until his or her successor is appointed or until such committee is sooner terminated, or until such person is removed, resigns, or otherwise ceases to qualify as a chair or member, as the case may be, of the committee. Chairs, Vice Chairs and members of special committees shall serve for the life of the committee unless they resign or are sooner removed, replaced, or cease to qualify as a Chair or member, as the case may be, of such committee.

Section 6. Vacancies. Vacancies on any committee may be filled for the unexpired portion of the term in the same manner as provided in the case of original appointment.

Section 7. Meetings, Quorum. Each committee shall meet as often as necessary to perform its duties, at such times and places as directed by its Chair or by the Board of Directors. A majority of the members of a committee shall constitute a quorum of such committee. The chair of each committee shall preside at such committee's meetings; in the absence of the chair, the vice chair will preside at such meetings. Each committee shall keep accurate minutes of its meetings, the chair designating a secretary of the committee for this purpose, and shall, make periodic reports and recommendations to the Board of Directors. Except as otherwise provided in this Article VIII, meetings of committees shall be governed by, and held and taken in accordance with the following provisions of Article IV, with such changes in the context therein as are necessary to substitute the committee and its members for the Board of Directors and its members: Section 2 (Regular Meetings), Section 3 (Special Meetings), Section 4 (Notice of

Meetings), Section 5 (Quorum and Actions), Section 6 (Place of Meetings), Section 8 (Action Without Meeting), and Section 9 (Adjournment of Meetings).

Section 8. Expenditures. Any expenditure of corporation funds by a committee shall require prior approval of the Board of Directors.

ARTICLE IX
MEDICAL STAFF

Section 1. Organization and Appointments.

(a) The Board of Directors shall require the physicians, dentists and podiatrists granted practice privileges in the Hospital to organize into a medical and dental staff under Medical and Dental Staff Bylaws approved by the Board of Directors. The Board of Directors shall consider recommendations of the Medical and Dental Staff and appoint to the Medical and Dental Staff physicians, dentists and podiatrists who meet the qualifications for membership as set forth in the Bylaws of the Medical and Dental Staff. Each member of the Medical and Dental Staff shall have appropriate authority and responsibility for the care of his patients subject to such limitations as are contained in these Bylaws and in the Bylaws, rules and regulations for the Medical and Dental Staff and subject, further, to any limitations attached to his appointment.

(b) Rules regarding applications for appointment, term of appointment, renewal of privileges, reduction, suspension or termination of staff membership, or other appropriate rules for the governing of the Medical Staff, shall be contained in Medical Staff Bylaws as approved from time to time by the Board of Directors, which approval shall not be unreasonably withheld.

(c) A physician or dentist in a medical-administrative position, who holds a concurrent appointment on the Medical and Dental Staff, shall not have his Medical Staff privileges terminated without the same due process

provisions as are available to any other member of the Medical and Dental Staff, unless otherwise provided in the terms of a formal agreement covering the individual's engagement.

Section 2. Medical Care and Its Evaluation.

(a) The Medical and Dental Staff shall conduct a continuing review and appraisal of the quality of professional care rendered in the Hospital, and shall report such activities and their results to the Board of Directors.

(b) The Medical and Dental Staff shall make recommendations to the Board of Directors concerning (1) appointments, reappointments, and alterations of staff status, (2) granting of clinical privileges, (3) disciplinary actions, (4) all matters relating to professional competency, and (5) such specific matters as may be referred to it by the Board of Directors.

Section 3. Medical and Dental Staff Bylaws. There shall be bylaws, rules and regulations for the Medical and Dental Staff setting forth its organization and government and which shall include a mechanism for review of decisions affecting the privileges of members which provides for the exercise of due process. Proposed bylaws, rules and regulations may be recommended by the Medical and Dental Staff, but only those approved by the Board of Directors shall become effective, which approval shall not be unreasonably withheld. Neither the Medical Staff nor the Board of Directors may unilaterally amend the Medical Staff Bylaws or Rules and Regulations.

ARTICLE X
AMENDMENTS

Section 1. Procedure. These Bylaws may be amended or repealed, or new Bylaws may be adopted, at any meeting of the Board of Directors, by the affirmative vote of a majority of all Directors then in office, provided that the notice of the meeting shall contain the language of the amendment or new Bylaws or the fact of such rescission; or these Bylaws may be amended or repealed, or new Bylaws adopted, without a meeting, by the written consent of all the Directors then in office; provided however, that these Bylaws may not be amended or

repealed nor may new Bylaws be adopted, except upon, the affirmative vote of a majority of the Directors who are Trustees of the Collis P. and Howard Huntington Memorial Hospital Trust.

Section 2. Review. The Bylaws of the Pasadena Hospital Association, Ltd., shall be reviewed periodically by a committee appointed by the Chairman of the Board of Directors with the observations and results of the review reported to the Board of Directors at a regular meeting.

ARTICLE XI

AUXILIARY ORGANIZATIONS

There may be established from time to time auxiliary volunteer organizations such as guilds, leagues and women's auxiliaries whose purpose is to assist the Hospital in obtaining its goals through volunteer service, fund raising, public relations and public information programs. All auxiliary organizations associated with the Hospital shall have bylaws which delineate the purpose and functions of the auxiliary organization and such bylaws shall be approved by the Board of Directors of the Association. These Bylaws and the Articles of Incorporation of the Association shall prevail and govern over the documents and actions of such adjunct organizations. To the extent required by the Board of Directors or President, auxiliary and associated organizations shall provide periodic financial reports to the Association and be carried under a fidelity bond if they handle any funds.

ARTICLE XII

CORPORATE SEAL

Section 1. Seal. The corporate seal of the corporation shall be the impression of a circular disc, with the following inscription upon the circumference thereof, to wit: "PASADENA HOSPITAL ASSN., LTD., a corporation" and within the last mentioned inscription, the word "SEAL".

ARTICLE XIII

MISCELLANEOUS

Section 1. Voting Shares. The Association may vote any and all shares held by it in any other corporation by such officer, agent or proxy as the Board of Directors or President may

appoint, or in default of any such appointment, by its Chair of the Board or by its Vice Chair and, in such case, such officers, or any of them, may likewise appoint a proxy to vote said shares.

Section 2. Checks, Drafts, Etc. All checks, drafts or other orders for payment of money, notes or other evidence of indebtedness issued in the name of or payable to the corporation, and any and all securities owned or held by the Association requiring signature for the transfer, shall be signed or endorsed by such person or persons and in such manner as, from time to time, shall be determined by a resolution of the Board of Directors.

Section 3. Execution of Contracts. The Board of Directors or President, except as in these Bylaws otherwise provided, may authorize any officer or officers, agent or agents, to enter into any contract or execute any instrument in the name of and on behalf of the Association, and such authority may be general or confined to specific instances and unless so authorized by the Board of Directors or President, no officer, agent or employee shall have any power or authority to bind the Association by any contract or engagement or to pledge its credit or to render it liable for any purpose or in any amount.

Section 4 Conflict of Interest. The Board of Directors shall enforce a policy on conflicts of interest and self-dealing that requires a disclosure by all directors and officers of the Association and other persons in a position to influence corporate decisions of actual and potential conflicts of interest and that will assure that no person holding such a position will be permitted to vote on any issue, motion or resolution that directly or indirectly inures to his or her benefit financially or with respect to which he or she shall have any other conflict of interest, except that such individual may be counted in order to qualify a quorum, and, except as the board may otherwise direct, may participate in a discussion of such an issue, motion, or resolution if he or she first discloses the nature of his or her own interest.

Section 5. Appropriation of Business Opportunity and Confidential Information.

(a) No director or officer of the Association may appropriate or divert to others any opportunity for profit in connection with a transaction in which it is known or could be anticipated that the Association is or would be interested. Such opportunities include but are not limited to, acquisition of

real or personal property, appointment of suppliers, or design or development of new products, services or areas of business related to the corporation's present or planned services or service areas.

(b) Each director or officer of the Association with access to confidential information regarding the corporation or the Association's business is expected to hold such information in confidence and to refrain from either using such information for personal gain or disclosing it unnecessarily outside the scope of the director's or officer's duty with respect to the corporation.

Section 6. Fiscal Year. The fiscal or business year of the Association shall be the calendar year.

CERTIFICATE

I, Lois Starke Matthews, the Secretary of Pasadena Hospital Association, Ltd., a California nonprofit public benefit corporation, do hereby certify that the Bylaws attached hereto constitute the Bylaws of said corporation as adopted by its Board of Directors on the 23 day of October, 2014.

By: REDACTED
/Lois Starke Matthews



Exhibit 13-C

Last Will and Testament and Court Orders Establishing the Trust

vided for; the other one-half of said sum to be invested by said Trustees in the most available manner so that the income thereof may be used and shall be used by said Board of Trustees of the "Henry E. Huntington Library and Art Gallery" in maintaining a museum to be housed in that part of the "Henry E. Huntington Library and Art Gallery" which is used for exhibition purposes, the same to constitute and be a memorial to my deceased wife, Arabella D. Huntington.

NINETEENTH: As a memorial to my uncle, Collis P. Huntington, and my son, Howard Huntington, I hereby give, devise and bequeath to Henry M. Robinson, Dr. Ernest A. Bryant, George S. Patton, W. E. Dunn and Caroline H. Holladay, IN TRUST, for the Collis P. and Howard Huntington Memorial Hospital, and for the uses and purposes hereinafter stated, the total sum of Two Million Dollars ($2,000,000.00); one-third of said sum to be used by said trustees in purchasing the necessary ground and constructing thereon a building to be used as such memorial hospital, and two-thirds of said sum to be invested and reinvested, loaned and reloaned by said trustees for the purpose of making the best available profit thereon, all profits and income derived from the same to constitute an endowment fund for the maintenance and operation of said memorial hospital, which said hospital shall be erected and maintained at or near the City of Los Angeles, in the State of California, for the reception and treatment of individuals, but not including persons afflicted with tuberculosis. I make no provision in this Will for persons afflicted with tuberculosis for the reason that many institutions are being established for the separate treatment of persons so afflicted, and in my opinion, they should be kept separate and apart from persons afflicted with other diseases. In case any of said trustees herein named shall die, resign or be removed, or for any reason become incapacitated to perform the duties imposed upon them under this Will, the surviving trustees shall fill such vacancy by appointment, made in writing, to the end that said trusteeship shall remain perpetual, and said endowment fund kept invested and reinvested, or loaned and reloaned, from time to time, so as to yield an income for the perpetual maintenance of said hospital.

TWENTIETH: I give and bequeath to the Riverside Cemetery, at Oneonta, New York, the sum of Five Thousand Dollars

EHC:ME 6 5/25/32.

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA,
IN AND FOR THE COUNTY OF LOS ANGELES.

In the Matter of the Estate of HENRY E. HUNTINGTON, Deceased.	NO. 88867 ORDER FOR RATABLE DISTRIBUTION TO TRUSTEES FOR COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL.

NOW COME Caroline H. Holladay and Security-First National Bank of Los Angeles, as Executors of the Last Will and Testament of Henry E. Huntington, deceased, by Messrs. Gibson, Dunn & Crutcher, their attorneys, and show to the Court that their petition for ratable distribution herein was filed on the 10th day of May, 1932, and that on the same day the Clerk appointed the 24th day of May, 1932, as the date for the hearing thereof, and that notice of the time and place of said hearing has been duly given as required by law; that Howard Huntington, Jr., Leslie Alice Huntington and Henry Edwards Huntington, II, appeared by their Guardian Leslie G. Brehm, by Messrs. Overton, Lyman & Plumb, her attorneys; that Marie Spreckels Elizalde (named in said will as Mrs. Anger Elizaldi) and John D. Spreckels, III (named in said will as John Spreckels) appeared by Messrs. Thomas, Beedy, Presley and Paramore, their attorneys; that said petition is now presented to the Court, and no person appearing to contest the same, and it appearing that the time for filing or presenting claims has expired and that all valid claims have been paid, the Court, after hearing the evidence, grants said petition as follows, to-wit:

IT IS ORDERED BY THE COURT that the said Caroline H. Holladay and Security-First National Bank of Los Angeles, Executors of the Estate of Henry E. Huntington, Deceased, deliver to Henry M. Robinson, Ernest A. Bryant, Caroline H. Holladay, Geo. C. Ward,

COPY

and Collis H. Holladay the following described property, to-wit:

2070 shares Redondo Improvement Company (incorporated in California) common stock, par value $100 per share

1651 shares San Gabriel River Improvement Company (incorporated in California) stock, Par value $100 per share

600 First and Refunding Mortgage Thirty-Year 5% Bonds of Los Angeles Railway Corporation (incorporated in California), par value $1,000 each

750 Pacific Electric Railway Company Refunding Mortgage 5% Gold Bonds due 1961, par value $1,000 each

IN TRUST, NEVERTHELESS, for the following uses and purposes:

To use one-third of the same in purchasing the necessary ground and constructing thereon a building to be known as the Collis P. and Howard Huntington Memorial Hospital and two-thirds of the same to be retained and/or invested and reinvested, loaned and reloaned by said Trustees for the purpose of making the best available profit thereon, all profits and income derived from the same to constitute an endowment fund for the maintenance and operation of said memorial hospital, which said hospital shall be erected and maintained at or near the City of Los Angeles, in the State of California, for the reception and treatment of individuals, but not including persons afflicted with tuberculosis. No provision is made for persons afflicted with tuberculosis for the reason that many institutions are being established for the separate treatment of persons so afflicted and it is felt that they should be kept separate and apart from persons afflicted with other diseases. In case any of said trustees shall die, resign or be removed, or for any reason become incapacitated to perform the duties imposed upon them under this trust, the surviving trustees shall fill such vacancy by appointment, made in writing, to the end that said trusteeship shall remain perpetual, and said endowment fund kept invested and reinvested, or loaned and reloaned, from time to time, so as to yield an income for the perpetual maintenance of said hospital.

IT IS FURTHER ORDERED, ADJUDGED and DECREED that said securities shall be delivered by the executors and received by said trustees as satisfaction in full of the legacy of Two Million Dollars ($2,000,000.00) provided by the terms of Clause Nineteenth of the Last Will and Testament of said deceased (subject to the

payment at a later date of any interest which may have accrued thereon), and that the value of said securities is Two Million Dollars ($2,000,000.00).

AND IT IS FURTHER ORDERED, ADJUDGED and DECREED that inasmuch as said legacy is satisfied in securities in lieu of cash, that said Trustees shall have the power to sell any or all of said securities at the best price obtainable in order to carry out the purposes of said trust.

DATED: May 27, 1938.

REDACTED

Judge of said Superior Court.

FLM/dk 3/6/58 1-6

GIBSON, DUNN & CRUTCHER
634 South Spring Street
Los Angeles 14, California
MUtual 5381
Attorneys for Trustees

FILED
MAR 7 1958
HAROLD J. OSTLY, County Clerk
By W. J. Mason DEPUTY

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF LOS ANGELES

In the Matter of the Estate of HENRY E. HUNTINGTON, Deceased.

No. 88867

ORDER SETTLING REPORT AND FOURTEENTH ACCOUNT CURRENT OF TRUSTEES OF COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL AND INSTRUCTING TRUSTEES

The Report and Fourteenth Account Current of Trustees of Collis P. and Howard Huntington Memorial Hospital and Petition for Instructions filed herein by Collis H. Holladay, John McWilliams, Edward R. Valentine, Shannon Crandall, Jr. and Herbert L. Hahn, as Trustees of the Collis P. and Howard Huntington Memorial Hospital under and by virtue of the Last Will and Testament and Decree of Distribution in the Estate of Henry E. Huntington, deceased, came on regularly for hearing January 14, 1958, at 9:15 o'clock A.M. in Department 5 of the above entitled Court. Said Trustees appeared by their attorneys, Messrs. Gibson, Dunn & Crutcher, by Frank L. Mallory. Evidence was offered and received, including the oral testimony of Edward R. Valentine. Written points and authorities in support of the Trustees' Petition for Instructions and written supplemental points and authorities having been filed herein by said attorneys, and the matter having been submitted, the Court finds that due notice of said hearing has been given as required by law; that all of the factual allegations of said Report, Account and Petition are true; and that said Report and Account should be approved, allowed and settled as rendered and reported.

GIBSON, DUNN & CRUTCHER

COPY

NOW, THEREFORE, IT IS HEREBY ORDERED, ADJUDGED AND DECREED that said Trustees have in their possession, after deducting the credits to which they are entitled, a balance of $5,132,713, of which $299,882 is in cash, belonging to the Collis P. and Howard Huntington Memorial Hospital Trust, and a balance of $2,531,208, of which $192,106 is in cash, belonging to the Pasadena Hospital Association, Ltd., and said Account and Report, including the acts of said Trustees as set forth in said Account and Report, is hereby approved, allowed and settled accordingly.

IT IS FURTHER HEREBY ORDERED, ADJUDGED AND DECREED that said Trustees be, and they are hereby, instructed that to carry out the expr purposes of the trust, and in aid of the execution and proper administration, management and disposition of the trust estate, and subject to the limitations applicable to the original endowment fund as provided in the Order for Ratable Distribution to Trustees for Collis P. and Howard Huntington Memorial Hospital dated May 27, 1932, the Trustees shall have the following powers and discretions in addition to any now or hereafter or heretofore conferred by law or otherwise affecting the trust and the trust estate:

1. At their option, and as long as they may deem advisable, to continue to hold any property, to retain any property which they may receive, and to operate at the risk of the trust estate any property or business received in this trust, as long as they may deem advisable, the profits and losses therefrom to inure and be chargeable to the trust estate and not to the Trustees.

2. To manage, control, sell, convey, exchange, partition, divide, subdivide, improve, repair; to grant options and to sell upon deferred payments; to lease for terms without regard to whether they are within or could possibly extend beyond the duration of this trust for any purpose, including exploration for and removal of

gas, oil and other minerals; to enter into community oil leases, pooling and unitization agreements; to create restrictions, easements and other servitudes; to compromise, arbitrate or otherwise adjust claims in favor of or against the trust; to institute, compromise and defend actions and proceedings; to carry such insurance as the Trustees may deem advisable.

3. To invest and reinvest the principal, and to purchase or acquire therewith every kind of property, real, personal or mixed, and every kind of investment, specifically including, but not by way of limitation, corporate obligations of every kind, and stocks, preferred or common, which men of prudence, discretion and intelligence acquire for their own account.

4. To advance funds to this trust for any trust purpose, such advances with interest at current rates to be a first lien on and to be repaid out of principal or income; to reimburse themselves from principal or income for any loss or expense incurred by reason of their ownership or holding of any property in this trust.

5. To borrow money for any trust purpose upon such terms and conditions as the Trustees may deem proper, and to obligate the trust estate for repayment.

6. To have respecting securities all the rights, powers and privileges of an owner, including the power to pay assessments and other sums deemed by the Trustees necessary for the protection of the trust estate; to participate in voting trusts, pooling agreements, foreclosures, reorganizations, consolidations, mergers and liquidations, and in connection therewith to deposit securities with and transfer title to any protective or other committee under such terms as the Trustees may

deem advisable; to exercise or sell stock subscription or conversion rights; to accept and retain as an investment any securities or other property received through the exercise of any of the foregoing powers, regardless of any limitations elsewhere in this instrument relative to investments by the Trustees.

7. To pay out of principal or income as they may elect, or partially out of each in such shares as they may determine any and all assessments, subscriptions, contributions, loans and other moneys deemed by the Trustees to be necessary, advisable or proper for the protection of the Trustees' interests as holders of any and all property, real or personal, tangible or intangible.

8. To create, place, replace, renew or extend any debt, pledge, or encumbrance upon any part of the trust estate when the same become due or at any time such creation, placement, replacement, renewal or extension may be, in the judgment of the Trustees, for the best interests of the trust estate, or necessary to protect the trust property, and upon such terms and conditions and by such means of security as said Trustees may deem proper, including the right and power to convey or assign the title to said property to such person or corpgration as they may select for the purpose of executing and delivering the necessary notes, mortgages, deeds of trust, or other instruments of hypothecation to evidence and secure such debt or debts and reconvey and reassign said property to the Trustees subject thereto; and, when such reconveyance or reassignment shall have been so made said Trustees shall be restored to their full estate hereunder; to mortgage, pledge, or otherwise hypothecate any of the property in the trust for a

term or terms extending beyond the life of the trust for the purpose of securing any indebtedness of any corporation, a majority of whose voting stock is held by the trust; to make contributions to the capital of any corporation, a majority of whose voting shares are held by the trust, whether such contributions shall be in the form of money or otherwise.

9. To maintain an office or offices, to employ any and all officers, agents and assistants that the Trustees may deem necessary or desirable for administering said trust or carrying on the work thereof pursuant to the provisions thereof, and to carry on any work and to incur any expenses that the Trustees may consider necessary or desirable in the conduct of the affairs of the trust estate.

10. In the event that any of the corporations, a majority of whose shares of voting stock shall become part of the trust estate, shall be liquidated so that the trust estate shall receive its share of the assets of such corporation, the Trustees shall be as fully empowered to run the business theretofore conducted by the said liquidating corporation as the said corporation was empowered so to do prior to the liquidation thereof.

11. To budget the estimated annual income and expenses of the trust and to provide and maintain out of income such reserves for depreciation, depletion, obsolescence and replacement of buildings and equipment, both present and future, as the Trustees in their discretion may deem necessary or appropriate to carry out the purposes of the trust.

12. To pay out of principal or income as they

may elect, or partially out of each in such shares as they may determine, property taxes, assessments, charges, attorneys' fees, and other expenses incurred in the administration or protection of this trust.

13. To determine what is principal or income of the trust estate and apportion and allocate in their discretion any and all receipts and expenses as between these accounts, including also the power to charge in whole or in part against principal, or to amortize out of or charge forthwith to income, premiums paid on purchase of bonds or other obligations.

14. To accept and retain gifts and additions of money or property or money and property in such form and amounts and subject to such conditions, charges, liens, encumbrances, covenants and restrictions as the Trustees may in their absolute discretion determine as an addition to and to carry out the purposes of this trust.

15. Unless specifically limited, all discretions conferred upon the Trustees shall be absolute. The enumeration of certain powers of the Trustees shall not limit their general or implied powers, and the Trustees, subject always to the discharge of their fiduciary obligations, are vested with and shall have all the rights, powers and privileges which an absolute owner of the same property would have.

IT IS FURTHER HEREBY ORDERED, ADJUDGED AND DECREED that the Trustees be, and they are hereby, instructed that they have the discretion, and may properly exercise their said discretion, with respect to the computation and maintenance of depreciation reserves to compute such reserves on the basis of estimated replacement cost and so as to provide for both (i) the maintenance, modernization, or replacement of existing buildings and equipment, and (ii) construct-

ing new buildings and installing new equipment.

IT IS FURTHER HEREBY ORDERED, ADJUDGED AND DECREED that the Trustees be, and they are hereby, instructed that they may act by a majority of the duly appointed and qualified Trustees, except as to the appointment of a successor Trustee. The appointment of a successor Trustee shall be made by all living Trustees then in office

IT IS FURTHER HEREBY ORDERED, ADJUDGED AND DECREED that the Trustees be, and they are hereby, instructed that they are authorized to and may properly consent to such amendment of the By-Laws of Pasadena Hospital Association, Ltd. as may be necessary to increase the number of directors of said Pasadena Hospital Association, Ltd. to seven, provided a majority of said Directors shall be Trustees of this trust.

DATED: March 7th, 1958.

REDACTED

Judge of the Superior Court

GIBSON, DUNN & CRUTCHER
515 South Flower Street
Los Angeles, California 90071
Telephone: (213) 620-9300
Attorneys for Trustees

Filed
Jun 19, 1972

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

In the Matter of the Estate of HENRY E. HUNTINGTON, Deceased) No. P 80867

ORDER SETTLING REPORT AND TWENTY-SEVENTH ACCOUNT CURRENT OF TRUSTEES OF COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL FUND; AND INSTRUCTING TRUSTEES

(COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL FUND)

The Report and Twenty-Seventh Account Current of Trustees of Collis P. and Howard Huntington Memorial Hospital Fund, and Petition For Instructions, filed herein on or about May 8, 1972, by James D. Macneil, David B. MacTavish, William E. Siegel, Gleeson L. Payne and John S. Griffith, Jr., as Trustees of the Collis P. and Howard Huntington Memorial Hospital Fund, under and by virtue of the Last Will and Testament and Decree of Distribution in the Estate of Henry E. Huntington, deceased, having come on regularly to be heard on the 13th day of June, 1972, at 9:15 A.M. in Department 5 of the above-entitled Court, the Honorable Victor E. Donatelli, Judge Pro Tempore Presiding, and petitioners appearing by their attorneys, Gibson, Dunn & Crutcher, by Frank L. Mallory, Esq., and evidence having been offered and received, and it appearing to the Court, and the Court finding therefrom as follows:

That notice of the time and place of hearing of the aforesaid matter has been duly and regularly given in the manner required by law; that Collis H. Holladay, one of the Trustees, died January 7, 1972, subsequent to the close of the accounting; that the Trustees may properly act with other directors of Pasadena Hospital Association, Ltd., a California non-profit corporation, in amending the By-Laws of said corporation as hereinafter set forth; and that all of the allegations of said Account and Report are true; NOW, THEREFORE,

IT IS HEREBY ORDERED, ADJUDGED AND DECREED by the Court that said Trustees have in their possession belonging to said trust estate, after deducting the credits to which they are entitled, the following balances:

$16,481,834, of which $1,328,777 is in cash, in the Collis P. and Howard Huntington Memorial Hospital Fund; and

$23,757,885, of which $4,385,636 is in cash, in the Pasadena Hospital Association, Ltd. Fund; and

IT IS FURTHER HEREBY ORDERED, ADJUDGED AND DECREED that said Account and Report, and the acts of said Trustees, as set forth in said account and report, are hereby approved, allowed and settled; and the Estate of Collis H. Holladay, deceased former Co-Trustee herein, is hereby discharged from all liability and any further responsibility as to this trust for the period covered by said account and report, to-wit, up to and including September 26, 1971; and

IT IS FURTHER HEREBY ORDERED, ADJUDGED AND DECREED that the Trustees be, and they are hereby, instructed that they may properly join with the other directors of the Pasadena Hospital Association, Ltd., a California non-profit corporation, in amending the By-Laws of the Association (i) to increase the number of directors, (ii) to provide that the affirmative vote of a majority of the Trustees shall be necessary for the trans-

action of any business of the Board of Directors, and (iii) to require the affirmative vote of a majority of the Trustees to amend that provision of the By-Laws described in (ii) above.

DATED: June 19, 1972.

REDACTED

Victor E. Donatelli

Judge Pro Tempore

GIBSON, DUNN & CRUTCHER
FRANK L. MALLORY
JAMES C. OPEL
515 South Flower Street
Los Angeles, California 90071
(213) 488-7000
Attorneys for Trustees

Filed November 10, 1975

SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES

In the Matter of the Estate of HENRY E. HUNTINGTON, Deceased.	NO. P 88867 ORDER SETTLING REPORT AND TWENTY-EIGHTH ACCOUNT CURRENT OF TRUSTEES OF COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL FUND; DISCHARGING CERTAIN CO-TRUSTEES; AND INSTRUCTING TRUSTEES (COLLIS P. AND HOWARD HUNTINGTON MEMORIAL HOSPITAL FUND)

The Report and Twenty-Eighth Account Current of the Trustees of the Collis P. and Howard Huntington Memorial Hospital Fund, and Petition for Instructions, filed herein on October 2, 1975 by James D. Macneil, David B. MacTavish, Gleeson L. Payne, Harry S. Meily and Henry A. Braun, as Trustees of the Collis P. and Howard Huntington Memorial Hospital Fund, under and by virtue of the Last Will and Testament of Henry E. Huntington, Deceased, and the Order for Ratable Distribution, dated May 27, 1932, in the Estate of Henry E. Huntington, Deceased, having come on regularly to be heard on the 4th day of November, 1975 at 9:15 A.M. in Department 11 of the above-entitled Court, the Honorable David N. Eagleson, Judge Presiding, and petitioners being represented by their attorneys, Gibson, Dunn & Crutcher, by Frank L. Mallory and

James C. Opel, and evidence having been offered and received, and it appearing to the Court, and the Court finding as follows:

That notice of the time and place of the hearing of the aforesaid matter has been duly and regularly given in the manner required by law; that William E. Siegel, the Co-Trustee previously occupying the Co-Trustee position currently held by Harry S. Neily, died on July 30, 1973; that John S. Griffith, Jr., the Co-Trustee previously occupying the Co-Trustee position currently held by Henry A. Braun, has resigned; and that all of the allegations of said Account and Report and Petition for Instructions are true; NOW, THEREFORE,

IT IS HEREBY ORDERED, ADJUDGED AND DECREED by the Court that said Trustees have in their possession belonging to said trust estate, after deducting the credits to which they are entitled, the following balances, as of September 30, 1974:

(a) $19,896,675.00, of which $1,621,070.00 is in cash, in the Collis P. and Howard Huntington Memorial Hospital Fund; and

(b) $25,986,737.00, of which $1,883,458.00 is in cash, in the Pasadena Hospital Association, Ltd. Fund; and

IT IS FURTHER HEREBY ORDERED, ADJUDGED AND DECREED that said Account and Report, and all the acts of said Trustees, as set forth in said Account and Report, are hereby approved, allowed and settled; and

IT IS FURTHER HEREBY ORDERED, ADJUDGED AND DECREED that the Estate of William E. Siegel, Deceased, is hereby discharged from all liability and any further responsibility as to this Trust; and

IT IS FURTHER HEREBY ORDERED, ADJUDGED AND DECREED that John S. Griffith, Jr., is hereby discharged from all liability and any further responsibility as to this Trust; and

---

IT IS FURTHER HEREBY ORDERED, ADJUDGED AND DECREED that the Trustees are hereby authorized to use trust funds to acquire, hold and maintain real property adjacent to or in the vicinity of the Collis P. and Howard Huntington Memorial Hospital and to lease, grant options on, sell (for cash or on deferred payments), and convey such real property to non-profit health care organizations, including, but not limited to, the Child Guidance Clinic; to operate any property of the trust in conjunction with any such non-profit health care organization for the purpose of providing health care services; to acquire and hold any property, and to operate and utilize any property held by the trust, for the purpose of providing health care services, in such manner and to such extent as the Trustees, in the Trustees' discretion, may determine. (As used herein, the term "health care" is to be interpreted broadly and shall include, but not be limited to, mental and physical health care, and counseling services related thereto.)

IT IS FURTHER HEREBY ORDERED, ADJUDGED AND DECREED that the Trustees and the Trust shall be and are hereby relieved from the restrictions, contained in Article Nineteenth of the Will of Henry E. Huntington, Deceased, which prohibit maintenance and operation of the Collis P. and Howard Huntington Memorial Hospital for the reception and treatment of persons afflicted with tuberculosis, and such restrictions shall be of no further force or effect.

DATED: November 10, 1975.

DAVID N. EAGLESON

DAVID N. EAGLESON, Judge of the Superior Court

THE DOCUMENT TO WHICH THIS CERTIFICATE IS ATTACHED IS A FULL, TRUE AND CORRECT COPY OF THE ORIGINAL ON FILE AND OF RECORD IN MY OFFICE.
SAME HAVING BEEN FILED NOV 10 1975

ATTEST NOV 25 1975, 19

CLARENCE E. CADELL, County Clerk and Clerk of the Superior Court of the State of California, for the County of Los Angeles

BY _____ DEPUTY

BIRCH, KUHN & CROCKER

GIBSON, DUNN & CRUTCHER
MARC R. ISAACSON
STEVEN A. RUBEN
333 South Grand Avenue
Los Angeles, California 90071
(213) 229-7000
Attorneys for Trustees

ORIGINAL FILED
AUG 18 1992
LOS ANGELES
SUPERIOR COURT

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

In the Matter of the Estate of HENRY E. HUNTINGTON, Deceased	CASE NO. P 88867 ORDER INSTRUCTING TRUSTEES Date: August 5, 1992 Time: 9:15 a.m. Dept: 11

The Petition For Instructions of Gleeson L. Payne, Leonard M. Marangi, James N. Gamble, Frank A. Thomas and Verne Orr, as Trustees of the Collis P. and Howard Huntington Memorial Hospital Fund (hereinafter the "Trust") came on regularly for hearing on August 5, 1992, in Department 11 of the above-entitled Court, the Honorable Ann E. Stodden, Judge Pro Tempore presiding. The Petitioners appeared by their attorneys, Gibson, Dunn & Crutcher, by Steven A. Ruben.

The Court finds:

1. All notices of the within matter have been given as required by law;

2. All of the allegations of the Petition are true;

COPY

3. It is for the benefit and in the best interests of the trust estate and those beneficially interested therein that the Trustees of the Trust possess all of the powers enumerated in Chapter 2 (commencing with Section 16200 of Part 4 of Division 9 of the Probate Code, as the same may be hereafter amended, and including any successor provisions thereto), irrespective of whether any of the powers so enumerated were or were not conferred upon the Trustees by any prior order of this Court (with the exception of those powers, not otherwise possessed by the Trustees, which the applicable statute confers only in the case of trusts created on or after a date subsequent to May 27, 1932, the date of the Order For Ratable Distribution by which the Trust was established);

4. In connection with the proposed issuance by the beneficiary of the Trust, Pasadena Hospital Association, Ltd., of approximately $93,000,000.00 in revenue bonds through the California Health Facilities Financing Authority, it is for the benefit and in the best interests of the trust estate and those beneficially interested in therein that the Trustees be permitted to guarantee the repayment of said bonds by Pasadena Hospital Association, Ltd., and to pledge the assets of the Trust as security for such guarantee or, alternatively, for the Trustees to cause the Trust to become a member of the group of entities obligated for repayment of said bonds; and

5. That the Petition should be granted as prayed.

NOW, THEREFORE, the Court hereby orders, adjudges, decrees and instructs the Trustees as follows:

1. The Trustees of the Trust possess all of the powers enumerated in Chapter 2 (commencing with Section 16200

of Part 4 of Division 9 of the Probate Code, as the same may be hereafter amended, and including any successor provisions thereto), irrespective of whether any of the powers so enumerated were or were not conferred upon the Trustees by any prior order of this Court (with the exception of those powers, not otherwise possessed by the Trustees, which the applicable statute confers only in the case of trusts created on or after a date subsequent to May 27, 1932, the date of the Order For Ratable Distribution by which the Trust was established).

2. In connection with the proposed issuance by the beneficiary of the Trust, Pasadena Hospital Association, Ltd., of approximately $93,000,000.00 in revenue bonds through the California Health Facilities Financing Authority, the Trustees are empowered and authorized to guarantee repayment of said bonds by Pasadena Hospital Association, Ltd., and to pledge the assets of the Trust as security for such repayment, or, alternatively, to cause the Trust to become a member of the group of entities obligated for repayment of said bonds.

DATED: AUG 18 1992

Ann E. Stodden

ANN E. STODDEN
JUDGE PRO TEM

LTK2208.01
Gibson, Dunn & Crutcher

GIBSON, DUNN & CRUTCHER
MARC R. ISAACSON
333 South Grand Avenue
Los Angeles, California 90071

(213) 229-7000

Attorneys for Trustees

FILED
LOS ANGELES SUPERIOR COURT
FEB 25 1993
JAMES H. DEMPSEY, CLERK
BY N. NAVARRO DEPUTY

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

MAR 04 1993

In the Matter of the Estate

of

HENRY E. HUNTINGTON,

Deceased

CASE NO. P 88867

ORDER INSTRUCTING TRUSTEES

Date: February 24, 1993
Time: 1:30 p.m.
Dept: 11

The Petition For Instructions of Gleeson L. Payne, Leonard M. Marangi, James N. Gamble, Frank A. Thomas and Lois Starke Matthews, as Trustees of the Collis P. and Howard Huntington Memorial Hospital Fund (hereinafter the "Trust"), as supplemented by the Supplement thereto, came on regularly for hearing on February 24, 1993, in Department 11 of the above-entitled Court, the Honorable Arnold H. Gold, Judge presiding. The Petitioners appeared by their attorneys, Gibson, Dunn & Crutcher, by Marc R. Isaacson.

The Court finds:

1. All notices of the within matter have been given as required by law;

2. All of the allegations of the Petition and the Supplement are true;

...

...

3. With respect to the Bylaws of Southern California Healthcare Systems, attached as Exhibit B to Affiliation Agreement (which Affiliation Agreement was attached as Exhibit A to the Petition), the language of the second sentence of Section 13 of Article III of said Bylaws means that any act or decision which is purported to be made or done at a meeting of the Board of Directors shall not be regarded as the act of the Board of Directors unless, inter alia, such act or decision is made or done by at least eighty percent (80%) of the members of the Board of Directors present at a meeting of the Board of Directors;

4. The proposed affiliation between Pasadena Hospital Association, Ltd. and Methodist Hospital of Southern California, as described in the Petition and the Supplement, and in the Affiliation Agreement which has been executed between Pasadena Hospital Association, Ltd. and Methodist Hospital of Southern California, will enable the Trust's beneficiary, Pasadena Hospital Association, Ltd. to achieve greater efficiencies in its operations and, therefore, to provide better health care in fullfillment of its charitable purposes, and, accordingly, it is for the benefit and in the best interests of the trust estate and those beneficially interested therein that the Trustees be permitted, in their capacities as directors of Pasadena Hospital Association, Ltd., to cause Pasadena Hospital Association, Ltd. to enter into the foregoing affiliation and that the Trustees be permitted to cause the Trust to participate in said affiliation (including committing the Trust to perform its obligations under, and to take no actions inconsistent with, the Affiliation Agreement); and

5. The Petition should be granted as prayed.

NOW, THEREFORE, the Court hereby orders, adjudges, decrees and instructs the Trustees as follows:

The Trustees are empowered and authorized, in their capacities as directors of Pasadena Hospital Association, Ltd., to cause Pasadena Hospital Association, Ltd., to enter into the foregoing affiliation with Methodist Hospital of Southern California, and the Trustees are further empowered and authorized to cause the Trust to participate in said affiliation (including committing the Trust to perform its obligations under, and to take no actions inconsistent with, the aforesaid Affiliation Agreement).

DATED: FEB 25 1993

REDACTED

ARNOLD H. GOLD

THE DOCUMENT TO WHICH THIS CERTIFICATE IS ATTACHED IS A FULL, TRUE, AND CORRECT COPY OF THE ORIGINAL ON FILE AND OF RECORD IN MY OFFICE.

ATTEST FEB 25 1993

JAMES H. DEMPSEY

Executive Officer/Clerk of the Superior Court of California, County of Los Angeles.

By M. Denton, Deputy

Electronically FILED by Superior Court of California, County of Los Angeles 3/7/2018 10:57 AM Sherri R. Carter, Executive Officer/Clerk, By H. Tam, Deputy Clerk

Christianne F. Kerns (State Bar 120595)
HAHN & HAHN LLP
Ninth Floor
301 East Colorado Boulevard
Pasadena, California 91101-1977
TEL: (626) 796-9123
FAX: (626) 449-7357

Attorneys for Trustees

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES, CENTRAL DISTRICT

P088867

In the Matter of the Estate of HENRY E. HUNTINGTON, Deceased.	CASE NO. P 88867 APPOINTMENT OF TRUSTEE MICHELLE QUINONES CHINO UNDER CLAUSE NINETEENTH OF WILL

KNOW ALL MEN BY THESE PRESENTS:

WHEREAS, by the Last Will and Testament of the late HENRY E. HUNTINGTON, of San Marino, California, executed on the first day of August, 1925, and particularly by the Nineteenth clause thereof, the following bequest was, and is, created, namely:

"NINETEENTH: As a memorial to my uncle, Collis P. Huntington, and my son, Howard Huntington, I hereby give, devise and bequeath to Henry M. Robinson, Dr. Ernest A. Bryant, George S. Patton, W. E. Dunn and Caroline H. Holladay, IN TRUST, for the Collis P. and Howard Huntington Memorial Hospital, and for the uses and purposes hereinafter stated, the total sum of Two Million Dollars ($2,000,000.00): one-third of said sum to be used by said trustees in purchasing the necessary ground and constructing thereon a building to be used as such memorial hospital, and two-thirds of said sum to be invested and reinvested, loaned and reloaned by said trustees for the purpose of making the best available

profit thereon, all profits and income derived from the same to constitute an endowment fund for the maintenance and operation of said memorial hospital, which said hospital shall be erected and maintained at or near the City of Los Angeles, in the State of California, for the reception and treatment of individuals, but not including persons afflicted with tuberculosis. I make no provision in this Will for persons afflicted with tuberculosis for the reason that many institutions are being established for the separate treatment of persons so afflicted, and in my opinion, they should be kept separate and apart from persons afflicted with other diseases. In case any of said trustees herein named shall die, resign or be removed, or for any reason become incapacitated to perform the duties imposed upon them under this Will, the surviving trustees shall fill such vacancy by appointment, made in writing, to the end that said trusteeship shall remain perpetual, and said endowment fund kept invested and reinvested, or loaned and reloaned, from time to time, so as to yield an income for the perpetual maintenance of said hospital."

and

WHEREAS, the foregoing provisions regarding the uses and purposes of the foregoing bequest, and regarding the appointment of Trustees to fill vacancies resulting from the death, resignation, removal or incapacity of a Trustee, were incorporated in this Court's Order For Ratable Distribution To Trustees For Collis P. And Howard Huntington Memorial Hospital, dated May 27, 1932, and

WHEREAS, by its Order Settling Report And Fourteenth Account Current Of Trustees Of Collis P. And Howard Huntington Memorial Hospital And Instructing Trustees, filed herein March 7, 1958, this Court ordered and instructed the Trustees "that they may act by a majority of the duly appointed and qualified Trustees, except as to the appointment of a successor Trustee. The appointment of a successor Trustee shall be made by all living Trustees then in office."

and

WHEREAS, after the execution of the foregoing Last Will and Testament, four of the Trustees originally named in the foregoing trust - - Henry M. Robinson, Dr. Ernest A. Bryant, George S. Patton and W. E. Dunn - - died, and Albert Crutcher, appointed as successor to W. E. Dunn, also died, and the vacancies created by such deaths were filled by the appointment by the surviving Trustees of Collis H. Holladay (to succeed Albert Crutcher), Max Mason (to succeed Henry M. Robinson), Dr. William B. Munro (to succeed Dr. Ernest A. Bryant), and George C. Ward (to succeed George S. Patton, Sr.); and

WHEREAS, upon the death of George C. Ward the vacancy so created was filled by the appointment by the surviving Trustees of E. H. Conley; and

WHEREAS, Caroline H. Holladay, one of the Trustees originally named in the foregoing trust, has heretofore resigned and said Max Mason has heretofore resigned and the vacancies created by said resignations have been filled by the appointment by the surviving Trustees of Edward R. Valentine and John McWilliams; and

WHEREAS, said E. H. Conley has died and the vacancy created by his death has been filled by the appointment by the surviving Trustees of Shannon Crandall, Jr.; and

WHEREAS, said Dr. William B. Munro has died and the vacancy created by his death has been filled by the appointment by the surviving Trustees of Herbert L. Hahn; and

WHEREAS, said John McWilliams has died and the vacancy created by his death has been filled by the appointment by the surviving Trustees of Ernest A. Bryant; and

WHEREAS, said Shannon Crandall, Jr., has died, and the vacancy created by his death has been filled by the appointment by the surviving Trustees of James D. Macneil; and

WHEREAS, Ernest A. Bryant has heretofore resigned and the vacancy created by said resignation has been filled by the appointment by the surviving Trustees of David B. MacTavish; and

//////

WHEREAS, Herbert L. Hahn has heretofore resigned and the vacancy created by his resignation has been filled by the appointment by the surviving Trustees of William E. Siegel; and

WHEREAS, said Edward R. Valentine has died, and the vacancy created by his death has been filled by the appointment by the surviving Trustees of Frederick C. Lindvall; and

WHEREAS, Frederick C. Lindvall has heretofore resigned and the vacancy created by his resignation has been filled by the appointment by the surviving Trustees of Gleeson L. Payne; and

WHEREAS, said Collis H. Holladay has died, and the vacancy created by his death has been filled by the appointment by the surviving Trustees of John S. Griffith, Jr.; and

WHEREAS, William E. Siegel has died, and the vacancy created by his death has been filled by the appointment by the surviving Trustees of Harry S. Meily; and

WHEREAS, John S. Griffith, Jr., has heretofore resigned and the vacancy created by his resignation has been filled by the appointment by the surviving Trustees of Henry A. Braun; and

WHEREAS, James D. Macneil has heretofore resigned and the vacancy created by his resignation has been filled by the appointment by the surviving Trustees of Leonard M. Marangi; and

WHEREAS, David B. MacTavish has heretofore resigned, and the vacancy created by his resignation has been filled by the appointment by the surviving Trustees of James N. Gamble; and

WHEREAS, Henry A. Braun has heretofore resigned, and the vacancy created by his resignation has been filled by the appointment by the surviving Trustees of Frank A. Thomas; and

WHEREAS, Harry S. Meily has heretofore resigned, and the vacancy created by his resignation has been filled by the appointment by the surviving Trustees of Verne Orr;

and

WHEREAS, Verne Orr has heretofore resigned, and the vacancy created by his resignation has been filled by the appointment by the surviving Trustees of Lois Starke Matthews; and

WHEREAS, Frank A. Thomas has heretofore resigned, and the vacancy created by his resignation has been filled by the appointment by the surviving Trustees of John F. Kooken; and

WHEREAS, Gleeson L. Payne has heretofore resigned, and the vacancy created by his resignation has been filled by the appointment by the surviving Trustees of James F. Rothenberg; and

WHEREAS, James N. Gamble has heretofore resigned, and the vacancy created by his resignation has been filled by the appointment by the surviving Trustees of Paul Ouyang; and

WHEREAS, John F. Kooken has died, and the vacancy created by his death has been filled by the appointment by the surviving Trustees of Harvey Lenkin; and

WHEREAS, Leonard M. Marangi has died, and the vacancy created by his death has been filled by the appointment by the surviving Trustees of Jaynie Studenmund;

WHEREAS, Harvey Lenkin has become incapacitated, and the vacancy created as a result thereof has been filled by the appointment by the surviving Trustees of Armando L. Gonzalez; and

WHEREAS, James F. Rothenberg has died, and the vacancy created by his death has been filled by the appointment by the surviving Trustees of Wayne Brandt; and

WHEREAS, Lois Starke Matthews has heretofore resigned, and it is necessary that the vacancy in such trusteeship created by the resignation of Lois Starke Matthews should now be filled.

NOW, THEREFORE, the undersigned, Paul Ouyang, Jaynie Studenmund, Armando L. Gonzalez and Wayne Brandt, as the surviving Trustees, have

appointed and do hereby appoint Michelle Quinones Chino as a Trustee of the trust created by the aforesaid Nineteenth clause of the Last Will and Testament of Henry E. Huntington, Deceased, to fill the vacancy created by the resignation of Lois Starke Matthews.

IN WITNESS WHEREOF, the undersigned have hereunto set their hands on the respective dates indicated opposite their signatures.

Dated: Febru 23, 2018. REDACTED

PAUL OUYANG

Dated: Feb 23, 2018. REDACTED

JAYNIE STUDENMUND

Dated: 23 FEB, 2018. REDACTED

ARMANDO L. GONZALEZ

Dated: 23 Feb, 2018. REDACTED

WAYNE BRANDT

THE UNDERSIGNED hereby accepts the appointment as a Trustee of the Collis P. and Howard Huntington Memorial Hospital Trust as set forth above.

Dated: Februany 23, 2018. REDACTED

MICHELLE QUINONES CHINO

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of)

On February 23, 2018, before me,
Linda Squillace Jackson, a Notary Public, personally appeared PAUL OUYANG, who proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument, and acknowledged to me that he executed the same in his authorized capacity, and that by his signature on the instrument, the person, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

REDACTED

Notary Public

LINDA SQUILLACE JACKSON
Commission # 2122156
Notary Public - California
Los Angeles County
My Comm. Expires Sep 2, 2019

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of)

On February 23, 2018, before me, Linda Squillace Jackson, a Notary Public, personally appeared JAYNIE STUNDENMUND, who proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument, and acknowledged to me that she executed the same in her authorized capacity, and that by her signature on the instrument, the person, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

REDACTED

Notary Public

LINDA SQUILLACE JACKSON
Commission # 2122156
Notary Public - California
Los Angeles County
My Comm. Expires Sep 2, 2019

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of)

On February 23, 2018, before me,
Linda Squillace Jackson, a Notary Public, personally appeared ARMANDO L. GONZALEZ, who proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument, and acknowledged to me that he executed the same in his authorized capacity, and that by his signature on the instrument, the person, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

REDACTED

Notary Public

LINDA SQUILLACE JACKSON
Commission # 2122156
Notary Public - California
Los Angeles County
My Comm. Expires Sep 2, 2019

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of)

On February 23, 2018, before me,
Linda Squillace Jackson, a Notary Public, personally appeared WAYNE BRANDT, who proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument, and acknowledged to me that he executed the same in his authorized capacity, and that by his signature on the instrument, the person, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

REDACTED

Notary Public

LINDA SQUILLACE JACKSON
Commission # 2122156
Notary Public - California
Los Angeles County
My Comm. Expires Sep 2, 2019

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of)

On February 23, 2016, before me, Linda Squillace Jackson, a Notary Public, personally appeared MICHELLE QUINONES CHINO, who proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument, and acknowledged to me that she executed the same in her authorized capacity, and that by her signature on the instrument, the person, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

REDACTED

Notary Public

LINDA SQUILLACE JACKSON
Commission # 2122156
Notary Public - California
Los Angeles County
My Comm. Expires Sep 2, 2019

#14

Title 11, California Code of Regulations, § 999.5(d)(4)(B)

Applicant's plan for use of the net proceeds after the close of the proposed transaction together with a statement explaining how the proposed plan is as consistent as possible with existing charitable purposes and complies with all applicable charitable trusts that govern use of Applicant's assets

The Affiliation does not involve a sale, transfer, merger or other disposition of any of PHA's assets, and therefore the Affiliation will not result in PHA's receipt of any net proceeds. Rather, pursuant to the Affiliation Agreement, Cedars-Sinai will become the sole member of PHA, with PHA retaining its assets (and liabilities) and continuing its operations in pursuit of its charitable purposes. Although the Affiliation requires PHA to amend its articles of incorporation so that Cedars-Sinai becomes its sole member, PHA's Amended Articles will continue to require PHA to operate exclusively for charitable purposes within the meaning of Internal Revenue Code Section 501(c)(3) and still provide that its property is irrevocably dedicated to charitable purposes.

In addition, the Affiliation Agreement ensures PHA continues to retain control over the charitable uses to which its assets can be put and compliance with charitable trust restrictions by giving PHA the right to approve (i) a change in the control, management or administration of any gifts, grants, donations or endowments (collectively, the "Restricted Assets"), and/or (ii) the transfer to Cedars-Sinai of any Restricted Assets, assuming such transfer is permitted by any underlying donor or charitable trust restrictions on the assets and California law.

Title 11, California Code of Regulations, § 999.5(d)(5)

IMPACTS ON HEALTHCARE SERVICES

#15

Title 11, California Code of Regulations, § 999.5(d)(5)(A)

A copy of the two most recent "community needs assessments" prepared by applicant for health facilities that are the subject of the agreement or transaction

1. Attached to this Section 999.5(d)(5)(A) as **Exhibit 15-A** is a copy of PHA's 2019 community health needs assessment.

2. Attached to this Section 999.5(d)(5)(A) as **Exhibit 15-B** is a copy of PHA's 2016 community health needs assessment.

Exhibit 15-A

PHA's 2019 Community Health Needs Assessment



Huntington Hospital

PASADENA PUBLIC HEALTH DEPARTMENT

2019 | Community Health Needs Assessment Greater Pasadena

TABLE OF CONTENTS

Acknowledgements i

Executive Summary iii

I. Introduction 1
II. Data Overview 5
III. Demographics 8
IV. Social Determinants of Health 12
- Economy, Housing, and Homelessness 12
- Education and Academic Achievement 16
- Social Environment and Public Safety 18
- Transportation and Physical Environment 20

V. Health Topics 24
- Access to Care 24
- Maternal, Infant, and Child Health 26
- Exercise, Nutrition, and Weight 29
- Diabetes 32
- Heart Disease and Stroke 33
- Cancer 34
- Immunization and Infectious Diseases 36
- Respiratory Diseases 40
- Alcohol, Tobacco, and Substance Abuse 42
- Oral Health 44
- Mental Health 45
- Older Adults and Aging 48
- Life Expectancy and Mortality 51

Appendix A: Participants in Listening Sessions and Individual Interviews 53
Appendix B: Community Resources 54
Appendix C: Community Scorecard 63

References 68

ACKNOWLEDGMENTS

CHNA PLANNING TEAM

Huntington Hospital:

- Cathi Chadwell, Executive Director, Philanthropy and Public Affairs
- Ruth Pichaj, RN, BSN, PHN, Manager of Communty Outreach and Benefits

Pasadena Public Health Deparement:

- Ying-Ying Goh, MD, MSHS, Director and Health Officer
- Matt Feaster, PhD, MPH, Epidemiologist

Center for Nonprofit Management:

- Maura Harrington, PhD, MBA, Senior Vice President
- Christine Newkirk, MA, Strategist

HUNTINGTON HOSPITAL COMMUNITY BENEFITS COMMITTEE

Akila Gibbs, Executive Director, Pasadena Senior Center
Ann Rector, Director, Health Programs, Pasadena Unified School District
Anne Miskey, Chief Executive Officer, Union Station
Mayor Terry Tornek, City of Pasadena
Betty Ho, Community Advocate
Bill Bogaard, Huntington Hospital Board Member
Cathi Chadwell, Executive Director, Public Affairs, Huntington Hospital
Celina Alvarez, Executive Director, Housing Works
Christian Port, MPA, Office of the President & Business Development Manager, Planned Parenthood of Pasadena & San Gabriel Valley
Chuck Sudvary, Director, Physician & Interoperability Services, Huntington Hospital
Cody Ruedaflores, Manager, Community Benefits Program, Kaiser Permanente
Debbie Williams, Community Advocate
Divina Bautista, RNP, Head Nurse Practitioner, Caltech Student Health Center
Dolores Hickambottom, Retired Field Representative, State Senator Jack Scott
Ellen Lee, Huntington Hospital Board Member
Hector LaFarga, Executive Director, Mothers' Club
Jane Haderlein, Senior Vice President Philanthropy & External Affairs, Huntington Hospital
Jennifer Howes, PhD, Acting Director, Caltech Health & Counseling Center
Jenny Vanslyke, Prehospital Care Coordinator/PFD Nurse Education, Huntington Hospital
Josh Ward, EMS Battalion Chief, Pasadena Fire Department
Juliana Serrano, Director, Office of Creative Connections, All Saints Church
Kathy Podley, Huntington Hospital Board Member
Kimberly Shriner, MD, Huntington Hospital
Lena Kennedy, Community Advocate
Lori J. Morgan, MD, MBA, President & CEO Huntington Hospital

Marcia Penido, Director, Care Coordination, Huntington Hospital
Margaret Morrow, President & CEO, Public Counsel
Margie Martinez, Chief Executive Officer, ChapCare
Mark Watterson, Executive Director, Convalescent Aid Society
Mary Donnelly-Crocker, Executive Director, Young & Healthy
Pamela Cantero, El Centro de Acción Social
Peggy Buchanan, Executive Director, The Pasadena Village
Priscilla Gamb, Community Advocate
Rary Simmons, Huntington Hospital Board Member
Rita Elshout, Community Advocate
R-lene Mijares deLang, Mijares Restaurant, Community Advocate
Ruth Pichaj, Manager, Community Outreach, Huntington Hospital
Sheri Bonner, President & CEO Planned Parenthood of Pasadena and San Gabriel Valley
Sheryl Rudie, Executive Director, Ambulatory Services, Huntington Hospital
Stacy Miller, Director Volunteer & Customer Services, Huntington Hospital
Steve Madison, City of Pasadena Councilmember District 6
Steve Ralph, Retired CEO, Huntington Hospital
Takako Suzuki, Field Representative District 6, City of Pasadena
Vannia DeLaCuba, Field Representative, District 5, City of Pasadena
Wendy Wang, MPP, Director of Community Education, Outreach, & Public Policy, Pacific Clinics
Ying-Ying Goh, MD, Health Officer & Director, Pasadena Public Health Department

ADDITIONAL COMMUNITY PARTICIPANTS

Betty McWilliams, Executive Director, Foothill Unity Center
Camille Connor, Community Resource Navigator, United Methodist Church
Carol Wang, Director, Herald Cancer Center
Christy Zamani, Executive Director, Day One
Danette Lew, Director of 0-5 Programs & Clinical Director, Asher Family Center, Foothill Family Services
Ernest Espinoza, Executive Administrator, El Monte Comprehensive Health Center
Gaby Rodriguez, Health Services Case Manager, Foothill Unity Center
Jane Fall, Executive Director, Our Savior Center
Jocelyn Estiandan, Senior Public Health Analyst, LAC Department of Public Health
Michelle Freridge, Executive Director, Asian Youth Center
Nina Paddock, Comprehensive Services Manager, Pacific Clinics
Noel Barakat, Area Health Officer (SPA 3), LAC Department of Public Health
Sandra Correa, Clinic Biller, Our Savior Center
Sophia Martini, Health Systems Manager, Hospitals, American Cancer Society, Inc. – California Division
Tashera Taylor, Client Services Director, Foothill Unity Center

EXECUTIVE SUMMARY

Huntington Hospital and the City of Pasadena Public Health Department are pleased to present the **2019 Community Health Needs Assessment of Greater Pasadena**. The goal of this collaboration was to conduct a joint, systematic analysis of health indicators that provides insight into the health status and needs of residents in the Greater Pasadena area.

The purpose of the community health needs assessment (CHNA) is to educate and inform our community about the health of the population, contributing factors to poorer health outcomes, key health disparities across diverse populations, and community resources available to improve health.

OUR COMMUNITY

The **2019 Community Health Needs Assessment of Greater Pasadena** focuses on the geographic area that includes Pasadena, Altadena, South Pasadena, and San Marino. The information gathered and contained in this report establishes the foundation upon which we will base future planning to address the health needs of Greater Pasadena residents. Our hope is that the findings of this assessment will assist civic leaders, non-profit organizations, and community constituents to support their planning and improvement efforts as well.

SIGNIFICANT COMMUNITY NEEDS

This CHNA contains a myriad set of indicators and metrics across a diverse set of health topics, including both quantitative and qualitative data. To facilitate the prioritization process, the CHNA Planning Team synthesized the quantitative data to a large set of indicators that showed the greatest need compared to other jurisdictions or national standards. Out of the seventeen total indicators, the following eleven emerged as areas of need:

- Access to Care
- Alcohol, Tobacco and Other Substance Use
- Cancer
- Exercise, Nutrition and Weight
- Heart Disease and Stroke
- Housing Insecurity and Homelessness
- Immunizations and Infectious Disease
- Maternal, Infant and Child Health
- Social Environment/Cultural Competency
- Mental Health

To further curate the indicators to the areas of highest need, the CHNA compared these eleven indicators against the qualitative data collected by the Center for Nonprofit Management. The 32 individual interviews and 9 listening sessions provided valuable insight on local social, economic and health topics. Based on feedback gathered from the community, several upstream factors emerged as the most urgent.

The key upstream factors threatening health according to those interviewed was:

- Transport and Commute Times: High costs of owning a car, complexity/cost/time associated with public transportation, distance between available services and low-income communities, and transportation barriers faced by the elderly and those with limited mobility.
- Economic Trends: Including rising housing and services costs, economic transition of low income communities, lack of new affordable housing, stagnant wages, and lack of coordination between sectors to respond to economic trends and rising housing costs.
- Socio-Political Environment: Impact of the current political climate on utilization of services, and need for culturally-responsive care providers.
- Demographic Shift: There is an increase in seniors, and fewer children.
- Physical Environment: Perceived increased violence in some areas, and air pollution next to freeways.

PRIORITIZATION PROCESS

Using the curated set of indicators, and bearing in mind the key upstream health issues identified by the community, a group of health and social service professionals with specific clinical and community knowledge participated in a review and discussion of the findings of the preliminary data analysis. During a facilitated prioritization session, participants rated health topic areas based on the urgency and magnitude of the problem, and the resources in the community availble to address the issue. The six highest rated areas of need were:

1. Housing Insecurity and Homelessness
2. Mental Health
3. Older Adults and Aging
4. Access to Care
5. Exercise, Nutrition, and Weight
6. Maternal, Infant, and Child Health

NEXT STEPS

Huntington Hospital is committed to caring for the physical, mental and social well-being of our community, and continues to seek ways to ensure that all individuals receive the services they need. Findings from the **2019 Community Health Needs Assessment of Greater Pasadena** will be the foundation upon which, with the involvement of the hospital's Community Benefits Committee, Executive Management Team, and Board of Directors, we will develop meaningful community health improvement efforts.

The City of Pasadena Public Health Department has developed with significant community guidance and input, the **2018 Greater Pasadena Community Health Improvement Plan (CHIP)**. The CHIP is a community-wide statement of priorities and goals for improving community health. The CHIP is the product of a rigorous participatory planning process that included significant involvement from a wide range of community stakeholders, and its purpose is to facilitate improved coordination of efforts and investments for maximal collective impact. The results from this CHNA will provide feedback on our efforts to improve those problem areas and will inform our efforts as we move towards our 2023 CHIP.

I. INTRODUCTION

Huntington Hospital and the Pasadena Public Health Department are pleased to present their second joint Community Health Needs Assessment (CHNA) report for Greater Pasadena. This report describes findings from a systematic, year-long CHNA process that was conducted collaboratively in order to provide insight into the health status and needs of the residents of the Greater Pasadena area. The data presented span a wide range of topics related to community well-being, including disease rates, risk factors for disease and death, health behaviors, and social determinants of health.

PURPOSE OF A CHNA

A Community Health Needs Assessment (CHNA) is a report that describes findings from a systematic, collaborative data collection process to gain insight into the health status and needs of the residents in a jurisdiction. Data presented in CHNAs span a wide range of topics related to community well-being, including disease rates, risk factors for disease and death, health behaviors, and social determinants of health. This examination of key health indicators in the Greater Pasadena area is designed to offer some understanding of health needs in this community and guide community health improvement planning efforts. Our CHNA is intended to provide a gateway for concerned community members, civic leaders, non-profit organizations, and policy makers to further delineate and address health issues in Greater Pasadena.

The purpose of the CHNA is to educate and inform our community about:

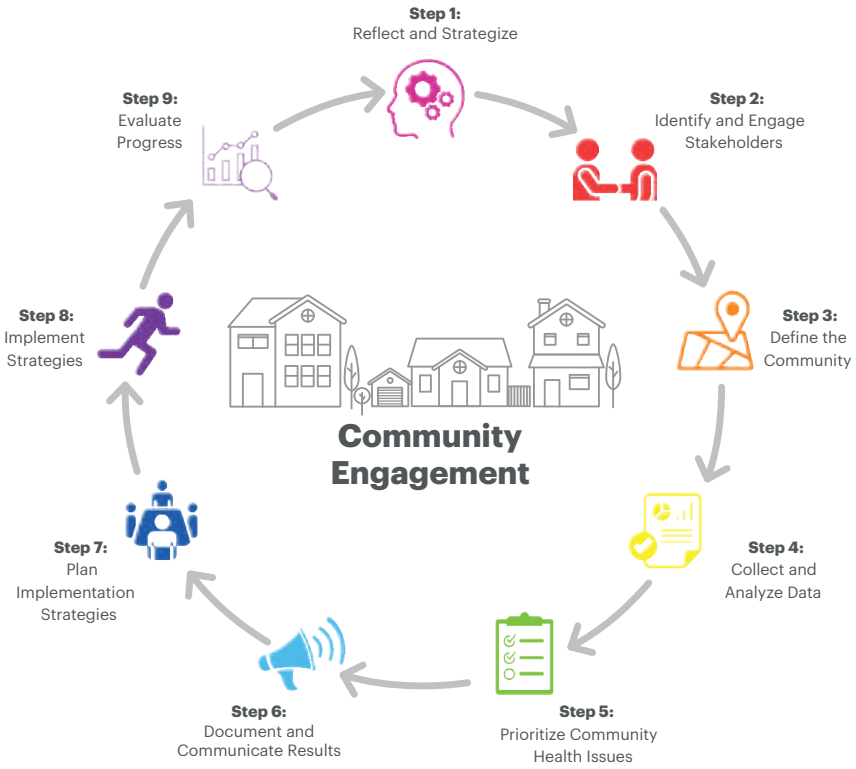
- The overall health of the population
- Contributing factors to poorer health outcomes
- Key health disparities across diverse populations, and
- Community resources available to improve health

This CHNA report can be used as a resource for health advocates and organizations that use data to guide planning, policy development, and procurement or allocation of resources. This report should be used in conjunction with the online resource healthypasadena.org that contains updated statistics in between finalized CHNA reports. While many factors can contribute to the overall health of a community -too many to list in a single document- our team endeavored to present a diverse set of indicators to capture the most urgent health issues in our community. These factors include traditional health indicators like rates of disease, but also social determinants of health that can be “upstream” causes of diseases. These social determinants of health include the environmental, social, and economic conditions that are important in determining the health and well-being of individuals and populations. In this CHNA, metrics for social determinants of health and health topics were collected and compiled to characterize the health status of the population in Greater Pasadena and, when possible, specific efforts were made to identify and highlight health disparities for sub-populations.

ABOUT THE CHNA PROCESS

The **2019 Community Health Needs Assessment (CHNA) of Greater Pasadena** was developed utilizing a framework adapted from the Association for Community Health Improvement (ACHI) provided below[1]. There are nine important steps to conducting community engagement to develop a CHNA and its companion community health improvement plan (CHIP), also known as a community benefit Investment Strategy. Our team followed the first five steps to create our CHNA.

Figure 1. Association for Community Health Improvement CHNA Process Map[1]



- Step 1: Reflect on the previous CHNA process, identify what worked well, and strategize improvements.
- Step 2: Identify CHNA users and other key stakeholders in the community and engage what their expectations are for the CHNA.
- Step 3: Specify the geographic focus of the CHNA and population characteristics or health topics considered important for the assessment. This includes considering data availability and granularity.
- Step 4: Collect and analyze quantitative and qualitative data from myriad sources to define demographic indicators, detect disparities, and identify health inequities.
- Step 5: Prioritize community health issues most pressing in the community.

ABOUT THE REGION OF FOCUS

For this CHNA, the region of focus is the Huntington Hospital Primary Service area, an area defined by nine ZIP codes (91103, 91105, 91030, 91101, 91001, 91104, 91106, 91108, and 91107). Data presented in this report represent four primary geographic regions that include and/or overlap with the Huntington Hospital Primary Service area. Some data represent the city of Pasadena (see Figure 2). Some data represent the total population of the Los Angeles County Service Planning Area (SPA) 3, an area that includes the entire San Gabriel Valley (see Figure 3). Finally, some data represent the population included in the Pasadena Unified School District, a district that includes Pasadena, Altadena and Sierra Madre (Figure 4).

Figure 2. Greater Pasadena and the City of Pasadena

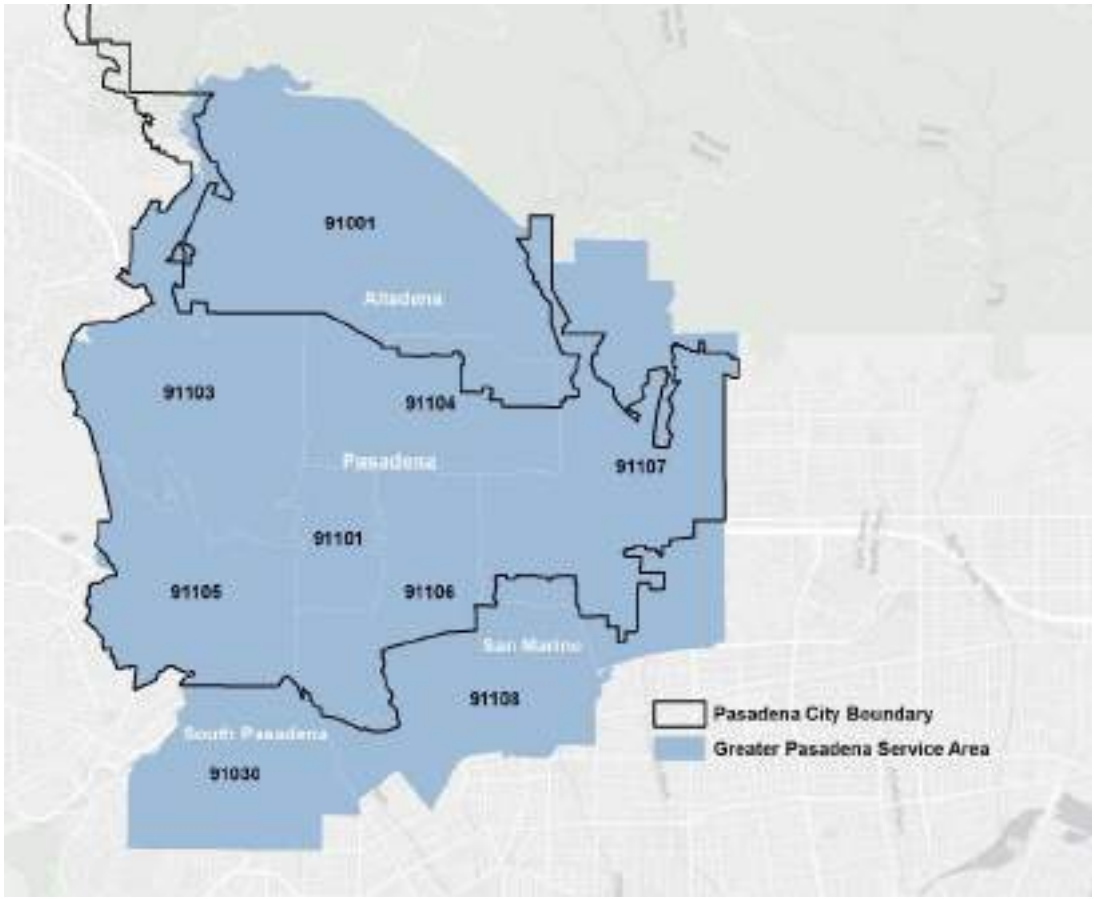


Figure 3. Los Angeles County Service Planning Area (SPA) 3 – San Gabriel Valley

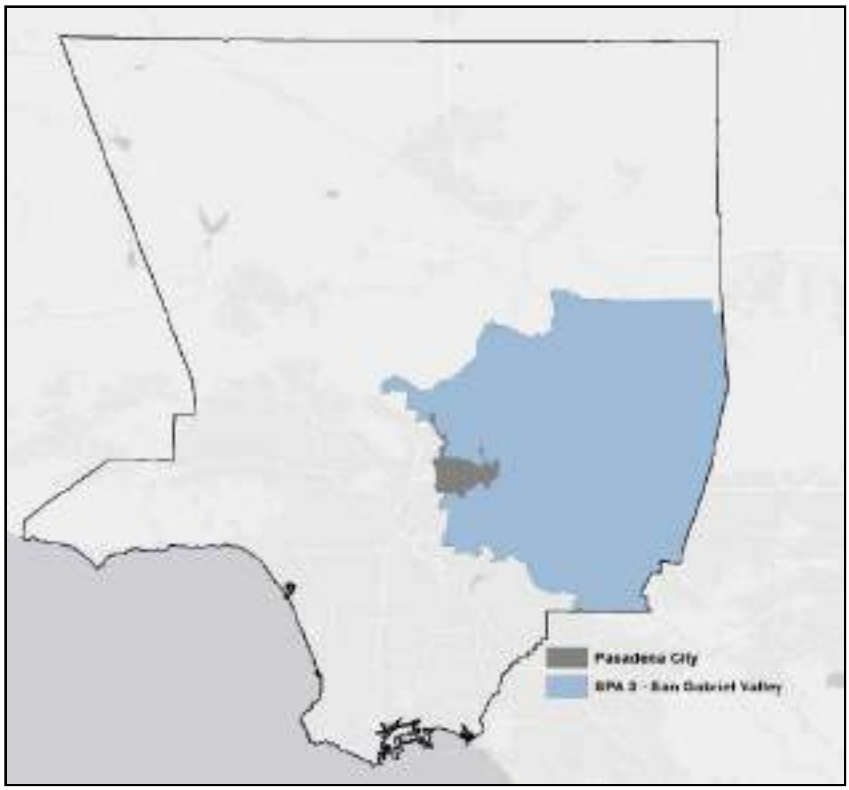


Figure 4. Pasadena Unified School District (PUSD) service area



II. DATA OVERVIEW

ABOUT THE DATA

Quantitative and qualitative data were collected and analyzed for this Community Health Needs Assessment (CHNA). Quantitative data refer to information that can be expressed in numerical terms, counted, measured or compared on a scale. Qualitative data, on the other hand, refers to information that is difficult to measure/count in numerical terms, but instead provides rich, in-depth descriptive information about the topic of interest.

Table 1: Data indicator topics included in the 2019 CHNA

Data Indicator Topics	
Demographics **Social Determinants of Health** Economy, Housing, & Homelessness Education & Academic Achievement Social Environment & Public Safety Transportation & Physical Environment	**Health Topics** Access To Care Maternal, Infant, & Child Health Exercise, Nutrition, & Weight Diabetes Heart Disease & Stroke Cancer Immunizations & Infectious Diseases Respiratory Diseases Oral Health Alcohol, Tobacco, & Substance Use Mental Health Older Adults & Aging Life Expectancy & Mortality

Quantitative Data

The quantitative data collected and analyzed for this assessment come from a variety of sources. They include public sources like United States Census Bureau, the California Health Interview Survey, Office of Statewide Health Planning and Development, and the California Department of Education, as well as data maintained by the City of Pasadena like birth, death and communicable disease records.

For each indicator in the social determinants of health or health topics, an Indicator Summary Table is provided at the end of the section. For each metric in the summary table, the local values (e.g., the city of Pasadena, Greater Pasadena, SPA 3, or PUSD) were compared to other jurisdictions to evaluate how we were doing. In most instances, the comparison value was from Los Angeles County (LAC), California or the United States.

For a number of indicators, we compared our values to Healthy People 2020 (HP2020) goals. These HP2020 goals are benchmarks based on national estimates for key health issues that are updated every ten years. When no comparison value was available for another jurisdiction or a HP2020 goal, we evaluated whether the metric was an increasing or decreasing health trend See Table 2 for the full scoring rubric. Note: this report contains only a curated set of quantitative data indicators, for more data please visit healthypasadena.org or the City of Pasadena Public Health Department's data page[2,3].

Table 2. Scoring Guide for Indicator Summary Tables

Trend	Interpretation
↑↓↗	Local values are performing **worse** (higher ↑ /lower ↓ *depending on the indicator*) when compared to county, state or national values; or the indicator has increased significantly over time ↗.
↔↗↘	Local values are either performing **comparably** to other estimates (↔); the metric does not have inherent negative or positive health risk, and we are denoting an increasing or decreasing trend (↗↘) (ex-Birth rates) ; or the metric is increasing/decreasing but not significantly and there are no comparison values from other jurisdictions (↗↘).
↑↓↘	Local values are performing **better** (higher ↑ /lower ↓ *depending on the indicator*) when compared to county, state or national values; or the indicator has decreased significantly over time ↘.
N/A	Local values were not available for comparison.

Qualitative Data

For this year's CHNA, the Center for Nonprofit Management was contracted by Huntington Hospital to collect qualitative data from community residents, organizational leaders and public agency leaders through individual interviews and listening sessions. A total of 32 individual interviews and nine listening sessions provided valuable insight on local social, economic and health topics (see Appendix A). Individual interviews and listening sessions entailed discussion of both a standardized set of health needs assessment questions, and questions customized to each interview participant. For example, community health promotoras and navigators were asked additional questions specific to the barriers to health care faced by undocumented community members; and a listening session with Spanish-speaking mothers included additional questions about their experiences securing housing as non-native English speaking and undocumented heads of household.

Detailed notes from individual interviews and listening sessions were coded using MAXQDA, a text analysis tool that allows for the coding of text, retrieval of related segments of text, counts of the frequency with which codes—or themes—occur in the text, and correlation between themes as they occur in the text.

Data Considerations

For both quantitative and qualitative data, efforts were made to include the widest range of data sources and indicators as possible. Limitations on data availability varied by topic. Although the CHNA planning team selected a diverse, comprehensive representation of stakeholders to minimize bias, qualitative data findings are inherently dependent upon both the selection and participation of stakeholders. Quantitative data was limited by the types of measures available at the time of analysis and the selection of measures. Analysis on disparities was possible for indicators with sufficient demographic data, such as those at a Service Planning Area (SPA) or city level.

This report aims to present the most granular level of analysis when possible, but in some instances, data at larger geographic level is reported due to limitations in either sample size or data availability. For example, data may only be available at the San Gabriel Valley (Service Planning Area (SPA) 3) area and thus is used as our local estimate. Additionally, while the Pasadena Unified School District (PUSD) serves three local communities (Pasadena, Sierra Madre and Altadena), district-level estimates are used to estimate health among our local students.

III. DEMOGRAPHICS

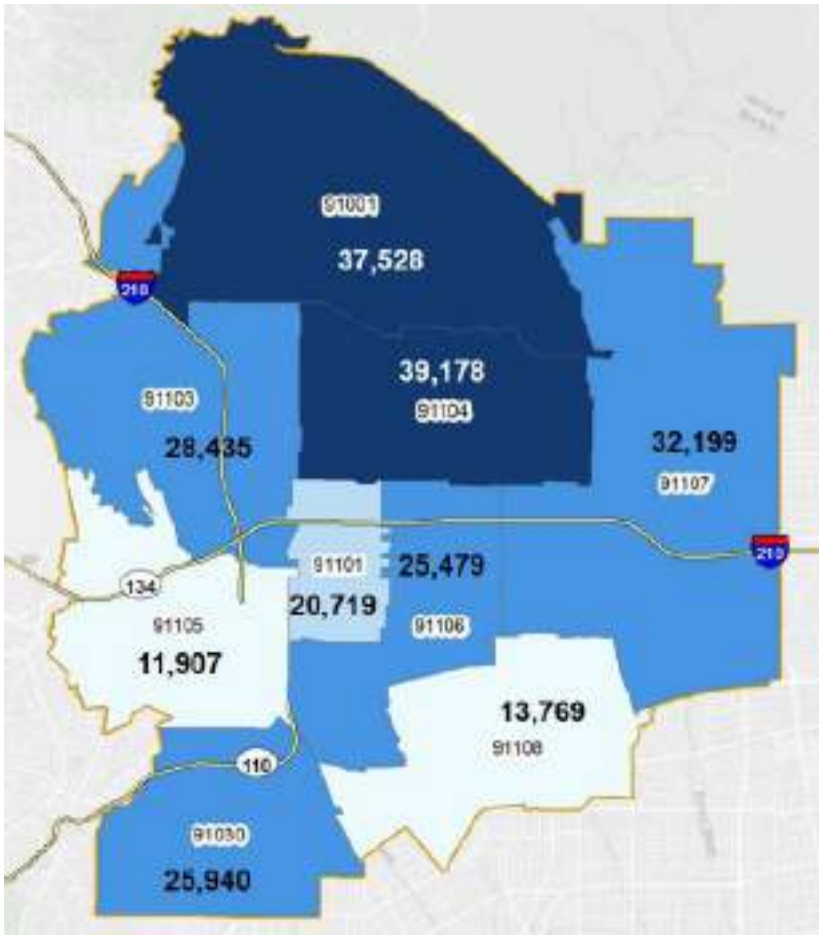
Population Size

The Greater Pasadena community is the primary service area for Huntington Hospital. The community consists of nine ZIP codes and the cities of Altadena, Pasadena, and Sierra Madre and portions of South Pasadena and San Marino.

The Greater Pasadena area is 2.3% of the LAC population[4].

235,819 people live in Greater Pasadena[4].

Figure 5. Greater Pasadena Population by ZIP Code, 2018[4]

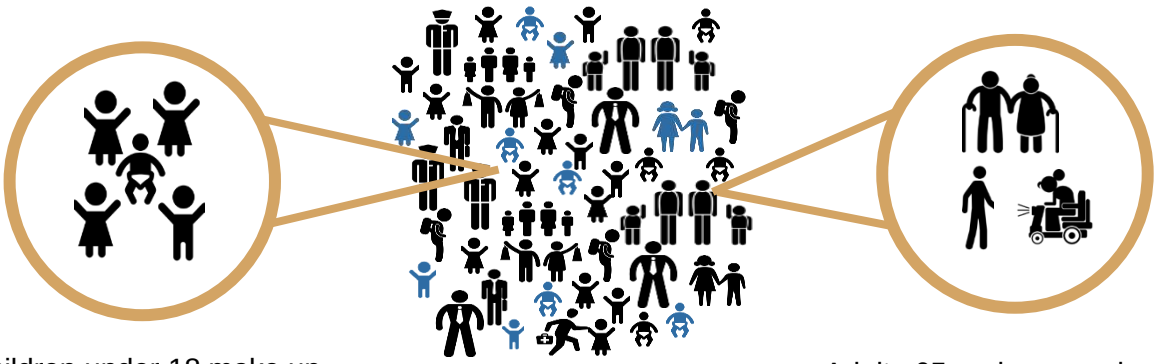


Age Distribution

The population of Greater Pasadena is on average older than that of Los Angeles County. In Greater Pasadena, the proportion of residents 65 years of age and older is around 15% of the total population (compared to 13.4% in Los Angeles County), while the population under 18 years makes up 18% of the total population (compared to 22.4% in Los Angeles County)[5].

25,628 children under 18 years old live in Pasadena.

21,921 adults ages 65 years and over lived in Pasadena in 2017.



Children under 18 make up **18%** of the more than 140,000 people populating Pasadena.

Adults 65 and over make up **15%** of the more than 140,000 people populating Pasadena.

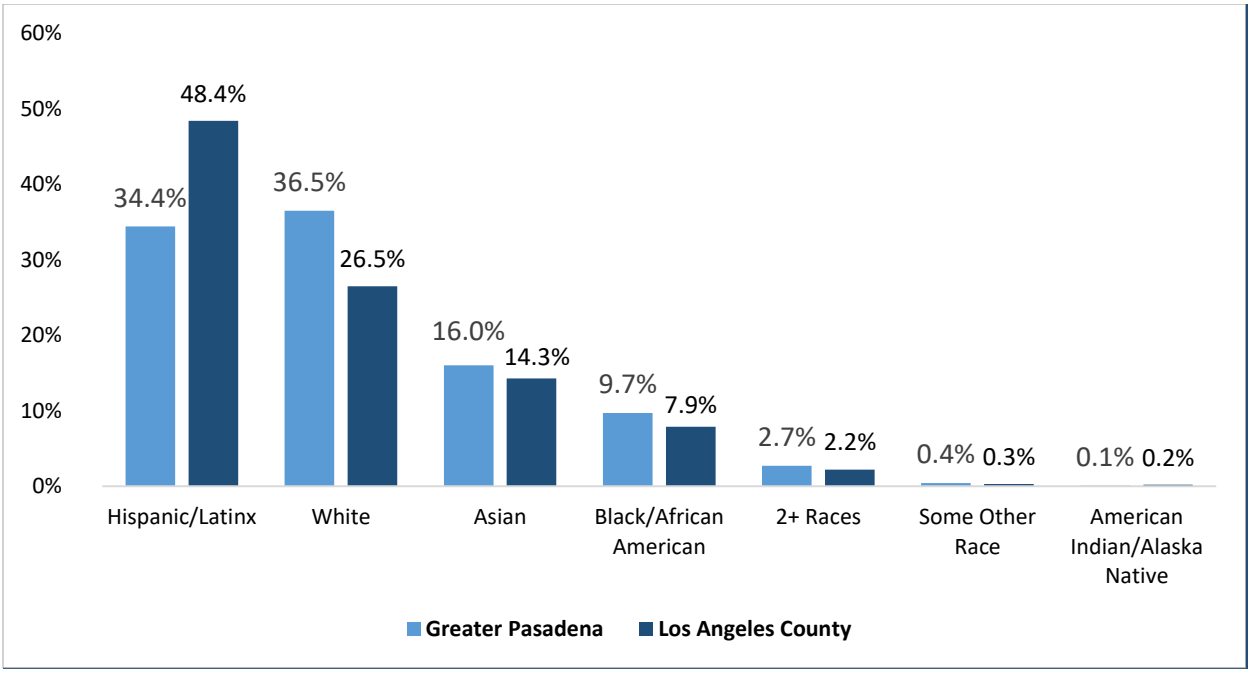
There are **10% fewer** children under 18 than there were 10 years ago.

There are **15% more** adults over 65 than there were 10 years ago.

Race and Ethnicity

The population of Greater Pasadena is less Hispanic/Latino (34.4%), more White (36.5%), more African American (9.7%) and more Asian (16.0%) than the population of Los Angeles County[5]. Also, while only about a third of all residents in Greater Pasadena are Hispanic/ Latino, nearly half (49%) of the population under 18 identifies as Hispanic/Latino[5].

Figure 6. Population by Race, Greater Pasadena and Los Angeles, 2018[5]



The geographic distribution of people with different racial/ethnic backgrounds living in Greater Pasadena is diverse. For example, the ZIP code 91103 –which includes most of the region known as Northwest Pasadena– is 17% African American, while 91108 –which is part of San Marino– is less than 1% African American. Additionally, more Greater Pasadena residents identify as Asian than residents of Los Angeles County (16.0% versus 14.3%, respectively)[5]; in fact, in five of the nine ZIP codes that comprise Greater Pasadena, over one-quarter of residents are Asian American. Likewise, there are five ZIP codes where at least one-quarter of residents identify as Hispanic/Latinx[5].

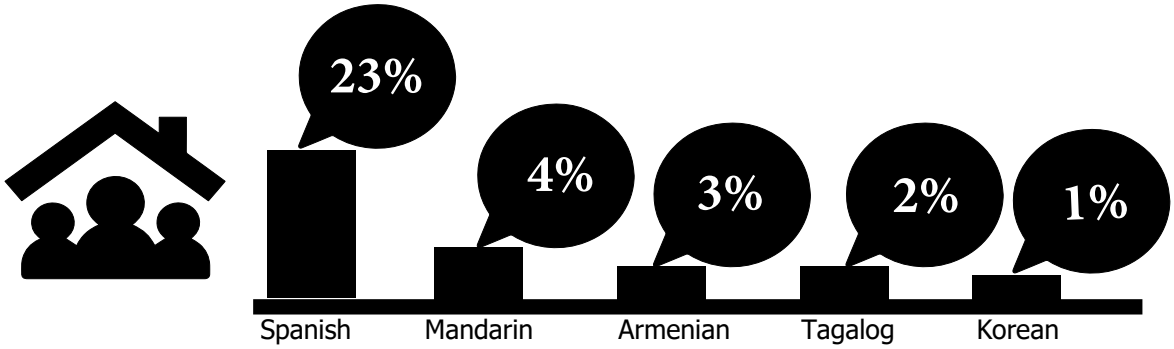
Foreign Born Status and English Language Proficiency

Greater Pasadena's population is less foreign-born (28.7%) than the population of Los Angeles County, of which more than a third (34.4%) were born in another country[5].



The most common language spoken in the home by Greater Pasadena residents is English (57.4% of residents speak this language at home). Spanish is the second most popular language spoken at home (22.6%); but nearly twice as many residents of Los Angeles County (39.7%) speak Spanish at home. Compared to Los Angeles County, a larger percentage of Greater Pasadena residents (13.2% vs. 11.0%) speak languages spoken in Asia (such as Mandarin, Tagalog and Korean) and Indo-European languages including Armenian (6.2% vs. 5.4%)[5].

LANGUAGES SPOKEN AT HOME (OTHER THAN ENGLISH) IN PASADENA[5]



Greater Pasadena overall had fewer households with Limited English Proficiency (8.2%) than Los Angeles County (13.2%) and California (9.2%)[5]. Limited English proficiency rates vary across ZIP codes in Greater Pasadena as well. Specifically, ZIP codes 91001 and 91105 have lower rates of limited English proficiency (2.4% and 2.7%, respectively), while ZIP codes 91103 and 91108 have significantly higher rates of limited English proficiency (12.1% and 14.1%, respectively)[5].

IV. SOCIAL DETERMINANTS OF HEALTH

ECONOMY, HOUSING, AND HOMELESSNESS

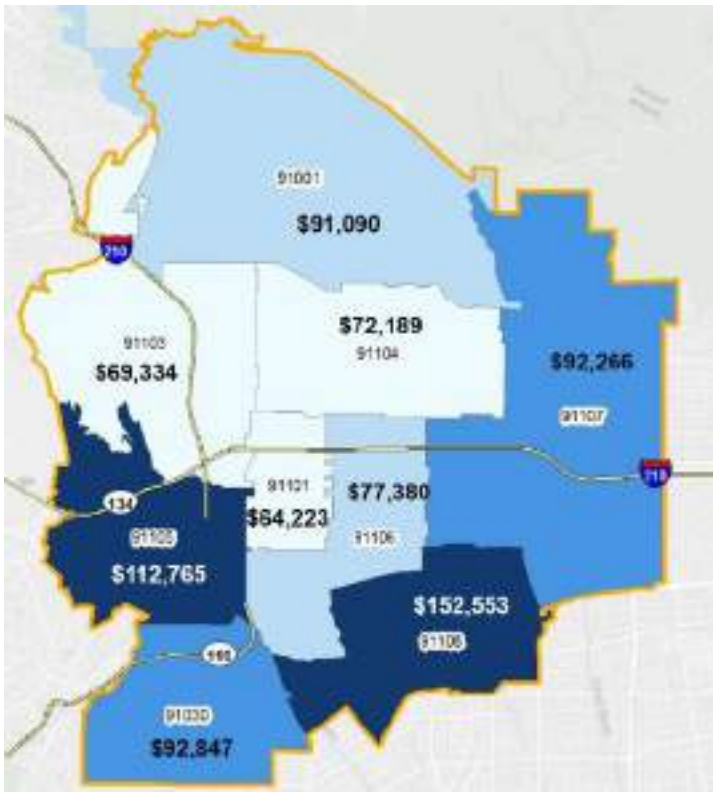
Income

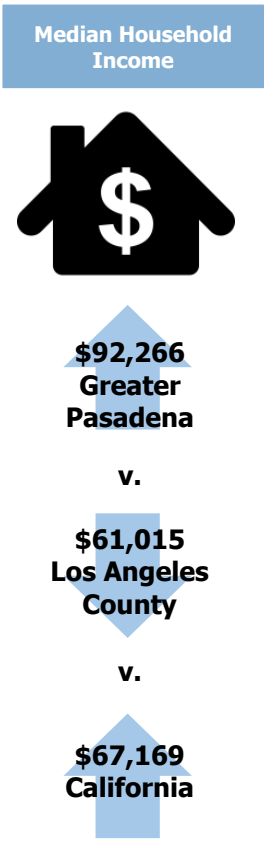
The median household income in 2019 was higher in Greater Pasadena ($92,266)[4] than in the city of Pasadena ($76,264)[5], California ($67,169)[5], and Los Angeles County ($61,015)[5]. Two ZIP codes, 91101 and 91103, had the lowest median household income levels in the Greater Pasadena region ($64,223 and $69,334, respectively)[4].

On average, in 2018, Asians and Whites in Greater Pasadena earned an estimated household income of $108,000 and $100,000, respectively; $30,000 more than their Black and Latinx counterparts, who earned an estimated $73,000 and $79,000 each, respectively[4].



Figure 7. Median Household Income by ZIP, 2018[4]





Poverty

The Federal Poverty Level (FPL) is the standard used by many assessments as a "bare bones" budget that takes into account family size, costs of living (like housing, childcare, groceries, healthcare, transportation, some miscellaneous items, and taxes). Using this threshold, an estimated 8.3% of Greater Pasadena families lived below the federal poverty level in 2017, lower than Los Angeles County (13.1%) and California (11.1%)[5]. ZIP codes 91103 and 91101 had the highest rates of children living in poverty in the service area (28.2% and 25.4%, respectively)[5]. Additionally, 16.3% of Pasadena seniors ages 65 and older were living below the poverty line compared to 13.4% in Los Angeles County and 10.2% in California[5].

The FPL is a standard across the United States and does not account for regional costs differences and other additional costs. When taking those into account, the cost of living for a single parent raising two children in the Los Angeles Metro area is estimated to be an annual salary of $84,144[6]. This has increased over $8,500 since 2015. Due to this high cost of living, a third of California households cannot meet their basic needs[7]. Though it is difficult to compare the cost of living for a family in LA to household income, if we did, the median household income only exceeds this threshold in five of the nine ZIP codes in the Greater Pasadena area: 91001, 91103, 91105, 91030 and 91108.

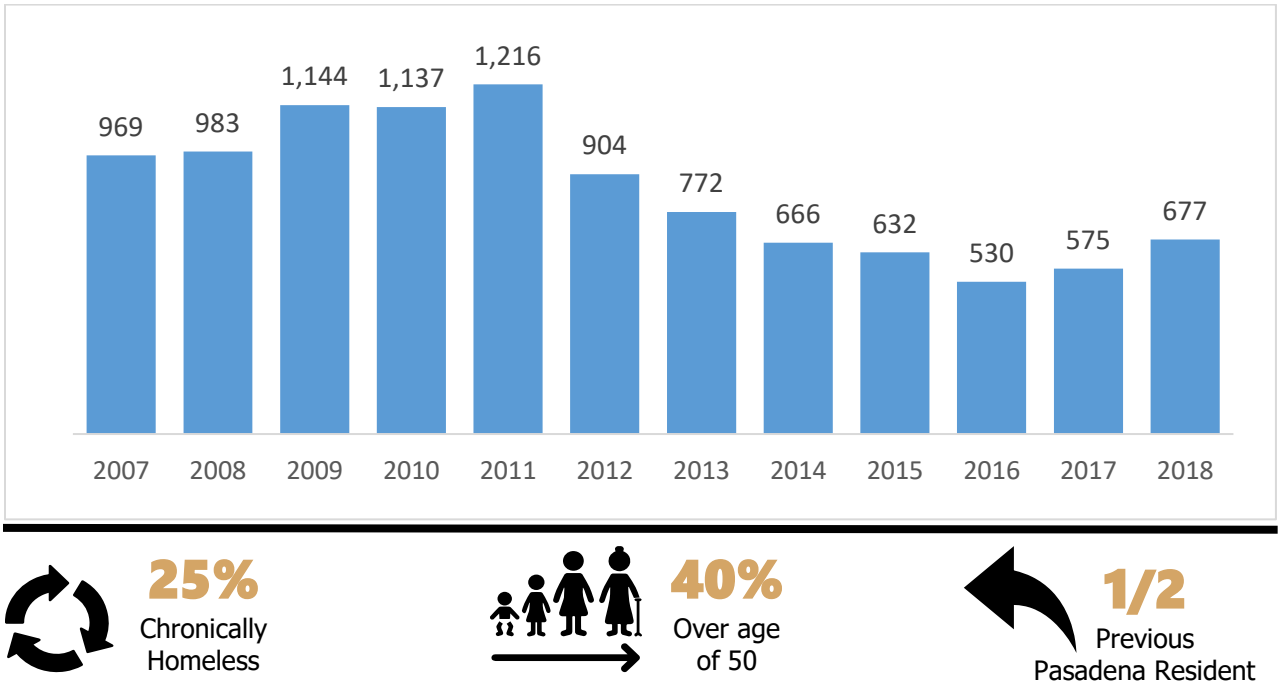
Homeownership and Overcrowding

In Pasadena, 43.6% of housing units were occupied by homeowners, which was lower than Los Angeles County (45.9%) and California (54.5%)[5]. ZIP codes 91001 and 91108 had the highest percentages of homes occupied by homeowners (75% and 84%, respectively)[5], while ZIP code 91101 had the lowest homeowner rate (17%) in 2018[5]. Finally, a common measure of overcrowding is measuring the number of occupants per room in a home. Households with more than 1 occupant per room can be an indication of crowded housing. That said, approximately 1.8% of Greater Pasadena households had more than 1.5 occupants per room, which is less than in Los Angeles County (4.8%) and California (2.8%)[5].

Homelessness

There are approximately 58,936 people experiencing homelessness in Los Angeles County[8–11]. As of January 2019, there were 677 homeless individuals living in the city of Pasadena, about a quarter of whom are chronically homeless and forty percent of whom are over the age of 50[9]. In Pasadena, there was an approximately 27% increase in the number of homeless people in Pasadena since 2016 (530 people to 677), but overall, since 2011, the count of people experiencing homelessness during Pasadena's annual homeless count has decreased by 56% (2011 to 2018). Finally, in Pasadena the rate of people experiencing chronic homelessness has decreased by 27% percent since 2016[9]. This is due to people being placed in permanent housing using programs like section 8 voucher programs.

Figure 8. Count of Homeless People in Pasadena, 2007-2018[9]



Community Input

Community members and key stakeholders explained that current economic trends, including the increasing cost of rental housing combined with comparatively stagnant wages, have put more and more residents in a position where they have little expendable income, and therefore less money to spend on nutritious food, transportation, childcare and other basic necessities. Specifically, stakeholders observed that higher housing costs are restricting the market to wealthier renters and homebuyers, and higher-end retailers. This results in lower access to goods and services for low-income residents, including affordable fresh fruits and vegetables. Another theme from the community input was that there is a growing number of residents who are at risk of missing rent payments and/or are facing eviction. This results in a number of families sharing single-family homes to spread out the cost, but at the expense of privacy, quiet places to sleep and study, and a kitchen to prepare food. Finally, community members explained that it is challenging to get out of poverty or improve your income; especially if you have a family, explaining a primary driving factor for this is cost of childcare.

> "The child care options are not very big in Pasadena…. the system isn't designed to help families move forward."
>
> -Community Resident

Economy, Housing, & Homelessness

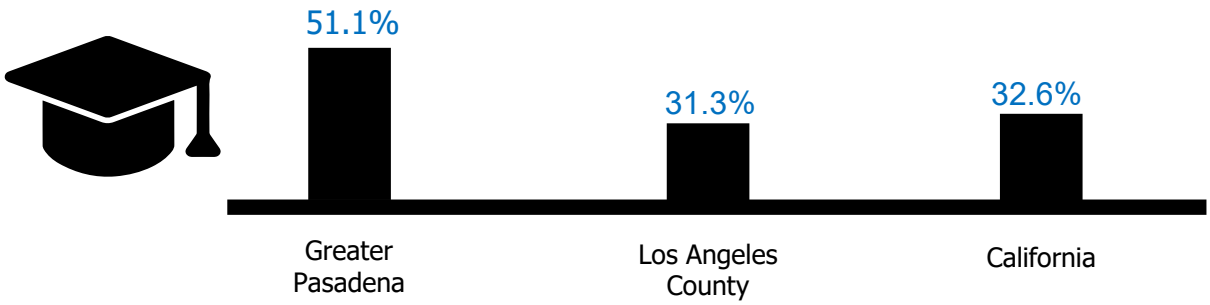
Indicator	Pasadena	LAC	CA	Trend
People 65+ Living Below Poverty Level[5]	16.3%	13.4%	10.2%	↑
People Living at or Below 150% of Poverty Level[5]	76.3%	71.9%	75.3%	↑
Median Gross Rent[5]	1,494	1,322	1,358	↑
Homeownership[5]	43.6%	45.9%	54.5%	↓
Homelessness Count[8–11]	677	58,936	---	↗
People Living Below Poverty Level[5]	15.5%	17.0%	15.1%	↔
Renters Spending 30% of more of Household Income on Rent[5]	51.9%	56.1%	53.1%	↓
Children Living Below Federal Poverty Level[5]	18.4%	24.0%	20.7%	↓
Median Household Income[5]	$76,264	$61,015	$67,169	↑
Households with >1.01 or more occupants per room[5]	5.8%	11.7%	8.2%	↓
Unemployment[5]	5.8%	7.8%	7.7%	↓

EDUCATION AND ACADEMIC ACHIEVEMENT

Academic Attainment and Preparedness

Overall, the population of Pasadena is highly educated: a large proportion (51.1%) of adults over 25 years of age in Pasadena had a Bachelor's degree or higher compared to peers in Los Angeles County (30.6%) and California (32.6%)[5]. Still, 12.4% of Pasadena adults over age 25 do not have a high school diploma[5].

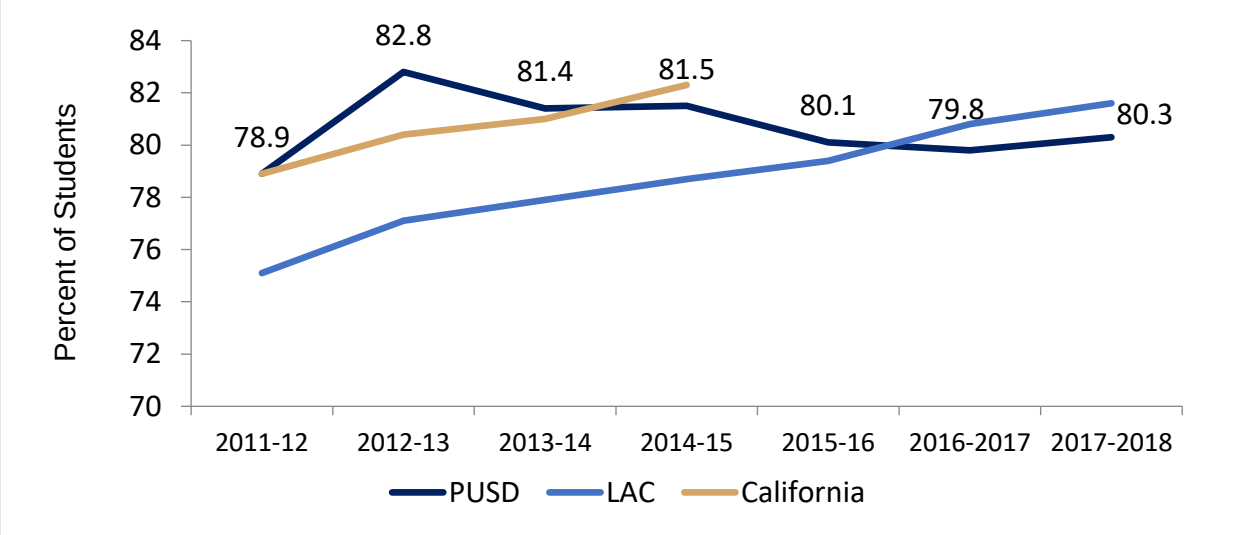
BACHELOR'S DEGREE OR HIGHER (AGES 25)[5]



High School Graduation Rates

Starting in 2016, Pasadena Unified School District graduation rates fell below those of Los Angeles County for the first time since at least 2011 (the earliest year data are available at the source)[12]. English learners and foster youth had the lowest rates of graduation in PUSD[12].

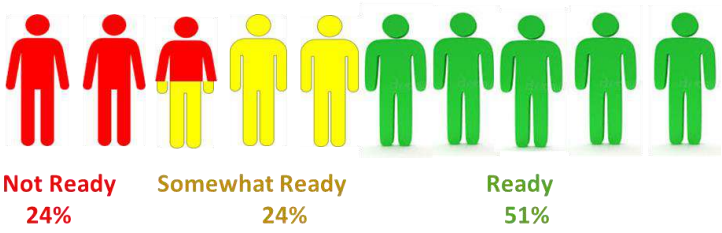
Figure 9. Cohort Graduation Rates* PUSD, LAC, and California, 2011-2018[12]



* Unadjusted cohort graduation rate

Kindergarten Readiness

According to the Early Development Instrument (EDI)—a measure of early child development in five key domains (physical health, emotional maturity, social competence, language and cognitive skills, and communications skills and general knowledge)—approximately 48% of students entering PUSD were identified as "not on track" (not ready and somewhat ready) for being ready for kindergarten[13].



Community Input

Stakeholders explained that among the public school population, they are seeing more and more families struggle with very low income, housing insecurity and homelessness. They explained that parents are working multiple jobs, parents have less time to spend to help their children with homework, and it's having impacts academically. Additionally, families are struggling to afford food, which makes it hard for them to thrive academically. Additionally, stakeholders explained the result of declines in enrollment on the public school population will impact the options our residents have for public schools.

> "Less kids means less money for public schools which…translate[s] to fewer well-funded school options for the public school population."
>
> -Key Stakeholder

Education & Academic Achievement

Indicator	Pasadena	LAC	CA	Trend
3rd Grade Students Proficient in English/Language Arts[12]	66.4%	71.8%	72.5%	↓
3rd Grade Students Proficient in Math[12]	59.1%	63.5%	64.5%	↓
Cohort Graduation Rate (4-year Adjusted)[14]	84.8%	85.3%	87.3%	↔
Cohort Graduates Meeting UC/CSU Course Requirements[12]	49.6%	56.2%	49.9%	↔
Kindergarteners entering PUSD who are "not on track"[13]	48.0%	---	---	↔
Adults (25+years) with a Bachelor's Degree or Higher[5]	51.1%	31.3%	32.6%	↔
Private School Enrollment[5]	28%	12%	11%	↔
Children (ages 3 and 4 years) enrolled in preschool[5]	73.8%	54.0%	48.7%	↑

SOCIAL ENVIRONMENT AND PUBLIC SAFETY

Crimes Rates

In Pasadena, incidence of crime has fluctuated over the past 10 years, though the frequency has been trending lower year-over-year for the past four years on the most common forms of crimes[15].

Bullying and Crime with Youth and Adolescents

Among students in the Pasadena Unified School District (grades 7, 9, and 11) in academic year 2017-2018, 31% reported that they experienced any kind of harassment or bullying, a slight increase from 29% in the previous year[16]. Additionally, 23% reported that they experienced cyberbullying, and 15% reported that they experienced harassment or bullying due to race/ethnicity[16]. When stratified on race, Asian students reported a higher rate of bullying than the other racial groups[16].



31%

reported ANY harassment or bullying
Increase from 29% in AY16-17



23%

reported ANY cyberbullying in last 12 months.
Increase from 18% in AY16-17



15%

reported harassment due to race/ethnicity.
No change from AY16-17

Among the same population of students, 14% reported being in a physical fight within the last 12 months, 11% had seen a weapon on campus, and 2% reported gang involvement[17]. Just over half of students (53%) perceived their school campus to be very safe – a decline from 62% in academic year 2016-2017[17].



14%

Have been in a physical fight in the last 12 mo.
Increase from 11% in AY16-17



11%

Have seen a weapon on school campus.
Decline from 13% in AY16-17



53%

Perceive school as very safe or safe.
Decline from 62% in AY16-17

The rate of minor and young adult perpetration of violent crimes in Pasadena has generally decreased since 2011, but the current rate (411.4) is still above the Healthy People Goal 2020 (339.6)[18]. Conversely, the rate of minor and young adult victimization from crimes of violence has remained steady from 2011 to 2017, at a rate of 8.8 incidents per 1,000 adolescents (ages 10 to 24)[18]. This remains below the Healthy People Goal 2020 set at 37.8 per 1,000.

Homicide

From 2006-2017, there was an average of 5.7 people who died by homicide per year in Pasadena[19]. Over the last ten years, Black and Hispanic residents were 6.2 times as likely and 2.3 times as likely to die by homicide when compared to their white counterparts. Specifically, the 10-year average homicide rate per 100,000 by race in Pasadena was 11.8 (Black), 4.3 (Hispanic), 1.9 (White), and 1.1 (Asian)[19]. Finally, approximately 22% of the homicide victims were female[19].

Figure 10. Age-adjusted death rate due to homicide, 2006-2017[19]



The average age of death by homicide by gender was 39.5 for females and 34.2 years for males. Firearms (including rifles and handguns) were the primary cause of death in 66.2% of homicides, followed by sharp objects (14.7%), assault (11.8%), suffocation/strangulation (4.4%), and arson (2.9%). During that time, firearms were used in an average of 3.8 homicides per year in Pasadena[19].

Social Environment & Public Safety

Indicator	Pasadena	LAC	HP2020	Trend
Bullying among Adolescents[16]	31.0%	---	19.9%	↑
Violent Crime Perpetration of Young Adults[18]	410.4*	---	339.6	↑
Perceive Neighborhood Safe from Crime[20]	87.3%	85.0%	---	↔
Firearm-Related Death Rate (per 100,000)[21]	2.8*	---	10.3	↓
Physical Fighting Among Adolescents[17]	14.0%	---	28.4%	↓
Violent Crime Victimization among Young Adults[18]	8.8	---	37.8	↓
Homicide Rate[19]	3.5*	---	5.5	↓
Have Firearms in/around Home[20]	9.1%^	11.4%	---	↓
Has Internet Access[20]	90.9%	84.8%	---	↓

HP2020 = Healthy People 2020 objective

*5-year average rate

^Statistically unstable

TRANSPORTATION AND PHYSICAL ENVIRONMENT

Commute Times

The travel time to work for residents of Pasadena has been increasing year-over-year for the past 10 years. In fact, the commute time has increased by almost a half-minute each year over the last 5 years. Though the change may appear to be subtle, the increase to residents in Pasadena and the region can result in increases in stress, loss of work, and increased risk for motor vehicle accidents[5].

Figure 11. Mean travel time to work among people who live in Pasadena, Los Angeles County (LAC) and California, 2009-2017[5]

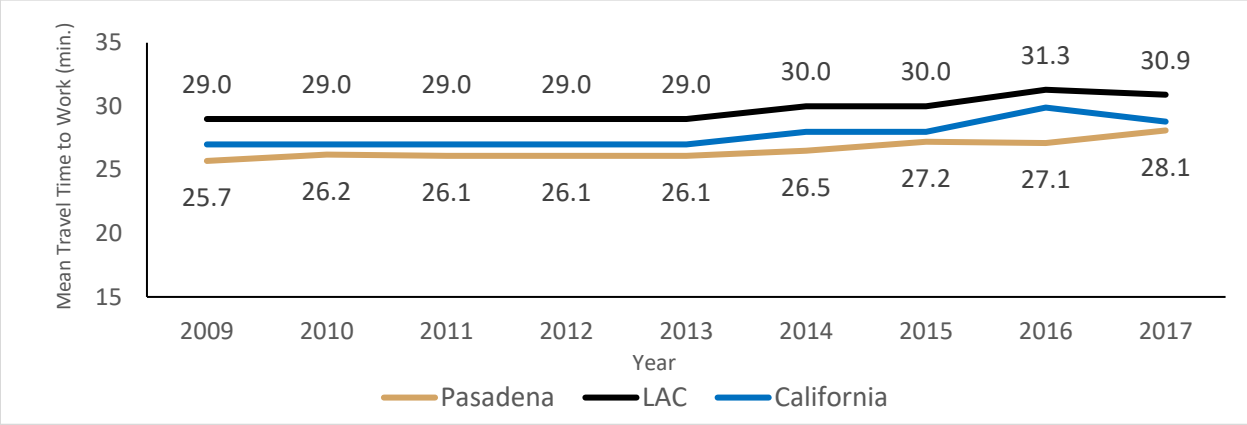
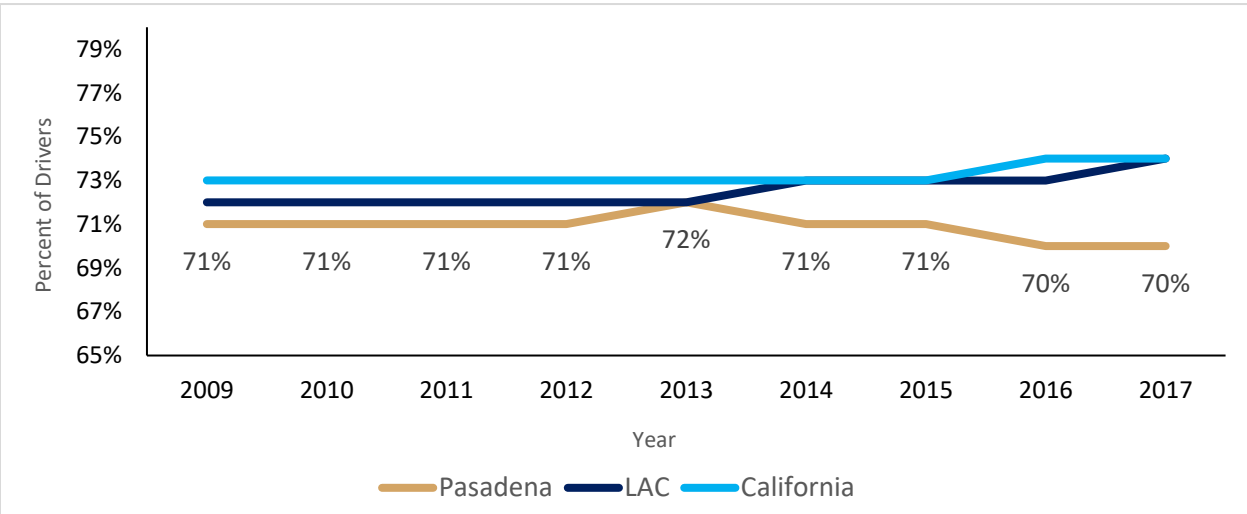


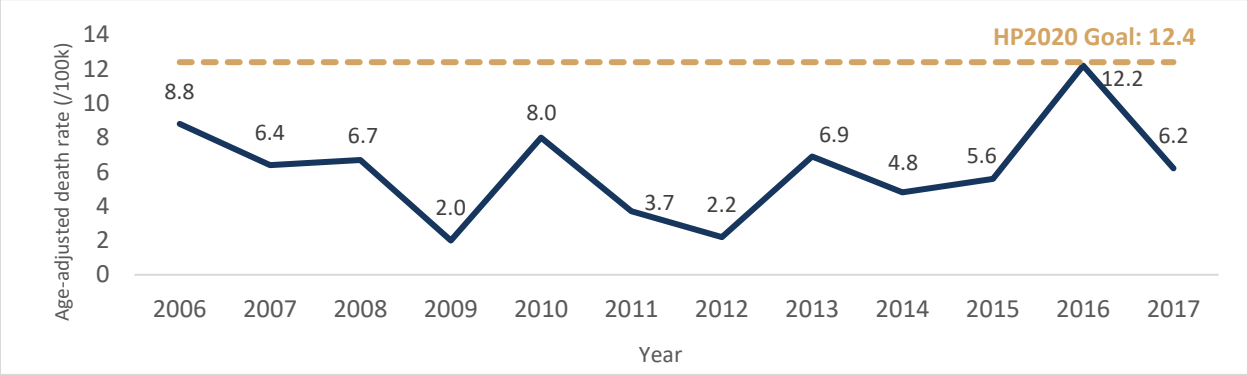
Figure 12. Workers who drove alone in Pasadena, LAC and California, 2009-2017[5]



Motor Vehicle Accidents

In 2017, land transport accidents, including motor vehicle accidents, was the 4th leading cause of premature death for residents of Pasadena[19]. From 2006 to 2017, there was an average of 9 deaths per year. Among land transport accident deaths, about 31% of the incidents were car occupants, 26% pedestrians, 16% motorcyclists, 6% pedal bicyclists, 2% van/pick-up truck occupants, and 19% heavy transport vehicle or some other vehicle occupants.

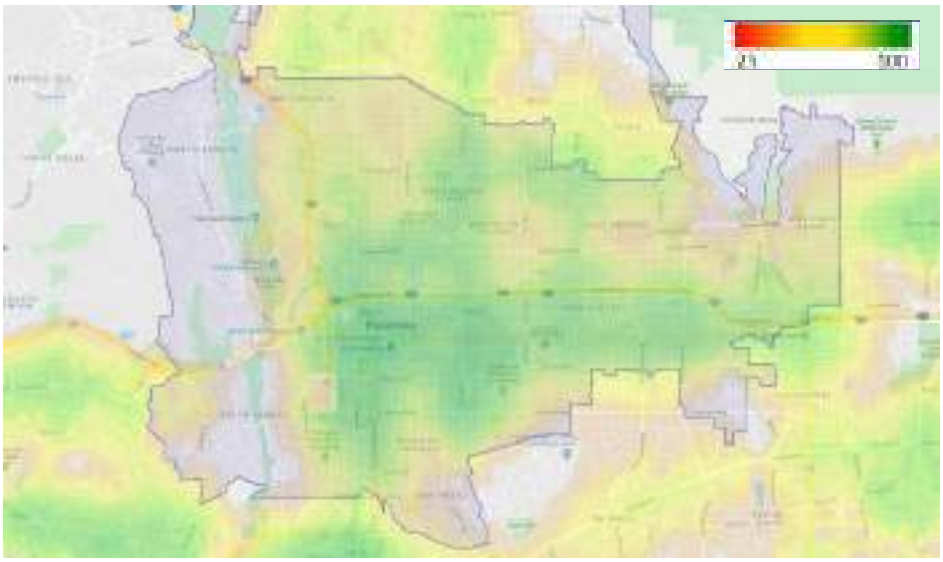
Figure 13. Age-adjusted death rate due to Land Transport Accidents, 2006-2017[19]



Walkability

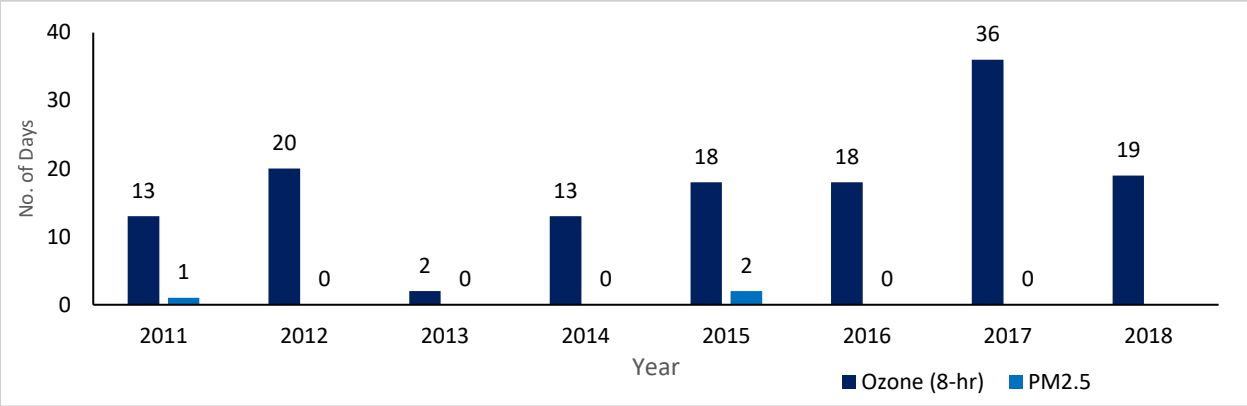
The Walk Score is a measure developed and processed by WalkScore.com[22]. It aims to assess the walkability of neighborhoods to nearby amenities. The score is highest when amenities that would normally be included during daily errands are within a 5-minute walk (0.25) and declines up until a 30-minute walk. Pasadena has an average walk score of 66, which is considered "somewhat walkable". It has good public transportation (Transit Score of 51) and is somewhat bikeable (Bike Score 66)[22].The most walkable neighborhoods are Raymond Hills, South Lake, and Downtown.

Figure 14. Walkability scores in and around Pasadena, 2019[22]



Air Pollution

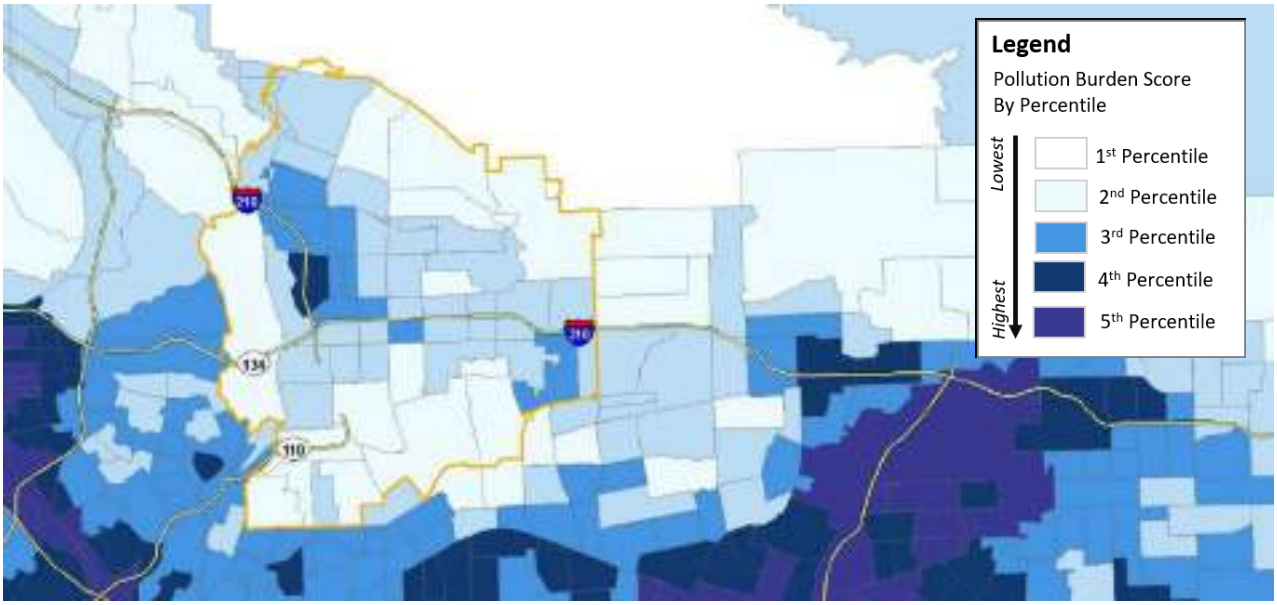
Figure 15. Annual number of days per year Ozone and Particulate Matter (PM) pollution exceeded government standards in Pasadena, 2011-2018[23]



Pollution Burden

CalEnviroScreen is a tool prepared by the Office of Health Hazard Assessment, on behalf of the California Environmental Protection Agency (CalEPA), which evaluates the burden of pollution from multiple sources in communities while accounting for the population's health risk to adverse effects of pollution[24]. The map below shows the Greater Pasadena area (circled in gold), and portions of Los Angeles and east San Gabriel Valley. The percentiles show the risk levels compared to other census tracts in California. The more blue/purple, the higher the risk.

Figure 16. Air pollution burden score by census tract, 2019[24]



Community Input

In interviews and focus groups, residents indicated that transportation and commute times are a barrier to accessing health care, particularly for low-income families with children who do not have private vehicles. Residents agree that Pasadena is walkable, yet necessary resources including free and low-cost clinics, grocery stores with affordable fresh foods, and public schools are often difficult to reach by public transportation, especially for residents with limited free time.

Transportation & Physical Environment

Indicator	Pasadena	LAC	CA	HP2020	Trend
Annual Number of Days Ozone Exceeded Government Stds.[23*]	<1	---	---	---	↔
Annual Number of Days PM2.5 Exceeded Government Stds.[23*]	20.8	---	---	---	↘
Mean Travel Time to Work[5]	28.1	30.9	28.8	---	↔
Percent working adults (age 16+) travel time to work >1 hr[5]	11.8%	13.6%	11.8%	---	↔
Self-Reported Distracted Driving[20]	16.6%^	14.6%	---	---	↔
Walk Score[22]	66	67	---	---	↔
Land Transport Fatality Rates[19]	7.1	---	---	12.4	↓
Workers who Drive Alone to Work[5]	69.7%	73.7%	73.6%	---	↓

*5-year average rate
^Statistically unstable

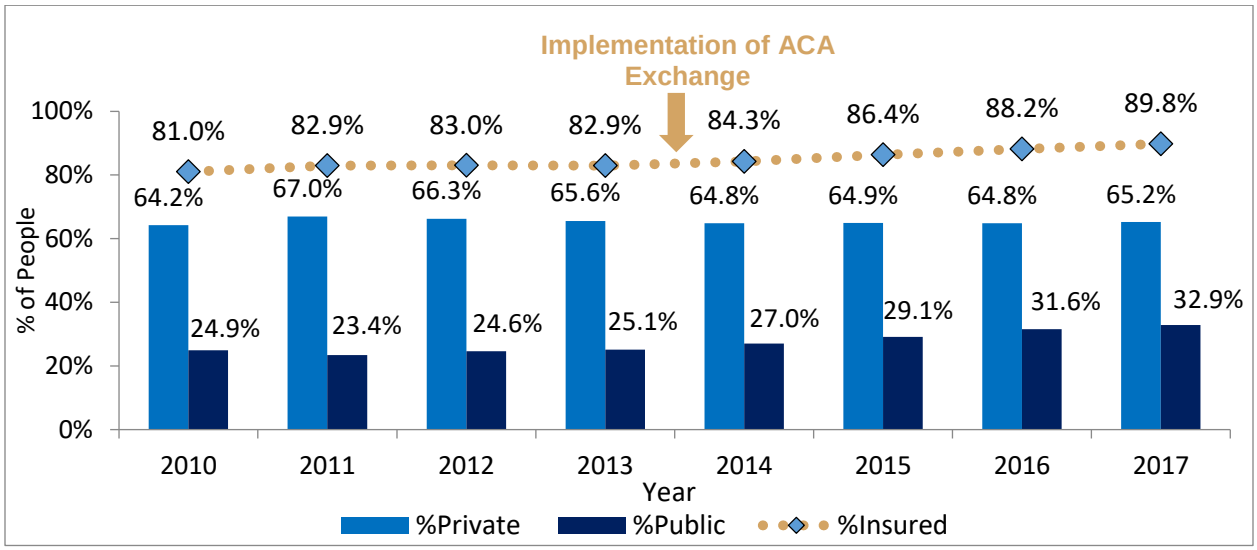
V. HEALTH TOPICS

ACCESS TO CARE

Health Insurance Coverage

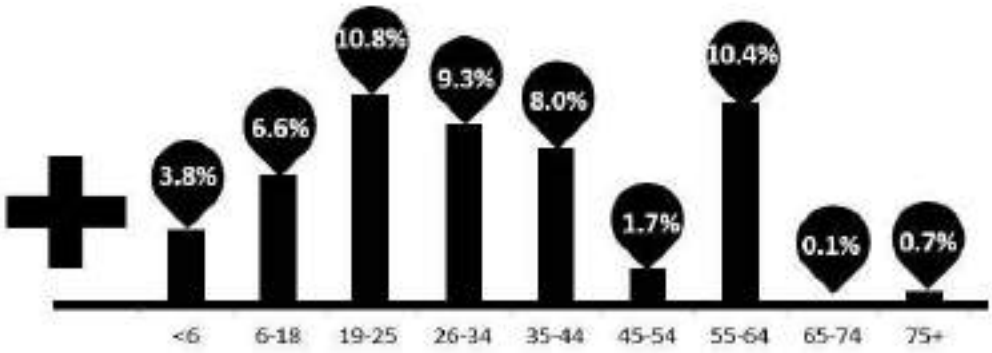
The rate of insured people in Pasadena has increased steadily by almost 9% in seven years, from 81.0% in 2010 to 89.8% in 2017[5]. Since the implementation of the Patient Protection and Affordable Care Act (ACA) health care exchange in 2013, the number of people who are newly insured has increased by more than 12,000 people. The biggest increases have been in public insurance enrollment, 25.1% in 2013 to 32.9% in 2017[5].

Figure 17. People living in Pasadena (all ages) with health insurance, 2010-2017[5]



By comparing the insurance rates in 2013 (before the ACA Exchange) and 2017 (after) by age groups, it is easier to see that the biggest gains were among younger, working-age adults ages 19-44 and people ages 55-64, with increases in excess of 10 percent in some instances[5].

PERCENT INCREASE IN INSURANCE RATES AFTER ACA[5]



Community Input

Despite increasing rates of health insurance, many residents still struggle to connect with and pay for health care. Some residents with health insurance said they do not seek care because they know they won't be able to cover the additional co-pays and other costs associated with treatment.

> "Health insurance doesn't pay for everything."
>
> -Community Resident

Many residents have an income just over the threshold to qualify for Medi-Cal. For example, part-time workers who do not qualify for employer-based health insurance can find themselves in a situation where they are required to purchase their own insurance, but their income does not allow them to afford Covered California plans.

Residents also reported struggling with navigating health care systems due to the complexity of the system, and confusion in the community over what health services would be considered "public charge" (and therefore count against an undocumented immigrant's appeals in the immigration process). Stakeholders explained that the lack of access to linguistically, culturally and socioeconomically responsive services, including health care navigation services, acts as a barrier to health care access.

Access to Care

Indicator	Pasadena	LAC	CA	Trend
Percent of people with health insurance[5]	89.8%	86.7%	89.5%	↔
Adults who reported difficulty obtaining needed medical care[20]	13.1%^	21.3%	---	↓
Difficulty communicating with a provider because of a language barrier[20]	---	4.5%	---	N/A
	SPA 3	**LAC**	**CA**	**Trend**
Insurance not accepted by general doctor in past year (adults)[25]	7.7%*	5.6%	5.1%	↑
Delayed care due to cost or lack of insurance (all ages)[25]	50.9%	46.0%	45.6%	↑
People with a usual place to go when sick or need health advice[25]	86.9%	84.9%	87.0%	↔
Ever experienced unfair treatment getting medical care due to race/ethnicity[25]	5.6%*	5.9%	5.1%	↔
Delayed or didn't get other medical care (all ages)[25]	9.1%	9.5%	10.3%	↔
Ever had problems paying for household's medical bill in past year (adults)[25]	8.9%	8.4%	9.2%	↔
Difficulty finding primary care (adults)[25]	4.3%*	5.0%	5.7%	↓
Difficulty finding specialty care (adults)[25]	10.9%*	11.5%	11.5%	↓
Delayed or did not get prescription medicine (all ages)[25]	5.9%*	8.2%	8.5%	↓

^Statistically unstable

* Pooled over 2 years

MATERNAL, INFANT, AND CHILD HEALTH

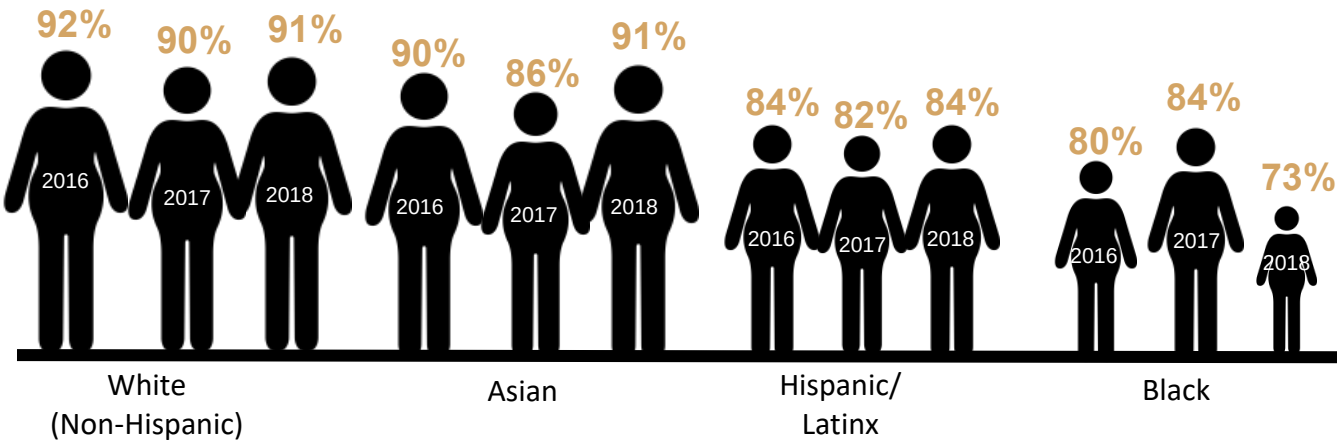
Birth Rates

Over the last ten years, there have been 50 fewer births each year in Pasadena on average, a 25% reduction[26]. The biggest decreases were among women ages 20-29, while in the United States rates have been increasing among 35-39 year-olds, and more modestly 30-34 year-olds, Pasadena's 10-year average rates have declined for all age groups except 35-39 year olds[26,27]. Finally, the teen birth rate has decreased by 81% over the last twelve years to its lowest level since the indicator was first tracked in the 1900s[26].

Prenatal Care

The percent of Pasadena mothers who received prenatal care in the first trimester was 87.4% in 2018, higher than the Healthy People (HP) 2020 goal of 77.9%[26]. This is true for Pasadena mothers year over year overall. Despite this, when you stratify by race, Asian and White women received prenatal care in the first trimester at higher rates (around 91%) than their Hispanic/Latinx and Black counterparts, with 2018 rates at 84% and 73%, respectively[26].

Figure 18. Percent of Women in Pasadena who Received Prenatal Care, by Race/Ethnicity, 2016-2018[26]



Caesarean Section (C-Section) Rates

In 2018, 32.9% of all births in Pasadena were by Caesarean Section (C-Section). This rate is in steady decline since 2010. Still, a consistently higher percentage of births to people living in Pasadena at the time of their birth are delivered by C-section (32.9%)[26], when compared to California (31.9%)[28].

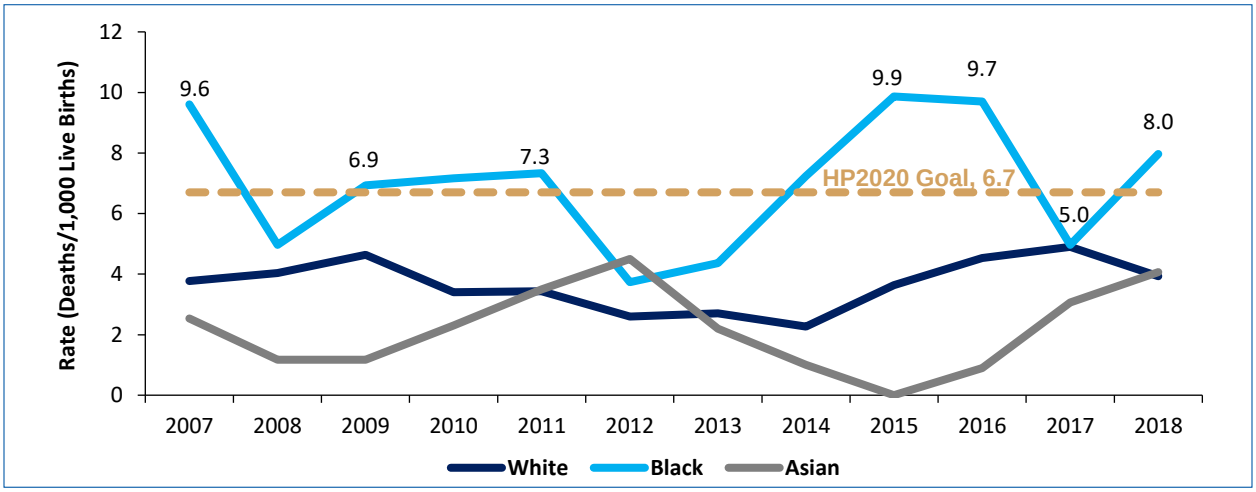
Low Birthweight and Preterm Births

In Pasadena, rates of low birth weight and very low birth weight in 2018 remained at or below the HP2020 goal levels[26]. Preterm births (less than 37 weeks gestational age) have declined in Pasadena over the past ten years, from 14.5% in 2006 to 8.1% in 2016. However, from 2016 to 2018 preterm births vacillated above and around the Healthy People 2020 goal of 9.4%[26].

Maternal and Infant Mortality Rates

In the last 10 years, Pasadena has had fewer than three maternal deaths due to complications of childbirth listed as the cause of death on the death certificate; however, there continue to be disparities in infant mortality rates by race. The three-year average rate is highest among Black infants, and in the past 10 years, the only group to exceed the HP2020 goal of 6.7[26].

Figure 19. Three-year average Infant Mortality Rates by race among Pasadenans, 2007-2018[26]



Breastfeeding Rates

During the last two Maternal and Infant Health Assessments, Pasadena has had an increase in mothers continuing to breastfeed infants into first three months, and that has been higher than the same measurements among California overall. In 2018, approximately 73.1% of mothers breastfed their babies for at least 3 months, and more than half (54.2%) breastfeed for at least six months after delivery.



Community Input

Community engagements focusing on the lived experience of Black mothers found that many had experienced prejudice, discrimination and neglect in their experiences with health care providers, including their experiences in labor and delivery. Black mothers expressed that they felt that their pain was minimized and ignored by practitioners, and that they were cut out of decisions made by practitioners, or that practitioners misinterpreted/misunderstood their efforts to explain physical or emotional symptoms. Community engagements indicated that there is opportunity to develop culturally responsive practices for Black patients, including expectant mothers, to improve prenatal and postpartum experiences and outcomes.

Maternal, Infant, & Child Health

Indicator	Pasadena	CA	HP2020	Trend
Black infant mortality rates[26]	9.2*	10.2	6.7	↑
Birth rates (/1,000)[26]	52.5	61.7	---	↘
Births delivered by Cesarean section[26,28]	32.9%	31.9%	---	↔
Children conceived within 18 months of previous birth[28]	28.3%	26.6%	29.8%	↔
Low birth weight rates[26]	7.7	6.9	7.8	↔
Very low birth weight rates[26]	1.6	1.1	1.4	↔
Mothers who reported receiving prenatal care in their 1st trimester[26]	87.4%	83.6%	77.9%	↑
Mothers who reported a postpartum medical visit[29]	95.4%	87.5%	90.8%	↑
Teen birth rates (/1,000 females ages 15-19)[26]	8.2	15.7	---	↘
Preterm birth (<37 weeks) rates[26]	8.5	8.7	9.4	↓
Breastfeeding rates 3 months after delivery[29]	73.1%	66.2%	46.2%	↑

*5-year average rate

EXERCISE, NUTRITION, AND WEIGHT

Physical Fitness and Nutrition among Children and Adolescents

Across all grades, students in the Pasadena Unified School District (PUSD) meet the fitness standards at higher levels than Los Angeles County (average across grades 5, 7 and 9: 30.2% PUSD versus 26.9% LAC)[30]. Still less than a third of students meet all standards[30]. When stratified by race, Hispanic/Latinx students and Black/African American students are meeting the standards at lower rates than their White and Asian counterparts.

Across SPA 3, nearly one in ten (8.3%)children are not physically active for at least one hour per week, and nearly two in ten (19.0%) children spend more than 5 hours per day on sedentary activities[25].

Among children (younger than 18 years) living in the San Gabriel Valley (SPA 3)[25]…

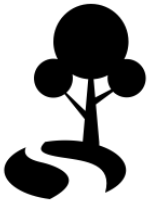


8.3%

were not physically active for at least one hour in the past week (zero days of activity).

86.5%

visited a park or other open space in the last month.





19.0%

spent more than 5 hours on sedentary activities on a typical weekday after school.

Among adolescents (ages 12-17) living in the San Gabriel Valley (SPA 3)[25]…



49.3%

ate 2 or more fruit servings per day.

20.2%

ate 5 or more servings of fruits and/or vegetables per day.





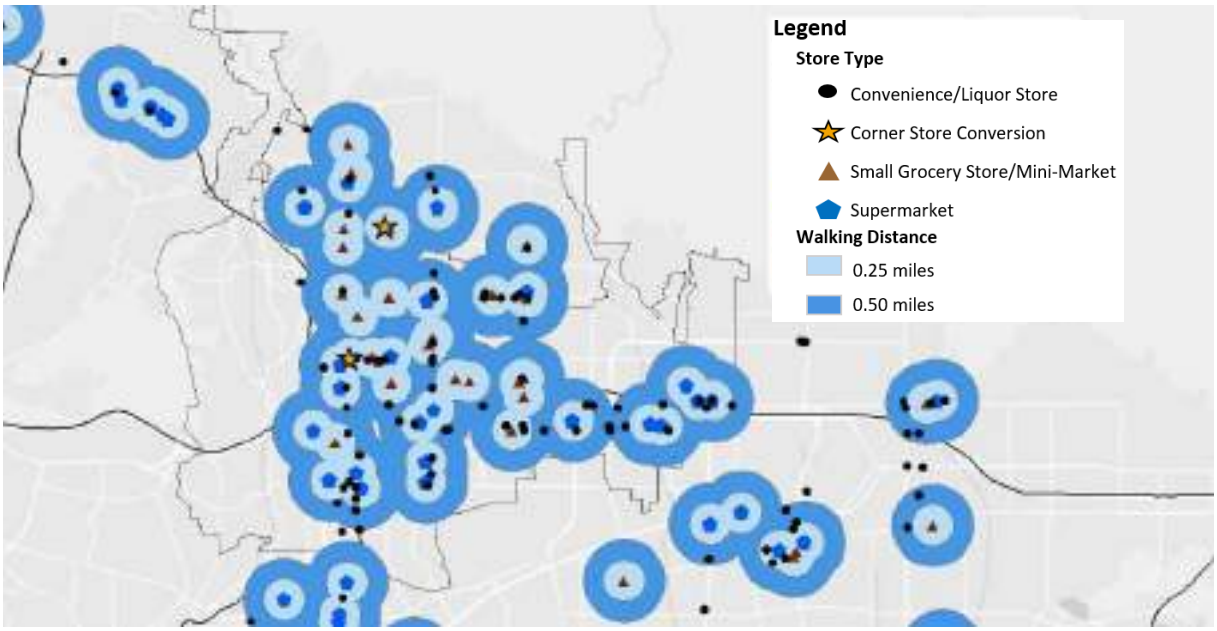
53.2%

ate fast food more than one time in the last week.

Access to Healthy Foods

The Access to Healthy Foods map assesses the walkability to grocery stores in the Greater Pasadena area. The "blue buffer" areas are within walking distance (1/4 and 1/2 mile) of a market that carries at least two or more fruits or vegetables. Convenience stores (marked with a black dot) with no blue buffer around it could be candidates for corner store conversion projects, where fresh fruits or vegetables can be sold. The two previous conversions by the Pasadena Public Health Department are represented by the gold stars.

Figure 20. Access to healthy foods and walking distance to grocery stores and markets in Greater Pasadena, 2019[31]



Obesity in Adolescents and Adults

Over nearly 20 years, the proportion of adults with obesity has increased in the United States by 30% such that almost 2 out of 5 (39.6%) adults in the country, aged 20 or more, are now obese[32]. In SPA 3, obesity rates are lower among adults, still nearly one in four (24.2%) adults are obese. Conversely, the rates of adolescents who are overweight/obese in SPA 3 is higher than Los Angeles County (LAC) and California (35.7% versus 26.5% versus 27.4%, respectively)[25].

Figure 21. Rates of Overweight/Obesity in Adolescents and Adults, 2017[25]

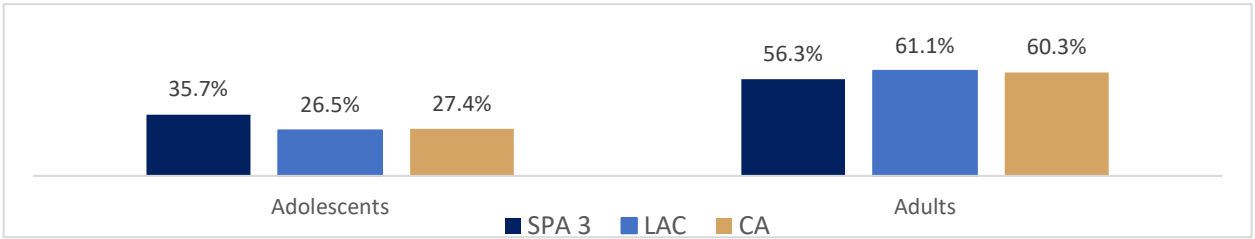
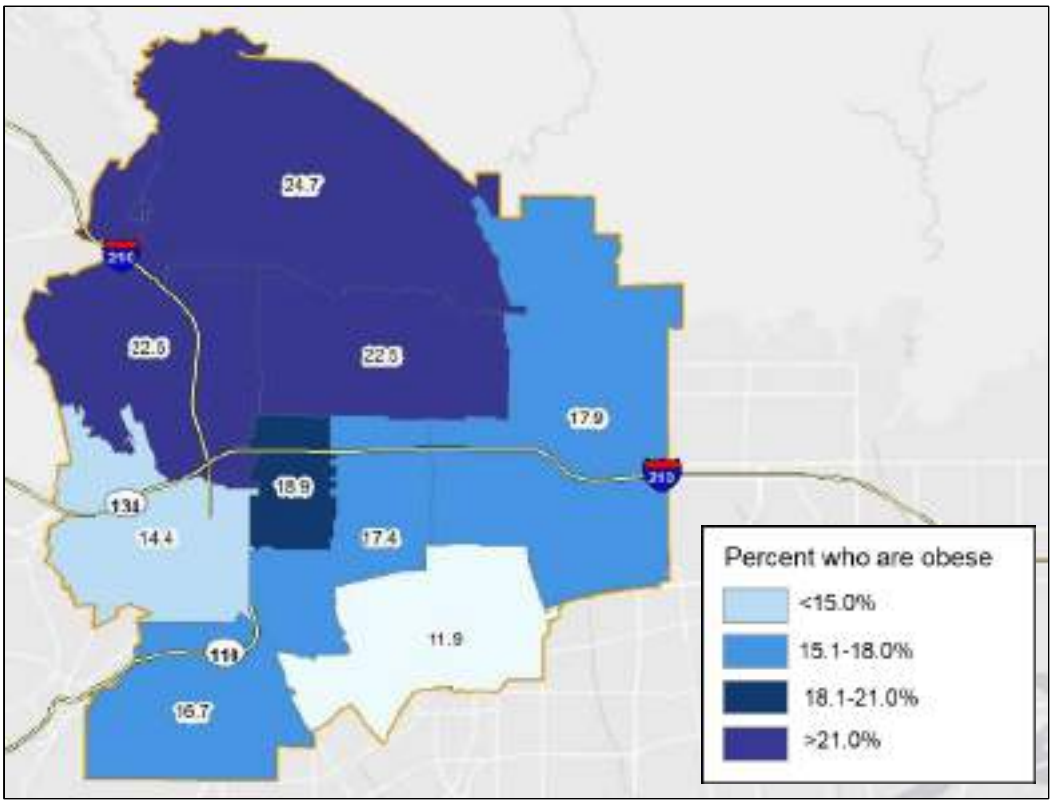


Figure 22. Percent of residents (all ages) who are obese in Greater Pasadena, 2017[25]



As rates appear to be steadying in SPA3 overall, disparities within the Greater Pasadena area continue. Estimates show higher rates of obesity in north/northwest Pasadena/Altadena than other regions of the service area. These are also areas with relatively less walkability, higher smoking rates, and other major risk factors, which are important risk factors for premature death due to downstream health conditions like heart disease and diabetes.

Exercise, Nutrition, & Weight

Indicator	SPA3	LAC	CA	Trend
Adolescents who are overweight or obese[25]	35.7%^	26.5%	27.4%	↑
Adolescents who ate 2+ fruit servings/day[25]	49.3%^	69.6%	66.9%	↓
Children active at least one hour[25]	8.3%^	7.3%^	6.2%	↓
Adult fast food consumption[25]	71.6%	72.5%	67.6%	↔
Adults who are overweight or obese[25]	56.3%	61.1%	60.3%	↓
	Pasadena	**LAC**	**CA**	
Students meeting physical fitness requirements[30*]	30.2%	26.9%	---	↓
No. days in last month where activity was limited due to health[20]	1.3	2.7	---	↓

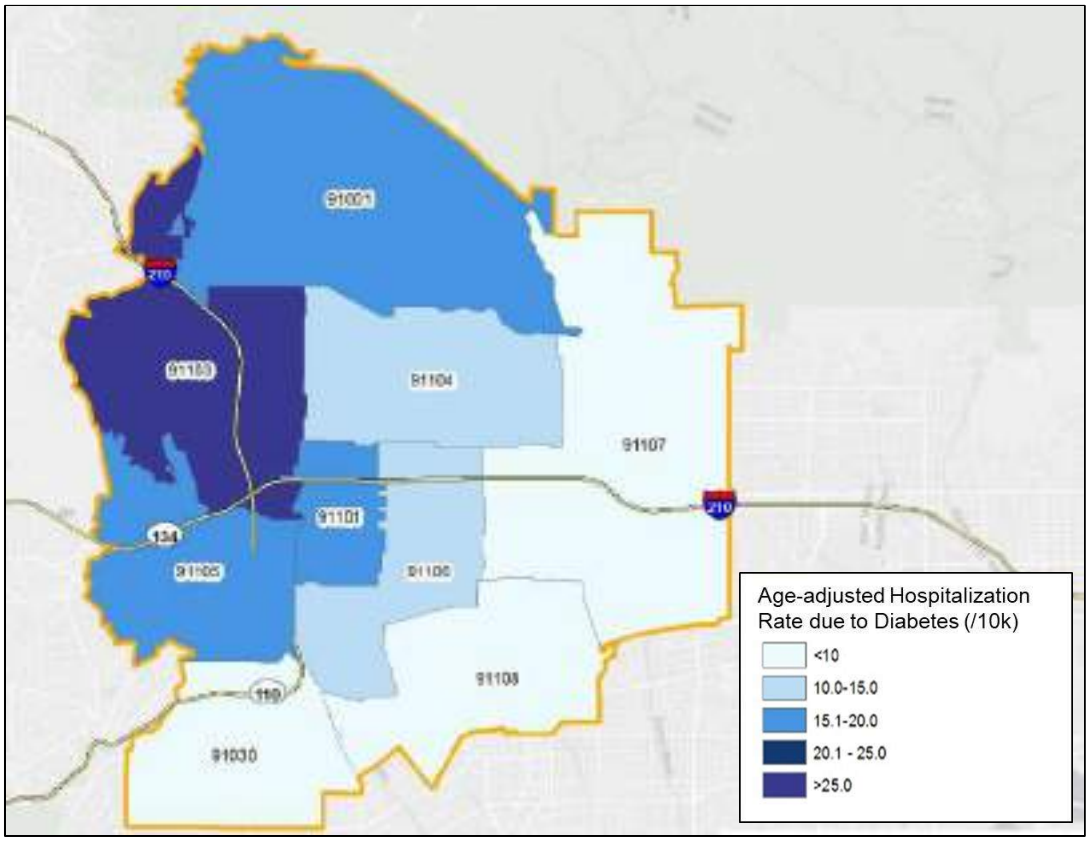
^Statistically unstable

*5-year average rate, average across grades

DIABETES

The rate of adults who have ever been diagnosed with diabetes was lower in 2017 for SPA 3 than in Los Angeles County and California, though the rate has been increasing for all jurisdictions[25]. Among people in Greater Pasadena, the hospitalization rate for people living with diabetes is highest in Northwest Pasadena[33].

Figure 23. Age-Adjusted Hospitalization Rate (/10,000) due to Diabetes, 2015-2017[33]



Diabetes Mortality

In 2017, diabetes was the 8th leading cause of death in Pasadena[19]. From 2006-2017, the average age of death for all races from diabetes was 75.0 years. The mean age of death by race was: 80.6 (Asian), 76.1 (White), 75.0 (Black), and 70.3 (Hispanic). In Pasadena, the age-adjusted death rate due to diabetes was below the HP2020 goal of 66.6 per 100,000[19].

Diabetes

Indicator	Pasadena	LAC	CA	HP2020	Trend
Adults ever diagnosed with diabetes[20,25]	9.1-9.3%^	11.3-12.1%	10.7%	---	↓
Death rates due to diabetes[19]	21.2*	---	---	66.6	↓

^Statistically unstable

HEART DISEASE AND STROKE

The rate of adults ever diagnosed with high blood pressure in SPA 3 is around 30.2%, slightly higher than LAC (30.0%) and California (29.0%)[25]. The same is true for the rates of adults ever diagnosed with heart disease (6.7% SPA 3, 6.1% LAC and 6.4% California)[25].

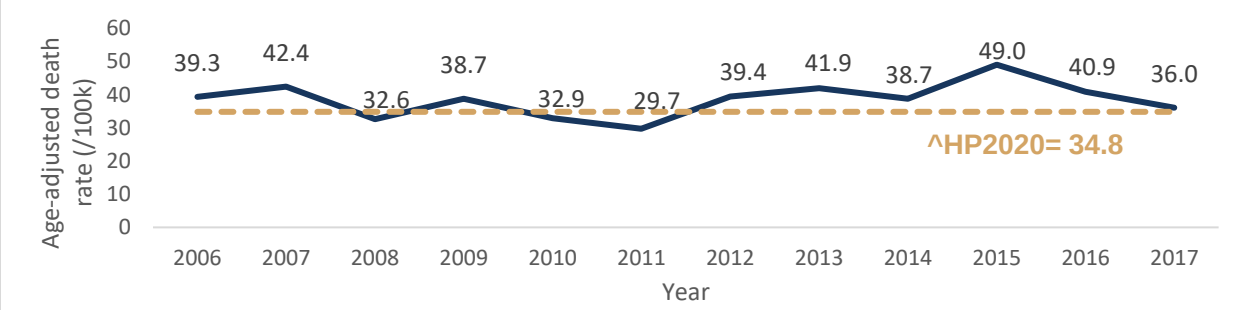
Heart Disease and Stroke Mortality

From 2006-2017, the average age of death due to heart failure was 83.8 years, but there were significant racial disparities[19]. Black and Hispanic Pasadena residents were more likely to die earlier (mean age 76.2 years and 77.0, respectively) than their White and Asian counterparts (86.2 and 85.6, respectively)[19]. The ZIP codes with the highest hospitalization rates due to heart failure were 91103 (38.0 per 10,000) and 91104 (34.2 per 10,000)[34].

In 2017, hypertensive diseases were the 5th leading cause of death in Pasadena[19]. Like heart failure, there were significant disparities in the mean age of death by race: 82.5 (White), 81.9 (Asian), 76.9 (Hispanic), and 69.3 (Black)[19].

In 2017, cerebrovascular disease, or stroke, was the 3rd leading cause of death. The age-adjusted death rate was 36.0 per 100,000, with the rate fluctuating above and below the HP2020 goal of 34.8 per 100,000[19].

Figure 24. Age-adjusted death rates due to stroke, 2006-2017[19]



Heart Disease & Stroke

Indicator	SPA3	LAC	CA	Trend
Adults (18+) with high blood pressure[25*]	30.2%	30.0%	29.0%	↔
Adults ever diagnosed with heart disease[25*]	6.7%	6.1%	6.4%	↔
	Pasadena	**LAC**	**HP2020**	
Age-adjusted death rates due to stroke[19]	41.3**	---	34.8	↔
Age-adjusted death rates due to hypertensive diseases[19]	27.8**	---	---	↔
Age-adjusted death rates due to heart failure[19]	21.7**	---	---	↔
Adults ever diagnosed with high cholesterol[20]	17.6%	26.8%	---	↓

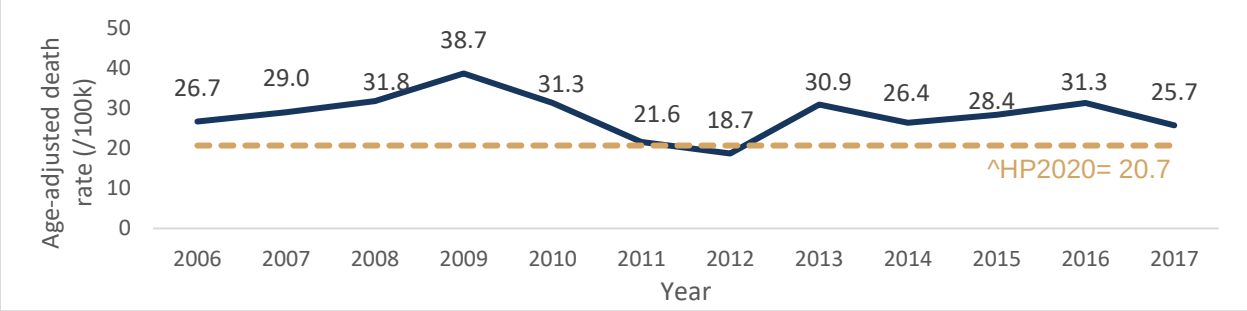
*Pooled across 2 years for stability
**5-year average rate

CANCER

Breast Cancer

Breast cancer was the 6th leading cause of death, and the leading cause of premature death, among females in Pasadena[19]. Since 2006, the age-adjusted death rate among females in Pasadena has been consistently higher than the Healthy People 2020 (HP2020) goal of 20.7 per 100,000 females[19]. Mammograms are an effective method for early detection of breast cancer. In Pasadena, equivalent or more people are getting mammograms in the Pasadena (76.7-80.7%) than LAC (77.0%) as whole (depending on the data source)[20,35].

Figure 25. Age-adjusted death rates due to Breast Cancer, 2006-2017[19]



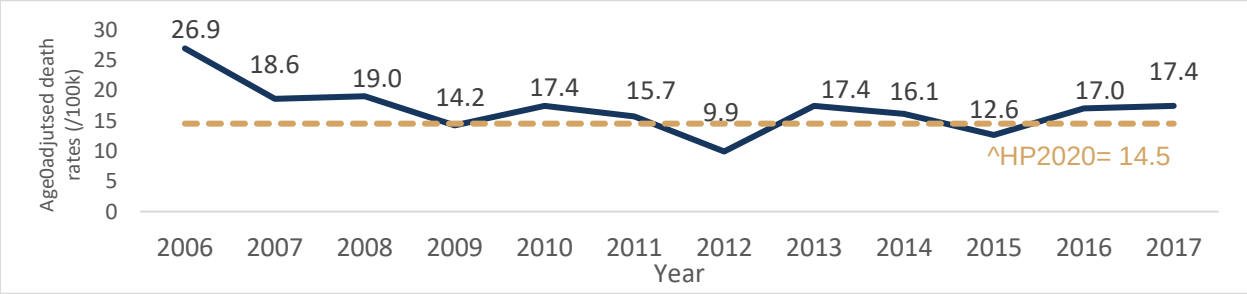
Cervical Cancer Screening

The Healthy People 2020 objective (C-15) for cervical cancer screening is for 93.0% of women ages 21 to 65 years to have a Pap smear within three years. In the San Gabriel Valley (SPA 3), estimates approximate around 80.9% of the eligible people had one in that time period[20]. Among people in Pasadena, estimates vary, but around 69.7%[20] to 86.2%[35] have had a pap smear in the last three years.

Colorectal Cancer

From 2006-2017, the average annual number of deaths due to colorectal cancer was 25.4[19]. The 10-year (2008-2017) average death rates per 100,000 by race were 25.2 (White), 24.1 (Black), 13.8 (Asian), and 7.5 (Hispanic). The types of colorectal cancer death reported since 2006 include 85% colon cancer, 15% rectal cancer, and less than 1% anal cancer[19].

Figure 26. Age-adjusted death rates due to Colorectal Cancer, 2006-2017[19]



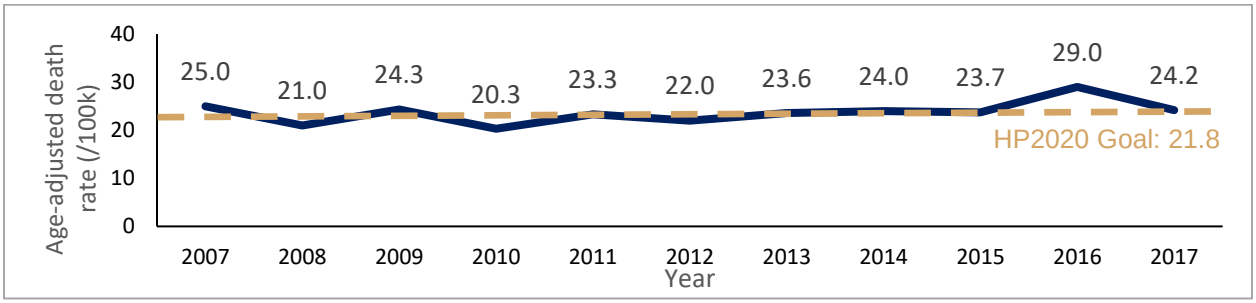
Lung Cancer

Lung cancer was the 7th leading cause of death in Pasadena, and accounted for an average of 47.1 deaths per year (2006-2017)[19]. Since 2006, the age-adjusted death rate has remained lower than the HP2020 goal of 45.5 deaths per 100,000 persons, with the exception of 2011. There are racial disparities in lung cancer mortality. The 10-year average death rate per 100,000 was 56.5 (Black), 47.4 (White), 32.7 (Asian), and 13.8 (Hispanic)[19].

Prostate Cancer

The average age-adjusted death rate due to prostate cancer was 24.2 per 100,000 males in Pasadena in 2017[21]. The rate in Pasadena has been above the HP2020 goal of 21.8 deaths per 100,000 since 2011.

Figure 27. 3-year average age-adjusted death rate due to prostate cancer, 2007-2017[19]



Community Input

Stakeholder engagements identified several opportunities for cancer prevention/treatment including: programs that are culturally and linguistically specific and that facilitate building community among patients going through similar experiences. This was particularly true for foreign-born and marginalized community members who may not have strong ties to the area.

Cancer

Indicator	Pasadena	LAC	HP2020	Trend
Age-adjusted death rate due to prostate cancer[19]	24.2*	---	21.8	↑
Women (21-65 years) who had a pap smear in last 3 years[20]	86.2%	81.4%	93.0%	↓
Age-adjusted death rate due to breast cancer (female)[19]	28.5*	---	20.7	↑
Women (50-74 years) who had a mammogram in last 12 months[20]	76.7%	77.0%	73.7%	↔
Age-adjusted death rate due to colorectal cancer[19]	16.1*	---	14.5	↔
Adults (50-74 years) who had a blood stool test[20]	29.0%	20.0%	---	↑
Age-adjusted death rate due to lung cancer[19]	24.4*	---	45.5	↓
Ever had an Human Papillomavirus (HPV) vaccine[20]	---	59.3%	---	N/A

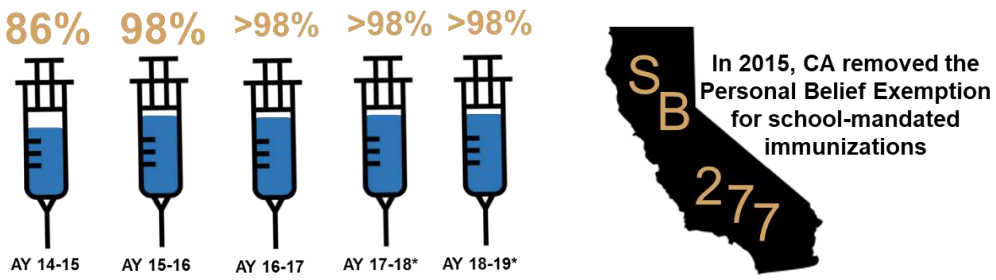
*3-year average rate (Prostate Cancer) or 5-year average rate (all other death rates)

IMMUNIZATIONS AND INFECTIOUS DISEASES

Immunization Rates

The percent of school-aged children in PUSD who completed their mandated school vaccines has been increasing, in part due to the change in California state law. In 2015, Senate Bill 277 (SB277), removed the personal belief exemption for school-mandated immunizations. Still, in academic year (AY18-19), there are 5 schools in the PUSD-service area that had vaccination completion rates less than 95%[36,37]. The lowest at 55%[36].

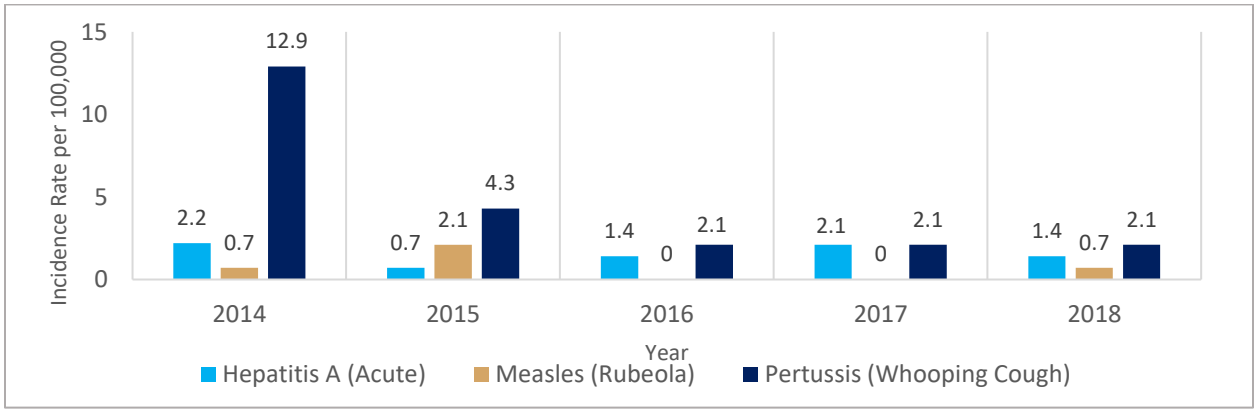
PERCENT OF CHILDREN IN PUSD WHO COMPLETED THEIR SCHOOL VACCINES[36]



Vaccine-Preventable Diseases

A vaccine-preventable disease (VPD) is an infectious disease for which an effective. Since the eradication of locally-acquired measles in the United States, the state of California has only rare cases of measles that are usually travel-associated among unvaccinated individuals. Over the past few years Pasadena has had a number of travel- and outbreak-associated cases[38]. Similarly, Pasadena has experienced cases of pertussis (whooping cough) and hepatitis A that have been associated with larger, statewide and regional outbreaks.

Figure 28.Annual incidence rates of select vaccine-preventable diseases in Pasadena, 2014-2018[38]



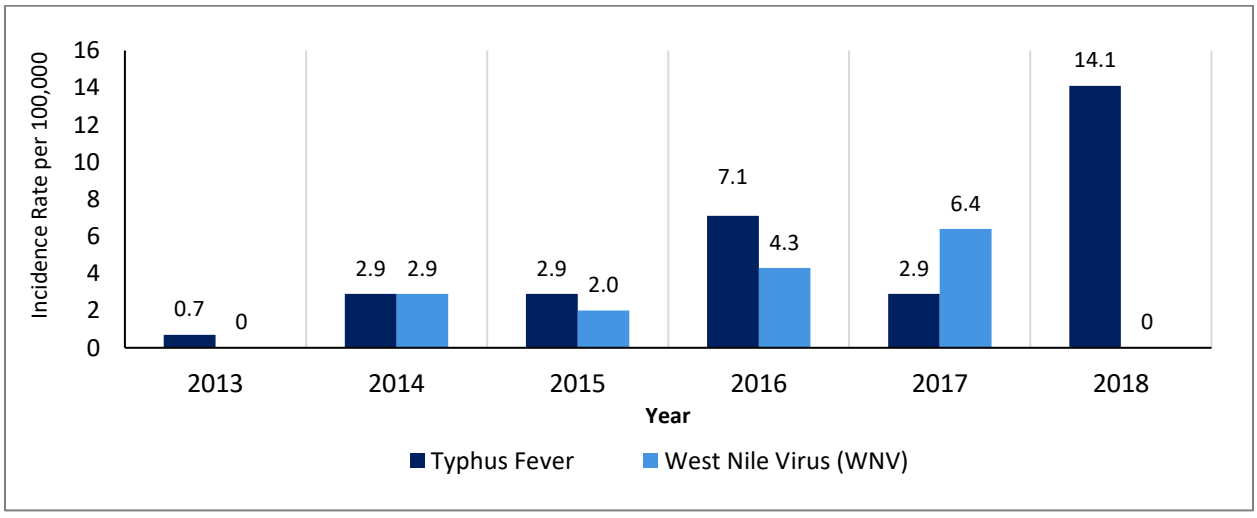
Vectorborne Diseases

Vectorborne diseases are infections transmitted by vectors, which include animals and insects. The most common disease-carrying vectors are mosquitoes, ticks, flies, and fleas. These insects spread disease to humans typically by biting a susceptible person. Vectorborne diseases are diverse, including diseases caused by viruses transmitted by mosquitos (e.g., Dengue, Zika), parasites spread by mosquitos (i.e. Malaria), and bacteria spread by ticks, lice and fleas (e.g., Q Fever, Rocky Mountain Spotted Fever and typhus fevers)[38].

Flea-borne Typhus Fever: Flea-borne typhus (*Rickettsia typhi*, and possibly *Rickettsia felis*), is spread by the bite of an infected flea. Pasadena has the highest rates of typhus fever compared with all other city or county health jurisdictions in California[38]. In 2018, Pasadena experienced one of the highest levels of reported typhus in more than 20 years. Most residents with typhus fever report seeing opossums or feral cats around their home around the time of exposure. Residents can prevent their risk of typhus by not feeding any animal outside, and using flea control on their pets.

West Nile Virus: West Nile virus (WNV) is transmitted through Culex mosquitos that have bitten infected birds. Culex mosquitos tend to bite in the morning and dusk and are not known to carry the mosquito-borne diseases Zika or dengue. Culex mosquitos are native to the U.S., including California. Rates of reported West Nile Virus cases were initially high in the early 2000s because of increased provider awareness and screening levels, were lower from 2006 to 2011, but have risen up to 2016. There were no cases of WNV in 2018[38].

Figure 29. Annual incidence rates of select vectorborne diseases in Pasadena, 2013-2018[38]



Sexually Transmitted Diseases

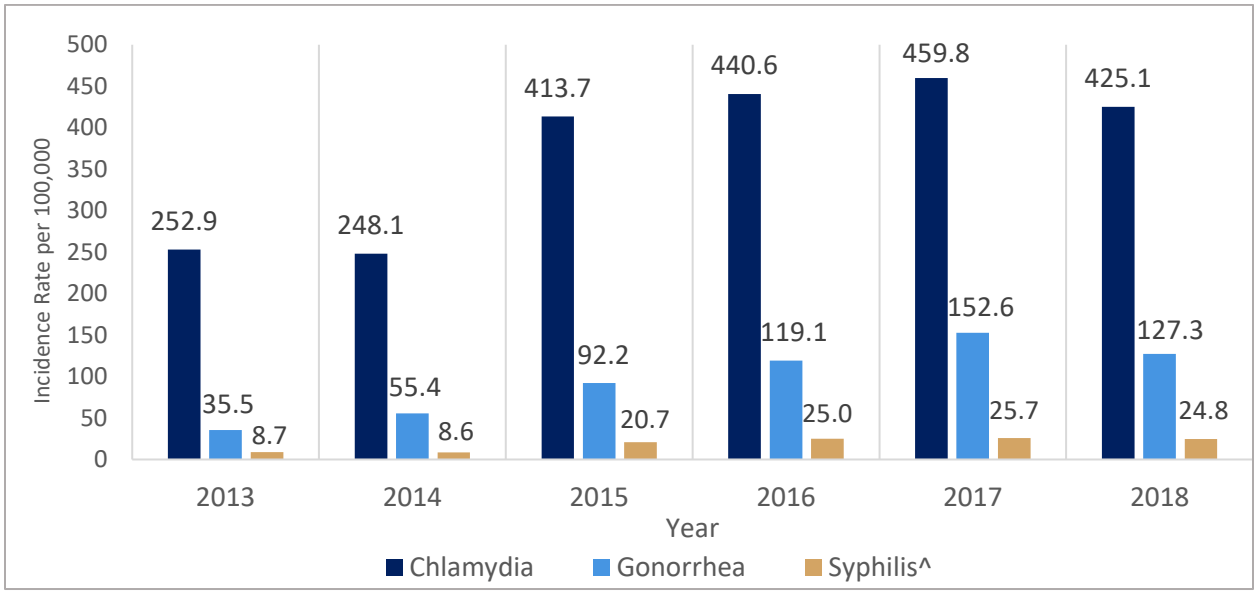
Within Pasadena, California and the United States, sexually transmitted diseases are on the rise and while the traditional high-risk groups remain, changing demographics of infections have emerged.

Chlamydia: In Pasadena, chlamydia was at its highest level in 2017 since modern reporting began in 1990. Important disparities exist, with the highest rates of chlamydia found among young people; African Americans; and gay, bisexual and other men who have sex with men (MSM). In Pasadena, approximately 80% of the chlamydia cases are among people less than 30 years old, with the majority of those between the ages of 20 to 24[38].

Gonorrhea: Gonorrhea cases have increased across all regions of California, including Pasadena, since at least 2007. This is the highest number of cases since the 1940s in Pasadena, and the late 60s and 70s in California. From 2013 to 2018 in Pasadena, just over two-thirds (67.8%) of all reported cases were in men. In 2018 among men, there was an equal number of heterosexual and MSM reports. For females, cases were stable at around 15 cases in previous years, but jumped to 40 in 2017 and 58 in 2018, indicating an increase as well[38].

Syphilis: Early syphilis cases (primary, secondary, and early latent) continued to increase across all regions of California with an overall 19% increase since 2015. In Pasadena, from 2001-2014, there were around 12-15 cases per year. In 2016-2018, there were 35-36 reported cases, more than double previous rates. From 2013 to 2018, more than 90% of Pasadena's cases were among men, though cases among females of reproductive age are increasing[38].

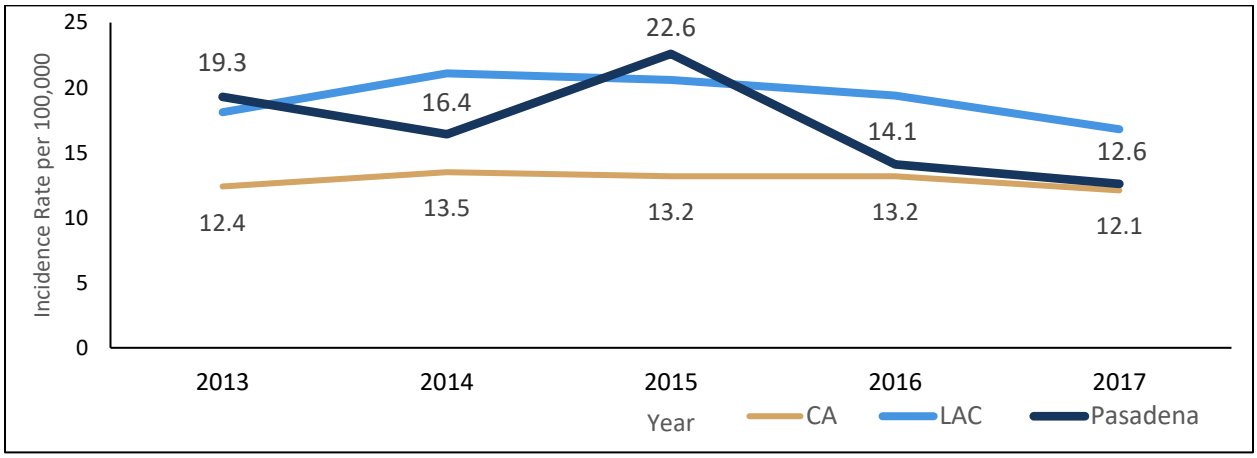
Figure 30. Annual incidence rates of sexually transmitted infections, 2013-2018[38]



^ Primary and secondary PLUS early late latent syphilis cases

Human Immunodeficiency Virus (HIV): The rate of newly diagnosed HIV cases are higher for the Los Angeles County (LAC) (16.8 per 100,000) than Pasadena (12.6 per 100,000) and the state (12.1 per 100,000)[39]. The rate of persons living with HIV infection stage 3, previously classified as acquired immune deficiency syndrome or AIDS, remains steady after more than a decade of dropping rates due to the introduction of better medication and medical care. While newly diagnosed stage 3 HIV infections are decreasing, disparities in death due to HIV/AIDS exist. For example, the 10-year average death rate due to HIV for Black females was 4.1 per 100,000, higher than the HP2020 goal of 3.3 per 100,000[19]. Further, Black females accounted for 50% of all HIV female deaths from 2008-2017. Among males, Black males (15.4 per 100,000) had the highest 10-year average death rate, followed by White (8.5 per 100,000) and Hispanic (3.5 per 100,000) males[19].

Figure 31. Incidence rates of persons newly diagnosed with HIV infection by year of diagnosis and health jurisdictions, 2013-2017[39]



Immunizations & Infectious Diseases

Indicator	Pasadena	LAC	CA	Trend
Rates of Vectorborne Diseases[38]	*various*	---	---	↗
Chlamydia incidence rate[38,40]	425.1	626.2	552.2	↗
Gonorrhea incidence rate[38,40]	127.3	254.2	190.3	↗
Syphilis (primary and secondary)^ incidence rate[40]	13.2	19.5	16.8	↗
HIV incidence rate[39]	12.6	16.8	12.1	↔
Age-adjusted death rate due to pneumonia and influenza[19]	26.2*	---	---	↔
Tuberculosis incidence rate[38,41]	3.1*	5.3	5.2	↓
Had a flu shot in the past year (ages 65+)[20]	87.1%	73.2%	---	↑

*5-year average rate

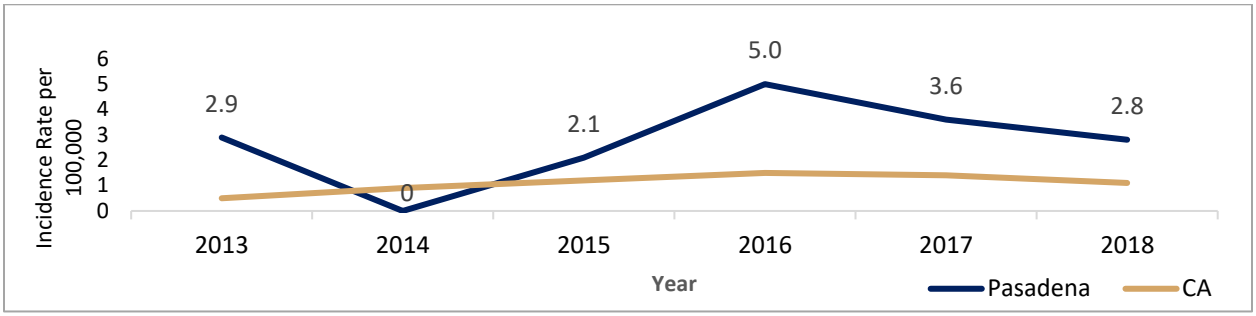
^ Excludes ealry latent for comparison

RESPIRATORY DISEASES

Legionellosis

Legionellosis, or Legionnaires' disease, is a serious type of pneumonia caused by the Legionella bacteria. People can become infected when they breathe water droplets from misters or spray sources, accidently swallow water containing Legionella bacteria into the lungs, or from invasive medical devices that affect the airways (e.g., ventilators). Cases in California have increased from around 50 cases per year in the years 2001-2006, to more than 500 cases per year[38] and the same increasing trend is apparent in Pasadena. From 2013-2018, 91.2% of all cases in Pasadena were among people age 50 years or older[38].

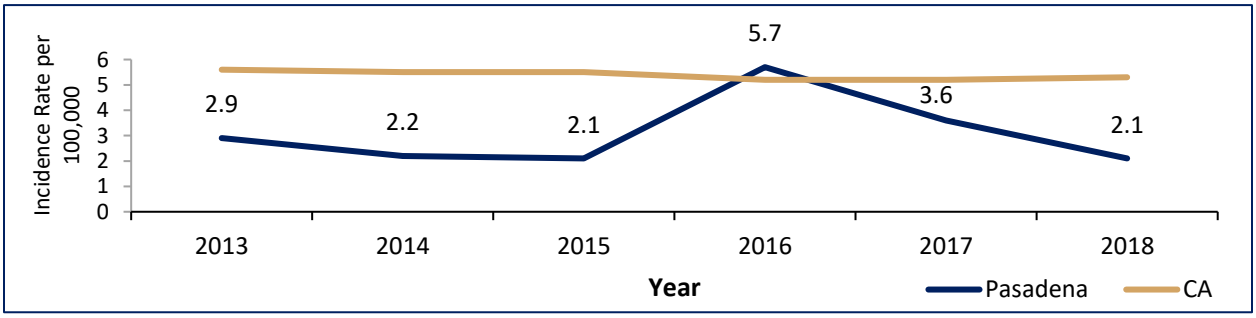
Figure 32. Annual incidence of Legionellosis in Pasadena vs. California, 2013-2018[38]



Tuberculosis

Tuberculosis (TB) is caused by the bacterium *Mycobacterium tuberculosis.* The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. The bacteria may spread from person-to-person through droplets in the air when a person with TB infection in the lungs coughs, speaks, or sings. After the resurgence of TB in the 1980s and the peak in 1992, rates of TB in California has been declining to a stable rate of around five cases per 100,000 population per year[38]. Pasadena's rate is generally lower than the state rate. TB rates in ethnic minorities are typically higher, especially among people who were born in a different country or spent significant time abroad.

Figure 33. Annual incidence rates of tuberculosis^ in Pasadena vs. California, 2013-2018[38,41]



^ Active pulmonary tuberculosis cases

Influenza and Pneumonia

In 2017, influenza and pneumonia was the 6th leading cause of death in Pasadena. An average of 46.6 deaths were reported per year since 2006. There were significant racial disparities. The 10-year average death rate per 100,000 by race was 52.3 (White), 33.8 (Black), 25.1 (Asian), and 12.9 (Hispanic)[19].

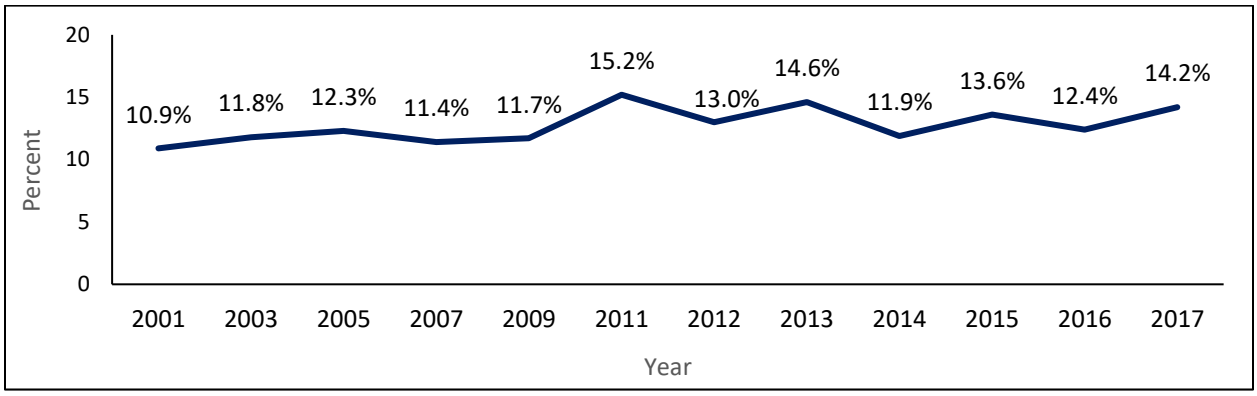
Chronic Lower Respiratory Diseases (CLPDs)

In 2017, the 4th leading cause of death was chronic lower respiratory diseases. In 2017, it was a leading cause of death and premature death among White (non-Hispanic) and Black residents[19].

Asthma

Rates of people ever diagnosed with asthma are generally lower in SPA 3 than LAC and California, though estimates vary from 9.3%[20] to 14.2%[25]. This rate has been steady, though increasing, since 2001 (see Figure 34).

Figure 34. Percent of people (all ages) in SPA 3 who have asthma, 2001-2017[25]



Respiratory Diseases

Indicator	Pasadena	LAC	CA	Trend
Age-adjusted death rate due to pneumonia and influenza[19]	26.2*	---	---	↔
Age-adjusted death rate due to chronic lower respiratory diseases[19]	37.3*	---	---	↔
Adults (18+) who are current smokers[20,25]	7.0-12.9%	11.2%	12.6%	↔
Age-adjusted death rate due to lung cancer[19]	24.4*	---	45.5	↓
Tuberculosis incidence rate[38,41]	3.1*	5.3	5.2	↓
	SPA3	**LAC**	**CA**	
Ever diagnosed with asthma[20,25]	9.3-14.2%	11.4-15.1%	15.4%	↓

* 5-year average rate

ALCOHOL, TOBACCO, AND SUBSTANCE ABUSE

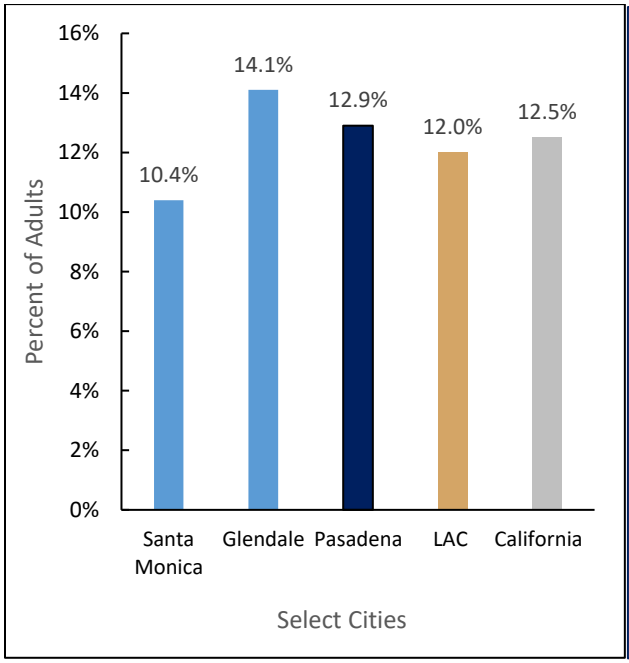
Alcohol Use

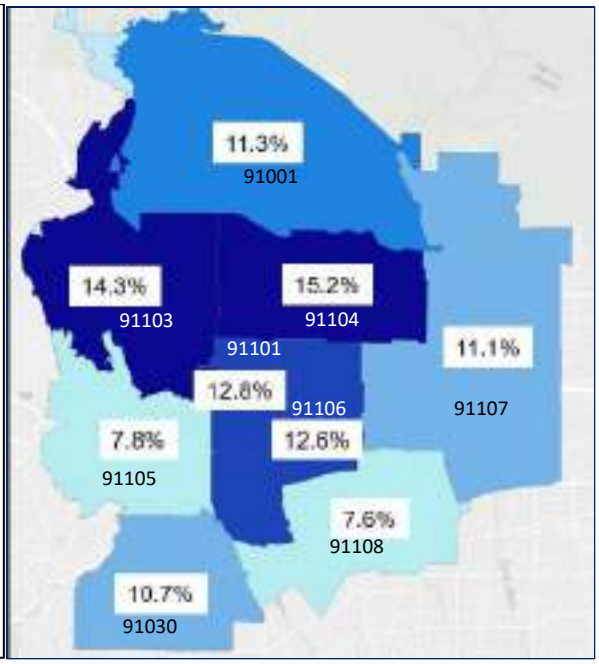
Since 2015, the percent of PUSD students who self-reported having had a full alcoholic drink has declined[17]. This trend is most dramatic among older students. Among 11th graders, the percent who have had a full alcoholic drink dropped from 50% in academic year (AY) 2014-2015 to 28% in AY 2017-2018[17]. This trend is also true for binge drinking[16]. Finally, adults in Pasadena binge drink at similar rates to Los Angeles County (LAC) as a whole. Specifically, about one in five (19.4%) reported binge drinking in the last month in 2018, compared with 17.9% in LAC[20].

E-Cigarette, Vaping, and Tobacco Use

Among PUSD students in the academic year (AY) 14-15, 15% of 7th graders had ever tried e-cigarettes or a vaping product, but this decreased to 5% in AY17-18. This same trend was observed in 9th and 11th graders, where the percent of students who had ever tried e-cigarettes decreased[17]. Similarly, among PUSD students, current use of an e-cig or vaping device (past 30 days) decreased as well[16]. Though, while e-cig use seems to be on a decreasing trend, compared with conventional cigarettes and smokeless tobacco use, the rates of usage are still much higher. For example, among 11th graders, students are 5 times as likely to have ever used an e-cig compared to a cigarette[16].

Figures 35 & 36. Percent of adults (18 years and over) who are current smokers in selected cities within LAC, and ZIP codes in Greater Pasadena, 2014[42]

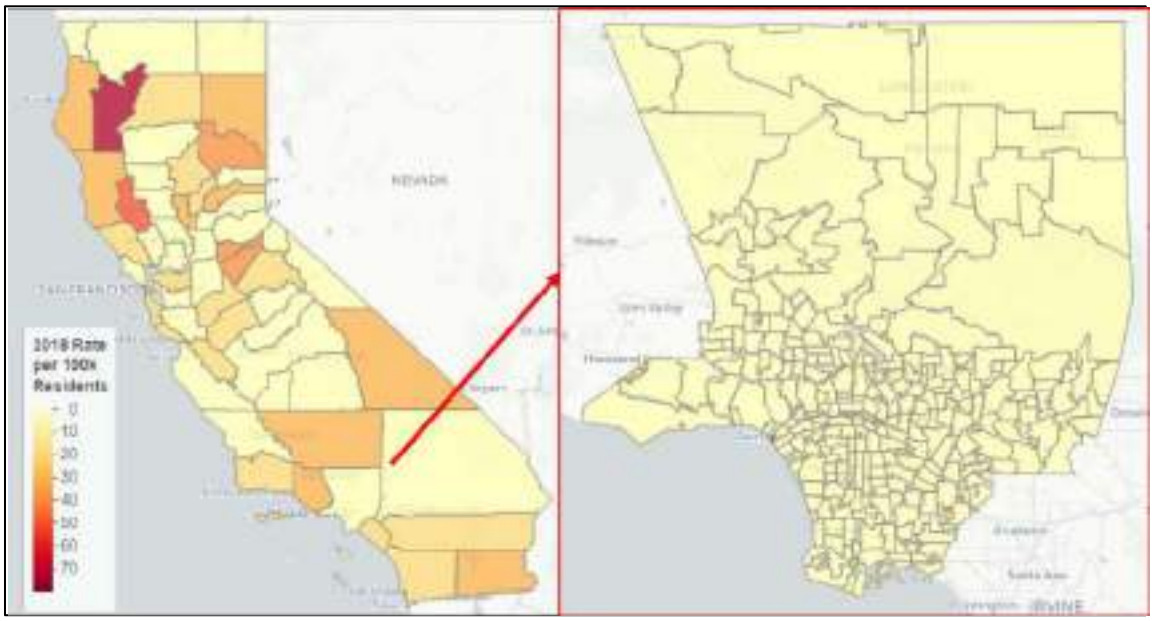




Drug Use and Overdose

Drug overdoses accounted for 10 deaths in Pasadena in 2017, and 122 deaths since 2006[19]. In 2017, the age-adjusted death rate was 6.9 per 100,000 population. One limitation to using data from death certificates is that they do not always specify what type of drug was the cause of death. Of the deaths with a drug listed, the most commonly cited causes of overdose deaths were alcohol intoxication, methamphetamines, cocaine, and opiates (e.g. morphine, heroin, fentanyl, OxyContin)[19].

Figure 37. Age-adjusted death rate due to opioid overdose by County and Census Tract in Los Angeles County, 2018[43]



Alcohol, Tobacco, & Substance Abuse

Indicator	Pasadena	LAC	CA	HP2020	Trend
PUSD students who reported marijuana use in past 30 days[16]	7.7%*	---	9.3%*	6.0%	↑
Adults (18+) who are current smokers[20,42]	7.0^-12.9%	11.2%	12.6%	12.0%	↔
Adults who binge drank in the last month[20]	19.4%	17.9%	---	24.2%	↔
Age-adjusted death rate due to drug overdose (accidental)[19]	7.3*	---	---	---	↔
Students who are current cigarette smokers[16]	<1%*	---	2.7%*	21.0%	↓
Students who have used an e-cig or vaping device in last month[16]	5.0%*	---	7.0%*	---	↓
Age-adjusted death rate due to prescription opioid overdose[43]	2.2	2.4	5.4	---	↓

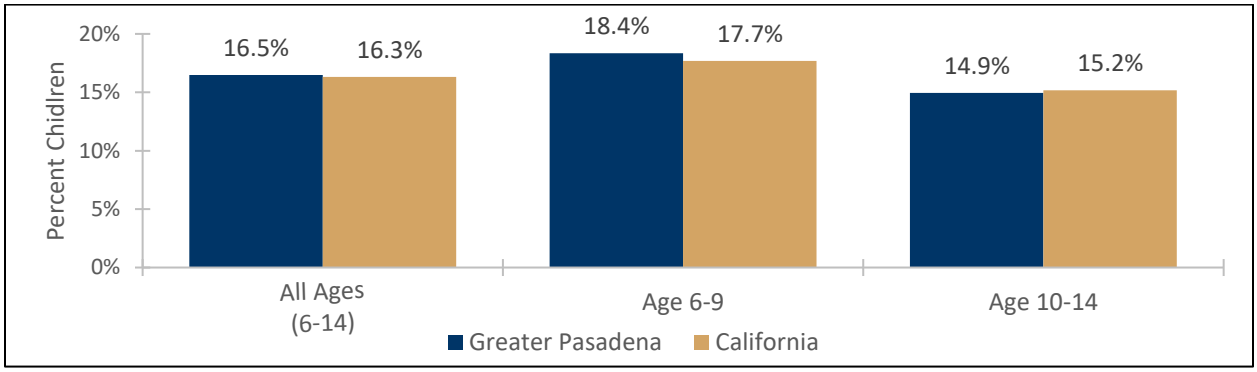
*5-year average rate or average across grades 7, 9, and 11
^Statistically unstable

ORAL HEALTH

Oral Health in Children

There appears to be a healthy decline in proportion of children who did not visit a dentist within San Gabriel Service Planning Area, though the trends appears in California as well[25]. In addition, 16.5% of children (ages 6-14) with Medi-Cal in Greater Pasadena received dental sealants in Greater Pasadena versus 16.3% in California[44].

Figure 38. Percent of Medi-Cal beneficiaries (ages 6-14) with a dental sealant, 2017[44]



Oral Health

Indicator	Pasadena	LAC	CA	HP2020	Trend
Medi-Cal beneficiaries with dental sealants (ages 6-9)[44]	18.4%	---	17.7%	28.1%	↓
Medi-Cal beneficiaries with an annual dental visit[44]	27.6%	29.9%	---	---	↔
Kindergarteners with untreated dental decay[45]	19.1%	12.5%	---	21.4%	↔
Adults (18+) who are current smokers[20,42]	7.0^-12.9%	---	12.6%	---	↔
ChapCare patients (ages 0-5) receiving dental services[45]	53.7%	---	---	33.3%	↑
Age-adjusted emergency department rate due to dental problem[45]	13.9%	22.9%	36.6%	---	↓
Pregnant women who visited a dentist during pregnancy[29]	55.8%	37.4%	43.0%	---	↑
	SPA 3	**LAC**	**CA**	**HP2020**	**Trend**
Adults who drink a soda at least once per week[25]	41.3%	41.7%	39.6%	---	↔
Children who have never been to the dentist[25]	13.4%*	14.1%	12.4%	---	↔
Children who visited the dentist in the last year[25]	80.5%*	86.0%	85.6%	---	↔
Adults (18+) who visited the dentist within the last year[25]	65.1%*	---	71.6%	---	↔

* Pooled across 2015, 2016, 2017 for statistical stability
^ Statistically unstable

MENTAL HEALTH

Mental Health among Youth and Teens

Approximately 31% of students grades 7, 9, and 11 in PUSD reported experiencing chronic sadness or hopelessness, a 6% increase from 2016-2017[16]. The proportion of teens in SPA 3 reporting needing emotional or mental health support has been trending higher over 10 years, with nearly one in four now requiring such support, but only 16.4% reporting receiving care[25].

Among youth and teens in PUSD and the San Gabriel Valley….

31.0%



Experienced chronic sadness/ hopelessness[16].
Increased from 25% in AY16-17.

24.5%



reported needing help for emotional/ mental health problem[25].

16.4%



received psychological/ emotional counseling in past year[25].

Mental Health among Mothers

A higher percent of new mothers in Pasadena reported prenatal and postpartum depressive symptoms, 19.8% and 18.9% respectively, compared to peers in the entire state[29]. However, the rate appears to be declining.

Among new mothers in Pasadena and California, the percent reporting symptoms of prenatal and postpartum depression are…



Prenatal

	Pasadena		California
2016	19.8%	vs.	14.1%
2018	10.2%		



Postpartum

	Pasadena		California
2016	18.9%	vs.	13.0%
2019	15.0%		

Suicide Ideation and Attempts among Youth

Among youth and teens…



14.5%

seriously considered suicide[16].
Increase from 11% in AY16-17.

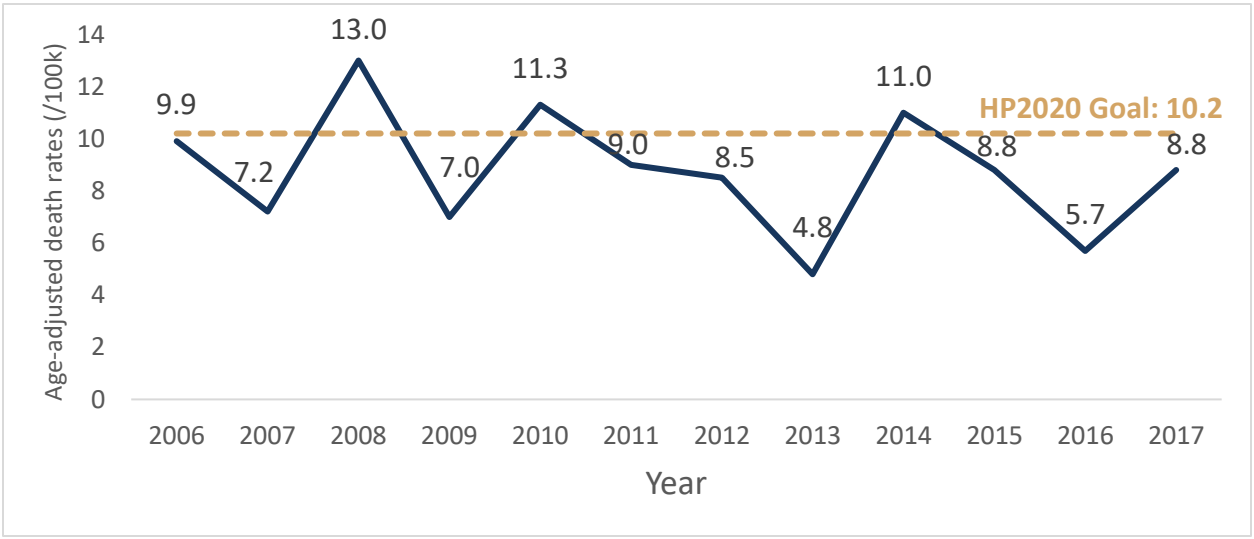
Among youth (ages 12-18) there is an average of **1.3** suicide attempts reported to Pasadena Police each year[18].

Among youth (ages 18-22) there is **<1** suicide in Pasadena each year[19].

Suicide

Over the last 10 years, Pasadena had an average of 13 suicides per year[19]. More than 82% of all suicides were among males. While Pasadena generally has a lower age-adjusted death rate due to suicide than the Healthy People 2020 (HP2020) goal of 10.2 deaths per 100,000, among whites (non-Hispanic), the 3-year average age-adjusted death rate was higher at 13.8 per 100,000. The 10-year average age-adjusted suicide rate by race was 15.3 (White, non-Hispanic), 7.0 (Asian), 6.0 (Black), and 3.0 (White, Hispanic)[19].

Figure 39. Age-adjusted suicide rates, 2006-2017[19]



Community Input

There was a concern about anxiety and depression becoming more widespread. Stakeholders explained they have observed a growth in people reporting symptoms of trauma- and stressor-related disorders, particularly among veterans and people experiencing homelessness. In addition, there is growing recognition in our community that racial trauma is an underlying factor that manifests in mental, behavioral and physical health outcomes. Given this, stakeholders explained that large numbers of individuals would benefit from mental and behavioral health care, but there are fewer than needed providers, and fewer than needed providers that offer culturally- and socially-responsive services.

Many stakeholders agreed there is a great need for more funding and services for children in terms of mental health support, prevention, and early intervention. Stakeholders explained that there is a great need for psychiatrists to serve the youth and homeless populations, in particular.

Mental Health

Indicator	SPA 3	CA	HP2020	Trend
Adolescents who reported needing help for emotional/ mental health problem[25]	24.5%	19.8%	---	↗
Adolescents who received psychological/emotional counseling in last year[25]	16.4%	14.8%	---	↑
	Pasadena	**CA**	**HP2020**	
Students who experienced chronic sadness/hopelessness in last year[16]	31.0%**	28.7%**	---	↔
Ever diagnosed with depression[20]	13.7%^	16.5%	---	↔
Taking medication and/or receiving counseling for depression[20]	91.7%	78.9%	75.9%	↑
Students who seriously considered suicide[16]	14.5%	10.7%	---	↓
Suicide attempt rate (/1,000) among youth (ages 12-18)[4]	0.2	---	1.7	↓
Age-adjusted suicide rate[19]	7.8*	---	10.2	↓

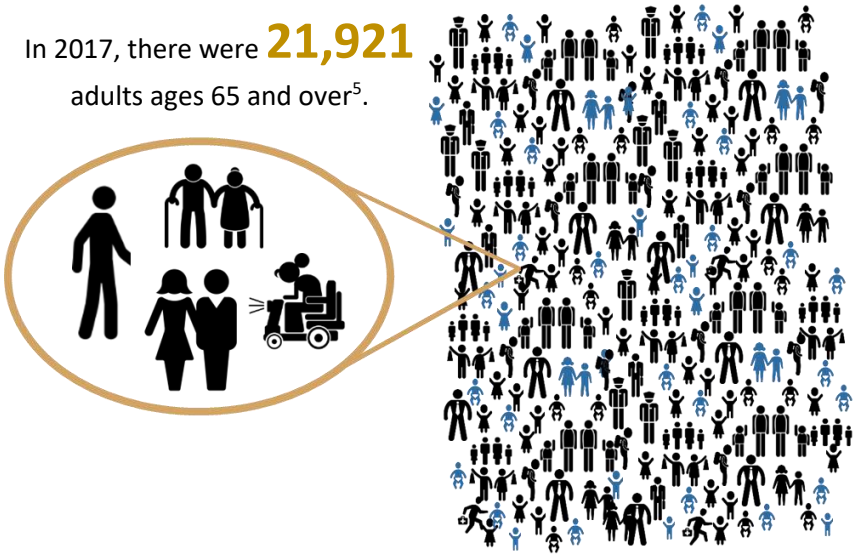
^Statistically unstable

** Average for grades 7, 9, and 11 in PUSD.

*5-year average rate

OLDER ADULTS AND AGING

In 2017, there were **21,921** adults ages 65 and over[5].



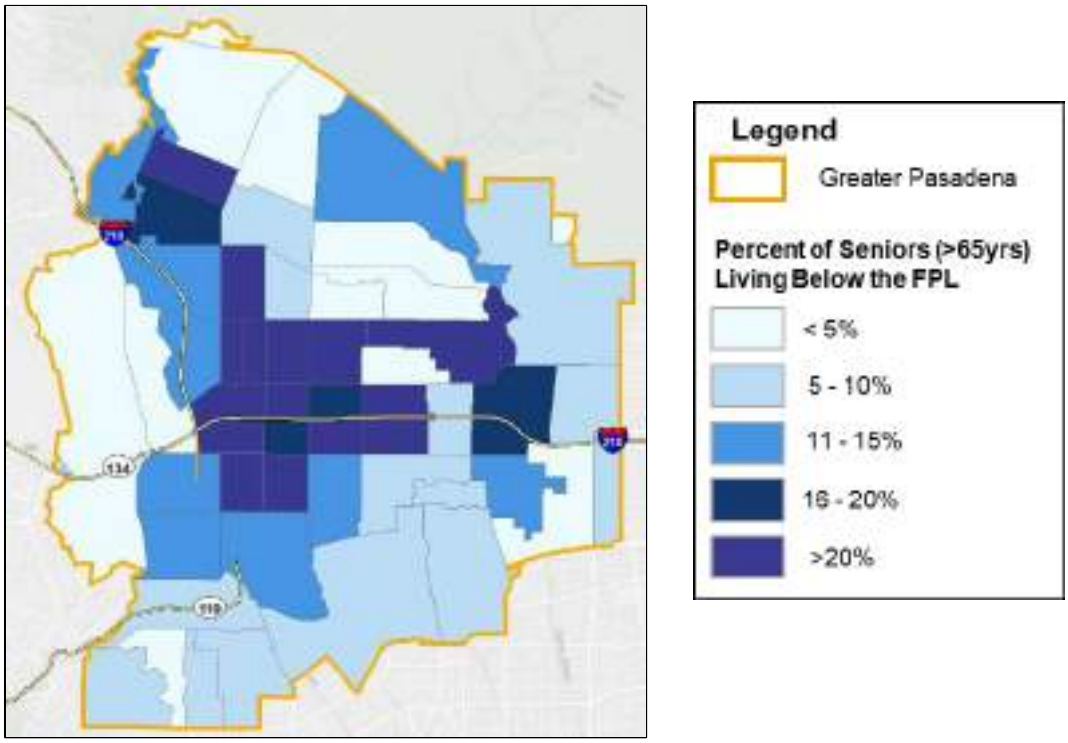
Older adults are about **15%** of the more than 140,000 people in Pasadena[5].

Seniors are the fastest growing age group. The senior population has increased by over **10%** in the last ten years[5].

Senior Poverty Levels

More seniors are living below the federal poverty level in Pasadena (16.3%) than in Los Angeles County as a whole (13.4%)[5]. This is higher than the percent of families living in poverty as well (11.3%)[5].

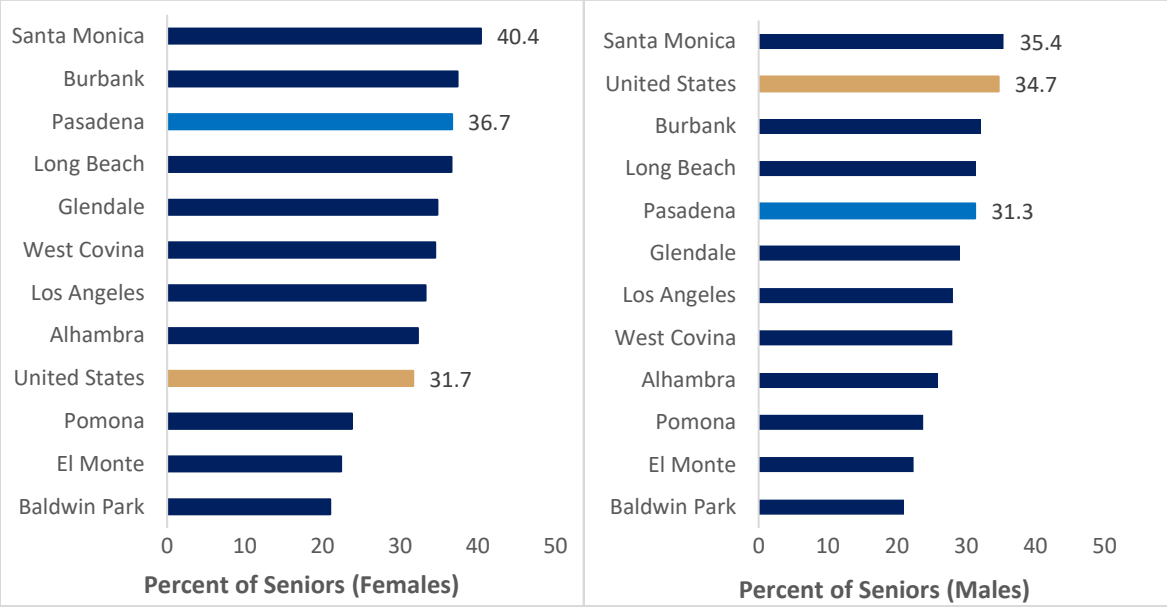
Figure 40. Percent of seniors (age 65 and over) living below the Federal Poverty Level by Census Tract in Greater Pasadena, 2017[5]



Healthy Aging

National experts agree on a set of recommended clinical preventive services for adults ages 65 years and over that can either prevent or delay disease onset, or identify disease at earlier, more treatable stages. These services include influenza vaccination, pneumococcal vaccination, and colorectal cancer screening, plus mammography screening for women[35]. Based on estimates from the CDC, females in Pasadena are doing better than most of the LAC cities and the United States. Males are outperforming some cities, but are lower than the US rates[35].

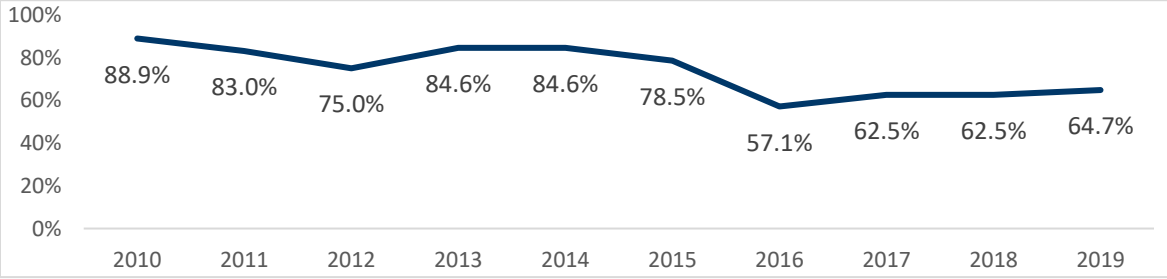
Figure 41. Percent of seniors (age 65 and over) who are up to date on core set of clinical preventive services by gender, 2016[35]



Seniors in Long-term Care Facilities

Pasadena has 17 skilled nursing facilities (SNFs) that house thousands of Pasadena residents. We monitor the Centers for Medicare and Medicaid Services (CMS) ratings as one measure of quality for these facilities. CMS rates each facility out of five stars[46].

Figure 42. Percent of SNFs with a 3-star CMS rating or higher, 2010-2018[46]



Note: The methodology changed in 2015 which accounts for the acute drop in facilities with over 3 stars.

Community Input

The Pasadena Public Health Department engaged seniors to identify key themes that help or hinder healthy aging in our community. In general, seniors and key stakeholders stated that the senior population in Pasadena is independent, and they want to be part of a community that values that independence. Sidewalks that promote mobility, affordable and accessible transportation, and affordable senior-friendly housing and services are examples of resources that would improve the quality of life and feeling of acceptance among the senior population. Seniors entering retirement face an entirely new social landscape where they can no longer rely on their office or colleagues for social interaction, which can lead to isolation. Many seniors may also be facing health issues for the first time, including conditions that may limit their mobility or activity. Opportunities that encourage social interaction, including community programs, could benefit these seniors.

> "Cultural events keep us young."
>
> -Pasadena Senior

Seniors communicated a frustration with the "system", saying that the balance between Medi-Cal, Medi-Care, Social Security, etc. was not always sufficient, confusing, or both. A resource to help navigate the systems could help many seniors. Finally, many seniors told stories of physical and gross neglect in care facilities. Opportunities to address this issue and develop a greater sense of security for seniors includes educating the public and seniors about elder abuse, developing systems to help seniors report elder abuse, and increased engagement for seniors in these facilities could help.

Older Adults & Aging

Indicator	Pasadena	LAC	US	Trend
Adults (age 65+) living below the federal poverty level[5]	16.3%	13.4%	9.3%	↑
Renters (age 65+) spending 30% of more of household income on rent[5]	68.4%	64.6%	54.4%	↑
Age-adjusted death rate due to Alzheimer's disease and dementia[2]	65.3*	---	---	↗
Living with a disability (age 65+)[5]	34.9%	36.5%	35.5%	↔
Ever had a pneumonia vaccination (age 65+)[3]	78.5%	72.3%	---	↔
Adults (age 65+) who received the recommended preventive services: male[35]	31.3%	---	34.7%	↓
Adults (age 65+) who received the recommended preventive services: female[35]	36.7%	---	31.7%	↓
Had a flu vaccine within the last year (age 65+)[20]	87.1%	73.2%	---	↑
Adults with arthritis[35]	17.6%	---	25.4%	↓

*5-year average rate

LIFE EXPECTANCY AND MORTALITY

Life Expectancy

Ultimately, the job of the health system is to improve how long our residents live, and the quality of life our residents experience throughout their lives. One key measure if the health of our community life expectancy, which tells us how long a typical resident is expected to live when they are born. Communities that have more opportunities for health will generally have a longer life expectancy. In general, Pasadena residents are living longer than the rest of the people in California and the United States[47].

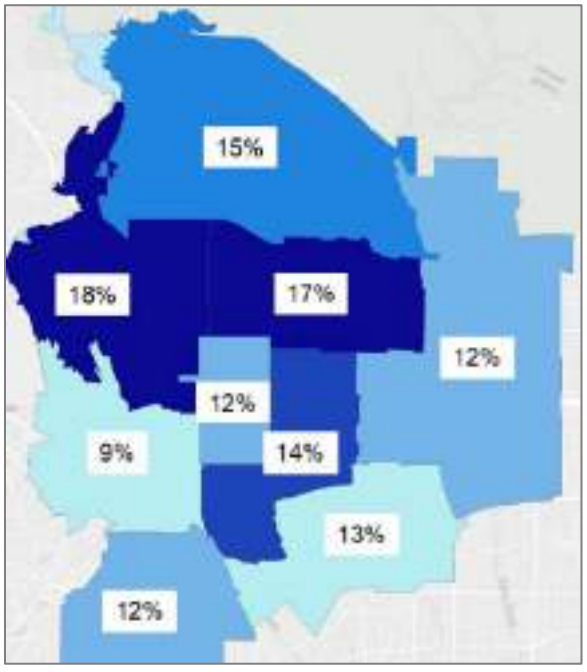
LIFE EXPECTANCY AT BIRTH ESTIMATES[47]

Pasadena	California	United States
81.8 years	80.3 years	78.8 years

Quality of Life

Good health is not only about living longer. Good health is about having a high quality of life, free from sickness or ill-health. Adults who report fair or poor health often have a lower quality of life, reduced productivity in the workplace, and increased healthcare costs.

Figure 43. Percent of Greater Pasadena adults with self-reported fair or poor health[25]



14%

of adults in Greater Pasadena reported fair or poor health[25].

Leading Causes of Death[19]

Gender No. of Deaths Death Rate/100k	#1 Cause No. Deaths Death Rate	#2 Cause No. Deaths Death Rate	#3 Cause No. Deaths Death Rate	#4 Cause No. Deaths Death Rate	#5 Cause No. Deaths Death Rate
Male 557 814 /100k	Ischemic Heart Disease 114 167/100k	Dementia & Alzheimer's 47 69/100k	Lung Cancer 24 35/100k	Stroke 22 32/100k	Hypertensive Diseases 21 31/100k
Female 559 778 /100k	Ischemic Heart Disease 95 132/100k	Dementia & Alzheimer's 90 127/100k	Chronic Lower Respiratory Diseases 39 54/100k	Stroke 37 51/100k	Hypertensive Diseases 26 36/100k

The five leading causes of death in Pasadena were: 1) Ischemic heart disease, 2) Dementia and Alzheimer's disease, 3) Cerebrovascular diseases (stroke), 4) Chronic lower respiratory diseases and 5) Hypertensive diseases. Ischemic heart disease was the overall leading cause of death and premature death, accounting for almost one out of every five deaths (19%). The mean age of death for males was 74.6 years and 80.9 years for females. The mean age of death by race/ethnicity was: 80.6 (White, non-Hispanic), 75.1 (Asian), 74.6 (Black), and 72.9 (White, Hispanic).[19]

Leading Causes of Premature Death[19]

Gender	#1 Cause Years of Life Lost	#2 Cause Years of Life Lost	#3 Cause Years of Life Lost	#4 Cause Years of Life Lost	#5 Cause Years of Life Lost
Male	Ischemic Heart Disease 536	Suicide 274	Land Transport Accidents 270	Drug Overdose (Unintentional) 267	Homicide 247
Female	Breast Cancer 209	Ischemic Heart Disease 192	Suicide 151	Pancreatic Cancer 109	Urinary Diseases 108

One way to evaluate the impact of death on a community is to see which diseases caused people to die earlier than others. In this way, we define premature deaths as deaths before the age of 75. To compare the overall impact we calculated the years of life lost before age 75, and sum it for each cause of death. Suicide, drug overdose (unintentional), and land transport accidents (including motor vehicle accidents) were the 2nd, 3rd, and 4th leading causes of premature death, respectively, because they disproportionately affect younger populations. Among males, these three causes were only approximately 4.5% of the deaths, but accounted for approximately 25% of the years of life lost[19].

APPENDIX A: PARTICIPANTS IN LISTENING SESSIONS AND INDIVIDUAL INTERVIEWS

Residents
LGBTQ Senior Adults
Asian American Adults
Latino Adults including Native Spanish Speakers
Senior Adults
African American Adults
African American Youth
Organizational Leaders
All Saints Church
Altadena Baptist Church
American Cancer Society, Inc. - California Division
Asian Youth Center
Community Health Alliance of Pasadena (ChapCare)
Citrus Valley Association of Realtors
Day One
East San Gabriel Valley Coalition for the Homeless
Emanate Health Foundation Board
Foothill Family Services
Foothill Unity Center
Health Consortium of the Greater San Gabriel Valley
Herald Christian Health Center
Huntington Hospital Community Benefit Committee
Los Angeles County Department of Mental Health
Los Angeles County Department of Public Health, SPA 3
Our Savior Center
Pacific Clinics
Pasadena Public Health Department
Pasadena Unified School District
San Gabriel Valley Economic Partnership
Young and Healthy

APPENDIX B: COMMUNITY RESOURCES

The following are resources available to Greater Pasadena area residents to respond to the health needs in the community. These were originally collected in a joint effort by Huntington Hospital and the Pasadena Public Health Department in May 2016, and updated for the **2019 Community Health Needs Assessment of Greater Pasadena**. This list does not represent a complete list of resources, but apologize to any group or organization inadvertently omitted from this list.

ACCESS TO HEALTH SERVICES

Armenian Relief Society Social Services. 740 E. Washington Blvd., Pasadena, CA 91104. (626) 797-6187. http://www.arswestusa.org. Social Services: low-income families with language barriers.

Community Health Alliance of Pasadena (ChapCare). 1855 N. Fair Oaks Ave. Pasadena, CA 91103. (626) 398-6300. http://www.chapcare.org. Clinic: primary care, dental, behavioral, children and adults.

Convalescent Aid Society. 3255 E. Foothill Blvd. Pasadena, CA 91107. (626) 793-1696. http://www.cas1.org. Medical equipment: free loan of medical equipment.

H.E.A.R. Center. 301 E. Del Mar Blvd.. Pasadena, CA 91101. (626) 796-2016. http://www.hearcenter.org. Testing center: hearing, speech/language evaluations, and screenings.

Huntington Ambulatory Care Center. 711 S. Fairmount Ave. Pasadena, CA 91105. (626) 397-2631. http://www.huntingtonhospital.com. Clinic: primary care, specialty care, social services.

Huntington Hospital. 100 W. California Blvd. Pasadena, CA 91105. (626) 397-5000. http://www.huntingtonhospital.com. Hospital: medical care, emergency care, Trauma Center.

Huntington Hospital Community Asthma Program. 100 W. California Blvd.. Pasadena, CA 91105. (626) 397-8637 or (626) 397-8636 (Spanish). http://www.huntingtonhospital.com. Clinic: children/youth, asthma management, education.

Huntington Hospital Community Outreach. 100 W. California Blvd. Pasadena, CA 91105. (626) 397-2581. http://www.huntingtonhospital.com/main/Communityoutreach.aspx. Community-based health screenings and counseling, information and referral, health classes, flu shots.

Huntington Health Physicians. 133 N. Altadena Dr. Pasadena, CA 91107. (626) 397-8300. https://huntingtonhealthphysicians.org/. Medical group: primary care, urgent care, children and adults.

Exer Urgent Care. 3160 E. Del Mar Blvd.. Pasadena, CA 91107. (626) 270-2400. http://www.PasadenaurgentCare.com. Clinic: urgent care.

Young and Healthy. 136 W Peoria St., Pasadena, CA 91103. (626) 795-5166. http://yhpasadena.org. Health services: children/youth, medical, dental, behavioral health, assistance with obtaining health insurance.

CANCER

American Cancer Society. 50 N. Hill Ave., #200 Pasadena, CA 91106. (626) 795-7774. http://www.cancer.org. Education: cancer, resource/referrals, advocacy.

Huntington Hospital Cancer Center. The Huntington Pavilion, 625 South Fair Oaks Avenue, Suite 100, Pasadena, CA 91105, (626) 397-2524. http://www.huntingtonhospital.com/Main/CancerCenter.aspx

Cancer Support Community Pasadena (CSCP): 76 East Del Mar Blvd., Suite 215, Pasadena, CA 91005, (626) 796-1083. http://www.cscpasadena.org/

CHILDREN'S HEALTH

Bienvenidos, an affiliate of Hillsides. 255 N. San Gabriel Blvd.. Pasadena, CA 91107. (626) 696-1270. http://www.bienvenidos.org. Social Services: children/youth, behavioral health, foster care.

Community Health Alliance of Pasadena (ChapCare). 1855 N. Fair Oaks Ave. Pasadena, CA 91103. (626) 398-6300. http://www.chapcare.org. Clinic: primary care, dental, behavioral, children and adults.

Hathaway-Sycamores Child and Family Services. 210 S. Delacey Ave. #110 Pasadena, CA 91105. (626) 395-7100. http://www.hathaway-sycamores.org. Foster Care Agency: children/youth, social services, education.

Pasadena Public Health Department - Child Health & Disability Prevention Program.
1845 N. Fair Oaks Ave., Pasadena, CA 91103. (626) 744-6168.
http://www.cityofpasadena.net/publichealth. Health Screening: children/youth, social services.

Pasadena Public Health Department - Childhood Lead Poisoning Prevention Program.
1845 N. Fair Oaks Ave. Pasadena, CA 91109. (626) 744-6089.
http://www.cityofpasadena.net/publichealth. Case Management: children/youth, lead poisoning prevention, education.

Pasadena Unified School District - Health Programs - 351 S. Hudson Ave. Pasadena, CA 91109. (626) 396-3600 x88240. Clinic: children/youth, school-based programs.

Pasadena Unified School District Primary Health Care Clinic. 351 S. Hudson Ave., #130 Pasadena, CA 91109. (626) 396-3600 x88180 Clinic: children/youth, medical services, screenings.

Young and Healthy. 136 W Peoria St, Pasadena, CA 91103. (626) 795-5166. http://yhpasadena.org/
Social and Clinical Services: children/youth, dental, mental health, trauma, eye care, clinical care.

DISABILITIES, ACCESS & FUNCTIONAL NEEDS (DAFN)

AbilityFirst. 201 S. Kinneloa Ave. Pasadena, CA 91107. (626) 449-5661. http://www.abilityfirst.org. DAFN Center: children/youth, adults.

Adaptive Recreation - City of Pasadena. 2575 Paloma St. Pasadena, CA 91107. (626) 744-7257. http://www.cityofpasadena.net/Humanservices/adaptiverecreation. DAFN Center: adults, recreation, referrals.

California Department of Rehabilitation. 150 S. Los Robles Ave., #300 Pasadena, CA 91101. (626) 304-8300. http://www.dor.ca.gov. DAFN Center: adults, counseling, vocational services.

Eastern Los Angeles Regional Center. 1000 S. Fremont Ave. Alhambra, CA 91802. (626) 299-4700. http://www.elarc.org. DAFN Center: adults, children/youth, community -based services.

Frank D. Lanterman Regional Center. 3303 Wilshire Blvd., #700 Los Angeles, CA 90010. (213) 383-1300. http://www.lanterman.org. DAFN Center: adults, children/youth, community-based services.

MERCI (Mentally & Educationally Retarded Citizens, Inc.). 525 N. Chandler Ave. Monterey Park, CA 91754. (626) 289-8817. http://www.merci.org. DAFN Center: adults, vocational training, education.

Villa Esperanza Services. 2060 E. Villa St. Pasadena, CA 91107. (626) 449-2919. http://www.villaesperanzaservices.org. DAFN Center: adults, children/youth.

ECONOMY

24-hour City Job Line. (626) 744-4600. Hotline: employment.

Flintridge Center. 236 West Mountain Street, Suite 106, Pasadena, CA 91103. (626) 449-0839. https://www.flintridge.org/. Programs with career opportunities and reentry issues for previously incarcerated individuals.

Foothill Employment and Training Center. 1207 E. Green St. Pasadena, CA 91106. (626) 796-5627. http://www.edd.ca.gov/. Career Center: employment, resources.

Ideal Youth. 83 E. Orange Grove Blvd. #2 Pasadena, CA 91103. (626) 796-7164 x 16. http://www.idealyouth.org. Career Center: teens, employment, vocational training.

Pasadena Community Job Center. 500 N. Lake Ave. Pasadena, CA 91101. (626) 440-0112. http://pasadenajobcenter.com. Job Center: employment, education.

Sources Career Development. 825 E. Orange Grove Blvd. Pasadena, CA 91104. (626) 240-4591. https://unionstationhs.org/programs/sources/. Career Center: employment, adults.

EDUCATION

AspiresWest Pasadena. 119 E. Washington Blvd. Pasadena, CA 91103. (626) 797-0789. http://aspireswestpasadena.com/. Education: children/youth, parenting, mentoring.

Boys & Girls Club of Pasadena. 3230 E. Del Mar Blvd.. Pasadena, CA 91107 Pasadena, CA 91107. (626) 449-9100. https://www.bgcpasadena.org/. Education: children/youth, recreation, tutoring.

Cancer Support Community. 200 E. Del Mar Ave. Pasadena, CA 91105. (626) 796-1083. https://www.cscpasadena.org/. Education.

Continuing and Community Education. 3035 E. Foothill Blvd. Pasadena, CA 91107. (626) 585-3000. https://pasadena.edu/academics/continuing-education.php. Education: extension, vocational training.

Families Forward Learning Center (formerly Mother's Club). 980 N. Fair Oaks Ave. Pasadena, CA 91103. (626) 792-2687. http://www.familiesforwardlc.org/. Education: parent education, literacy.

Huntington Community Health Library. 100 W. California Blvd. Pasadena, CA 91105. (626) 397-5161. https://www.huntingtonhospital.org/Education.aspx. Library: medical information.

Huntington Hospital Community Outreach. 100 W. California Blvd., Pasadena, CA 91105. (626) 397-2581. https://www.huntingtonhospital.org/Community/Community-Outreach-Programs.aspx. Health classes.

Huntington Hospital Classes and Events. 100 W. California Blvd. Pasadena, CA 91105. (626) 397-5000. https://www.huntingtonhospital.org/Events.aspx. Education: obesity prevention, diabetes management, cardiovascular health.

Jackie Robinson Community Center. 1020 N. Fair Oaks Ave. Pasadena, CA 91103. (626) 744-7300. https://www.cityofpasadena.net/human-services/parks/jackie-robinson-community-center/. Community Center: education, social services, recreation.

Los Angeles County Human Services. 211. https://www.211la.org/. Hotline: resource and referral, health and human services.

Neighbors Acting Together Helping All (NATHA). 456 W. Montana St. Pasadena, CA 91103. (626) 794-5889. Education: children/youth, tutoring, community development.

Pasadena YMCA. 2844 E. Foothill Blvd., Pasadena, CA 91107. (626) 432-5880. https://www.ymcala.org/pasadena. Education: children/youth, after-school programs, recreation.

Pasadena LEARNs After School Program. 351 S. Hudson Ave. Pasadena, CA 91109. (626) 396-3614. https://www.pusd.us/domain/95 Education: children/youth, after-school programs.

Pasadena Unified School District — Early Childhood Development Programs. 2046 N. Allen Ave. Pasadena, CA 91101. (626) 396-5900. https://www.pusd.us/domain/91. Childcare: children/youth, pre-school.

Stars (formerly Lake Avenue Community Foundation). 712 E. Villa St. Pasadena, CA 91101. (626) 449-4960. https://gostars.org/. Education: children/youth, tutoring, referrals, health services.

Victory Park Community Center. 2575 Paloma St. Pasadena, CA 91107. (626) 744-7500. https://www.cityofpasadena.net/human-services/parks/victory-park/. Community Center: education, social services, recreation.

Villa-Parke Community Center. 363 E. Villa St. Pasadena, CA 91101. (626) 744-6530. https://www.cityofpasadena.net/human-services/parks/villa-parke-community-center/. Community Center: education, social services, recreation.

YWCA Pasadena-Foothill Valley. 1200 N. Fair Oaks Ave., #9 Pasadena, CA 91103. (626) 296-8433. https://www.ywca-pasadena.org/. Education: women, children/youth, parenting, mammograms.

EXERCISE, NUTRITION, & WEIGHT

Huntington Hospital Community Outreach. 100 W. California Blvd.. Pasadena, CA 91105. (626) 397-2581. https://www.huntingtonhospital.org/Community/Community-Outreach-Programs.aspx. Chair yoga classes.

Pasadena Public Health Department – Nutrition and Physical Activity. 1845 N Fair Oaks Ave., 1st Floor, Pasadena CA 91103. (626) 744-6134. https://www.cityofpasadena.net/public-health/
Education: nutrition courses, defensive dining, corner store conversion

FAMILY PLANNING

Pasadena Public Health Department — Maternal, Child and Adolescent Health Outreach. 1845 N. Fair Oaks Ave., 2nd floor Pasadena, CA 91103. (800) 304-0015. https://www.cityofpasadena.net/public-health/. Education: family planning, life course, STD/Pregnancy classes.

Planned Parenthood of Pasadena and San Gabriel Valley. 1045 N. Lake Ave. Pasadena, CA 91104. (626) 798-0706 https://www.plannedparenthood.org/planned-parenthood-pasadena-san-gabriel-valley. Clinic: family planning, reproductive health, sex education.

IMMUNIZATIONS & INFECTIOUS DISEASES

Huntington Hospital Phil Simon Clinic. 711 Fairmount Ave. Pasadena, CA 91105. (626) 397-5480. http://philsimonclinic.org/ Clinic: HIV/AIDS medical care, case management, social services.

Wesley Health Centers (Pasadena) — Andrew Escajeda Comprehensive Care Services. 1845 N. Fair Oaks Ave., Pasadena, CA 91103, (562) 867-7999. http://jwchinstitute.org/primary-medical-care/wesley-health-centers-pasadena/. Clinic: HIV/AIDS medical care, testing, care coordination, behavioral health, food pantry, dental care.

Pasadena Public Health Department — Immunization Clinic. 1845 N. Fair Oaks Ave. #122 Pasadena, CA 91103. (626) 744-6121. http://www.cityofpasadena.net/publichealth. Clinic: immunizations.

Healthy Traveler Clinic. 1250 E. Green St., Pasadena, CA 91106. (626) 584-1200. https://www.healthytraveler.com/ Clinic: immunizations.

MATERNAL, INFANT, AND CHILD HEALTH

Elizabeth House. P.O. Box 94077 Pasadena, CA 91109. (626) 577-4434. http://www.elizabethhouse.net. Shelter: women, children, shelter.

Pasadena Public Health Department — Women, Infants and Children (WIC). 363 East Villa Street (Villa Parke Community Center), Pasadena, CA 91101. (626) 744-6005. https://www.cityofpasadena.net/public-health/wic/ Education: nutrition education, food checks, breastfeeding support.

Pasadena Public Health Department — Maternal, Child and Adolescent Health Outreach. 1845 N. Fair Oaks Ave., 2nd floor Pasadena, CA 91103. (800) 304-0015. https://www.cityofpasadena.net/public-health/maternal-child-adolescent-health-program/ . Info and Referral: women, children/youth.

MENTAL HEALTH

Arcadia Mental Health Center / Los Angeles County Department of Mental Health. 330 E. Live Oak Ave. Arcadia, CA 91006. (626) 821-5858. Info and Referral: mental health, adults.

Aurora Las Encinas Hospital. 2900 E. Del Mar Ave. Pasadena, CA 91107. (626) 795-9901. http://www.lasencinashospital.com. Hospital: mental health, chemical dependency.

D'Veal Family and Youth Services. 1855 N. Orange Grove Blvd. Pasadena, CA 91103. (626) 796-3453. http://www.dveal.com. Social Services: behavioral health, at-risk youth, drug and gang prevention, job training.

Foothill Family Service. 2500 E. Foothill Blvd. Pasadena, CA 91107. (626) 564-1613. http://www.foothillfamily.org. Social Services: behavioral health, children, adults.

Fuller Psychological and Family Services. 180 N. Oakland Ave. Pasadena, CA 91101. (626) 584-5555. Counseling Center: mental health.

Huntington Hospital Della Martin Center. 100 W. California Blvd. Pasadena, CA 91105. (626) 397-2329. http://www.huntingtonhospital.com. Hospital: mental health, chemical dependency.

Pacific Clinics. 2471 E. Walnut St. Pasadena, CA 91107. (877) 722-2737. http://www.pacificclinics.org. Social Services: behavioral health, outpatient treatment, substance abuse.

Pacific Clinics — Child & Family Specialty Services. 2550 E. Foothill Blvd. Pasadena, CA 91107. (626) 744-5230. http://www.pacificclinics.org. Counseling Center: mental health, children/youth.

Pacific Clinics — Hudson Family Services. 70 N. Hudson St. Pasadena, CA 91101. (626) 795-8471. http://www.pacificclinics.org .Counseling Center: mental health, children/youth, adults.

Pacific Clinics — Pasadena Family Services. 66 Hurlbut St. Pasadena, CA 91105. (626) 441-4221. http://www.pacificclinics.org. Counseling Center: mental health, case management, education.

Pasadena Mental Health Center. 1495 N. Lake Ave. Pasadena, CA 91104. (626) 798-0907. http://www.pmhc.org. Counseling Center: mental health, education.

Rose City Center. 595 E. Colorado Blvd. #418 Pasadena, CA 91101. (626) 793-8609. http://www.rosecitycenter.org. Counseling Center: mental health.

Westminster Center. 867 E. Atchison Pasadena, CA 91104. (626) 798-0915. http://www.westminstercenter.org. Counseling Center: mental health.

OLDER ADULTS & AGING

Altadena Senior Center. 560 E. Mariposa Altadena, CA 91001. (626) 798-0505. Senior Center: seniors, education, recreation.

Convalescent Aid Society. 3255 Foothill Blvd., Pasadena, CA 91107. (626) 793-1696. https://www.convalescentaidsociety.com/. Free loan of medical equipment.

Hart Park House Senior Center. 222 W. Sierra Madre Blvd., Sierra Madre, CA 91024. (626) 355-7394. http://www.cityofsierramadre.com/services/seniors/hart_park_house. Senior Center: education, recreation.

Hospice of Grace. 351 E. Foothill Blvd. Arcadia, CA 91006. (888) 769-7444. http://www.hospiceofgrace.com. Hospice Care.

Huntington Senior Care Network. 837 S. Fair Oaks Ave. Pasadena, CA 91105. (626) 397-3110. http://www.huntingtonhospital.com/SCN. Information, referral, care coordination, caregiver support.

National Association for Hispanic Elderly. 234 E. Colorado Blvd., #300 Pasadena, CA 91101. (626) 564-1988. http://www.anppm.org. Social Services: seniors, job training.

Pasadena Senior Center. 85 E. Holly St. Pasadena, CA 91103. (626) 795-4331. http://www.pasadenaseniorcenter.org. Senior Center: seniors, education, recreation.

South Pasadena Senior Center. 1102 Oxley St. South Pasadena, CA 91030. (626) 403-7360. Senior Center: seniors, education, recreation.

PREVENTION & SAFETY

Pasadena Public Health Department. 1845 N Fair Oaks Ave., Pasadena, CA 91103. (626) 744-6005. https://www.cityofpasadena.net/public-health/ Prevention: tobacco and AOD prevention, environmental health, disease investigation, emergency preparedness/bioterrorism, immunization, HIV testing, physical activity and nutrition, WIC.

Pasadena Public Health Department — Tuberculosis Clinic. 1845 N. Fair Oaks Ave., #122 Pasadena, CA 91103. (626) 744-6024. https://www.cityofpasadena.net/public-health/tuberculosis/. Clinic: TB testing, treatment, case management.

SOCIAL ENVIRONMENT

Casa Maria — URDC Human Services Corporation. 691 E. Washington Blvd. Pasadena, CA 91104. (626) 296-8689. http://www.urdchsc.org/casamaria.html. Shelter: women, transitional housing, support services.

Child Care Information Services (CCIS). 2465 E. Walnut St. Pasadena, CA 91107. (626) 449-8221. https://www.optionsforlearning.org/. Childcare: children/youth, referrals, GAIN, CalWorks.

Food for Faith — Pasadena Church. 404 E. Washington Blvd., Pasadena, CA 91104. (626) 794-2951. https://www.pasadenachurch.com/. Food Bank: homeless, low-income.

Foothill Unity Center. 191 N. Oak Ave. Pasadena, CA 91107. (626) 584-7420. http://www.foothillunitycenter.org. Food Bank: homeless, social services.

Friends in Deed. 444 E. Washington Blvd. Pasadena, CA 91104. (626) 797-2402. http://www.friendsindeedpas.org. Food Bank: homeless, bad weather shelter, women's daytime shelter.

Grace Center. P.O. Box 40250 Pasadena, CA 91114. (626) 355-4545. http://www.grace-center.org. Shelter: women, domestic violence, support services.

Haven House. P.O. Box 50007 Pasadena, CA 91115. (323) 681-2626. http://www.jfsla.org/havenhouse. Shelter: women, domestic violence, support services.

Holy Family Giving Bank. 1524 Fremont Ave. South Pasadena, CA 91030. (626) 403-6140. http://holyfamily.org/giving-bank/ Food Bank: homeless services.

Housing Works. 1277 N. Wilcox Ave. Los Angeles, CA 90038. (323) 466-0042. http://www.housingworksca.org. Social Services: homeless, behavioral health, case management.

Meals on Wheels, Pasadena. 54 N. Oakland Ave. Pasadena, CA 91101. (626) 449-6815. Food Delivery: seniors.

Los Angeles Rape & Battering Hotline. (626) 793-3385. http://www.peaceoverviolence.org. Hotline: domestic violence, sexual assault.

Salvation Army Social Services. 960 E. Walnut St. Pasadena, CA 91106. (626) 773-4400. http://pasadena.salvationarmy.org. Food Bank: homeless.

Shepherd's Door Domestic Violence Resource Center. P.O. Box 40441 Pasadena, CA 91114. (626) 765-9967. http://shepherddoor.org. Shelter: domestic violence, women, children/youth.

Union Station. 825 E. Orange Grove Blvd. Pasadena, CA 91104. (626) 240-4550. http://www.unionstationfoundation.org. Shelter: homeless, social services, housing assistance, health services.

SUBSTANCE ABUSE

Casa Treatment Center. (626) 792-2770. https://www.casatreatmentcenter.org.
Treatment Center: substance abuse, support services.

CHOICES — URDC Human Services Corporation. 1460 N. Lake Ave., #105 Pasadena, CA 91104. (626) 398-3796. http://www.urdchs.org/choices.html. Treatment Center: women, substance abuse, perinatal.

Gooden Center – 191 North El Molino Avenue Pasadena, California 91101
Treatment Center: men, residential, day and outpatient treatment.

IMPACT - 1680 N. Fair Oaks Ave. Pasadena, CA 91103. (626) 798-0884. http://www.impacthouse.com.
Treatment Center: substance abuse, support services.

Pasadena Council on Alcoholism and Drug Dependence (PCADD). 1245 E. Walnut St., #117 Pasadena, CA 91106. (626) 795-9127. http://www.socialmodel.com. Treatment Center: outpatient, substance abuse, screenings, referrals.

Passageways Multi-Service Center. 1020 S. Arroyo Parkway Pasadena, CA 91105. (626) 403-4888. Shelter: homeless, substance abuse, behavioral health.

The Walter Hoving Home. 127 S. El Molino Ave. Pasadena, CA 91101. (626) 405-0950. http://www.walterhovinghome.com. Treatment Center: substance abuse.

TEEN & ADOLESCENT HEALTH

Day One. 175 N. Euclid Ave. Pasadena, CA 91101. (626) 229-9750. http://www.godayone.org. Education: substance abuse, parenting.

La Pintoresca Teen Education Center. 1415 N. Raymond Ave., Pasadena, CA 91103. (626) 792-5101, ext. 111. http://www.ci.pasadena.ca.us/LPTEC. Community Center: computer lab, tutoring, activity center, teens, adolescents.

TRANSPORTATION

Dial-A-Ride. 221 E. Walnut St., #199 Pasadena, CA 91101. (626) 744-4094.
http://www.cityofpasadena.net/DAR. Transportation: seniors, disabled.

APPENDIX C: COMMUNITY SCORECARD

Legend	
↑↓↗	Local values are performing **worse** (higher ↑ /lower ↓ *depending on the indicator*) when compared to county, state or national values; or the indicator has increased significantly over time ↗.
↔↗↘	Local values are either performing **comparably** to other estimates (↔); the metric does not have inherent negative or positive health risk, and we are denoting an increasing or decreasing trend (↗↘) (ex-Birth rates) ; or the metric is increasing/decreasing but not significantly and there are no comparison values from other jurisdictions (↗↘).
↑↓↘	Local values are performing **better** (higher ↑ /lower ↓ *depending on the indicator*) when compared to county, state or national values; or the indicator has decreased significantly over time ↘.
N/A	Local values were not available for comparison.

*Averaged or Pooled for stability
^ Statistically Unstable

Social Determinants of Health

	Year	Pasadena	SPA 3	LAC	California	HP2020	Trend
Economy, Housing, & Homelessness							
People 65+ living below poverty level[5]	2017	16.3%	---	13.4%	10.2%	---	↑
People (all ages) living at or below 150% of poverty level[5]	2017	76.3%	---	71.9%	75.3%	---	↑
Median gross rent[5]	2017	$1,494	---	1,322	1,358	---	↑
Homeownership[5]	2017	43.6%	---	45.9%	54.5%	---	↓
Homelessness count[8–11]	2019	677	---	58,936	---	---	↗
People living below poverty level[5]	2017	15.5%	---	17.0%	15.1%	---	↔
Renters spending 30% of more of household income on rent[5]	2017	51.9%	---	56.1%	53.1%	---	↓
Children living below federal poverty level[5]	2017	18.4%	---	24.0%	20.7%	---	↓
Median household income[5]	2017	$76,264	---	$61,015	$67,169	---	↑
Households with >1.01 or more occupants per room[5]	2017	5.8%	---	11.7%	8.2%	---	↓
Unemployment[5]	2017	5.8%	---	7.8%	7.7%	---	↓
Education & Academic Achievement							
3rd grade students proficient in English/language arts[12]	2018	66.4%	---	71.8%	72.5%	---	↓
3rd grade students proficient in math[12]	2018	59.1%	---	63.5%	64.5%	---	↓
Cohort graduation rate (4-year adjusted)[14]	2018	84.8%	---	85.3%	87.3%	---	↔
Cohort graduates meeting UC/CSU course requirements[12]	2018	49.6%	---	56.2%	49.9%	---	↔
Kindergarteners entering PUSD who are "not on track"[13]	2018	48.0%	---	---	---	---	↔
Adults (25+years) with a Bachelor's degree or higher[5]	2017	51.1%	---	31.3%	32.6%	---	↔
Private school enrollment[5]	2017	28%	---	12%	11%	---	↔
Children (ages 3 and 4 years) enrolled in preschool[5]	2017	73.8%	---	54.0%	48.7%	---	↑

	Year	Pasadena	SPA 3	LAC	California	HP2020	Trend
Social Environment & Public Safety							
Bullying among adolescents[16]	2018	31.0%	---	23.3%	31.0%	19.9%	↑
Violent crime perpetration of young adults[18]	2017	410.4*	---	---	---	339.6	↑
Perceive neighborhood safe from crime[20]	2018	87.3%	---	85.0%	---	---	↔
Firearm-related death rate (per 100,000)[21]	2018	2.8*	---	---	---	10.3	↓
Physical fighting among adolescents[17]	2018	14.0%	---	---	---	28.4%	↓
Violent crime victimization among youth[18]	2017	8.8	---	---	---	37.8	↓
Homicide rate (per 100,000)[19]	2018	3.5*	---	---	---	5.5	↓
Have firearms in/around home[20]	2018	9.1%^	---	11.4%	---	---	↓
Transportation & Physical Environment							
Annual number of days ozone exceeded government stds.[23]	2018	<1*	---	---	---	---	↔
Annual number of days PM2.5 exceeded government stds.[23]	2018	20.8*	---	---	---	---	↘
Mean travel time to work[5]	2017	28.1	---	30.9	28.8	---	↔
Percent working adults (age 16+) travel time to work >1 hr.[5]	2017	11.8%	---	13.6%	11.8%	---	↔
Self-reported distracted driving[20]	2018	16.6%^	---	14.6%	---	---	↔
Walk Score[22]	2018	66	---	67	---	---	↔
Land transport fatality rates[19]	2017	7.1	---	---	---	12.4	↓
Workers who drive alone to work[5]	2017	69.7%	---	73.7%	73.6%	---	↓

Health Topics

	Year	Pasadena	SPA 3	LAC	California	HP2020	Trend
Access to Care							
Insurance not accepted by general doctor in past year (adults)[25]	2017	---	7.7%*	5.6%	5.1%	---	↑
Delayed care due to cost or lack of insurance[25]	2017	---	50.9%	46.0%	45.6%	---	↑
Percent of people with health insurance[5]	2017	89.8%	---	86.7%	89.5%	100%	↔
People with a usual place to go when sick or need health advice[25]	2017	---	86.9%	84.9%	87.0%	83.9%	↔
Ever experienced unfair treatment getting medical care due to race/ethnicity[25]	2017	---	5.6%*	5.9%	5.1%	---	↔
Delayed or didn't get other medical care (all ages)[25]	2017	---	9.1%	9.5%	10.3%	4.2%	↔
Ever had problems paying for household's medical bill in past year (adults)[25]	2017	---	8.9%	8.4%	9.2%	---	↔
Difficulty finding primary care (adults)[25]	2017	---	4.3%*	5.0%	5.7%	---	↓
Difficulty finding specialty care (adults)[25]	2017	---	10.9%*	11.5%	11.5%	---	↓
Delayed or did not get prescription medicine (all ages)[25]	2017	---	5.9%*	8.2%	8.5%	2.8%	↓
Adults who reported difficulty obtaining needed medical care[20]	2018	13.1%^	---	21.3%	---	---	↓
Difficulty communicating with a provider because of a language barrier[20]	2018	---	---	4.5%	---	---	N/A

	Year	Pasadena	SPA 3	LAC	California	HP2020	Trend
Maternal, Infant, & Child Health							
Black infant mortality rates[26]	2018	9.2*	---	9.7	10.2	6.7	↑
Birth rates (per 1,000)[26]	2018	52.5	---	57.7	61.7	---	↘
Births delivered by Cesarean section[26,28]	2018	32.9%	---	---	31.9%	---	↔
Child conceived within 18 mo. of previous births[28]	2015	28.3%	---	---	26.6%	29.8%	↔
Low birth weight rates[26]	2018	7.7	---	7.1	6.9	7.8	↔
Very low birth weight rates[26]	2018	1.6	---	1.3	1.1	1.4	↔
Mothers who report receiving prenatal care in 1st trimester[26]	2018	87.4%	---	85.0%	83.6%	77.9%	↑
Mothers who reported a postpartum medical visit[29]	2018	95.4%	---	---	87.5%	90.8%	↑
Teen birth rates (/1,000 females ages 15-19)[26]	2018	8.2	---	15.0	15.7	---	↘
Preterm birth (<37 weeks) rates[26]	2018	8.5	---	9.2	8.7	9.4	↓
Breastfeeding rates 3 months after delivery[29]	2018	73.1%	---	---	66.2%	46.2%	↑
Exercise, Nutrition, & Weight							
Adolescents who are overweight or obese[25]	2017	---	35.7%^	26.5%	27.4%	---	↑
Adolescents who ate 2+ fruit servings/day[25]	2017	---	49.3%^	69.6%	66.9%	---	↓
Children active at least one hour[25]	2017	---	8.3%^	7.3%^	6.2%	---	↓
Adult fast food consumption[25]	2017	---	71.6%	72.5%	67.6%	---	↔
Adults who are overweight or obese[25]	2017	---	56.3%	61.1%	60.3%	---	↓
Students meeting physical fitness reqs.[30]	2018	30.2%*	---	26.9%*	---	---	↓
No. days in last month where activity was limited due to health[20]	2018	1.3	---	2.7	---	---	↓
Diabetes							
Adults ever diagnosed with diabetes[20,25]	2018	9.2%*	11.1%*	11.7%*	10.7%	---	↓
Death rates due to diabetes[19]	2018	21.2*	---	---	---	66.6	↓
Heart Disease & Stroke							
Adults (18+) with high blood pressure[25]	2018	---	30.2%*	30.0%	29.0%	---	↔
Adults ever diagnosed with heart disease[25]	2018	---	6.7%*	6.1%	6.4%	---	↔
Age-adjusted death rates due to stroke[19]	2018	41.3*	---	---	---	34.8	↔
Age-adjusted death rates due to hypertensive diseases[19]	2018	27.8*	---	---	---	---	↔
Age-adjusted death rates due to heart failure[19]	2018	21.7*	---	---	---	---	↔
Adults ever diagnosed with high cholesterol[20]	2018	17.6%	---	26.8%	---	---	↓

	Year	Pasadena	SPA 3	LAC	California	HP2020	Trend
Cancer							
Age-adjusted death rate due to prostate cancer[19]	2018	24.2*	---	---	---	21.8	↑
Women who had a pap smear in last 3 years[20]	2018	86.2%	80.9%	81.4%	---	93.0%	↓
Age-adjusted death rate due to breast cancer[19]	2018	28.5*	---	---	---	20.7	↑
Women who had a mammogram in last year[20]	2018	76.7%	78.3%	77.0%	---	73.7%	↔
Age-adjusted death rate due to colorectal cancer[19]	2018	16.1*	---	---	---	14.5	↔
Adults who had a blood stool test[20]	2018	29.0%	---	20.0%	---	---	↑
Age-adjusted death rate due to lung cancer[19]	2018	24.4*	---	---	---	45.5	↓
Ever had an Human Papillomavirus (HPV) vaccine[20]	2018	---	---	59.3%	---	---	N/A
Immunizations & Infectious Diseases							
Rates of Vectorborne Diseases[38]	2019	*various*	---	---	---	---	↗
Chlamydia incidence rate[38,40]	2019	425.1	---	626.2	552.2	---	↗
Gonorrhea incidence rate[38,40]	2019	127.3	---	254.2	190.3	---	↗
Syphilis (primary & secondary) incidence rate[40]	2019	13.2	---	19.5	16.8	---	↗
HIV incidence rate[39]	2019	12.6	---	16.8	12.1	---	↔
Age-adjusted death rate due to pneumonia and influenza[19*]	2019	26.2*	---	---	---	---	↔
Tuberculosis incidence rate[38,41]	2019	3.1*	---	5.3	5.2	---	↓
Had a flu shot in the past year (ages 65+)[20]	2018	87.1%	---	73.2%	---	---	↑
Respiratory Diseases							
Age-adjusted death rate due to pneumonia and influenza[19]	2018	26.2*	---	---	---	---	↔
Age-adjusted death rate due to chronic lower respiratory diseases[19]	2018	37.3*	---	---	---	---	↔
Adults (18+) who are current smokers[20,25]	2018	7.0^-12.9%	9.6%	11.2%	12.6%	12.0%	↔
Age-adjusted death rate due to lung cancer[19]	2018	24.4*	---	---	45.5	---	↓
Tuberculosis incidence rate[38,41]	2018	3.1*	---	---	5.2	---	↓
Ever diagnosed with asthma[20,25]	2018	---	9.3-14.2%	11.4-15.1%	15.4%	---	↓
Alcohol, Tobacco, & Substance Abuse							
Students who reported current marijuana use[16]	2018	7.7%*	---	---	9.3%*	6.0%	↑
Adults (18+) who are current smokers[20,42]	2018	7.0^-12.9%	9.6%	11.2%	12.6%	12.0%	↔
Adults who binge drank in the last month[20]	2018	19.4%	16.0%	17.9%	---	24.2%	↔
Age-adjusted death rate due to drug overdose (accidental)[19]	2018	7.3	---	---	---	---	↔
Students who are current cigarette smokers[16]	2018	<1%*	---	---	2.7%*	21.0%	↓
Students who have used an e-cig or vaping device in last month[16]	2018	5.0%*	---	---	7.0%*	---	↓
Age-adjusted death rate due to prescription opioid overdose[43]	2018	2.2	---	2.4	5.4	---	↓

	Year	Pasadena	SPA 3	LAC	California	HP2020	Trend
Oral Health							
Medi-Cal patients with sealants (ages 6-9)[44]	2019	18.4%	---	---	17.7%	28.1%	↓
Medi-Cal patients with an annual dental visit[44]	2019	27.6%	---	29.9%	---	---	↔
Kindergarteners with untreated dental decay[45]	2018	19.1%	---	12.5%	---	21.4%	↔
Adults (18+) who are current smokers[20,42]	2018	7.0^-12.9%	9.6%	11.2%	12.6%	12.0%	↔
Adults who drink a soda at least once/week[25]	2017	---	41.3%	41.7%	39.6%	---	↔
Children who have never been to the dentist[25]	2017	---	13.4%*	14.1%	12.4%	---	↔
Children who visited dentist in last year[25]	2017	---	80.5%*	86.0%	85.6%	---	↔
Adults who visited dentist within last year[25]	2017	---	65.1%*	---	71.6%	---	↔
ChapCare patients (<5yrs.) receiving dental services[45]	2018	53.7%	---	---	---	33.3%	↑
Age-adjusted emergency department rate due to dental problem[45]	2018	13.9%	---	22.9%	36.6%	---	↓
Women who visited dentist during pregnancy[29]	2018	55.8%	---	37.4%	43.0%	---	↑
Mental Health							
Adolescents who reported needing help for mental health problem[25]	2018	---	24.5%^	19.2%^	19.8%	---	↗
Students who experienced chronic sadness/hopelessness in last year[16]	2018	31.0%*	---	---	28.7%*	---	↔
Ever diagnosed with depression[20]	2018	13.7%^	---	---	16.5%	---	↔
Adolescents who received psychological/ emotional counseling in last year[25]	2018	---	16.4%^	12.5%^	14.8%	---	↑
Taking medication and/or receiving counseling for depression[16]	2018	91.7%	---	---	78.9%	75.9%	↑
Students who seriously considered suicide[16]	2018	14.5%	---	---	10.7%	---	↓
Suicide attempt rate (/1k) among youth[4]	2017	0.2	---	---	---	1.7	↓
Age-adjusted suicide rate[19*]	2018	7.8	---	---	---	10.2	↓
Older Adults & Aging							
Seniors living below the federal poverty level[5]	2017	16.3%	---	13.4%	10.2%	---	↑
Senior renters spending 30% or more of Household Income on Rent[5]	2017	68.4%	---	64.6%	62.0%	---	↑
Male seniors with recc. preventive services[35]	2016	31.3%	---	---	---	44.6%	↓
Female seniors with recc. preventive services[35]	2016	36.7%	---	---	---	46.8%	↓
Age-adjusted death rate due to Alzheimer's disease and dementia[2]	2018	65.3*	---	---	---	---	↗
Living with a disability (age 65+)[5]	2017	34.9%	---	36.5%	35.6%	---	↔
Ever had a pneumonia vaccination (ages 65+)[3]	2018	78.5%	---	72.3%	---	---	↔
Had a flu vaccine in the last year (ages 65+)[20]	2018	87.1%	78.0%	73.2%	---	---	↑
Adults with arthritis[35]	2016	17.6%	---	---	---	---	↓
Life Expectancy & Mortality							
Life expectancy at birth[47]	2018	81.8	---	80.6	80.3	---	↑
Self-perceived health status as Fair/Poor[25]	2017	14.0%	15.7%	21.0%	16.6%	---	↓

REFERENCES

1. Association for Community Health Improvement. Community Health Assessment Toolkit. https://www.healthycommunities.org/resources/community-health-assessment-toolkit. Accessed August 18, 2018.
2. Huntington Hospital, City of Pasadena Public Health Department. Community Health Needs Assessment. https://dashboards.mysidewalk.com/healthy-pasadena. Published 2019. Accessed November 13, 2019.
3. City of Pasadena Public Health Department. Data. https://www.cityofpasadena.net/public-health/data/. Accessed November 13, 2019.
4. Claritas. *2018 Population Estimates*.
5. U.S. Census Bureau. *American Community Survey, 2017 5-Year Estimates, Generated by the Pasadena Public Health Department; Using American Factfinder*.
6. Economic Policy Institute. Family Budget Calculator. https://www.epi.org/resources/budget/. Accessed October 2, 2019.
7. Bhattacharya J, Price A. *The Cost of Being California: A Look at the Economic Health of California Families*. Oakland; 2018. https://insightcced.org/wp-content/uploads/2018/04/Cost_of_Being_Californian_April_2018_final.pdf.
8. Los Angeles Homeless Services Authority. 2019 Homeless Count by Community/City. https://www.lahsa.org/data?id=13-2019-homeless-count-by-community-city. Published 2019. Accessed November 14, 2019.
9. Urban Initiatives. *2018 Pasadena Homeless Count*. Pasadena; 2019.
10. Long Beach Department of Health and Human Services. *Attachment A, Biennial Homeless County Comparison, Homelessness Data Exchange*. Long Beach; 2019. http://www.longbeach.gov/globalassets/health/homeless-services-divsion/attachment-a_2015-2019-hdx-detailed-biennial-homeless-count-comparison_final-20190415.
11. City of Glendale. *City of Glendale: 2019 Homeless Count Report*. Glendale, CA https://www.glendaleca.gov/home/showdocument?id=51110.
12. California Department of Education, EdSource and the FC and MATSIS (FCMAT/CSIS). Ed-Data. 2019. http://www.ed-data.org/district/Los-Angeles/Pasadena-Unified. Accessed August 28, 2019.
13. Pasadena Unified School District (PUSD) in partnership with UCLA. *Early Development Index: PUSD*. Pasadena; 2019.
14. California Department of Education. 2017-2018 Four-Year Adjusted Cohort Graduation Rate, Pasadena Unified District Report (19-64881). https://data1.cde.ca.gov/dataquest/dqcensus/CohRate.aspx?agglevel=district&year=2017-18&cds=1964881. Published 2019. Accessed August 18, 2019.
15. Pasadena Police Department. *Monthly Statistical Reports*. Pasadena; 2019. https://www.cityofpasadena.net/police/crime/.

16. California Department of Education. CalSCHLS, Secondary Dashboard. https://calschls.org/reports-data/public-dashboards/secondary-dashboard/. Published 2019. Accessed August 18, 2019.

17. California Department of Education. *California Health Kids Survey: Pasadena Unified Secondary 2017-2018 Main Report*. https://data.calschls.org/resources/Pasadena_Unified_1718_Sec_CHKS.pdf.

18. Pasadena Police Department by Request. 2019.

19. City of Pasadena Public Health Department. *2017 Mortality Report. Leading Causes of Death in Pasadena 2006-2017*. Pasadena; 2018. https://www.cityofpasadena.net/wp-content/uploads/sites/32/Pasadena-Mortality-Report-2017.pdf.

20. LAC Department of Public Health, Health Assessment Unit. *2018 LA County Health Survey - Topics & Data*.; 2019. http://www.publichealth.lacounty.gov/ha/LACHSDataTopics2018.htm.

21. City of Pasadena Public Health Department, Epidemiology. *Data by Request*. Pasadena; 2019.

22. Walk Score. https://www.walkscore.com/. Published 2019. Accessed October 15, 2019.

23. South Coast Air Quality Management District (AQMD). *Air Quality: Historical Data by Year*. Diamond Bar; 2019. https://www.aqmd.gov/home/air-quality/historical-air-quality-data/historical-data-by-year.

24. Office of Environmental Health Hazard Assessment (OEHHA), California Environmental Protection Agency. *CalEnviroScreen 3.0 Results (June 2018 Update)*.; 2019. https://oehha.ca.gov/calenviroscreen/report/calenviroscreen-30.

25. UCLA Center for Health Policy Research. *California Health Interview Study. CHIS 2016 Public Use Files.* Los Angeles, CA https://healthpolicy.ucla.edu/Pages/AskCHIS.aspx.

26. Pasadena Public Health Department. Electronic Birth Registation System (EBRS). *Birth Statistics*.; 2019. https://www.cityofpasadena.net/public-health/data/.

27. Martin JA, Hamilton BE, Osterman MJ, Driscoll AK, Drake P. *Births: Final Data for 2017. National Vital Statistics Report. Volume 67, Number 8.* Hyattsville, MD; 2018. https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_08-508.pdf.

28. California Center for Health Statistics. *Birth Statistical Master File*; 2019.

29. City of Pasadena Public Health Department. *Pasadena Maternal Infant Health Assessment (MIHA)*. Pasadena https://www.cityofpasadena.net/public-health/data/.

30. California Department of Education. *Students Meeting All Fitness Standards, Physical Fitness Testing Research File*. Accessed online through kidsdata.org on Septemeber 4, 2019.

31. City of Pasadena Public Health Department Environmental Health Division mapped using ArcGIS by the Epidemiology Program. *Access to Healthy Foods Map*.; 2019.

32. Centers for Disease Control and Prevention (CDC). *NCHS Data Brief No. 288*. https://www.cdc.gov/nchs/data/databriefs/db288.pdf.

33. California Office of Statewide Health Planning and Development data analyzed and made available through ThinkHeallthLA. *Age-Adjusted Hospitalization Rate Due to Diabetes by ZIP Code*.; 2019. https://www.thinkhealthla.org/indicators/index/view?indicatorId=147&localeTypeId=3.

34. California Office of Statewide Health Planning and Development data analyzed and made available through ThinkHeallthLA. *Age-Adjusted Hospitalization Rate Due to Heart Failure by ZIP Code*.; 2019. https://www.thinkhealthla.org/indicators/index/view?indicatorId=144&localeTypeId=3.

35. Centers for Disease Control and Prevention (CDC), Division of Population Health NC for CDP and HP. *500 Cities Project*.; 2017. ftp://ftp.cdc.gov/pub/MAPBOOKS/CA_Pasadena_MB_2016-P.pdf.

36. California Department of Education (EDSource). School Vaccination Rates. https://edsource.org/2019/vaccination-rates-at-california-schools/614359. Published 2019. Accessed September 23, 2019.

37. Pasadena Unified School District. *Vaccine Raw Data Provided by Request*; 2019.

38. City of Pasadena Public Health Department. *2018 Annual Report of Communicable Diseases in Pasadena*.; 2019. https://www.cityofpasadena.net/public-health/data/.

39. California Department of Public Health. *California HIV Surveillance Report-2017, Table 1c*.; 2017. https://www.cdph.ca.gov/Programs/CID/DOA/CDPH Document Library/California HIV Surveillance Report - 2017.pdf .

40. California Department of Public Health. *All STDs Tables*.; 2017. https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH Document Library/STD-Data-All-STDs-Tables.pdf.

41. California Department of Public Health. *Tuberculosis Cases and Case Rates*.; 2017.

42. UCLA Center for Health Policy Research. AskCHIS Neighborhood Edition. http://askchisne.ucla.edu. Published 2014. Accessed December 13, 2018.

43. California Department of Public Health. Opioid Dashboard. https://discovery.cdph.ca.gov/CDIC/ODdash/. Published 2018. Accessed August 23, 2019.

44. Data provided by the California Department of Public Health Office of Oral Health. *Department of Health Care Services Data Warehouse as of November 2018*.

45. Pasadena Public Health Department. *Oral Health Needs Assessment*.; 2019. https://www.cityofpasadena.net/public-health/data/.

46. Centers for Medicare & Medicade Services. Five-Star Quality Rating System. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.

47. CDC, National Center for Health Statistics. US Small-area life expectancy estimates project (USALEEP). http://www.healthypasadena.org/.

Suggested Citation: Huntington Hospital, Pasadena Public Health Department. 2019 Greater Pasadena Community Health Needs Assessment. December 2019.

To download a copy, please visit: http://www.healthypasadena.org/





Exhibit 15-B

PHA's 2016 Community Health Needs Assessment



2016 Community Health Needs Assessment

Greater Pasadena

Huntington Hospital

PASADENA PUBLIC HEALTH DEPARTMENT

TABLE OF CONTENTS

Acknowledgements i

Executive Summary iv

I. Introduction 1

II. Data Overview 6

III. Demographics 8

IV. Community Input 11

V. Social Determinants of Health 16

- Economy, Housing, and Homelessness 16
- Education 22
- Social Environment 24
- Environment 25
- Public Safety 28
- Transportation 30

VI. Health Topics 33

- Access to Care 33
- Maternal, Child, and Adolescent Health 36
- Exercise, Nutrition, and Weight 39
- Diabetes 42
- Heart Disease and Stroke 43
- Cancer 44
- Immunizations and Infectious Diseases 45
- Respiratory Diseases 48
- Injury Prevention and Safety 50
- Other Conditions 50
- Older Adults and Aging 51
- Mental Health 53
- Substance Abuse 55
- Mortality 57

VII. Prioritization 58

VIII. Conclusion 61

Appendices 62

- Appendix A: Community Health Needs Assessment Progress Reports 62
- Appendix B: Healthy Communities Institute Data Analysis Methods 80
- Appendix C: Community Resources 83

References 93

Acknowledgements

CHNA PLANNING TEAM

Huntington Hospital:

- Cathi Chadwell, Executive Director, Public Affairs
- Lois Zagha, Manager, Community Outreach and Community Benefits

Pasadena Public Health Department:

- S. Michael Johnson, MPA, Director
- Ying-Ying Goh, MD, MSHS, Health Officer
- Matt Feaster, MPH, Epidemiologist

HUNTINGTON HOSPITAL COMMUNITY BENEFITS COMMITTEE

Mike Barilla, Chief, Emergency Services, Pasadena Fire Department
Bill Bogaard, Member, Board of Directors, Huntington Hospital
Sheri Bonner, President and CEO, Planned Parenthood of Pasadena and San Gabriel Valley
Peggy Buchanan, Executive Director, The Pasadena Village
Cathi Chadwell, Executive Director, Public Affairs, Huntington Hospital
Vannia De La Cuba, City Council District 5 Liaison, City of Pasadena
R-lene Mijares de Lang, Community Advocate
Mary Donnelly-Crocker, Executive Director, Young and Healthy
Rita Elshout, Community Advocate
Priscilla Gamb, Community Advocate
Akila Gibbs, Executive Director, Pasadena Senior Center
Ying-Ying Goh, MD, Health Officer, Pasadena Public Health Department
Jane Haderlein, Senior Vice President, Philanthropy and External Affairs, Huntington Hospital
Dolores Hickambottom, Retired Field Representative, City of Pasadena
Betty Ho, Community Advocate
S. Michael Johnson, Director, Pasadena Public Health Department
Lena Kennedy, Community Advocate
Mary Kirchen, Executive Director, Housing Works
Hector La Farga, Executive Director, Mothers' Club
David Lee, CEO, Huntington Health Physicians
Ellen Lee, Member, Board of Directors, Huntington Hospital
Lolita Lopez, Member, Board of Directors, Huntington Hospital
Steve Madison, Councilmember, District 6, City of Pasadena
Margaret Martinez, CEO, ChapCare

Lois Matthews, Member, Board of Directors, Huntington Hospital
Stacy Miller, Director, Volunteer and Customer Services, Huntington Hospital
Jeremy Mo, Employer Relations Specialist, Huntington Hospital
Kathy Podley, Member, Board of Directors, Huntington Hospital
Stephen A. Ralph, President and CEO, Huntington Hospital
Ann Rector, Director, Health Programs and School Support Services, Pasadena Unified School District
Sheryl Rudie, Executive Director, Ambulatory Services, Huntington Hospital
Cody Ruedaflores, Manager, Community Benefits Program, Kaiser Permanente
Juliana Serrano, Director, Office of Creative Connections, All Saints Church
Kimberly Shriner, MD, Huntington Hospital
Rosemary Simmons, Member, Board of Directors, Huntington Hospital
Rhonda Stone, City Council District Liaison, Office of Mayor Terry Tornek, City of Pasadena
Takako Suzuki, City Council District 6 Liaison, City of Pasadena
Wendy Wang, Director, Community Education, Outreach and Public Policy, Pacific Clinics
Mark Waterson, Executive Director, Convalescent Aid Society
Debbie Williams, Member, Board of Directors, Huntington Hospital
Lois Zagha, Manager, Community Outreach and Community Benefits, Huntington Hospital

COMMUNITY MEETING PARTICIPANTS

Sergio Bautista, CFO, ChapCare
Ioakim Boutakidis, Professor, California State University, Fullerton
Peggy Buchanan, Executive Director, The Pasadena Village
Cathi Chadwell, Executive Director, Public Affairs, Huntington Hospital
Nicole Collins, Choose Health LA Program, Pasadena Public Health Department
Latrease Crockett, Community Resident
Erika Davies, HIV Programs, Pasadena Public Health Department
Bill Davis, Community Services Supervisor, Villa Parke Community Center, Pasadena Human Services & Recreation Department
Mary Donnelly-Crocker, Executive Director, Young and Healthy
Judith Dunaway, WIC Program Director, Pasadena Public Health Department
Kathleen Eastwood, RN, Community Health Practitioner, Huntington Hospital
Rita Elshout, Community Advocate
Nicole Evans, Black Infant Health, Pasadena Public Health Department
Matt Feaster, Epidemiologist, Pasadena Public Health Department
Ying-Ying Goh, MD, Health Officer, Pasadena Public Health Department
Jane Haderlein, Senior Vice President, Philanthropy and External Affairs, Huntington Hospital

Sophia Herrera, Social Worker, Ambulatory Care Center, Huntington Hospital
Dolores Hickambottom, Retired Field Representative, City of Pasadena
Betty Ho, Community Advocate
S. Michael Johnson, Director, Pasadena Public Health Department
Kristin Karlyn, MD, Medical Director of Pasadena Urgent Care, Huntington Health Physicians
Eileen Koons, Director, Senior Care Network, Huntington Hospital
Adrienne Kung, Public Health Emergency Manager, Pasadena Public Health Department
David Lee, CEO, Huntington Health Physicians
Tyswaya Marin, Pasadena Public Health Department
Margaret Martinez, CEO, ChapCare
Lois Matthews, Member, Board of Directors, Huntington Hospital
Diane Mgrublian, Director, Social Services, Pasadena Senior Center
Marilyn Myers, Clinical Director, Foothill Family Services
Laura Pancake, VP, Wellness, Recovery, Integrated Care and Training, Pacific Clinics
Geraldine Perry-Williams, PHN, Director, Maternal, Child, Adolescent Health, Pasadena Public Health Department
Ruth Pichaj, RN, Community Health Practitioner, Huntington Hospital
Stephen A. Ralph, President and CEO, Huntington Hospital
Ann Rector, Director, Health Programs and School Support Services, Pasadena Unified School District
Christine Reeder, Adult Services Librarian, Pasadena Public Library
Rudy Salinas, Program Director, Housing Works
Juliana Serrano, Director, Office of Creative Connections, All Saints Church
Rosemary Simmons, Member, Board of Directors, Huntington Hospital
Laura Smith, Professor, California State University, Fullerton
Noreen Sullivan, City Council District 4 Liaison, City of Pasadena
Takako Suzuki, City Council District 6 Liaison, City of Pasadena
Salomon Torrescano, Clinic Administrator, John Wesley Community Health Institute
Patricia Valencia, Emergency Preparedness, Pasadena Public Health Department
Jenny Van Slyke, RN, Pre-hospital Care Coordinator, Huntington Hospital
Mark Waterson, Executive Director, Convalescent Aid Society
Patty Watson-Wood, RN, Clinical Supervisor, Senior Care Network, Huntington Hospital
Debbie Williams, Member, Board of Directors, Huntington Hospital
Lois Zagha, Manager, Community Outreach and Community Benefits, Huntington Hospital

Executive Summary

Huntington Hospital and the City of Pasadena Public Health Department are pleased to present the **2016 Community Health Needs Assessment of Greater Pasadena**. The goal of this collaboration was to conduct a joint, systematic analysis of health indicators that provides insight into the health status and needs of residents in the Greater Pasadena area.

For 120 years, Huntington Hospital (HH) has served the Greater San Gabriel Valley community through health care services, medical research, professional education and training, provision of care for vulnerable populations, and support of programs that may otherwise be absent from the community. Huntington Hospital takes its mission seriously and, along with its community partners, actively seeks opportunities to ensure access to care for everyone.

Since 1892, the City of Pasadena Public Health Department (PPHD) has been responsible for helping protect, maintain and improve the health of the Pasadena community. The city of Pasadena is one of only three cities in the state of California that maintains its own independent local health jurisdiction.

Huntington Hospital has conducted a triennial Community Health Needs Assessment (CHNA) in accordance with California Senate Bill 697 since its implementation in 1994, requiring tax-exempt hospitals to document activities undertaken to address community health needs. The Patient Protection and Affordable Care Act (ACA), enacted in 2010, included in IRS Section 501(r), directs tax-exempt hospitals to conduct a Community Health Needs Assessment and develop an Implementation Strategy every three years. The CHNA serves as a tool for effectively planning the allocation of community benefits to improve the health of the community.

Since 1992, the PPHD has published several Quality of Life Index reports for the Pasadena/Altadena region. Each report was a broad assessment of indicators related to social determinants of health. Both HH and PPHD leadership recognized the opportunity to partner as we work toward our shared goal of improved community health.

OUR COMMUNITY

The **2016 Community Health Needs Assessment of Greater Pasadena** focuses on the geographic area of Greater Pasadena, which includes Pasadena, Altadena, South Pasadena, and San Marino. The information gathered and contained in this report establishes the foundation for future planning to address the health needs of Greater Pasadena residents. The findings of this assessment can assist the planning and improvement efforts of civic leaders, non-profit organizations, and community constituents.

SIGNIFICANT COMMUNITY NEEDS

Quantitative and qualitative data were collected and analyzed for this CHNA. Quantitative data refers to information that can be expressed in numerical terms, counted, measured or compared on a scale. Qualitative data, on the other hand, refers to information that is difficult to measure, count or express in numerical terms, but provides rich, in-depth descriptive information about a field of interest. The synthesized data results were combined and arranged by topic. In the Huntington Hospital community benefit prioritization process, the following twelve areas of need emerged:

- Access to Care
- Exercise, Nutrition, and Weight
- Mental Health
- Economy/Affordable Housing
- Social Environment/Cultural Competency
- Transportation
- Child and Adolescent Health
- Older Adults and Aging
- Heart Disease and Stroke
- Dental Health
- Public Safety
- Education Equity

PRIORITIZATION PROCESS

A group of health and social service professionals with specific clinical and community knowledge participated in a review and discussion of the findings of the preliminary data analysis. In a facilitated prioritization session, participants rated each health topic area based on criteria reflecting the hospital's mission, values, strengths, and resources. The six highest rated areas of need were:

- Access to Care
- Heart Disease and Stroke
- Child and Adolescent Health
- Mental Health
- Older Adults and Aging
- Exercise, Nutrition and Weight

NEXT STEPS

Findings from the **2016 Community Health Needs Assessment of Greater Pasadena** will be the foundation upon which the hospital's Community Benefits Committee, Executive Management Team, and Board of Directors will develop meaningful community health improvement efforts.

The City of Pasadena Public Health Department will be launching a separate community-wide effort to evaluate, prioritize and plan for health improvements based on the findings from this **2016 Community Health Needs Assessment of Greater Pasadena**. This broader Community Health Improvement Plan (CHIP) process will include the full spectrum of community partners, in addition to Huntington Hospital, to create an improvement plan with a full range of community health issues.

I. Introduction

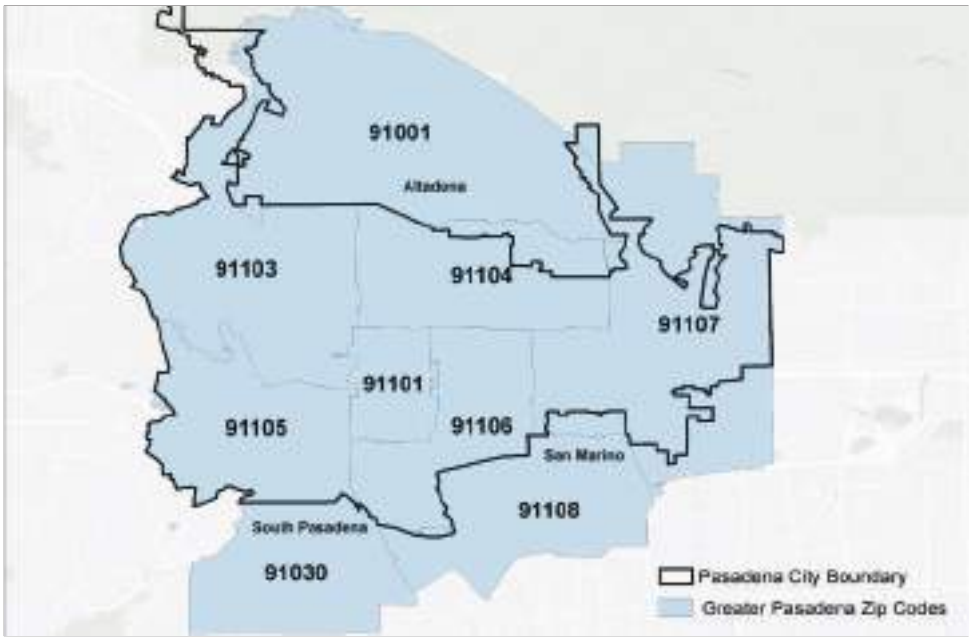
Huntington Hospital and the Pasadena Public Health Department (PPHD) are pleased to present the first joint Community Health Needs Assessment (CHNA) report for Greater Pasadena. This report describes findings from a systematic, year-long CHNA process that was conducted collaboratively in order to provide insight into the health status and needs of the residents of the Greater Pasadena area. Data presented in this report span a wide range of topics related to community well-being, including disease rates, risk factors for disease and death, health behaviors, and social determinants of health.

The examination of key health indicators in the Greater Pasadena area offers some understanding of health needs in this community and will guide community health improvement planning efforts. This CHNA is intended to provide a gateway for concerned community members, civic leaders, non-profit organizations, and policy makers to further delineate and address health issues in Greater Pasadena. This report and healthypasadena.org are meant to be resources for health and health care advocates and organizations that use the data to guide planning, policy development, and procurement or allocation of resources.

Although genetics and individual behaviors contribute to health status, research shows that other risk-factors, such as environmental, social, and economic conditions, are very important in determining the health and well-being of individuals and populations. By studying these social determinants of health, health advocates can address "upstream" causes of diseases. In this CHNA, a variety of data were collected and compiled to characterize the health status of the population in Greater Pasadena. These data include demographics, social determinants of health, and health metrics. Specific efforts were made to identify and highlight health disparities for sub-populations, when the data were available.

ABOUT THE REGION OF FOCUS

FIGURE 1. GREATER PASADENA AND CITY OF PASADENA



While the geographic focus of this report is the Greater Pasadena area, the data come from a variety of sources with different catchment areas. This report aims to present the most granular level of analysis when possible, but in some instances data are only shown at the higher geographic level due to limitations in sample size or data availability. In this report, data are reported in one of three distinct geographic regions: 1) Greater Pasadena (*Figure 1*), 2) city of Pasadena (*Figure 1*), or 3) Service Planning Area (SPA) 3–San Gabriel Valley (*Figure 2*).

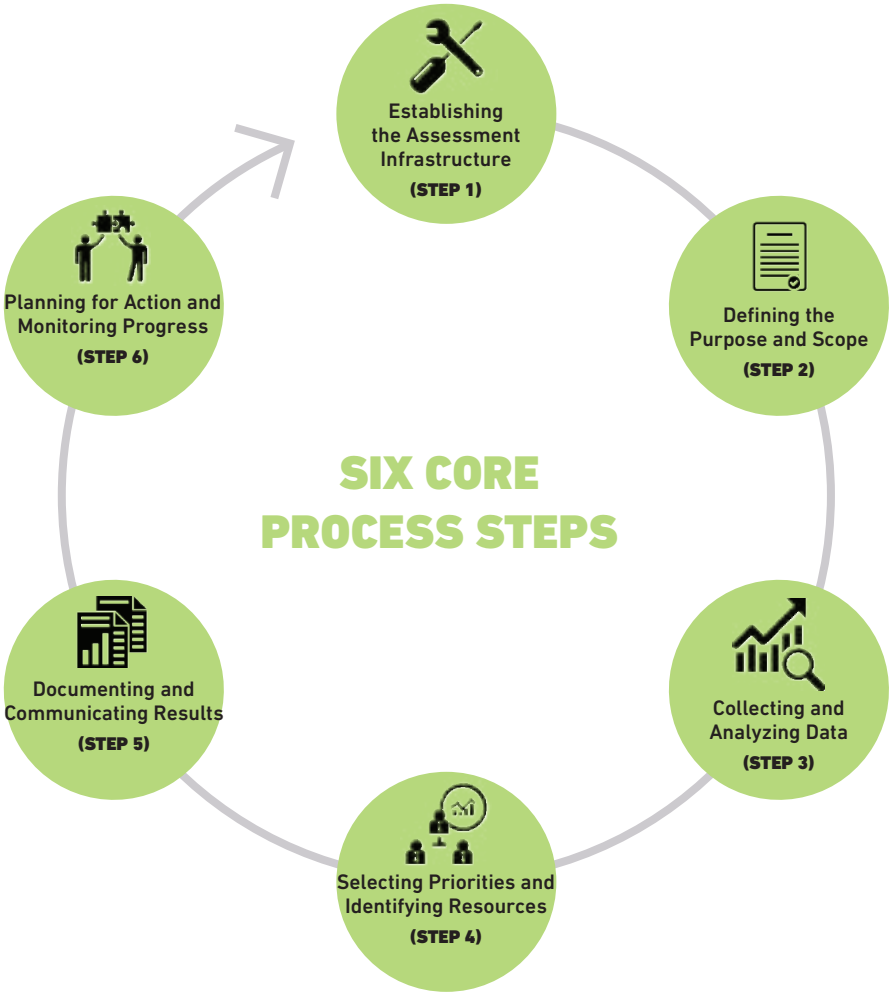
FIGURE 2. LOS ANGELES COUNTY AND SERVICE PLANNING AREA (SPA) 3 - SAN GABRIEL VALLEY



ABOUT THE CHNA PROCESS

The **2016 Community Health Needs Assessment of Greater Pasadena** was developed utilizing a framework adapted from the Association for Community Health Improvement (ACHI) (*Figure 3*).[1] There are six important steps in the process: 1) establishing the assessment infrastructure, 2) defining the purpose and scope of the assessment, 3) collecting and analyzing data, 4) selecting priorities and identifying related resources, 5) documenting and communicating results, and 6) planning for action and monitoring progress.

FIGURE 3. 2016 COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS



ABOUT THE CHNA TEAM

HUNTINGTON HOSPITAL

Huntington Hospital is a 625-bed, not-for-profit community hospital located in Pasadena, California. Founded in 1892, Huntington Hospital is committed to providing excellent patient care delivered with compassion and respect. The hospital offers a full complement of acute medical care and community services, ranging from general medicine to the foremost specialized programs in cardiovascular, oncology, and neurosciences, is nationally recognized for Huntington Hospital Senior Care Network's innovation, quality care, and aging expertise, and operates the only Level II trauma center in the San Gabriel Valley. Huntington offers state of the art orthopedic surgery, inpatient and outpatient psychiatric care, women's and children's services, and an ambulatory care center. Huntington is a designated California Children's Services Facility. Through a partnership between Huntington Hospital and Shriners Hospital for Children-Southern California, inpatient surgical and medical services for pediatric patients are available.

As a teaching facility affiliated with the University of Southern California Keck School of Medicine, Huntington supported 26 internal medicine and 15 general surgery residents in 2015. More than one-third of Huntington's residents remain in the area to practice, providing a seamless transition through generations of care.

In accordance with both state and federal legislation applying to non-profit, tax-exempt hospitals and set forth by California Senate Bill 697 and the Patient Protection and Affordable Care Act, Huntington Hospital conducts a triennial CHNA to analyze and identify the health needs of the Greater Pasadena community, and develops an implementation strategy to meet the identified needs. Please see *Appendix A: Community Health Needs Assessment Progress Reports* for an evaluation of progress since the previous CHNA.

PASADENA PUBLIC HEALTH DEPARTMENT

Since 1892, the City of Pasadena Public Health Department has been responsible for helping protect, maintain and improve the health of the Pasadena community. The city of Pasadena is one of only three cities in the state of California that maintains its own independent local health jurisdiction.

The PPHD is responsible for ensuring a healthy community through legally mandated services, essential public health functions, enforcement of the State Health and Safety Code, and administration of other policies, statutes, regulations and programs. To meet the needs of Pasadena's diverse community, the PPHD tailors interventions, monitors health status, diagnoses and investigates health problems, empowers community members, mobilizes community partnerships, enforces laws and regulations, works to promote access to health care, and continuously evaluates effectiveness in services.

The City of Pasadena Public Health Department is dedicated to the physical, social and mental well-being of all who live, work, learn and play in Pasadena. The PPHD is committed to building trusting relationships with the community; providing high-quality services; making health services accessible; achieving health equity; and creating opportunities that foster health professional excellence.

HEALTHY COMMUNITIES INSTITUTE

Healthy Communities Institute (HCI), a Xerox Company, was retained by Huntington Hospital to provide technical assistance for the **2016 Community Health Needs Assessment of Greater Pasadena**. HCI provides customizable, web-based information systems that offer a full range of tools and content to improve community health. HCI and Huntington Hospital have collaborated since 2010 and leveraged HCI technology to develop the Healthy Pasadena platform (www.healthypasadena.org).

To learn more, please visit www.HealthyCommunitiesInstitute.com.

II. Data Overview

ABOUT THE DATA

Quantitative and qualitative data were collected and analyzed for this Community Health Needs Assessment (CHNA). Quantitative data refers to information that can be expressed in numerical terms, counted, measured or compared on a scale. Qualitative data, on the other hand, refers to information that is difficult to measure, count, or express in numerical terms, but provides rich, in-depth descriptive information about a field of interest.

QUANTITATIVE DATA

The quantitative data collected and analyzed for this assessment comes from a variety of sources, including public agencies like the United States Census Bureau and the Pasadena Public Health Department.

For certain social determinants of health or health topics, an Indicator Summary Table is provided at the end of each section. Each table lists indicators that are tracked on healthypasadena.org, a web-based community health data platform developed by Healthy Communities Institute, sponsored by Huntington Hospital, and contributed to by the Pasadena Public Health Department. The indicators are derived from local primary data sources and state and national public secondary data sources.

Each indicator in the Summary Tables was assigned a comparison score from zero to three and a corresponding color on a spectrum ranging from green, to yellow, to red, in order to show how the local community indicator value compared to selected comparison values. The comparison value for any indicator could be one of the following: a distribution of counties in California or the United States, the value for the state of California, the value for the U.S., the trend of the indicator's value over time, and/or the value stated in national Healthy People 2020 goals. Healthy People 2020 goals are national objectives for improving the health of the nation set by the U.S. Department of Health and Human Services' Healthy People Initiative.

For indicators highlighted in green with number scores approaching zero, the local indicator value was better than the comparison values. For indicators highlighted in red with number scores approaching the maximum of three, the local indicator was worse than the comparison values. Many indicators were assigned colors and number scores somewhere between the extremes of the scale. These comparison scores were utilized to consider which indicators might demonstrate more or less community health need. For additional details on each indicator, please reference healthypasadena.org.

When sufficient demographic data was available (e.g., race, ethnicity, gender), analyses of sub-populations were conducted to look for disparities. Please see *Appendix B: Healthy Communities Institute Data Analysis Methods* for more details on the quantitative data methodology.

TABLE 1. SOCIAL DETERMINANTS OF HEALTH AND HEALTH TOPICS INVESTIGATED FOR GREATER PASADENA COMMUNITY, 2016

SOCIAL DETERMINANTS OF HEALTH	HEALTH TOPICS	
Economy, Housing, and Homelessness	Access to Care	Respiratory Diseases
Education	Maternal, Child, and Adolescent Health	Injury Prevention and Safety
Social Environment	Exercise, Nutrition, and Weight	Other Conditions
Environment	Diabetes	Older Adults and Aging
Public Safety	Heart Disease and Stroke	Mental Health
Transportation	Cancer	Substance Abuse
	Immunizations and Infectious Diseases	Mortality

QUALITATIVE DATA

The Pasadena Public Health Department gathered qualitative data through key informant interviews and a community stakeholder meeting. Ten in-person key informant interviews were conducted with knowledgeable community members who provided feedback on social and health topics. The community stakeholder meeting held at Huntington Hospital had forty-nine participants. Participants included representatives from health care organizations, mental health agencies, social service organizations, local government, the public school district, and other interested professionals and community members familiar with the health needs of the Greater Pasadena community.

The qualitative data are described further in section *IV. Community Input* and in the respective topic sections in the main assessment (Sections V and VI)

DATA CONSIDERATIONS

For both quantitative and qualitative data, efforts were made to include as wide a range of data indicators as possible. Limitations on data availability varied by topic. Although the CHNA planning team selected a diverse, comprehensive representation of stakeholders to minimize bias, qualitative data findings are inherently dependent upon both the selection and participation of stakeholders. Quantitative data was limited by the types of measures available at the time of analysis and the selection of measures. Analysis on disparities was possible for indicators with sufficient demographic data, such as those at a SPA or city level.

III. Demographics

POPULATION

The geographic boundary of Greater Pasadena is the primary unit of analysis for this assessment. Greater Pasadena is made up of the following nine ZIP codes: 91001, 91030, 91101, 91103, 91104, 91105, 91106, 91107, and 91108. *Figure 4* illustrates the geographic boundaries of the Greater Pasadena service area and the city of Pasadena limits (black outline in *Figure 4*), and *Table 2* displays the population counts for each ZIP code.

FIGURE 4. GREATER PASADENA POPULATION BY ZIP CODE, 2016[2]

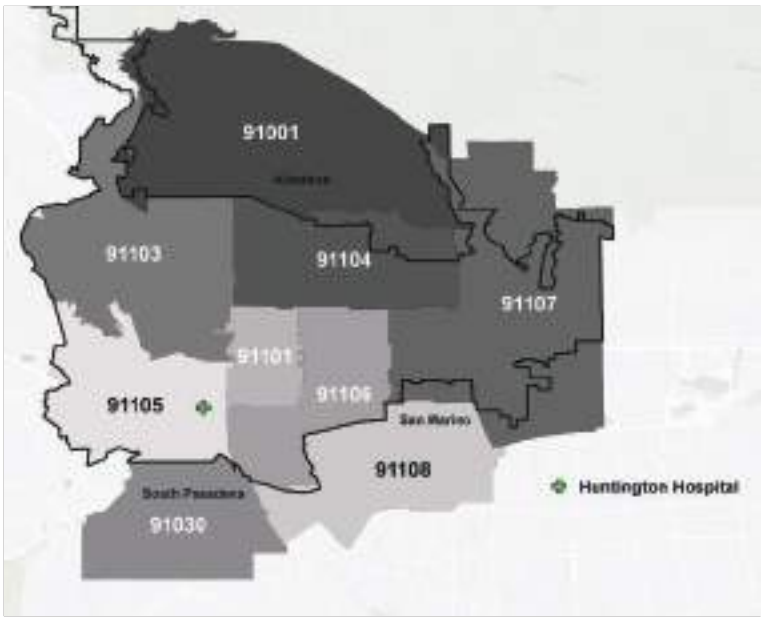


TABLE 2. GREATER PASADENA POPULATION, 2016[2]

ZIP CODE	POPULATION COUNT
91105	12,869
91108	13,620
91101	21,260
91106	24,584
91030	26,692
91103	29,309
91107	33,967
91104	37,011
91001	37,111

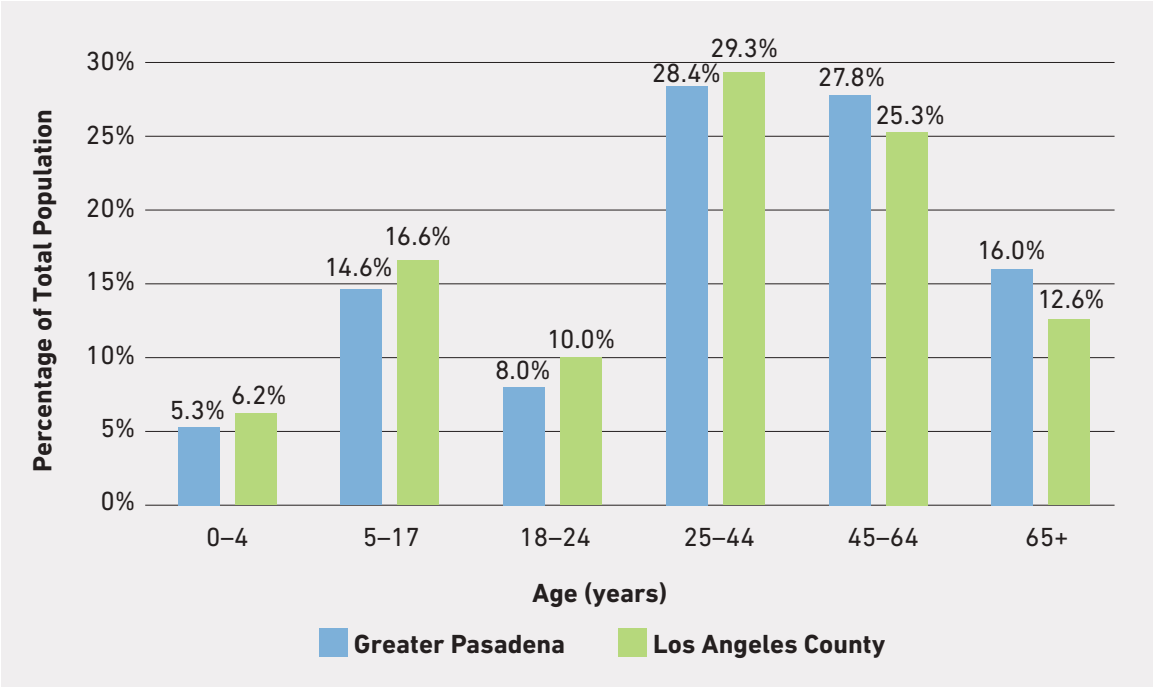
The total population for Greater Pasadena is 236,423, which is approximately 2.3% of the entire population of Los Angeles County.[2] The population of the city of Pasadena is 142,250.[3] The majority of Greater Pasadena residents live in ZIP codes 91001, 91104, and 91107. Between 2010 and 2016, the population of Greater Pasadena grew by 3.7%, which is slower than the population growth experienced by Los Angeles County (4.3%) and the state of California (5.6%).[2]

AGE AND GENDER

The proportion of residents below 18 years of age (19.9%) is lower in Greater Pasadena than in Los Angeles County (22.8%).[2] The proportion of residents ages 45-64 and 65 and older is higher in Greater Pasadena than in Los Angeles County.

In Pasadena, the proportion of males and females are 49.1% and 50.9%, respectively. Among adults 18 years and over, 51.7% are female while seniors age 65 and over are 58.6% female.[3]

FIGURE 5. POPULATION BY AGE, GREATER PASADENA AND LOS ANGELES COUNTY, 2016[2]



RACE, ETHNICITY, AND LANGUAGE

The racial and ethnic diversity of Greater Pasadena differs from that in Los Angeles County, as shown in *Table 3*. In Greater Pasadena, 53.8% of the population identifies as White compared to 49.3% in Los Angeles County.[2] The percentage of Asian residents is 18.6% in Greater Pasadena, while approximately 14.3% of Los Angeles County residents are Asian.[2] A lower percentage of Pasadena residents identify as Some Other Race (11.6%) compared to the percentage in Los Angeles County (22.2%).

In addition, Greater Pasadena has a lower percentage of residents who identify as Hispanic, approximately 29.2% of the population, compared to the percentage in Los Angeles County (48.7%).[2]

TABLE 3. POPULATION BY RACE/ETHNICITY, GREATER PASADENA AND LOS ANGELES COUNTY, 2016[2]

	GREATER PASADENA	LOS ANGELES COUNTY
Race		
White	53.8%	49.3%
Black/African American	9.9%	8.4%
American Indian/Alaska Native	0.6%	0.7%
Asian	18.6%	14.3%
Some Other Race	11.6%	22.2%
2+ Races	5.4%	4.7%
Ethnicity		
Hispanic	29.2%	48.7%

Table 4 shows the most common languages spoken at home by Greater Pasadena residents. The most common language spoken by Greater Pasadena residents is English (57.3% of the population).[2] Compared to Los Angeles County and California, a larger percentage of Greater Pasadena residents speak Asian and Indo-European languages (such as Armenian) at home.

TABLE 4. LANGUAGE SPOKEN AT HOME, GREATER PASADENA, LOS ANGELES COUNTY, AND CALIFORNIA, 2016[3]

	GREATER PASADENA	LOS ANGELES COUNTY	CALIFORNIA STATE
Speak Only English at Home	57.3%	43.2%	56.1%
Speak Spanish at Home	22.8%	39.5%	28.8%
Speak Asian/Pacific Islander Languages at Home	12.5%	10.8%	9.6%
Speak Indo-European Languages at Home	6.4%	5.4%	4.4%
Speak Other Languages at Home	0.9%	1.1%	1.0%

In the city of Pasadena, the top five languages spoken at home other than English were: Spanish (27%), Chinese (Mandarin) (4.2%), Armenian (3.3%), Tagalog (1.9%), and Korean (1.2%).[3]

IV. Community Input

Community feedback (primary qualitative data) was collected as an important component of the needs assessment. First, ten semi-structured key informant interviews were conducted in order to identify and confirm significant community health issues. The data from these interviews with community stakeholders helped to ensure that quantitative data were collected, when available, in those issue areas. The findings from the interviews were also used to identify other knowledgeable community members to participate in interviews and provide feedback on the design of the health assessment.

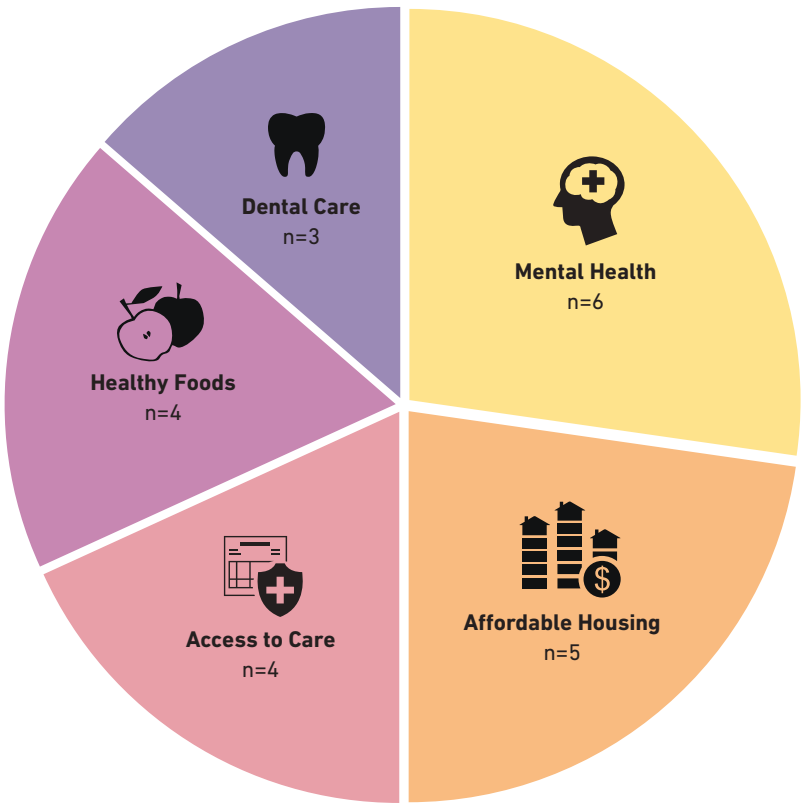
The second method for obtaining community feedback was to conduct a large community stakeholder meeting. At the meeting, the preliminary data analysis was presented by the CHNA planning team, and stakeholders provided input on gaps in data, quality of data, additional sources of data in the community, and the community health needs assessment process.

KEY INFORMANT INTERVIEWS

TOP HEALTH NEEDS

Figure 6 below illustrates the top health needs for the Greater Pasadena community that were identified by key informants.

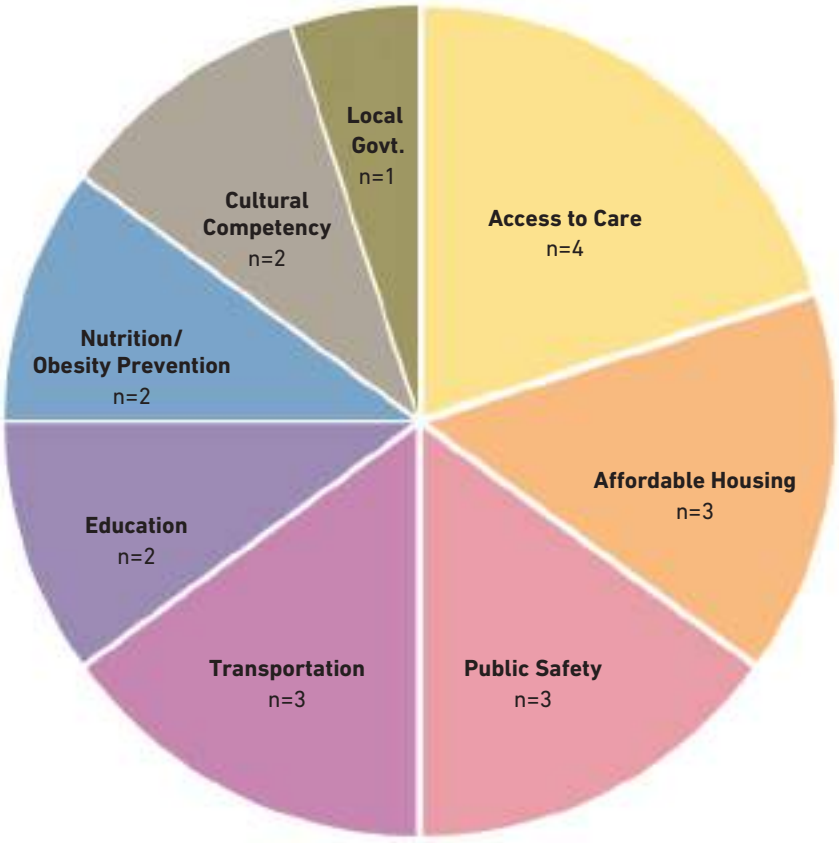
FIGURE 6. TOP HEALTH NEEDS IDENTIFIED BY KEY INFORMANTS



CHALLENGES TO QUALITY OF LIFE

Figure 7 illustrates the top challenges identified by key informants that might lower quality of life for the Greater Pasadena community.

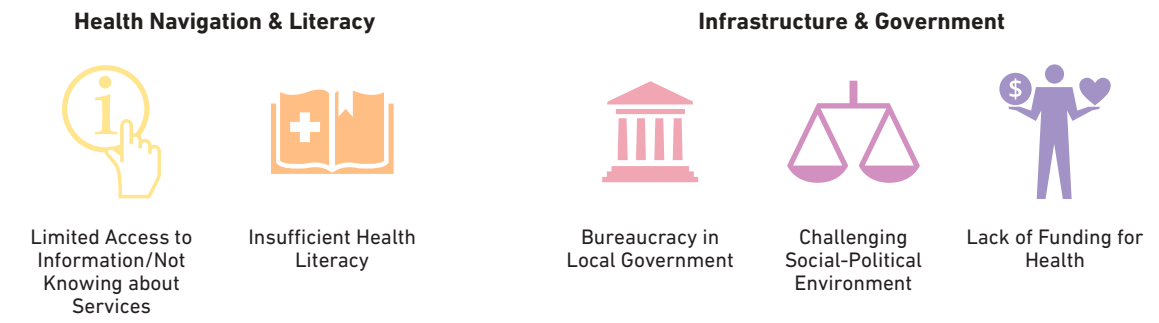
FIGURE 7. TOP QUALITY OF LIFE CHALLENGES IDENTIFIED BY KEY INFORMANTS



BARRIERS TO ADDRESSING HEALTH NEEDS

Figure 8 illustrates what key informants identified as top barriers to addressing the health needs of the community and includes quotes from key informants.

FIGURE 8. TOP BARRIERS TO HEALTH IDENTIFIED BY KEY INFORMANTS



"We need to connect and collaborate better to promote information. So much good stuff goes under the radar."

"Instead of saying 'no' automatically, officials should work to see how it could happen."

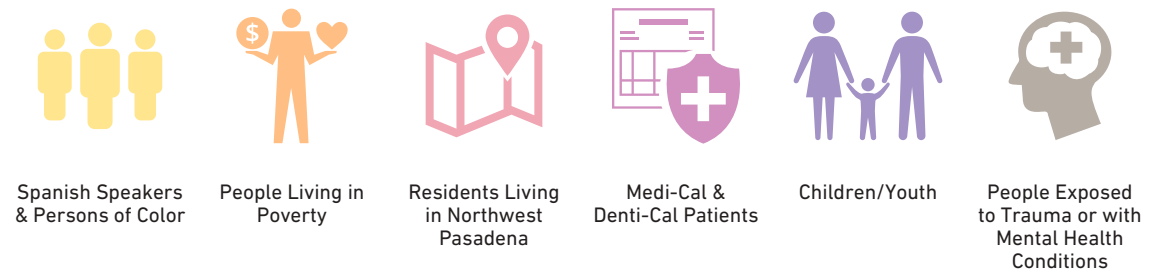
"Information is power, and people are underpowered."

"Pasadena has a culture of, 'this is how it has always been'."

GROUPS AT-RISK FOR LOWER QUALITY OF LIFE

Figure 9 below illustrates vulnerable populations mentioned by key informants.

FIGURE 9. VULNERABLE POPULATIONS IDENTIFIED BY KEY INFORMANTS



COMMUNITY STRENGTHS SUPPORTING QUALITY OF LIFE

Strengths and resources in the Greater Pasadena community that were identified by key informants were categorized into six main areas: Health Organizations and Resources, Health Interventions, Local Organizations and Resources, Pasadena Unified School District, Residents, and City Council/Local Government. *Figure 10* illustrates the most commonly cited community strengths for each of these topics.

FIGURE 10. TOP COMMUNITY STRENGTHS IDENTIFIED BY KEY INFORMANTS



KEY INFORMANT INTERVIEW PARTICIPATING ORGANIZATIONS

TABLE 5. KEY INFORMANT INTERVIEWS PARTICIPATING ORGANIZATION TYPES AND POPULATIONS SERVED

ORGANIZATION TYPE	POPULATIONS SERVED
Faith-Based Organization	Faith Community
Ambulatory Care Clinic	Medically Underserved Adults
Maternal Care Management Program (Client)	Expectant African American Mothers and Families
Youth-Advocacy Non-Profit	Youth, At-Risk Youth for Alcohol and Other Drug Abuse
Governmental Child Services Agency	Youth, Families, At-Risk Children and Families
Behavioral and Mental Healthcare Agency	Mental Health Medically Underserved
Pasadena Community Advocate	Pasadena Community
Local School District (Staff)	Youth
Local School District (Parent)	Youth, Pasadena Community
Youth and Family Services Non-Profit	Youth, Families, Medically Underserved

COMMUNITY MEETING

At the community meeting, participants were presented with preliminary needs assessment data, including findings from the key informant interviews. Participants were asked to identify additional health indicators, and to describe barriers to health as well as resources that contribute to health and wellness that exist in the community. The indicators and the associated resources are included in the next two sections of this report. Additional resources are listed in *Appendix C: Community Resources*.

Table 6 lists the topics that were identified by community meeting participants as health concerns and discussed in detail during the meeting.

TABLE 6. TOP HEALTH AND QUALITY OF LIFE CONCERNS IDENTIFIED IN COMMUNITY MEETING

TOPIC	KEY POINTS
Access to Health Services	Medi-Cal providers and specialists have low ratings from their patients; difficulties with eligibility, navigating system, and choosing providers; need for an improved 2-1-1 system for health information exchange
Economy	Analyzing economic disparities by ZIP code can be misleading because disparities occur within such a large geographic area
Housing Affordability and Supply	Issues include gentrification, limited supply of affordable housing and limited budgets due to high rent
Homelessness	Challenging for outreach workers to build trust with the homeless
Public Safety	More information and data needed on gun violence, domestic violence, and incarceration/re-entry rates
Mental Health and Mental Disorders	Not enough mental health providers serving children — possible barriers include liabilities working with children or language barriers

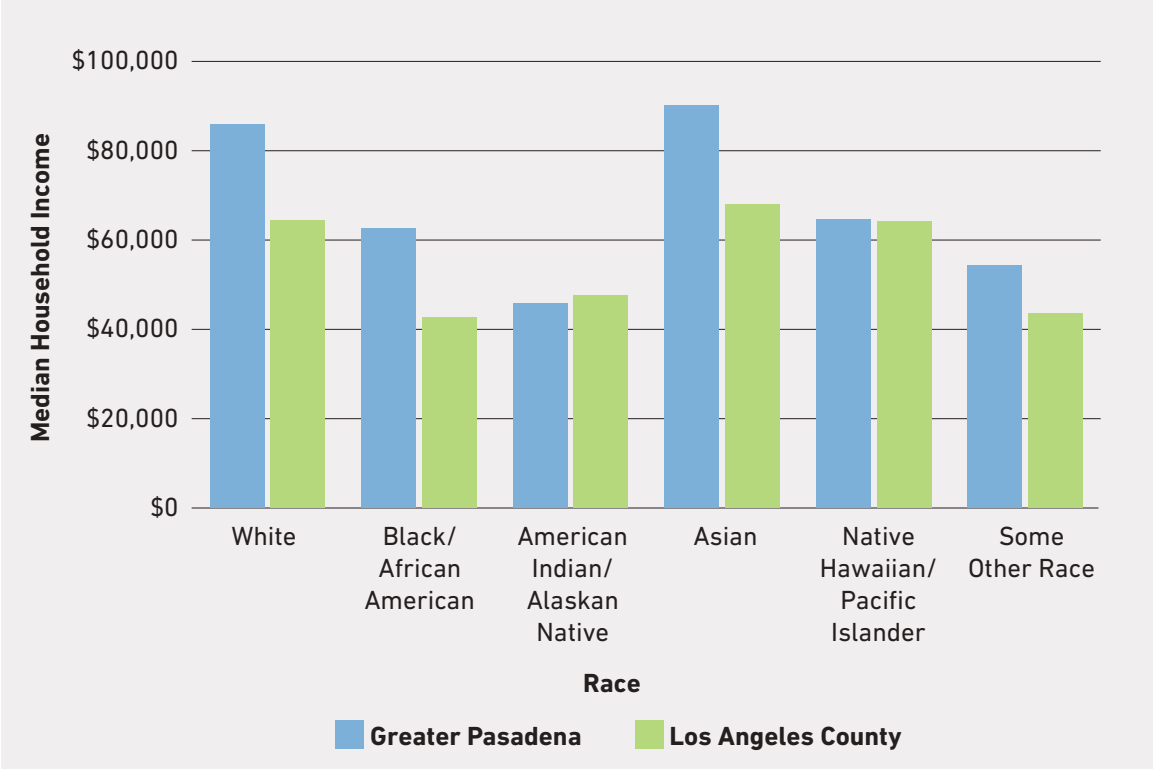
Please see the *Acknowledgements* section for a full list of community participants.

V. Social Determinants of Health

ECONOMY, HOUSING, AND HOMELESSNESS

- **Income:** The median household income in 2016 was higher in Greater Pasadena ($79,727) than in California ($63,566) and in Los Angeles County ($57,864).[2] ZIP codes 91101 and 91103 had the lowest median household income levels in the Greater Pasadena region ($58,394 and $61,478, respectively).[2] *Figure 11* shows median household income by race. The median household income for White, African American, Asian, and Some Other Race groups in Greater Pasadena was higher than for their counterparts in the County.

FIGURE 11. MEDIAN HOUSEHOLD INCOME BY RACE IN GREATER PASADENA, 2016[2]



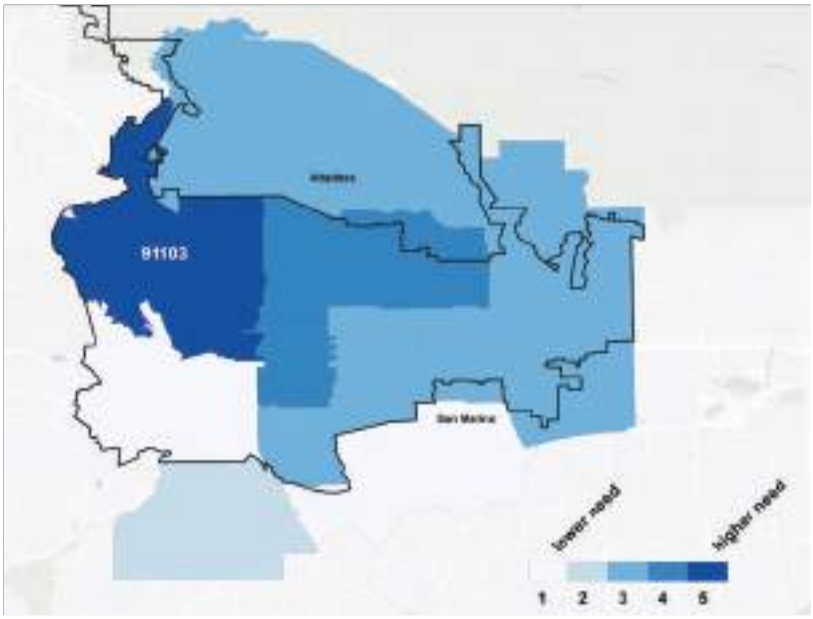
- **Poverty:** An estimated 7.4% of Greater Pasadena families lived below the federal poverty level in 2016.[2] This was a smaller percentage of families living in poverty compared to Los Angeles County (14.9%) and California (12.6%).[2] ZIP code 91103 had the highest rate of families living in poverty in the service area (14%).[2] During 2010-2014, 14.5% of Pasadena seniors ages 65 and older were living below the poverty line compared to 10.0% in California overall.[3]

- **Cost of Living:** In order to afford basics needs in Pasadena, a single-parent adult with one preschooler and one school-age child would need to earn approximately $30.92 per hour in 2015.[4] For an hourly, full-time worker that is equivalent to $64,313 per year. This is similar to what would be needed in Los Angeles County: a yearly income of $65,519.[4]
- **Unemployment:** An estimated 9.2% of Greater Pasadena residents were unemployed in 2016, which was slightly lower than the Los Angeles County and California rates, 10.8% and 10.6%, respectively. ZIP code 91103 had the highest unemployment rate in the service area (11.8%).[2]
- **SocioNeeds Index:** Healthy Communities Institute developed the SocioNeeds Index as a measure of socioeconomic need that is correlated with poor health outcomes.[5] The Index incorporates estimates for six different social and economic determinants of health: income, poverty, unemployment, occupation, educational attainment, and linguistic barriers. All ZIP codes in the United States are given an Index value from 0 (low need) to 100 (high need). Within Greater Pasadena, ZIP codes are ranked by relative levels of need, from 1 (lower need) to 5 (higher need) (*Table 7* and *Figure 12*). The ZIP code with the highest level of socioeconomic need is 91103 (Index value: 69.5). Los Angeles County has an Index value of 56.4, meaning ZIP code 91103 has higher relative need than the county overall, while other ZIP codes in the Greater Pasadena service area have lower relative need when compared to Los Angeles County.

TABLE 7. HCI SOCIONEEDS INDEX, 2016[5]

LOCATION	INDEX	RANK
91103	69.5	5
91101	42.8	4
91104	40.1	4
91001	18.8	3
91106	18.0	3
91107	15.1	3
91030	8.7	2
91105	2.8	1
91108	0.8	1

FIGURE 12. SOCIONEEDS INDEX MAP, GREATER PASADENA RANKINGS, 2016[5]



- **Housing:** In Pasadena, 40.9% of housing units were occupied by homeowners in 2010-2014, which was lower than in Los Angeles County (43.4%) and in California (50.1%).[3] As illustrated by *Figure 13*, ZIP codes 91001 and 91108 had the highest percentages of homes that are occupied by homeowners (over 76%), and ZIP code 91101 had the lowest homeowner rate (17%) in 2015.[6]
- **Housing Affordability:** In *Figure 14*, ZIP codes 91101 and 91105 are shown to have the highest costs of rent in Pasadena in 2015: $2,452 and $2,559 per month on average for a two-bedroom apartment, respectively.[6]
- **Homelessness:** According to Pasadena Homeless Count estimates, there were 530 homeless persons in the city of Pasadena in 2016. This rate has been declining since at least 2012, when 904 homeless persons were counted in Pasadena.[7]
- **Disparities in Homelessness:** The majority of the people counted as homeless were between the ages of 25 and 61 (67%). In addition, the majority of the people included in the homeless count were individuals who identified as White (43%) or Black (33%).[7]

FIGURE 13. PERCENT OWNER OCCUPIED HOUSING IN GREATER PASADENA, 2015[3]

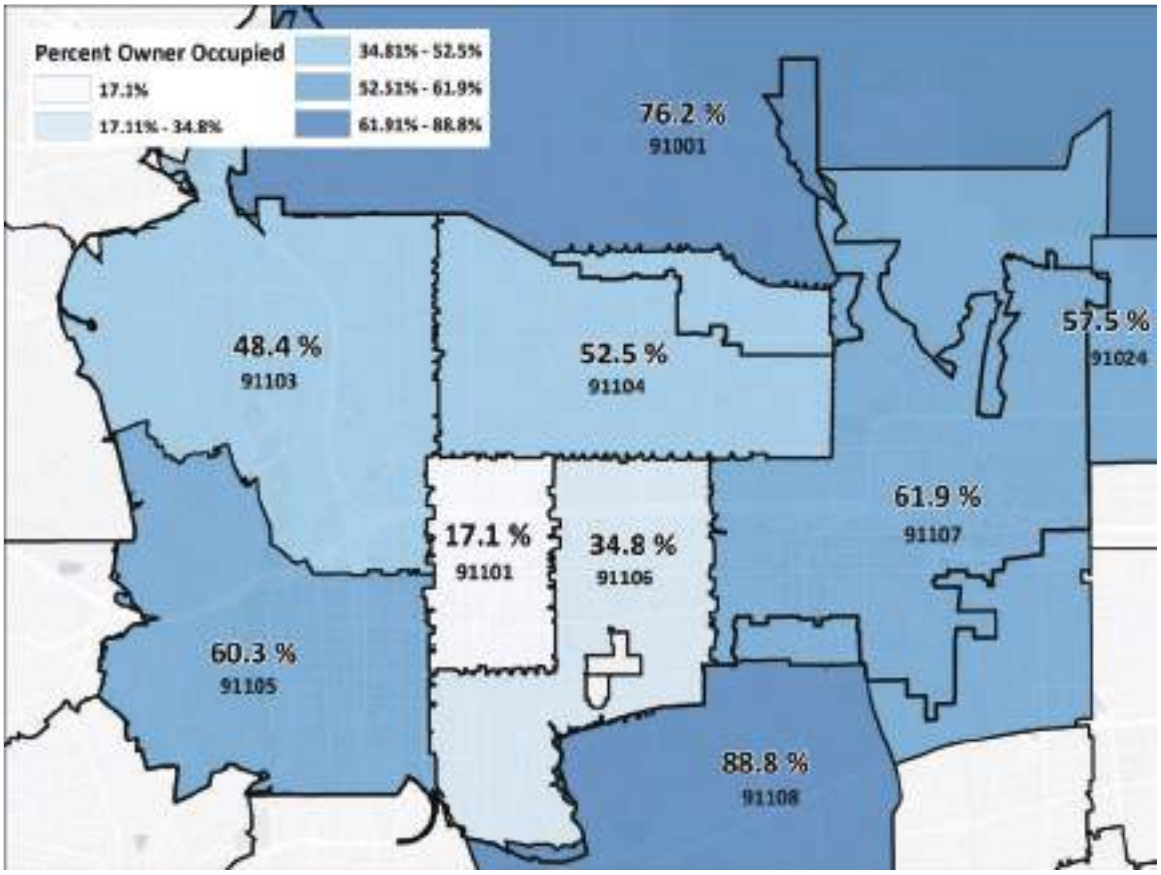


FIGURE 14. AVERAGE RENT FOR 2-BEDROOM APARTMENT IN GREATER PASADENA, 2015[6]

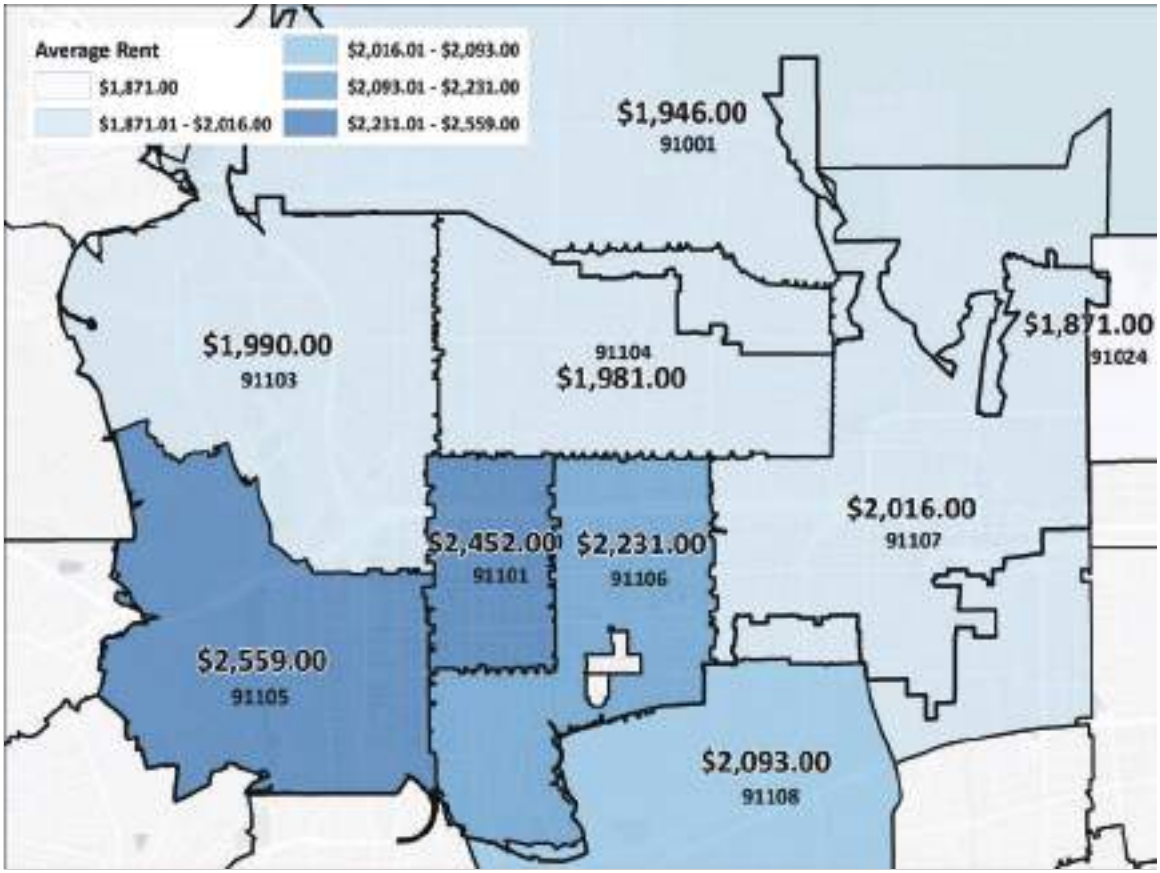


TABLE 8. SUMMARY OF SCORED ECONOMY, HOUSING, AND HOMELESSNESS INDICATORS

ECONOMY, HOUSING, AND HOMELESSNESS *(TOPIC SCORE: 1.19)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
Homeownership [3]	2010-2014	40.9	%	2.78
People 65+ Living Below Poverty Level [3]	2010-2014	14.5	%	2.78
Income Inequality: Gini Index [3]	2010-2014	0.5		2.25
People Living 200% Above Poverty Level [3]	2010-2014	68.4	%	1.23
People Living Below Poverty Level [3]	2010-2014	14.6	%	1.03
Renters Spending 30% or More of Household Income on Rent [3]	2010-2014	51.7	%	0.73
Families Living Below Poverty Level [3]	2010-2014	8.7	%	0.60
Children Living Below Poverty Level [3]	2010-2014	15.0	%	0.23
Median Household Income [3]	2010-2014	70,845	dollars	0.23
Per Capita Income [3]	2010-2014	41,268	dollars	0.08

COMMUNITY INPUT



Five out of ten key informants cited affordable housing as a quality of life need in the Greater Pasadena service area.

Themes from the **Key Informant Interviews**:

- Affordable and low-income housing were seen as a huge and increasing concern
- Issues with overcrowding, too many families in single-room residences, and overall poor living conditions
- Not enough landlords accepting affordable housing vouchers

"There is a huge gap between Section 8 housing and everybody else."

"We have an affordable housing crisis."

The figures to the right include direct quotes from Key Informants regarding this topic area.

Community Meeting Participants discussed specific concerns: large economic disparities by ZIP code; issues with gentrification, affordable housing, and high rent; and ongoing challenges with building trust between outreach workers and homeless individuals.

COMMUNITY RESOURCES

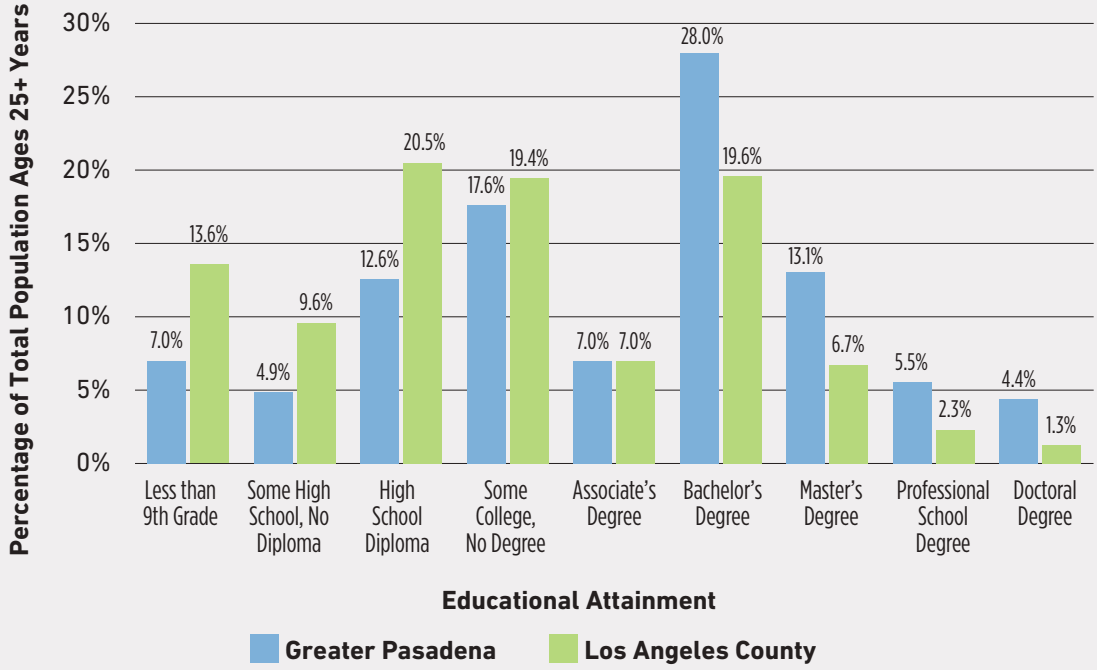
- In 2016 the **Pasadena City Council** unanimously approved an ordinance that requires incremental increases to the minimum wage starting at $10.50 on July 1, 2016 and increasing to $13.25 by July 2018. The California state minimum wage as of January 2016 was raised to $10.
- The **Pasadena Altadena Community Team** (PACT) fair was created to help formerly incarcerated individuals and their families access resources needed during their transition back into the community. A variety of local service providers are introduced to community members, addressing topics such as housing, employment opportunities, substance abuse, recovery resources, and health screening.
- **Flintridge Center**, a local community program, provides monthly seminars for formerly incarcerated individuals to assist with employment. Flintridge also holds monthly PACT trainings for formerly incarcerated individuals to provide resources for reintegration.
- The **Survival Guide**, a resource available online through the City of Pasadena Human Services and Recreation Department, lists services available to Pasadena residents, including basic needs, child care, community center programs, housing, home health services, pregnancy and family planning, senior services, substance abuse resources, and veterans' resources.

- The **Housing First** program, sponsored by the **Pasadena Partnership**, offers permanent, affordable housing as quickly as possible to homeless individuals and families, and provides supportive services to avoid returning to homelessness.
- **Union Station Homeless Services** is part of the group of human services agencies in Los Angeles County that are leading the way to address homelessness. Their comprehensive set of services includes providing housing and shelter for individuals and families who are homeless.
- **Friends in Deed**, an interfaith collaborative, is dedicated to meeting the many needs of the most vulnerable residents of Greater Pasadena—homeless and at-risk individuals including women and children. Their services include a food pantry, bad weather shelter, and housing.
- **Passageways** is an adult multi-service center operated by Pacific Clinics. Passageways provides a safe haven for mentally ill homeless individuals. The program helps homeless community members secure shelter, and provides support services and assistance with money management.
- **The City of Pasadena** receives funding from the **U.S. Department of Housing and Urban Development (HUD)** to provide housing vouchers for low income individuals. Additionally, the city receives funding from HUD to provide permanent supportive housing.

EDUCATION

- **Educational Attainment in Adults:** In 2016, more than half (51%) of Greater Pasadena adults over 25 years of age had a Bachelor's degree or higher. This is a higher percentage than in Los Angeles County (29.9%) and California (30.9%).[2]

FIGURE 15. PERCENTAGE OF TOTAL POPULATION AGES 25+ YEARS BY EDUCATIONAL ATTAINMENT IN GREATER PASADENA, 2016[2]



- **Private School Enrollment:** Nearly one in four (24.7%) school-age children (kindergarten through 12th grade) is enrolled in private school in Pasadena. This is higher than Los Angeles County (9.1%), California (8.4%), and nationwide (10.1%).[3]
- **School Performance:** For the Pasadena Unified School District (which serves residents of Pasadena, Sierra Madre, and Altadena) class of 2014-2015, the dropout rate was 8.6%, which is lower than the Los Angeles County rate (12.5%). The racial/ethnic group with the highest dropout rate was among Hispanics (any race) at 9.8%. The lowest rates were among African Americans (6.8%) and Non-Hispanic Whites (7.5%).[8]
- **Academic Achievement:** In the 2012-2013 school year, 82.9% of Pasadena Unified School District (PUSD) graduates met the University of California/California State University course requirements.[9] *Table 9* reports several school performance indicators for PUSD, Los Angeles County, and California students.

TABLE 9. SCHOOL PERFORMANCE AMONG PASADENA UNIFIED SCHOOL DISTRICT (PUSD) STUDENTS

	PUSD	LOS ANGELES COUNTY	CALIFORNIA STATE
4th Grade Students Proficient in English/ Language Arts (2013)[10]	62%	63%	65%
4th Grade Students Proficient in Math (2013)[10]	69%	73%	72%
10th Grade Students Passing the California High School Exit Exam: English (2014-2015)[8]	80%	84%	85%
10th Grade Students Passing the California High School Exit Exam: Math (2014-2015)[8]	80%	84%	85%
High School Graduation (2014-2015)[8]	81.5%	78.7%	82.3%

COMMUNITY INPUT



Two out of ten key informants cited Education Equity as a quality of life need in the Greater Pasadena service area.

Themes from the **Key Informant Interviews**:

- Appears to be low public support for the public school system
- Many affluent families opting for private school
- Families being pushed out to school jurisdictions outside Pasadena due to high housing costs

Community Meeting Participants specifically mentioned that the community could benefit from more information and data on early childhood learning.

COMMUNITY RESOURCES

- Pasadena Unified School District's strong **Parent Teacher Association (PTA)**.
- The PUSD is instituting **Wellness Councils** made up of parents and health officials designed to support overall health and well-being.
- PUSD has robust Spanish/English and Chinese (Mandarin)/English **Dual Language Immersion Programs** in elementary schools.
- The **Pasadena Education Foundation** provides support to local students with grants and services.
- **Collaborate PASadena** is a framework for the Pasadena Unified School District, the City of Pasadena, the unincorporated community of Altadena, and the City of Sierra Madre to work together to build a commitment toward a shared vision to create better outcomes for children, youth, families and all residents.

SOCIAL ENVIRONMENT

- **Social and Linguistic Isolation:** In 2010-2014, a higher percentage of Pasadena adults 65 years and older lived alone (28.6%) than in California overall (24%). Additionally, 9.1% of Pasadena residents lived in linguistic isolation, which was a higher percentage than the median among California counties (6.0%).[3]

  A household is linguistically isolated if all adults speak a language other than English and none speak English "very well." Adult is defined as age 14 or older, which identifies household members of high school age and older.[3]

- **Single-Parent Households:** The estimated percentage of single-parent households in Pasadena was 32% during the 2010-2014 time period. The percentage of single-parent households in Pasadena has been generally increasing since the 2007-2011 measurement period.[3]
- **Volunteering:** In 2014, 8% of the adults in the San Gabriel Valley volunteered in the previous year, compared to 11.9% in Los Angeles County.[11]

TABLE 10. SUMMARY OF SCORED SOCIAL ENVIRONMENT INDICATORS

SOCIAL ENVIRONMENT *(TOPIC SCORE: 1.68)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
People 65+ Living Alone[3]	2010-2014	28.6	%	2.63
Linguistic Isolation[3]	2010-2014	9.1	%	1.98
Single-Parent Households[3]	2010-2014	32	%	1.88
Children Living Below Poverty Level[3]	2010-2014	15	%	0.23

COMMUNITY INPUT



Two out of ten key informants cited Cultural Competency as a quality of life need in the Greater Pasadena service area.

Themes from the **Key Informant Interviews**:

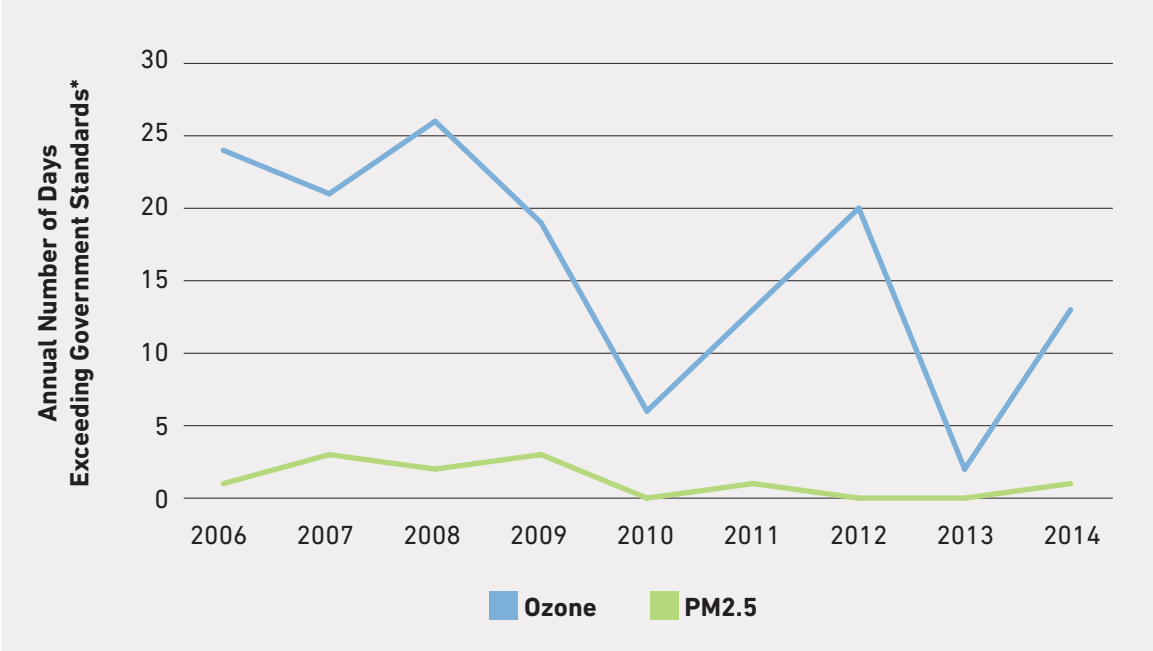
- There was a general consensus that Pasadena was a welcoming and diverse community, but there was still room for improvement
- Need continued outreach to residents who do not speak English as their first language
- More health education materials needed in other languages

Community Meeting Participants cited specific concerns regarding Social Environment and Cultural Competency: possible language barriers with child psychiatry providers and a need for more information and data on child care providers and elder abuse.

ENVIRONMENT

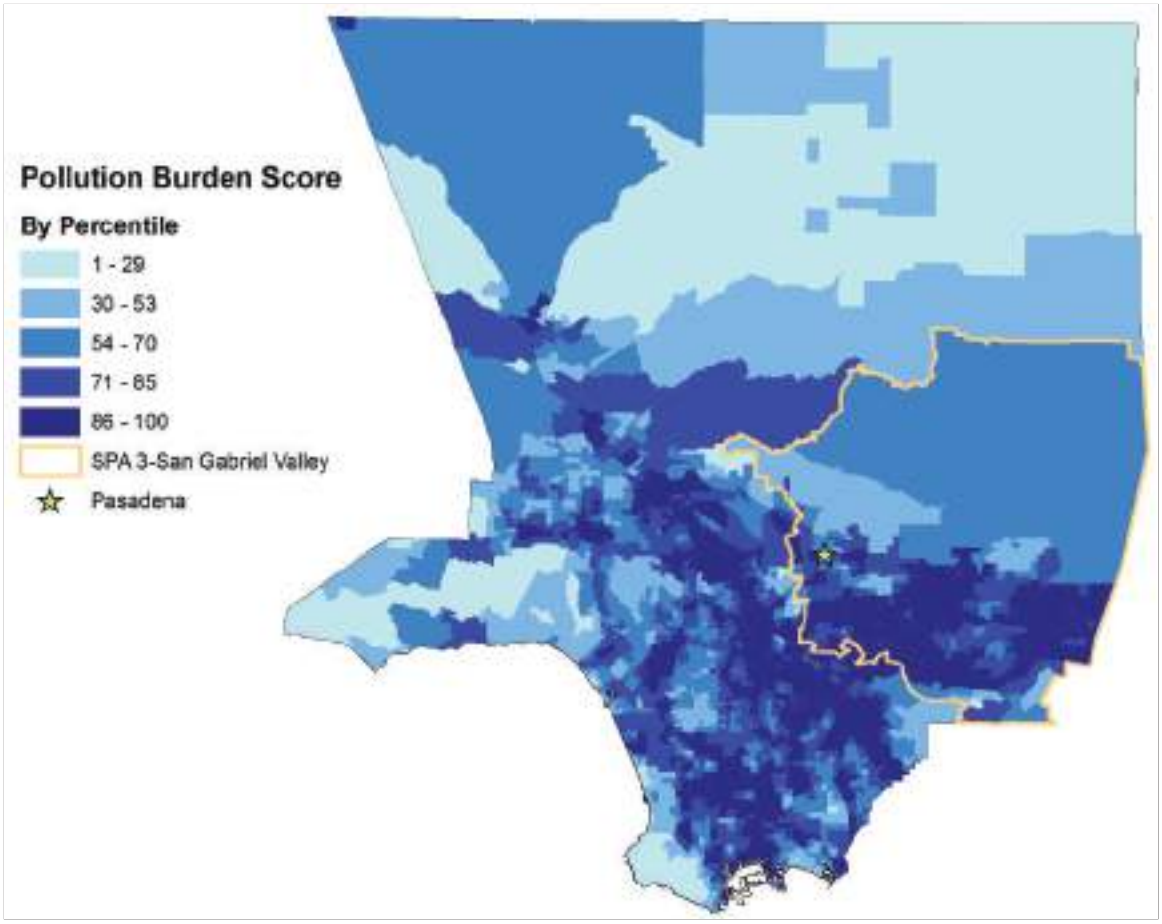
- **Air Quality:** The South Coast Air Quality Management District (SCAQMD) is the air pollution control agency for all of Orange County and the urban portions of Los Angeles (including Pasadena), Riverside and San Bernardino counties. The SCAQMD reports that about 25% of this area's ozone-forming air pollution comes from stationary sources, both businesses and residences. The other 75% comes from mobile sources–mainly cars, trucks and buses, but also construction equipment, ships, trains and airplanes. A total of 42% of the ozone-forming pollution comes from on-road vehicles.[12]
- **Air Quality:** In Pasadena, the number of days per year that pollution levels due to fine particles (PM2.5) exceeded government standards has remained relatively steady over the past several years (under five days exceeding standards per year). The number of days per year that ozone levels exceeded government standards varied over the past several years, but had a generally decreasing trend.[12] See *Figure 16* for this trend over time.

FIGURE 16. NUMBER OF DAYS PER YEAR OZONE AIR QUALITY AND PARTICLE POLLUTION EXCEEDED GOVERNMENT STANDARDS IN PASADENA, 2006-2014[12]



** State ozone standards are >0.070 ppm over 8-hr. Fine Particles (PM2.5) include % samples exceeding Federal Std. of >35 µg/m³ over 24-hr.*

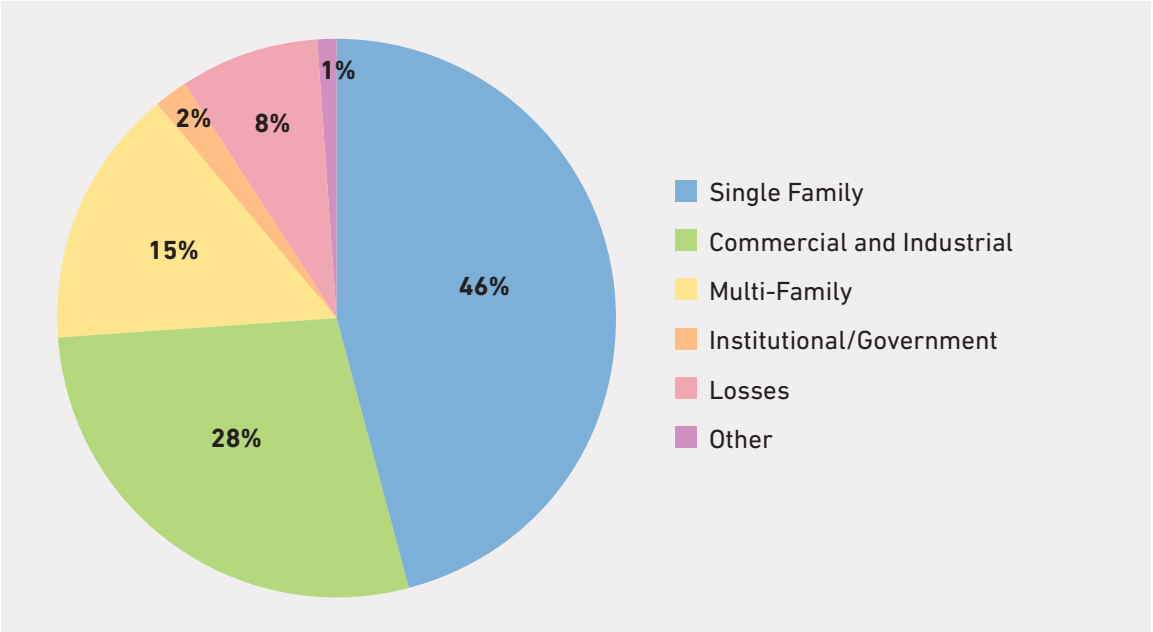
FIGURE 17. POLLUTION BURDEN SCORES, LOS ANGELES COUNTY, 2014[13]



- **Pollution Burden Scores:** The CalEnviroScreen[13] is a tool to measure the amount of pollutants from multiple sources of pollution in the state of California. The Pollution Burden Score shown in *Figure 17*, illustrates certain communities in Los Angeles County, and specifically the San Gabriel Valley (SPA 3), that are exposed to higher levels of pollution than others. Areas in the darkest blue have the highest amounts of pollution compared to the lighter areas. In SPA 3, communities in the San Gabriel Valley basin and along the freeways were the most exposed.

- **Water Usage:** California is currently in its fifth consecutive year of severe drought.[14] In January 2014, Governor Brown declared a state of emergency due to the drought.[14] In Pasadena, the City Council declared a water emergency on June 1, 2015 and Pasadena's Level 2 Water Supply Shortage Plan took effect. The majority of water usage in Pasadena in 2015 was among single family homes (*Figure 18*).[15]

FIGURE 18. WATER USE BY SECTOR IN PASADENA, 2015[15]



COMMUNITY RESOURCES

- In September 2016, Governor Brown signed one of the most progressive climate bills into law. **Senate Bill 32** aims to reduce greenhouse gas emissions to 40% below the 1990 level by 2030, and help achieve the global goal to limit temperature rise to below two degrees Celsius.
- The City of Pasadena is currently initiating the development of a **Climate Action Plan (CAP)**, which will include a greenhouse gas inventory to establish a baseline and set future greenhouse gas emissions reduction targets. The goals of the CAP will be achieved through a series of greenhouse emission reduction measures.

PUBLIC SAFETY

- **Violent Crimes:** In the city of Pasadena, there has been little change in homicide rates over the last 6 years. Since 2010, incidence of rape increased by 57%, assaults by 18%, and domestic violence assaults by 17%. However, there was an almost 27% decrease in robbery.[16]
- **Shootings and Homicide:** The total number of shooting events has increased since 2012.[17] In 2015 however, Pasadena had 5.0 deaths per 100,000 residents due to firearms.[18] This is nearly half the rate of the prior year (10.7/100,000) and is lower than the Healthy People 2020 target of 9.3 deaths per 100,000.[19]
- **School Safety:** When asked about school safety, 64% of students ages 11-18, in public or private school, polled in 2014 felt safe on campus. One in five students reported a history of being bullied in the last year, and about 10% of the students reported feeling some amount of racial discrimination from adults.[20]
- **Suicide:** The age-adjusted death rate due to suicide in Pasadena was 8.6 per 100,000.[18] This is lower than the Healthy People 2020 goal (10.2 suicides per 100,000 population).[19]

TABLE 11. INCIDENCE OF SELECTED CRIMES IN PASADENA, 2010-2015[16]

	2010	2011	2012	2013	2014	2015
Homicide	4	6	5	3	9	4
Rape	30	26	22	28	28	47
Robbery	182	178	171	145	126	132
Assault with a deadly weapon	154	126	138	136	150	148
Assault	262	241	273	274	293	310
Assault domestic violence	150	154	150	156	188	176
Burglary Commercial	357	421	447	419	393	367
Burglary Other	86	96	83	97	106	204
Burglary Residential	645	719	642	623	518	437
Burglary Vehicle	1094	650	428	531	504	695
Stolen Vehicle	378	278	257	228	224	288
Theft	1259	1189	1342	1668	1625	1725
Total	**4721**	**4173**	**3958**	**4362**	**4164**	**4533**

COMMUNITY INPUT



Three out of ten key informants cited Public Safety as a quality of life need in the Greater Pasadena service area.

Themes from the **Key Informant Interviews**:

- Gun violence was viewed as an important and timely issue that relates to health
- Overall, key informants felt that Pasadena was a generally safe place

The figure to the right includes a direct quote from a **Key Informant** regarding this topic area.

Community Meeting Participants mentioned that the community could benefit from more information and data on gun violence, domestic violence, incarceration, and re-entry rates.

"Jobs, housing, and violence are preventing happy, healthy, and fruitful lives."

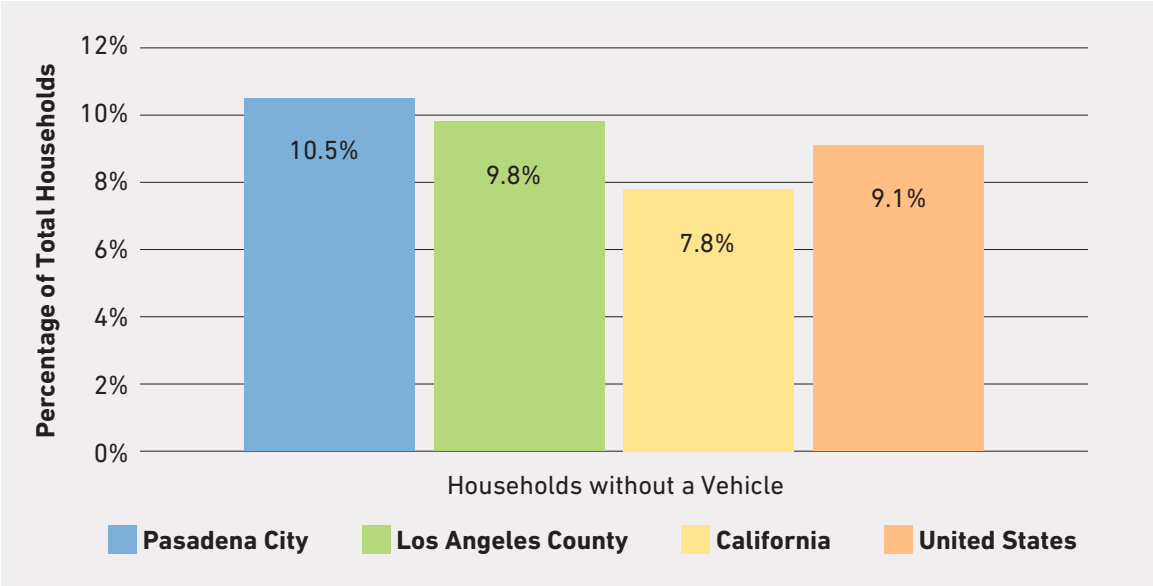
COMMUNITY RESOURCES

- The **Gun Violence Prevention Task Force** of the **Office for Creative Connections** at All Saints Church works to "educate, advocate and organize to prevent gun violence and to respond to the impact of gun violence through sustained action in partnership with advocacy groups, elected officials, schools, children, youth, families, public safety and public health officials, and inter-faith leaders."
- The **Gun Disposal Program** of the Pasadena Police Department is a free program offered year-round.
- Coordinated by Flintridge Center, the **Pasadena/Altadena Reintegration Council (PARC)** is a network of local service providers and public agencies working together to meet the needs of formerly incarcerated individuals returning to our community. Trying to prevent recidivism, the multisector coalition includes the Pasadena Police Department and community-based, faith-based, philanthropic, business, civic and educational organizations. The PARC works to provide a safety net of effective and comprehensive services and resources for out-of-custody life.

TRANSPORTATION

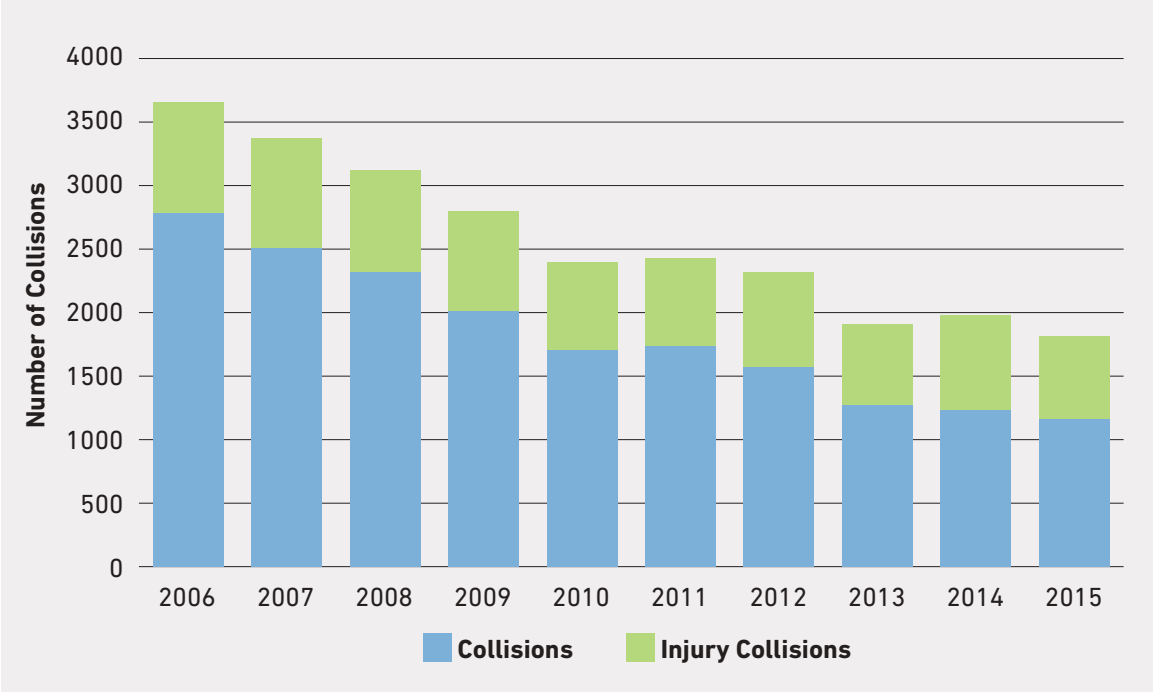
- **Mean Travel Time to Work:** The average amount of time Pasadenans spent traveling to work in 2010-2014 was 26.5 minutes. This was lower than the Los Angeles County value (29.6 minutes), but higher than the median value of all California counties (25 minutes).[3]
- **Commute Mode:** During 2011-2015, 71.0% of Pasadena commuters drove alone to work, 7.9% carpooled, 6.1% used public transportation, 5.2% walked, and 1.7% used a bicycle.[3] In California 73.4% drove alone, while in the United States 76.4% did so.

FIGURE 19. HOUSEHOLDS WITHOUT A VEHICLE IN PASADENA, 2010-2014[3]



- **Households without a Vehicle:** In 2010-2014, 10.5% of Pasadena households had no vehicle, which was higher than the California state value (7.8%). *(Figure 19)*. [3]

FIGURE 20. NUMBER AND TYPE OF COLLISIONS IN PASADENA, 2010-2015[21]



- **Collisions:** The number of collisions and injury collisions in Pasadena has been decreasing over the past ten years, from over 3,600 collisions in 2006 to over 1,800 collisions in 2015 (*Figure 20).* [21]

TABLE 12. SUMMARY OF SCORED TRANSPORTATION INDICATORS

TRANSPORTATION *(TOPIC SCORE: 1.00)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
Households without a Vehicle[3]	2010-2014	10.5	%	2.70
Mean Travel Time to Work[3]	2010-2014	26.5	minutes	1.80
Workers who Drive Alone to Work[3]	2010-2014	71.1	%	0.93
Workers Commuting by Public Transportation[3]	2010-2014	5.9	%	0.38
Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions[18]	2015	3.9	%	0.23

COMMUNITY INPUT



Three out of ten key informants cited Transportation as a quality of life need in the Greater Pasadena service area.

Themes from the **Key Informant Interviews**:

- Impact of delays due to traffic seen as a significant challenge for maintaining quality of life
- Lack of public transportation is a barrier to seeking medical care
- Buses may be too expensive for some clients trying to access health care

Community Meeting Participants did not specifically mention issues related to Transportation during the discussion.

COMMUNITY RESOURCES

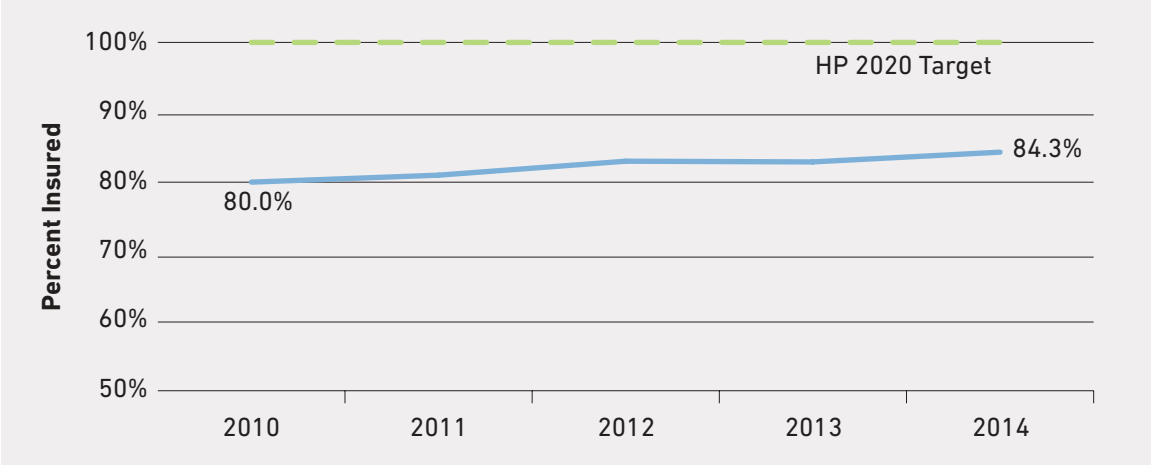
- **Dial-A-Ride** is a shared, curb-to-curb transportation service provided for residents who live in Pasadena, San Marino, Altadena, and the other unincorporated Los Angeles County areas in the service area (i.e., Chapman Woods, Kinneloa area, and the unincorporated area of the city of San Gabriel) who are 60 years and older or for those under 60 years with a physician-certified disability that prevents the use of regular public transit.

VI. Health Topics

ACCESS TO CARE

- **Health Insurance:** An estimated 92.5% of non-institutionalized children in Pasadena had health insurance in 2014. Of employed adults in Pasadena, 80.9% had health insurance that same year, which is lower than in the U.S. (83.0%). In total, 15.7% of the Pasadena population does not have health insurance. This is down from almost 20% in 2010. *(Figure 21).* [3]

FIGURE 21. PERCENT OF EMPLOYED PASADENANS WITH HEALTH INSURANCE, 2010-2014[3]



- **Access to Care:** In 2014, 83.9% of residents in San Gabriel Valley reported having a usual source of ongoing health care.[11] This is lower than the Healthy People 2020 target (95.0%).[19] For the year 2014, 10.3% of San Gabriel residents reported delaying or having difficulty obtaining care. This is slightly lower than for California residents (11.3%).[11]
- **Dental Care:** In 2013-2014, 68.2% of San Gabriel Valley children (ages 2-11) visited a dentist within the last year, compared to 78.7% of California children.[22] In 2013-2014, 60.8% of the adults in San Gabriel Valley reported going to the dentist within the last year.[22] These percentages exceed the Healthy People 2020 national goal for the proportion of children, adolescents and adults who have used the oral health care system in the past year (49.0%).[19]

TABLE 13. SUMMARY OF SCORED ACCESS TO CARE INDICATORS

ACCESS TO CARE *(TOPIC SCORE: 1.56)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
People with a Usual Source of Health Care[11]	2014	83.9	%	2.35
Adults with Health Insurance[22]	2013-2014	80.2	%	2.33
Adults Needing and Receiving Mental Health Care[22]	2013-2014	56.7	%	1.73
Adults with Private Health Insurance[11]	2014	61.1	%	1.28
People Delayed or had Difficulty Obtaining Care[11]	2014	10.3	%	0.93
Disabled Persons with Health Insurance[22]	2013–2014	93.4	%	0.75

COMMUNITY INPUT



Four out of ten key informants cited Access to Care as a health need in the Greater Pasadena service area.

Themes from the **Key Informant Interviews**:

- Coverage issues and lack of providers for Medi-Cal patients in area
- Lack of screening services and limited clinic hours
- Need assistance with navigating system and locating services/physicians
- Lack of advocates in mental health and dental care
- Limited knowledge on Medi-Cal eligibility and how to access care
- Dental health seen as an unmet need for attaining quality of life
- Some saw the dental care situation as improving as evidenced by an increasing number of low-cost or free dental clinics in the community

The figure to the right includes a direct quote from a **Key Informant** regarding this topic area.

Community Meeting Participants cited specific concerns: low patient ratings of Medi-Cal providers and specialists in the community; challenges with eligibility, navigating the system, and accessing providers; and the need for an improved 211 system for health information exchange.

"There are people out there who are not getting dental, mental, or health care."

COMMUNITY RESOURCES

- **Young and Healthy** facilitates access to no cost, high quality health care services for underinsured children including primary and specialty care, dental, vision, and mental health care services; assists with health insurance plan enrollment for eligible children and families; and provides support, education and information to Pasadena Unified School District's Healthy Start family case managers through regularly scheduled meetings.
- **Covered Pasadena**, a collaboration between local partners and Young and Healthy, works to increase the number of health insurance enrollers and outreach agents who help navigate the Covered California platform and enrollment.
- Low-cost providers for the un- and under-insured, like **ChapCare, Wesley Health Centers** and **Huntington Ambulatory Care Center**, work to provide clinical services that are affordable.
- The **Huntington Hospital Financial Assistance Program** helps low-income, uninsured or under-insured patients who need help paying for all or part of their medically necessary care.
- **Michael D. Antonovich Dental Clinic**, opened by the City of Pasadena in 2013, and now operated by Wesley Health Centers, serves the oral health needs of immunocompromised individuals and seniors. They also accept Denti-Cal adult benefits.

MATERNAL, CHILD, AND ADOLESCENT HEALTH

- **Prenatal Care:** The percentage of Pasadena mothers who received prenatal care in the first trimester in 2015 was 87.3%.[23] This is higher than the Healthy People 2020 goal (77.9%).[19] Overall, the percentage of Pasadena mothers who receive care in the first trimester has been relatively stable (2015: 87.3%, 2014: 89.0%, 2013: 88.2%, 2012: 89.0%, 2011: 86.8%, 2010: 88.7%).[23]
- **Disparities in Prenatal Care:** In 2015, Asian and White (non-Hispanic) women received prenatal care in the first trimester at a higher rates (90.5% and 92.8%, respectively) than Black (80.3%) and White (Hispanic) (81.7%) women.[23]
- **Caesarean Section (C-Section) Rates:** In 2015, 36.3% of all births to Pasadenans was by C-Section. This rate has been steadily declining since 2010 (2010: 40.6%, 2011: 39.0%, 2012: 37.4%, 2013: 38.7, 2014: 38.3%, and 2015: 36.3%).[23]
- **Birth Outcomes:** In 2015, 7% of babies were born with low birth weight in Pasadena.[23] This meets the Healthy People 2020 target (7.8%)[19] and falls below the U.S. value (8%)[24], but is higher than the California value (6.8%).[23]
- **Preterm Births:** Preterm births (less than 37 weeks gestational age) have declined in Pasadena over the past ten years, from 14.5% in 2006 to 9.4% in 2015 (see *Figure 22*).[23] This is now below the Healthy People 2020 goal (11.4%).[19]
- **Women's Health:** In 2007 fewer San Gabriel Valley women reported having a Pap test in the past three years (79.5%)[25] than California women (84.1%).[25]*

**The data source for this measure, the California Health Interview Survey (CHIS), last collected this data in 2007.*

FIGURE 22. PRETERM BIRTHS IN PASADENA, 2006-2015[23]

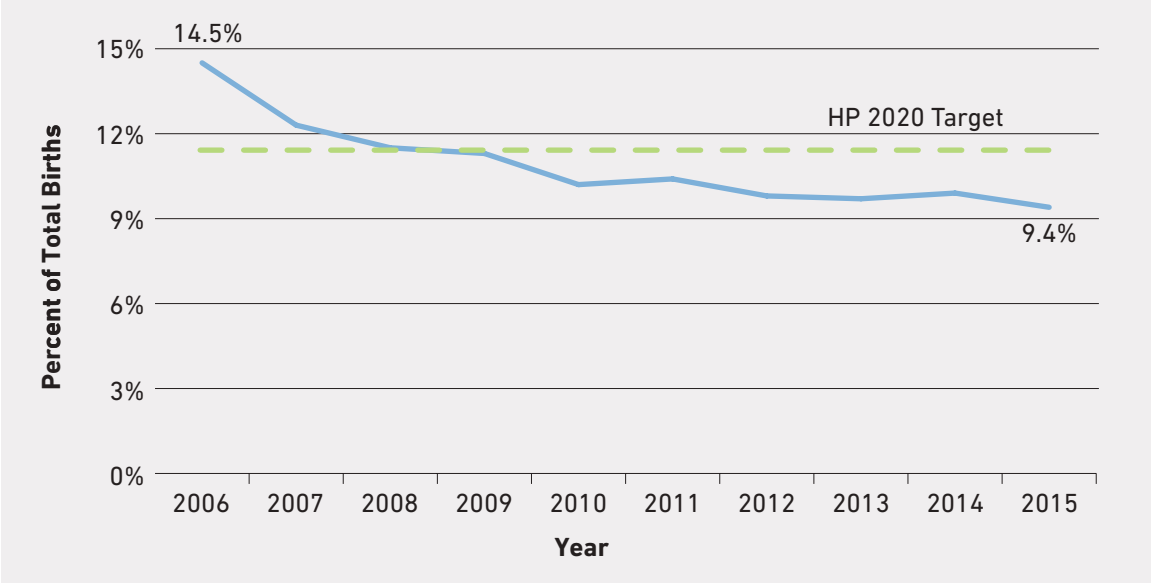


TABLE 14. SUMMARY OF SCORED CHILDREN'S HEALTH INDICATORS

CHILDREN'S HEALTH *(TOPIC SCORE: 2.00)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
Child and Teen Fruit Consumption: 2 or more servings in previous day[11]	2014	54.0	%	2.70
Children and Teens with Asthma[22]	2013–2014	19.3	%	2.63
Age-Adjusted Hospitalization Rate due to Pediatric Asthma[26]	2011–2013	6.9	hospitalizations/ 10,000 population under 18 years	0.68

TABLE 15. SUMMARY OF SCORED TEEN AND ADOLESCENT HEALTH INDICATORS

TEEN AND ADOLESCENT HEALTH *(TOPIC SCORE: 1.20)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
Teens (12-17 yrs) who Engage in Regular Physical Activity: 3+ days/week[22]	2013–2014	60.2	%	2.70
Children and Teens with Asthma[22]	2013–2014	19.3	%	2.63
Teens (12-17 yrs) who have Ever had an Alcoholic Drink[22]	2013–2014	22.4	%	0.93
Teens (14-17 yrs) who are not Sexually Active[27]	2009	95.9	%	0.38
Teen (15-19 yrs) Birth Rate[23]	2015	13.6	live births/1,000 females aged 15-19	0.23

TABLE 16. SUMMARY OF SCORED MATERNAL, FETAL, AND INFANT HEALTH INDICATORS

MATERNAL, FETAL, AND INFANT HEALTH *(TOPIC SCORE: 1.03)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
Babies with Low Birth Weight[23]	2015	7.0	%	1.73
Babies with Very Low Birth Weight[23]	2015	1.2	%	1.53
Mothers who Received Early Prenatal Care[28]	2012	89.0	%	0.58
Infant Mortality Rate[23]	2015	3.2	deaths/1,000 live births	0.23

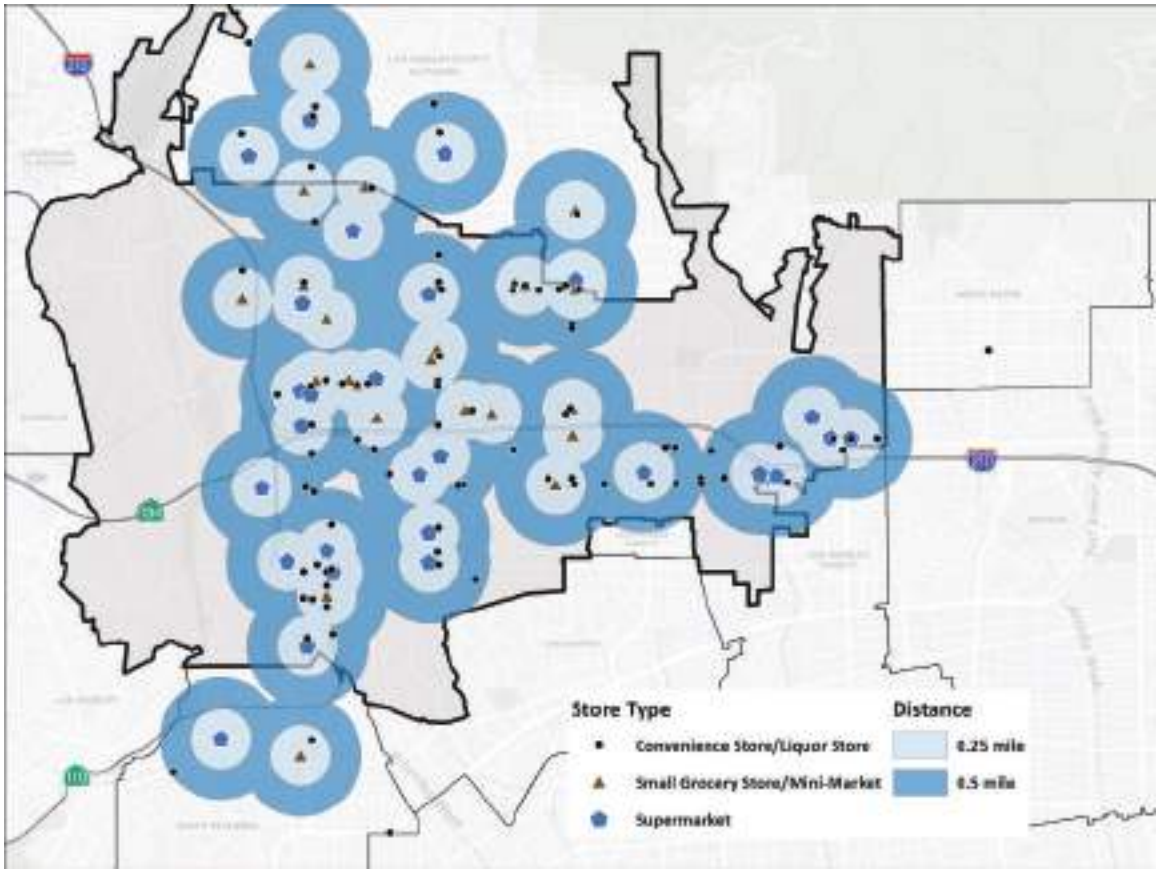
COMMUNITY RESOURCES

- In 2015, the **Pasadena City Council** adopted the **Early Child Development Policy** and formed the **City of Pasadena Office of the Young Child** to support activities that will move the community toward the goal of nurturing every child and creating an environment where young children are healthy, safe, and find early success in school and life.
- The **Maternal, Child, and Adolescent Health Outreach Program** of the Pasadena Public Health Department improves access to services for women, children and adolescents without health insurance. The program provides education on programs and resources available to the community.
- The **Black Infant Health Program** of the Pasadena Public Health Department aims to improve health among African American mothers and babies and to reduce disparities in maternal and infant health by helping women become empowered to make healthy choices for themselves, their families, and their communities.
- The **Childhood Lead Poisoning Prevention Program** of the Pasadena Public Health Department provides services to the community for the purpose of increasing awareness regarding the hazards of lead exposure, reducing lead exposure, and increasing the number of children assessed and appropriately blood tested for lead poisoning.
- The **Women, Infants and Children (WIC) Supplemental Nutrition Program** is a free nutrition program that helps pregnant women, new mothers, and young children eat well and stay health by providing special vouchers to purchase healthy food. WIC also provides breastfeeding support and information.

EXERCISE, NUTRITION, AND WEIGHT

- **Adult Exercise:** In 2009, 31% of San Gabriel Valley adults reported engaging in regular physical activity, 57.4% reported engaging in some physical activity, and 11.6% reported no physical activity.[27]
- **Youth Exercise:** In San Gabriel Valley, 60.2% of teens, ages 12 to 17, engaged in physical activity for at least one hour three or more times a week in 2013-2014.[22] This percentage was lower than the California percentage (70%).[22] In the Pasadena Unified School District, during the 2014-2015 school year, 55.4% of 7th grade students met the Healthy Fitness Zone standards for Aerobic Capacity, compared to 61.8% of students in Los Angeles County and 65.4% in California.[8]
- **Adult Nutrition:** In San Gabriel Valley, 65.8% of adults reported consuming fast food at least once in the past week, which is higher than the median value across all California counties in 2014 (56%).[11]
- **Youth Nutrition:** For the 2013-2014 measurement period, 54% of children and teens in San Gabriel Valley ate at least two servings of fruit in the previous day, which is lower than for children and teens in California (63%).[22]
- **Adult Weight:** In 2014, 34.9% of the adults in San Gabriel Valley reported being overweight (Body Mass Index (BMI) between 25.0-29.9) and 25.7% reported being obese (BMI>30.0). The percent of San Gabriel Valley males who are self-reported overweight or obese (73.6%) is higher than the percent of females (48.6%).[11]
- **Teen Weight:** In 2013-2014, 65.9% of San Gabriel Valley teens reported being normal weight.[22]

FIGURE 23. GROCERY AND CONVENIENCE STORES IN PASADENA, 2016[29]



- **Food Environment:** *Figure 23* illustrates the location of different types of grocery and liquor stores in Pasadena in 2016.[29] In areas where there is no grocery store or market within walking distance (0.5 mile), there is an opportunity to increase access to fresh foods and vegetables. Neighborhoods with a scarcity of markets with fresh fruits and vegetables result in limited affordability of, and access to, healthy food options. These areas are sometimes known as "food deserts." Areas where there is a convenience store, but no market within walking distance, may be candidates for a market conversion to increase the stocking of fresh fruits and vegetables.

TABLE 17. SUMMARY OF SCORED EXERCISE, NUTRITION, AND WEIGHT INDICATORS

EXERCISE, NUTRITION, AND WEIGHT *(TOPIC SCORE: 1.72)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
Child and Teen Fruit Consumption: 2 or more servings in previous day[11]	2014	54.0	%	2.70
Teens (12-17 yrs) who Engage in Regular Physical Activity: 3+ days/week[22]	2013–2014	60.2	%	2.70
Adult Fast Food Consumption[11]	2014	65.8	%	2.13
Adults who are Overweight or Obese[11]	2014	60.5	%	1.28
Adults who are Obese[11]	2014	25.7	%	1.18

COMMUNITY INPUT



Five out of ten key informants cited Access to Healthy Foods and/or Nutrition/Obesity Prevention (both sub-topics more broadly classified as Exercise,Nutrition, and Weight) as health needs in the Greater Pasadena service area.

Themes from the **Key Informant Interviews**

- Food deserts in the northwest and northeast areas of Pasadena are a barrier to healthy eating
- There is the need to ensure affordable access to healthy foods
- Limited high quality foods available
- Lack of knowledge about how to utilize affordable, healthy foods

Community Meeting Participants mentioned that the community could benefit from more information and data on nutrition and physical activity among seniors.

DIABETES

- **Diabetes Prevalence:** In 2014, 12.0% of the adult population in San Gabriel Valley reported having diabetes. This is higher than in either Los Angeles County (10.0%) or California (8.9%).[11]
- **Diabetes Outcomes and Complications:** Adults in Greater Pasadena were hospitalized due to uncontrolled diabetes (when a patient's blood sugar levels are not maintained within the recommended range) at a higher rate (1.2 hospitalizations per 10,000 population) than the median rate of all California counties (0.7 per 10,000).[26] The age-adjusted death rate due to diabetes in the city of Pasadena was 19.9 deaths per 100,000 population in 2015.[18]

TABLE 18. SUMMARY OF SCORED DIABETES INDICATORS

DIABETES *(TOPIC SCORE: 1.14)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
Adults with Diabetes[11]	2014	12.0	%	2.78
Age-Adjusted Hospitalization Rate due to Uncontrolled Diabetes[26]	2011–2013	1.2	hospitalizations/ 10,000 population 18+ years	2.48
Age-Adjusted Death Rate due to Diabetes[18]	2015	19.9	deaths/100,000 population	1.73
Age-Adjusted Hospitalization Rate due to Long-Term Complications of Diabetes[26]	2011-2013	9.0	hospitalizations/ 10,000 population 18+ years	0.98
Age-Adjusted Hospitalization Rate due to Diabetes[26]	2011–2013	14.5	hospitalizations/ 10,000 population 18+ years	0.70
Age-Adjusted ER Rate due to Uncontrolled Diabetes[26]	2011–2013	1.1	ER visits/10,000 population 18+ years	0.58
Age-Adjusted Hospitalization Rate due to Short-Term Complications of Diabetes[26]	2011–2013	4.0	hospitalizations/ 10,000 population 18+ years	0.58
Age-Adjusted ER Rate due to Diabetes[26]	2011–2013	15.7	ER visits/10,000 population 18+ years	0.23
Age-Adjusted ER Rate due to Long-Term Complications of Diabetes[26]	2011–2013	8.7	ER visits/10,000 population 18+ years	0.23

HEART DISEASE AND STROKE

- **Blood Pressure:** In 2014, 29.8 percent of San Gabriel Valley adults reported being diagnosed with high blood pressure.[11] The Healthy People 2020 target is 27%.[19]
- **Heart Disease and Stroke Deaths:** The death rate due to stroke (48.8 deaths per 100,000 population) and coronary heart disease (116.4 deaths per 100,000 population) for Pasadena adults was higher in 2015 than for California adults (34.4 deaths per 100,000 and 97 deaths per 100,000, respectively) *(Figure 24)*.[18]

FIGURE 24. AGE-ADJUSTED DEATH RATES FOR HEART DISEASE AND STROKE IN PASADENA, 2015[18]

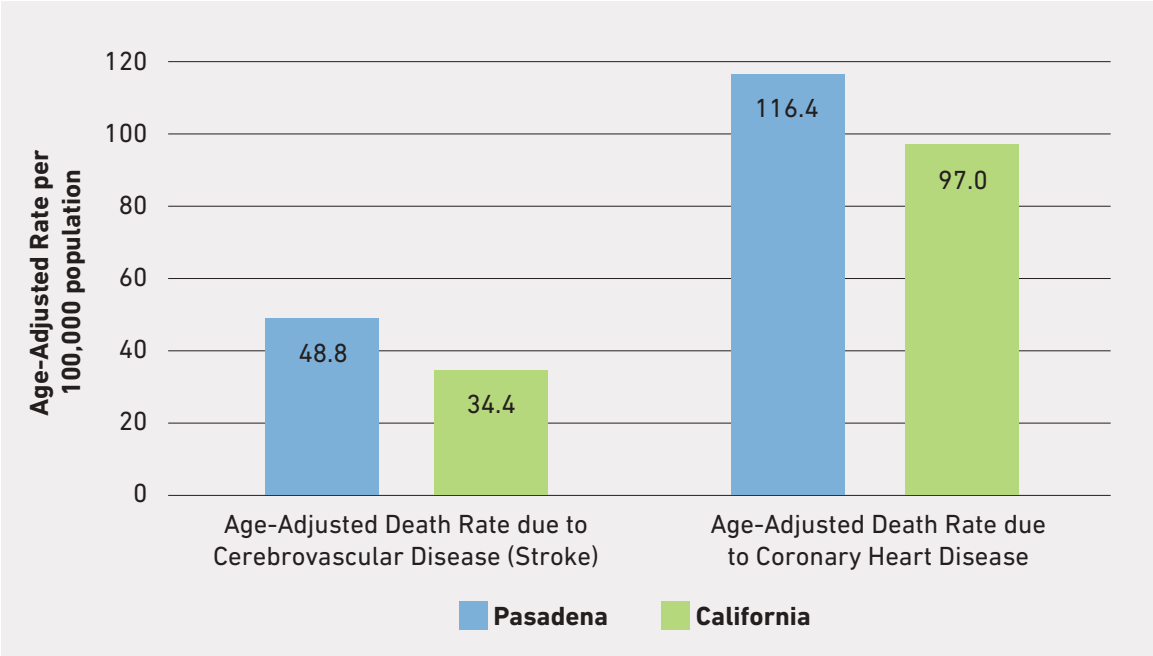


TABLE 19. SUMMARY OF SCORED HEART DISEASE AND STROKE INDICATORS

HEART DISEASE AND STROKE *(TOPIC SCORE: 1.67)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)[18]	2015	48.8	deaths/100,000 population	2.78
Age-Adjusted Death Rate due to Coronary Heart Disease[18]	2015	116.4	deaths/100,000 population	2.60
High Blood Pressure Prevalence[11]	2014	29.8	%	1.68
Age-Adjusted Hospitalization Rate due to Congestive Heart Failure[26]	2011-2013	18.6	hospitalizations/ 10,000 population 18+ years	0.73
Age-Adjusted ER Rate due to Congestive Heart Failure[26]	2011-2013	3.5	ER visits/10,000 population 18+ years	0.58

CANCER

- **Deaths due to Cancer:** Approximately 160 out of every 100,000 Pasadena residents died of cancer in 2015.[18] The community's most common type of cancer-related death is lung cancer, which increased from 21.4 to 34.9 deaths per 100,000 between 2014 and 2015.[18]
- **Lung Cancer:** Lung cancer was the fifth leading cause of premature death (before age 75) in the San Gabriel Valley, following coronary heart disease, liver disease, suicide and diabetes.[18] Lung cancer was the third leading cause of premature death among females in the San Gabriel Valley. Lung cancer was also the fifth leading cause of death in Pasadena following coronary heart disease, stroke, COPD, and pneumonia.

TABLE 20. SUMMARY OF SCORED CANCER INDICATORS

CANCER *(TOPIC SCORE: 1.26)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
Pap Test: Past 3 Years[25]	2007	79.5	%	2.25
Age-Adjusted Death Rate due to Lung Cancer[18]	2015	34.9	deaths/100,000 population	2.13
Age-Adjusted Death Rate due to Cancer[18]	2015	159.8	deaths/100,000 population	1.98
Colon Cancer Screening Compliant[27]	2009	67.4	%	1.35
Mammogram: Women ages 40+, Past 2 Years[30]	2011–2012	80.1	%	0.93
Age-Adjusted Death Rate due to Breast Cancer[18]	2015	14.3	deaths/100,000 females	0.58
Age-Adjusted Death Rate due to Prostate Cancer[18]	2015	9.0	deaths/100,000 males	0.53
Age-Adjusted Death Rate due to Colorectal Cancer[18]	2015	11.4	population	0.35

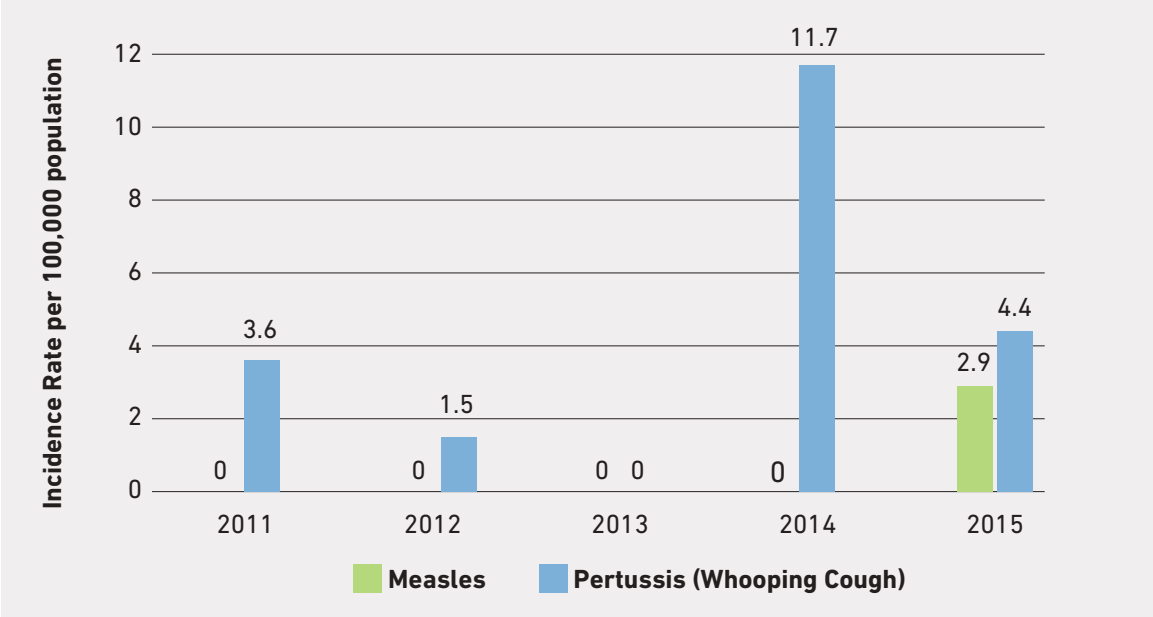
COMMUNITY RESOURCES

- Founded in 1982, **Cancer Support Community (CSC)** is an international non-profit organization providing free support, cancer education, and hope. They provide a robust calendar of events in Pasadena including nutrition, physical fitness, mental health support classes, and more.
- The **Huntington Cancer Center** delivers treatment options as well as care coordination and emotional support services to patients with cancer diagnoses.
- **Planned Parenthood of Pasadena and San Gabriel Valley** offers mammograms, pap smears, and human papilloma virus (HPV) screening services.

IMMUNIZATIONS AND INFECTIOUS DISEASES

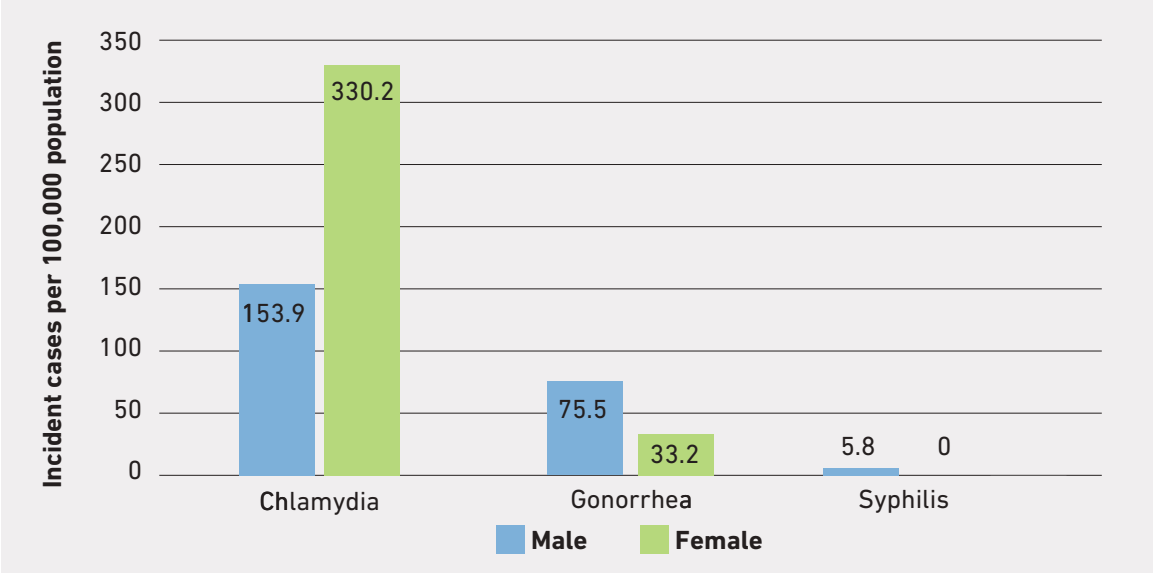
- **Immunizations**: In the Pasadena Unified School District, 86% of students completed mandatory vaccinations for the 2014-15 school year. One percent of students filed personal belief exemptions. As of October 2016, the immunization rates for PUSD increased to approximately 98%, reflecting school staff efforts to encourage completion of immunizations and the new California law that eliminated the personal belief exemption for children enrolled in public or private schools.[31]
- **Vaccine-Preventable Diseases:** Over the last few years there has been an increase in vaccine-preventable diseases in the United States, particularly in measles and pertussis (whooping cough) incidence. Increases in pertussis have been due, in part, to an increased number of unvaccinated individuals and changes in vaccine efficacy. Pertussis incidence has been observed to peak every three years, which could partly account for the spike in 2014. Measles, on the other hand, is rare in the United States, and outbreaks are generally limited to international exposures. In 2015, an outbreak linked to a Southern California amusement park caused a surge in measles cases throughout the state, including Pasadena (*Figure 25*), and largely among unvaccinated individuals.

FIGURE 25. RATES OF SELECTED VACCINE PREVENTABLE DISEASES IN PASADENA (2011-2015)[23]



- **HIV Prevalence**: The number of people living with HIV increased in Pasadena by almost 24% from 2011 to 2013.[32] This is in part due to increases in new cases, but also due to better treatment regimens and people living longer with HIV.
- **Disparities in Sexually Transmitted Infections (STIs):** In Pasadena, the incidence rate of gonorrhea and syphilis among males in 2014 was higher than among females. However, females had higher rates of chlamydia than males (*Figure 26*).[33]

FIGURE 26. SEXUALLY TRANSMITTED INFECTIONS (STIS) INCIDENCE BY GENDER IN PASADEN , 2014[33]



- **Vectorborne Diseases:** Vectorborne diseases are diseases transmitted by small organisms, or vectors. These organisms transmit pathogens and parasites from one infected person or animal to another, causing serious diseases. Common vectors include mosquitoes, ticks, and fleas. In Pasadena, the most commonly reported vectorborne diseases are West Nile virus, Lyme disease, and Typhus Fever. The 5-year average annual incidence rate from 2012 to 2016 was 0.29 cases of Lyme disease, 2.63 cases of Typhus Fever and 2.77 cases of West Nile virus per 100,000 residents in Pasadena.[23] As of December, 11 cases of Typhus Fever were confirmed for 2016, the highest number in at least 10 years.
- **Emerging Infectious Diseases:** Emerging Infectious Diseases (EIDs) are those whose incidence in humans has increased in the past two decades, including novel diseases, or those that threaten to increase in the near future. Since the last community health assessment, several EIDs posed new threats to U.S. populations, requiring local health departments to deploy resources to respond. In 2014-2015, local health departments in Pasadena and Los Angeles monitored people travelling from Ebola-affected areas of West Africa to prevent local spread of the disease. Additionally, recent research linking Zika virus infection with devastating symptoms like microcephaly have prompted health departments to form workgroups and task forces to mitigate the spread of the virus in the Greater Pasadena area and beyond.

TABLE 21. SUMMARY OF SCORED IMMUNIZATIONS AND INFECTIOUS DISEASES INDICATORS

IMMUNIZATIONS AND INFECTIOUS DISEASES *(TOPIC SCORE: 0.70)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
Age-Adjusted Death Rate due to Influenza and Pneumonia[18]	2015	19.9	deaths/100,000 population	2.63
Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza 65+[26]	2011-2013	3.4	hospitalizations/ 10,000 population 65+ years	1.63
Adults 65+ with Influenza Vaccination[11]	2014	71.3	%	1.45
Age-Adjusted Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza 18+[26]	2011-2013	0.9	hospitalizations/ 10,000 population 18+ years	0.80
Gonorrhea Incidence Rate[33]	2014	53.8	cases/100,000 population	0.78
Syphilis Incidence Rate[33]	2014	2.8	cases/100,000 population	0.58
Age-Adjusted ER Rate due to Bacterial Pneumonia 18+[26]	2011-2013	8.8	ER visits/10,000 population 18+ years	0.53
Chlamydia Incidence Rate[33]	2014	245.6	cases/100,000 population	0.53
Age-Adjusted ER Rate due to Hepatitis 18+[26]	2011-2013	0.4	ER visits/10,000 population 18+ years	0.38
Age-Adjusted Hospitalization Rate due to Hepatitis 18+[26]	2011-2013	1.5	hospitalizations/ 10,000 population 18+ years	0.38
Age-Adjusted Hospitalization Rate due to Bacterial Pneumonia 18+[26]	2011-2013	15.1	hospitalizations/ 10,000 population 18+ years	0.23
Tuberculosis Incidence Rate[23]	2015	0.7	cases/100,000 population	0.08

COMMUNITY RESOURCES

- In 2016, a new California State law **strengthened immunization requirements** for children entering child care or school to provide better protection against vaccine-preventable diseases.
- The Pasadena Public Health Department offers a variety of **low-to no-cost vaccines** to un- and underinsured community members through its Immunization Clinic.
- The Pasadena Public Heath Department offered **free vaccines to high-risk groups** to prevent the spread of disease following the 2015 measles outbreak associated with a Southern California amusement park and a regional bacterial meningitis outbreak. Flu vaccines are also offered annually at the Immunization Clinic and at community sites.
- Huntington Hospital Community Outreach Nurses provide **annual flu shot clinics** at sites throughout the community. The schedule is available on the Huntington Hospital website.

RESPIRATORY DISEASES

- **Asthma**: In San Gabriel Valley, 19.3% of children and teens had asthma in 2013-2014.[22] This was higher than in California (15%). In 2014, 11.8% of San Gabriel Valley adults had asthma, which is slightly lower than in California (13.8%).[11]
- **Influenza and Pneumonia**: In 2015, the age-adjusted death rate due to influenza and pneumonia was 19.9 deaths per 100,000 population.[18] This is slightly lower than the rate during the three preceding years (*Figure 27*).
- **Lung Cancer**: In 2015, the Age-Adjusted Death Rate due to Lung Cancer in Pasadena was higher than in 2014 (35.0 vs. 21.4 deaths per 100,000).[18]

FIGURE 27. DEATH RATE DUE TO INFLUENZA AND PNEUMONIA AS A CONTRIBUTING CAUSE OF DEATH IN PASADENA, 2012-2015[18]

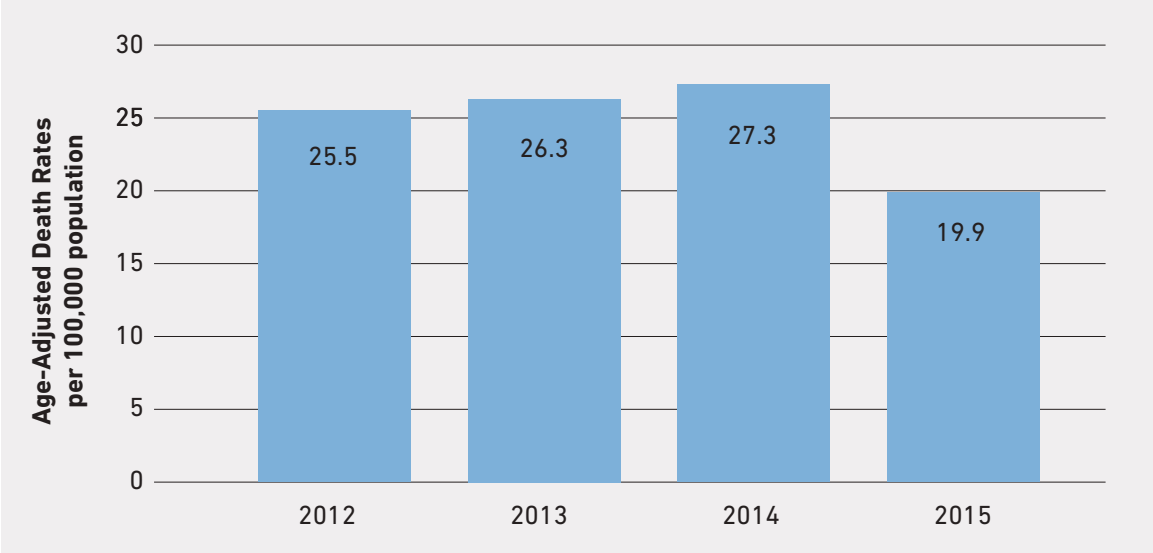


TABLE 22. SUMMARY OF SCORED RESPIRATORY DISEASES INDICATORS

RESPIRATORY DISEASES *(TOPIC SCORE: 0.94)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
Age-Adjusted Death Rate due to Influenza and Pneumonia[18]	2015	19.9	deaths/100,000 population	2.63
Children and Teens with Asthma[22]	2013-2014	19.3	%	2.63
Age-Adjusted Death Rate due to Lung Cancer[18]	2015	34.9	deaths/100,000 population	2.13
Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza 65+[26]	2011-2013	3.4	hospitalizations/ 10,000 population 65+ years	1.63
Adults 65+ with Influenza Vaccination[11]	2014	71.3	%	1.45
Age-Adjusted Hospitalization Rate due to Adult Asthma[26]	2011-2013	7.0	hospitalizations/ 10,000 population 18+ years	1.43
Age-Adjusted Hospitalization Rate due to Asthma[26]	2011-2013	7.0	hospitalizations/ 10,000 population	1.00
Age-Adjusted Hospitalization Rate due to COPD[26]	2011-2013	14.0	hospitalizations/ 10,000 population 18+ years	1.00
Age-Adjusted Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza[26]	2011-2013	0.9	hospitalizations/ 10,000 population 18+ years	0.80
Age-Adjusted Hospitalization Rate due to Pediatric Asthma[26]	2011-2013	6.9	hospitalizations/ 10,000 population under 18 years	0.68
Age-Adjusted ER Rate due to Asthma[26]	2011-2013	24.3	ER visits/10,000 population	0.53
Age-Adjusted ER Rate due to Bacterial Pneumonia[26]	2011-2013	6.4	ER visits/10,000 population 18+ years	0.53
Age-Adjusted ER Rate due to COPD[26]	2011-2013	6.4	ER visits/10,000 population 18+ years	0.43
Adults with Asthma[11]	2014	11.8	%	0.23
Age-Adjusted ER Rate due to Adult Asthma[26]	2011-2013	17.9	ER visits/10,000 population 18+ years	0.23
Age-Adjusted Hospitalization Rate due to Bacterial Pneumonia[26]	2011-2013	15.1	hospitalizations/ 10,000 population 18+ years	0.23
Tuberculosis Incidence Rate[23]	2015	0.7	cases/100,000 population	0.08

COMMUNITY RESOURCES

- The **Huntington Hospital Community Asthma Program** helps to decrease emergency room visits, hospitalizations, and absences from work and school. The program provides one-on-one asthma education, including an overview of asthma triggers and asthma medications. Participants receive asthma literature and handouts, in addition to free equipment (peak flow meter and spacer). The Asthma Clinic offers free asthma treatment to individuals who qualify for services.

INJURY PREVENTION AND SAFETY

- **Older Adult Injuries**: The rate of adults 65 years of age and older in Greater Pasadena hospitalized due to hip fractures in 2011-2013 was lower than the Healthy People 2020 targets: 350.3 hospitalizations/100,000 males 65+ and 641.9 hospitalizations/100,000 females 65+ compared to 418.4 and 741.2, respectively.[26]
- **Unintentional Injuries**: In 2015, Pasadena residents experienced approximately 19.0 deaths per 100,000 population due to unintentional injuries.[18] This rate is lower than the rate in California (28.2, 2012-2014).[34]

TABLE 23. SUMMARY OF SCORED INJURY PREVENTION AND SAFETY INDICATORS

INJURY PREVENTION AND SAFETY *(TOPIC SCORE: 0.95)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
Hospitalization Rate due to Hip Fractures Among Males 65+[26]	2011-2013	350.3	hospitalizations/ 100,000 males 65+ years	1.48
Hospitalization Rate due to Hip Fractures Among Females 65+[26]	2011-2013	641.9	hospitalizations/ 100,000 females 65+ years	1.03
Age-Adjusted Death Rate due to Unintentional Injuries[18]	2015	19	deaths/100,000 population	0.35

OTHER CONDITIONS

- **Hospitalization Rates**: In 2011-2013, Greater Pasadena residents 18 years or older were hospitalized due to dehydration (11.7 per 10,000 population) and urinary tract infections (14.8 per 10,000 population) at higher rates than California residents (4.9 and 13.2 per 10,000 population, respectively).[26]

TABLE 24. SUMMARY OF SCORED OTHER CONDITIONS INDICATORS

OTHER CONDITIONS *(TOPIC SCORE: 1.46)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
Age-Adjusted Hospitalization Rate due to Dehydration[26]	2011-2013	11.7	hospitalizations/ 10,000 population 18+ years	2.13
Age-Adjusted Hospitalization Rate due to Urinary Tract Infections[26]	2011-2013	14.8	hospitalizations/ 10,000 population 18+ years	2.03
Age-Adjusted ER Rate due to Dehydration[26]	2011-2013	12.3	ER visits/10,000 population 18+ years	1.28
Age-Adjusted ER Rate due to Urinary Tract Infections[26]	2011-2013	44.2	ER visits/10,000 population 18+ years	0.38

OLDER ADULTS AND AGING

- **Social and Economic Conditions**: More Pasadena residents 65 years and older lived below the poverty level (14.5%) in 2010-2014 than California residents overall (10%).[3] Additionally, more Pasadena adults 65 years and older lived alone (28.6%) than in the state overall (24%).[3]
- **Infectious Diseases**: Greater Pasadena had a higher hospitalization rate due to immunization-preventable pneumonia and influenza among people 65 years and older in 2011-2013 (3.4 hospitalizations per 10,000 population) than in 2010-2012 (1.9 hospitalizations per 10,000 population).[26]

TABLE 25. SUMMARY OF SCORED OLDER ADULTS AND AGING INDICATORS

OLDER ADULTS AND AGING *(TOPIC SCORE: 1.83)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
People 65+ Living Below Poverty Level[3]	2010-2014	14.5	%	2.78
People 65+ Living Alone[3]	2010-2014	28.6	%	2.63
Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza 65+[26]	2011-2013	3.4	hospitalizations/ 10,000 population 65+ years	1.63
Hospitalization Rate due to Hip Fractures Among Males 65+[26]	2011-2013	350.3	hospitalizations/ 100,000 males 65+ years	1.48
Adults 65+ with Influenza Vaccination[11]	2014	71.3	%	1.45
Hospitalization Rate due to Hip Fractures Among Females 65+[26]	2011-2013	641.9	hospitalizations/ 100,000 females 65+ years	1.03

COMMUNITY INPUT

None of the ten key informants specifically cited Older Adults and Aging as a need in the Greater Pasadena service area.

Community Meeting Participants identified many missing indicators and issues associated with senior health and aging. In particular, they requested more information on older adult poverty, dental care, specialty nutrition/education, mental health and dementia resources, substance abuse prevention, and elder abuse statistics.

COMMUNITY RESOURCES

- **The Pasadena Senior Center** is a local resource for seniors that provides services including: educational classes and lectures, events and activities designed for seniors, social services, and more.
- **Altadena Senior Center** offers services, programs and activities to promote senior independence and to encourage involvement in the community.
- **South Pasadena Senior Center** offers services and activities for older adults and is centrally located, adjacent to the library on Mission Street.
- **Huntington Hospital Senior Care Network** has assisted older adults and adults with disabilities to remain healthy and independent since 1984. Support programs are available for family caregivers.

MENTAL HEALTH

- **Mental Health Services**: In 2014, 9.8% of adults in San Gabriel Valley reported seeing a health care professional in the past year for emotional, mental health, or substance abuse recovery services.[11] This is a slight increase from the previous year (8.2%), but is lower than in Los Angeles County (13%) and California (12%).[11] In San Gabriel Valley, almost half (43.3%) of adults reported that they did not receive the mental health care they needed in 2013-2014, which is higher than the median value of all California counties (38%).[22]

TABLE 26. SUMMARY OF SCORED MENTAL HEALTH INDICATORS

MENTAL HEALTH *(TOPIC SCORE: 0.94)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
Adults Needing and Receiving Mental Health Care[22]	2013-2014	56.7	%	1.73
Adults with Likely Psychological Distress[22]	2013-2014	5.3	%	0.73
Age-Adjusted Death Rate due to Suicide[18]	2015	8.6	deaths/100,000 population	0.35

COMMUNITY INPUT



Six out of ten key informants cited Mental Health as a health need in the Greater Pasadena service area.

Themes from the **Key Informant Interviews**:

- Attention needed on mental well-being issues as part of health
- Limited resources for mental health
- Need more focus on depression, anxiety, and role of social media among youth

Community Meeting Participants felt that there are not enough child psychiatry providers, and that possible reasons for this include the liabilities of working with children or language barriers.

COMMUNITY RESOURCES

- An annual Greater Los Angeles **Out of the Darkness Walk** is held in Pasadena to raise awareness, fund scientific research, and provide resources and aid to those affected by suicide.
- The Pasadena Public Health Department's **Maternal, Child, and Adolescent Health Program** hosted a Call to Action Conference on Adverse Childhood Experiences and Trauma-Informed Care in 2015 and a follow-up conference in 2016 in order to increase community awareness of these issues and to provide skills training to medical and social services providers who serve youth and families.
- **Foothill Family Services** conducts programs that include mental health and counseling services, child abuse prevention and treatment, and domestic violence prevention and treatment.
- **Rose City Center** was founded in 2004 by a group of Pasadena area mental health professionals to provide therapy services for low-to-moderate income populations.
- **Five Acres** provides mental health services for children, teens and families with school-based counseling and intensive services for severely emotionally disturbed children.
- **Pasadena Mental Health Advisory Committee (PMHAC)** is a voluntary group aimed at improving the overall mental health and wellness of the Pasadena community. Through educational forums, community partner collaboration, and the annual Pasadena Mental Health Day celebration, PMHAC strives to destigmatize mental illness and increase access to high quality mental health services for the City's most vulnerable. PMHAC welcomes people interested in learning about improving mental health in the community.
- **Young and Healthy** provides training to medical and social services providers on trauma-informed care.

SUBSTANCE ABUSE

- **Alcohol Abuse:** In San Gabriel Valley, 28.8% of adults reported binge drinking in the past year in 2014. More adult males in San Gabriel Valley reported binge drinking (40.4%) than females (18.3%).[11] In 2011-2013 the rate of adult hospitalizations due to alcohol abuse in Greater Pasadena was 12.7 hospitalizations per 10,000 population, which was higher than in California (8.2).[26]
- **Drug Poisoning Deaths**: There were 43 deaths associated with drug poisoning from 2012 to 2015 among Pasadena residents.[23]
- **Adult Smoking:** In San Gabriel Valley, 10.6% of residents reported being current smokers in 2014, which is slightly lower than in Los Angeles County (10.8%). More adult males in San Gabriel Valley reported smoking (17.6%) than females (4.3%). Of the people who have ever smoked in the San Gabriel Valley, almost 28% of them still smoke every day and about 60% have quit.[11]
- **Youth Smoking**: The use of electronic cigarettes (e-cigarettes) among teens is a new public health risk. In the Pasadena Unified School District during the 2014-2015 school year, 16% of 7th grade students, 29% of 9th grade students, and 34% of 11th grade students reported having ever tried e-cigarettes (*Figure 28*).[35]

F GURE 28. SMOKING HISTORY AMONG PASADENA UNIFIED SCHOOL DISTRICT STUDENTS, 2014-2015[35]

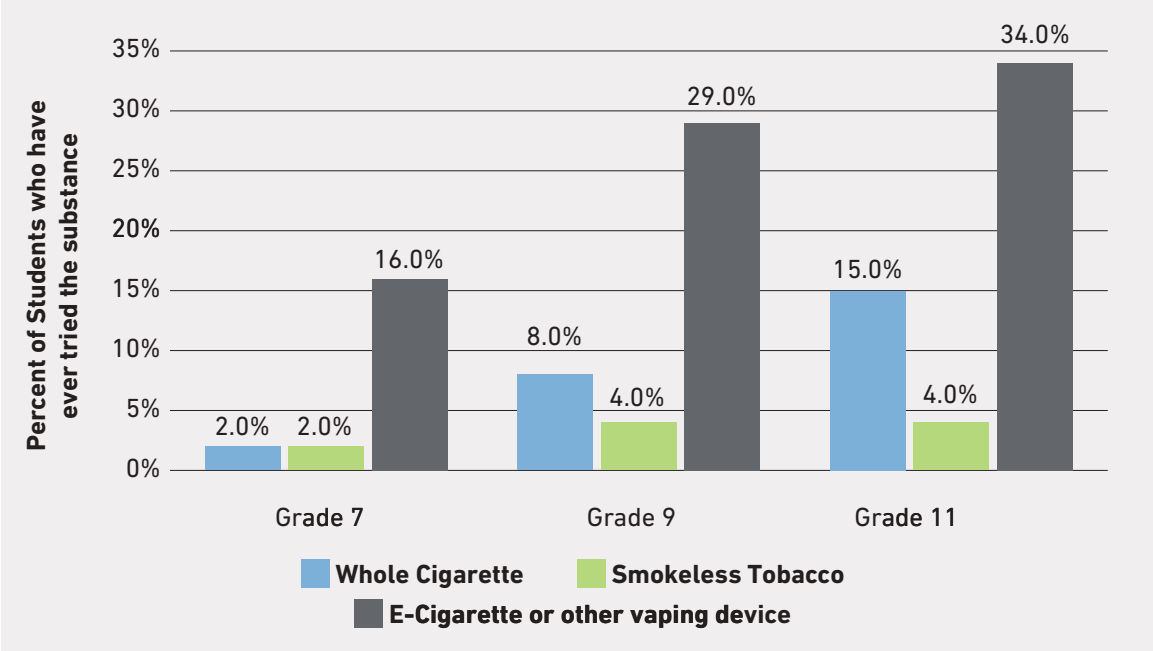


TABLE 27. SUMMARY OF SCORED SUBSTANCE ABUSE INDICATORS

SUBSTANCE ABUSE *(TOPIC SCORE: 0.94)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
Age-Adjusted Hospitalization Rate due to Alcohol Abuse[26]	2011-2013	12.7	hospitalizations/ 10,000 population 18+ years	2.70
Teens who have Ever Used Alcohol[22]	2013-2014	22.4	%	0.93
Adults who Binge Drink: Past Year[11]	2014	28.8	%	0.83
Age-Adjusted ER Rate due to Alcohol Abuse[26]	2011-2013	27.8	ER visits/10,000 population 18+ years	0.58
Adults who Smoke[11]	2014	10.6	%	0.38
Age-Adjusted Death Rate due to Drug Use[18]	2015	7.1	deaths/100,000 population	0.23

COMMUNITY RESOURCES

- On July 11, 2011, Pasadena City Council unanimously approved amendments to the City's **Tobacco Use Prevention Ordinance** to prohibit smoking in apartments and condominiums to protect residents from drifting tobacco smoke. This policy includes e-cigarettes.
- In 2014 the City of Pasadena passed a **Smoke Free Library policy** that prohibited smoking (including e-cigarette use) at all city-owned public libraries.
- In June 2016, **a new California state law** went into effect that raised the legal smoking age from 18 to 21.

MORTALITY

- **Death Rates:** In 2015, Pasadena had higher death rates when compared to the median of California counties for the following causes of death: cerebrovascular disease (stroke), influenza and pneumonia, coronary heart disease, lung cancer, all cancers, and diabetes (these measures received indicator scores above 1.5).[18]
- **Life Expectancy:** Females had higher life expectancy than males in Pasadena; according to 2015 estimates, females were expected to live to 81.2 years, and males to 75.8 years.[23]

TABLE 28. SUMMARY OF SCORED MORTALITY INDICATORS

MORTALITY *(TOPIC SCORE: 1.13)*				
Indicator	**Period**	**Value**	**Unit**	**Score**
Age-Adjusted Death Rate due to Influenza and Pneumonia[18]	2015	19.9	deaths/100,000 population	2.63
Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)[18]	2015	48.8	deaths/100,000 population	2.78
Age-Adjusted Death Rate due to Coronary Heart Disease[18]	2015	116.4	deaths/100,000 population	2.60
Age-Adjusted Death Rate due to Lung Cancer[18]	2015	34.9	deaths/100,000 population	2.13
Age-Adjusted Death Rate due to Cancer[18]	2015	159.8	deaths/100,000 population	1.98
Age-Adjusted Death Rate due to Diabetes[18]	2015	19.9	deaths/100,000 population	1.73
Age-Adjusted Death Rate due to Breast Cancer[18]	2015	14.3	deaths/100,000 females	0.58
Age-Adjusted Death Rate due to Prostate Cancer[18]	2015	9.0	deaths/100,000 males	0.53
Age-Adjusted Death Rate due to Colorectal Cancer[18]	2015	11.4	deaths/100,000 population	0.35
Age-Adjusted Death Rate due to Suicide[18]	2015	8.6	deaths/100,000 population	0.35
Age-Adjusted Death Rate due to Unintentional Injuries[18]	2015	19.0	deaths/100,000 population	0.35
Age-Adjusted Death Rate due to Drug Use[18]	2015	7.1	deaths/100,000 population	0.23
Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions[18]	2015	3.9	deaths/100,000 population	0.23
Infant Mortality Rate[23]	2015	3.2	deaths/1,000 live births	0.23

VII. Prioritization

OVERVIEW

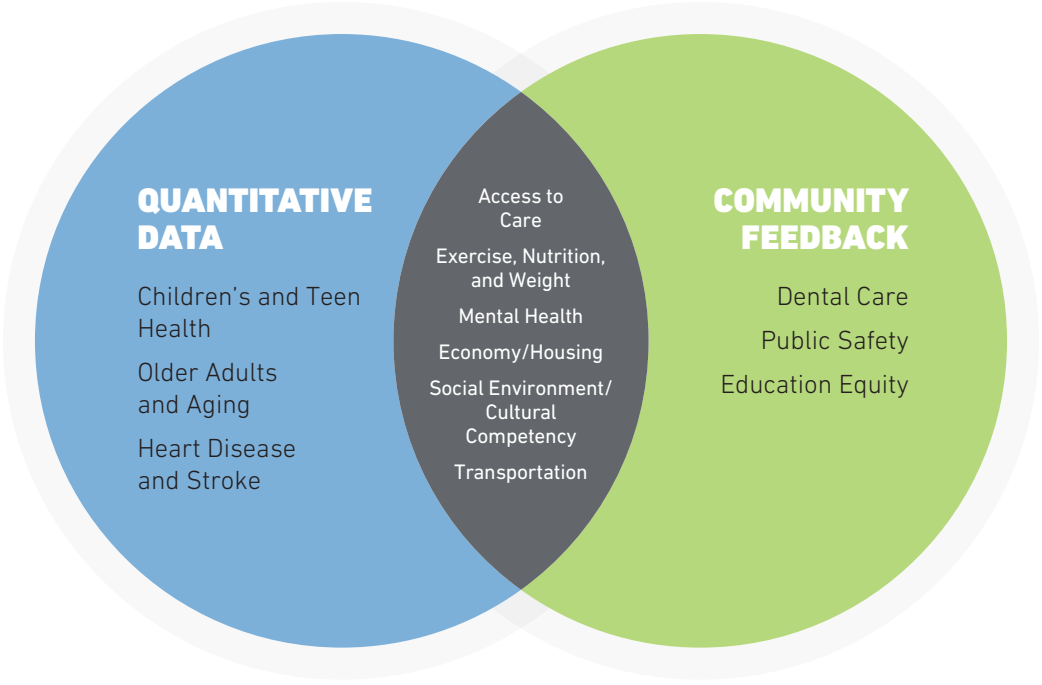
The fourth step in the Community Health Needs Assessment Process was selecting priorities and identifying resources. The following prioritization process was conducted by Huntington Hospital in order to identify important health issues that require attention over the next three years. The City of Pasadena Public Health Department will conduct a separate, broader, city-wide prioritization during the Community Health Improvement Plan (CHIP) planning process.

The prioritization of health issues for Huntington Hospital was divided into two phases: 1) synthesizing the health indicators and the community feedback into the most pressing health issues and 2) identifying the top health issues for which Huntington Hospital has the resources to address.

PROCESS

The quantitative and qualitative data were analyzed and synthesized to determine the mos critical and significant health needs for the Greater Pasadena community. *Figure 29* below lists the top health needs by data type and highlights areas of overlap. The blue circle identifies the three topic areas where there was strong evidence of need based on the quantitative data alone, and the green circle identifies the three topic areas where there was strong evidence based on the community feedback alone. The area in the middle identifies the six topic areas with strong evidence of need for both types of data.

FIGURE 29. SIGNIFICANT HEALTH NEEDS BY DATA SOURCE IN GREATER PASADENA



On June 28, 2016, leaders from Huntington Hospital, along with invited representatives from Pasadena Public Health Department, met to review and discuss the preliminary top twelve significant health needs as determined by the community input and quantitative data analysis.

Following the data presentation, consultants from HCI led participants through the Hanlon Method for prioritization.[36] Participants rated each of the twelve significant health needs on a scale of zero to ten based on the following specified criteria:

1. Size of the Health Problem: How many persons does the problem affect? Size of heath problem should be based on baseline data.
2. Seriousness of Health Problem: What degree of hospitalization, disability, or premature death occurs because of the problem? What is the impact on quality of life? Does it require immediate attention? Is there public demand? What are the potential burdens to the community, such as economic or social burdens?
3. Effectiveness of Interventions: Is the problem amenable to interventions (i.e. is the intervention feasible scientifically as well as acceptable to the community?) Is the problem preventable? Are there evidence-based practices available?

TABLE 29. HANLON METHOD RATING GUIDE FOR PRIORITIZATION

THE HANLON METHOD CRITERIA RATING			
Rating	**Size of Health Problem** *(% of population w/ health problem)*	**Seriousness of Health Problem** *(Severity of the health problem)*	**Effectiveness of Intervention** *(Are evidence-based interventions available and effective)*
9 or 10	Very Large (>25%)	Very Serious	80%-100% effective
7 or 8	Relatively Large	Relatively Serious	60%-80% effective
5 or 6	Medium	Serious	40%-60% effective
3 or 4	Small	Moderately Serious	20%-40% effective
1 or 2	Relatively Small	Relatively Not Serious	5%-20% effective
0	Very Small (50/100,000)	Not Serious	<5% effective

With all twelve health topics scored and weighted according to the Hanlon Method, the group applied the 'PEARL' Test to screen out health problems based on the following feasibility factors:

- Propriety – Is a program for the health problem suitable?
- Economics – Does it make economic sense to address the problem? Are there economic consequences if a problem is not addressed?
- Acceptability – Will a community accept the program? Is it wanted?
- Resources – Is funding available or potentially available for a program?
- Legality – Do current laws allow program activities to be implemented?

Health topics which received an answer of "No" to any of the above factors were eliminated. Priority scores were calculated for the remaining health problems and rank was assigned accordingly.

RESULTS

The aggregate ranking for the six topics that passed the PEARL test can be seen in *Table 30.*

TABLE 30. PRIORITIZED HEALTH NEEDS

HEALTH TOPIC	PASSED PEARL TEST?	RANK
Access to Health, Mental, and Dental Care	Y	1
Heart Disease and Stroke	Y	2
Children's Health / Teen and Adolescent Health	Y	3
Mental Health	Y	4
Older Adults and Aging	Y	5
Exercise, Nutrition, and Weight	Y	6

The following six health needs were eliminated during the PEARL test based on the condition of 'propriety'. Participants agreed there were no programs in these topic areas that would be suitable for Huntington Hospital to develop or lead.

- Dental Care
- Public Safety
- Economy / Affordable Housing
- Transportation
- Social Environment / Cultural Competency
- Education Equity

PARTICIPANTS

Huntington Hospital

- Alison Birnie, RN, Director, Critical Care
- John Carmody, MD, Medical Director, Huntington Ambulatory Care Center
- Cathi Chadwell, Executive Director, Public Affairs
- Jane Haderlein, Senior Vice President, External Affairs
- Marcia Penido, LCSW, Director, Care Coordination, Social Work, Palliative Care
- Sheryl Rudie, Executive Director, Ambulatory Services
- Lois Zagha, Manager, Community Outreach Services and Community Benefits

Pasadena Public Health Department

- Michael Johnson, MPA, Director
- Ying-Ying Goh, MD, MSHS, Health Officer
- Matthew Feaster, MPH, Epidemiologist

VIII. Conclusion

The **2016 Community Health Needs Assessment of Greater Pasadena** utilized a broad set of quantitative and qualitative data to determine the greatest health needs in the Greater Pasadena service area. The findings of this report will be used to identify the best strategies to address the health needs of our community, such as developing new programs, enhancing existing programs, and building new partnerships. The Huntington Hospital Implementation Strategy will identify which prioritized areas of need Community Benefits will focus on over the next three years. The Pasadena Public Health Department will conduct a city-wide prioritization to identify health issues that will be addressed in the next Community Health Improvement Plan (CHIP) for Pasadena.

Members of the community are invited to provide feedback and comments on this report through the Healthy Pasadena website (www.healthypasadena.org).

Appendices

APPENDIX A:
COMMUNITY HEALTH NEEDS ASSESSMENT PROGRESS REPORTS



2013 COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGY

YEAR ONE PROGRESS REPORT-2014

BACKGROUND

In 2013, Huntington Hospital conducted the triennial Community Health Needs Assessment, per federal requirements, reporting its findings to the Board of Directors of the hospital, the Community Benefits Committee, and the greater community. Findings were based on 1) community feedback gathered during the Community Health Improvement Plan (CHIP) process conducted by the Pasadena Public Health Department, with participation of over fifty community partners familiar with the needs of uninsured, low-income, marginalized and other high needs groups in Pasadena, and 2) an analysis of secondary data through http://www.HealthyPasadena.org, which includes a comprehensive dashboard of over 100 community health and quality of life indicators covering over 20 topic areas.

Under the leadership of Cathi Chadwell, Executive Director of Public Affairs, a work group composed of Huntington leaders with specific community and clinical knowledge was established to prioritize the significant community needs based on criteria important to the hospital, including:

- Alignment with Huntington Hospital strengths, mission, and resources
- Opportunity for partnership
- Solutions that impact multiple problems
- Availability of feasibility-effective methods

Results were presented to the hospital's Executive Management Team which selected the following prioritized needs:

- Cancer, with a focus on breast cancer and screening
- Immunization, with a focus on vaccination

2014 GOALS

The short-term objectives for year one of the three-year period in which we will focus on the two prioritized needs are:

Cancer

- Develop a plan in partnership with community partners to increase access to mammograms.
- Inventory current community resources for education about breast cancer screening and investigate best practices.

Immunizations

- Develop a plan with partner community organizations to increase influenza vaccinations among adults 65 and older.
- Inventory current community resources for education about flu vaccinations and investigate best practices.

PROCESS

The following Community partners were engaged to develop strategies for goal achievement.

CANCER WORK GROUP:

Cathi Chadwell, Executive Director, External Affairs — Huntington Hospital
Sharon Carrillo, Manager, Cancer Data Center — Huntington Hospital
Edna DeLeon, MSN, Director of Quality and Clinical Research — Huntington Hospital
Bethany Eshleman, CEO — Planned Parenthood of Pasadena
Rosalie Garcia, Executive Director — Bill Moore Clinic, URDC
Julianne Hines, VP, External Affairs — Planned Parenthood of Pasadena
Adrienne Kung, MPH — Pasadena Public Health Department
Margie Martinez, CEO — Community Health Alliance of Pasadena (ChapCare), FQHC
Sheryl Rudie, Executive Director, Ambulatory Services — Huntington Hospital
Cathy Vesolowski, VPO-Hill Imaging Center, Huntington — Hill Breast Center
Eric Walsh, MD, DPH, Chief Health Officer — Pasadena Public Health Department
Lois Zagha, Manager, Community Outreach and Community Benefits — Huntington Hospital

IMMUNIZATION WORK GROUP:

Cathi Chadwell, Executive Director, External Affairs — Huntington Hospital
Rosalie Garcia, Executive Director — Bill Moore Clinic
Margie Martinez, CEO — Community Health Alliance of Pasadena (ChapCare), FQHC
Jean Pallares, Director, Pharmacy and Laboratory Services — Huntington Hospital
Carla Partma, RN, Community Outreach Health Practitioner — Huntington Hospital
Leticia Saenz, PHN — Pasadena Public Health Department
Lois Zagha, Manager, Community Outreach and Community Benefits — Huntington Hospital

Community partners participated in workgroup meetings conducted at Huntington Hospital. Each group engaged in a parallel process in which:

- Goal selection was reviewed and consensus reached with regard to how best to gather data and measure improvement
- Current practices were described by each provider
- Resources and best practices were identified
- Brainstorming to design effective approach to goal achievement was conducted

BREAST CANCER SCREENING: MAMMOGRAPHY

Research has found that while breast cancer is not always preventable, women can mitigate risk factors by adhering to healthy lifestyle practices such as regular physical activity, weight control, and limiting alcohol consumption. The American Cancer Society recommends that all women perform routine self-exams and report any changes to their physicians. Women are also encouraged to have routine screenings at their medical visits, such as clinical breast exams. Screening mammograms offer the best way to detect cancers in the early stages when treatment is more likely to be efficacious. By raising women's awareness that a screening mammogram has the potential to save their lives, we hope to reduce the death rate attributable to breast cancer in our community.

WORKGROUP DISCUSSION

Data Collection and Measuring Progress:

The group engaged in discussion around how to realistically collect data to determine goal success. It was agreed that:

- Screening mammography is the best tool we currently have to detect breast cancer in its earliest stages when it can respond to treatment, thus preventing death.
- Given the lag in public health reporting which makes it difficult to acquire real-time data, it was decided that a specific group would be identified for measuring progress: women 40 years and older* who are patients of workgroup partnering organizations.
- The volume of screening mammograms for women 40 and older will be reported to Huntington Hospital for each of three years, 2014, 2015, and 2016. Data for 2014 will be used a baseline. At the end of the three year period we hope to see a 10% increase in screening mammograms for the identified group.
- Providers volume of screening mammograms for women 40 and older will be reported to Lois Zagha of Huntington Hospital on the following schedule:

**Based on American Cancer Society guidelines*

TIME PERIOD	DATA SUBMISSION DUE
January 1, 2014 – June 30, 2014	July 15, 2014
July 1, 2014 – December 31, 2014	January 15, 2015
January 1, 2015 – June 30, 2015	July 15, 2015
July 1, 2015 – December 31, 201	January 15, 2016
January 1, 2016 – June 30, 2016	July 15, 2016
July 1, 2016 – December 31, 2016	January 15, 2017

Note: Data does not include Bill Moore Clinic due to 2014 closure.

ACCESS TO SERVICES:

A sector of the population of Pasadena is uninsured/underserved women 40 years and older. Huntington Hospital convened a group of community partners in early 2013 to address the issue of access to healthcare in Pasadena. The *Covered Pasadena* initiative grew out of this collaboration (see attachment). The number of newly insured women has increased over the past year, in large part due to the efforts of this group.

During the enrollment process women are referred to community healthcare providers such as ChapCare, Bill Moore Clinic, and the Huntington Ambulatory Care Center. Patients who visit their new medical home are educated by their physician about the importance of routine health screenings, including breast cancer screening, and are referred for screening mammograms when appropriate.

Services are available to all sectors of the population, including patients who cannot pay for services. Bill Moore Clinic,* whose patients are predominantly the uninsured, has agreements with Madison Radiology and City of Hope. ChapCare refers patients with insurance to Huntington-Hill Imaging Center and utilizes a mobile provider at its clinic sites. Planned Parenthood of Pasadena partners with White Memorial Hospital. Huntington Ambulatory Care Center (HACC) refers women to Huntington–Hill Imaging Center. The HACC social worker assists women who are unable to pay for a mammogram to obtain services through funding made available by hospital donors. Huntington-Hill offers a reduced rate to patients unable to pay for mammography. Patients in the community may not be aware of these resources. As the number of insured grows, these beneficiaries will have access to physicians who will counsel them about screening and make appropriate referrals. In addition, community health workers, such as Huntington Hospital's Community Outreach nurses, provide education, counseling, and referrals on a regular basis in the community. Information about the location and schedule of community screening sites is posted on the Hospital website, shared with community partners, and posted in newsletters and at the various sites which include, libraries, senior and community centers, and faith organizations.

Patients with medical homes who visit their providers at least annually are educated by their physicians about the importance of breast cancer screening. Physicians help the individual patient to make decisions about when to begin having screening mammograms based on family history and other relevant factors. Referrals are made to imaging providers.

**Bill Moore Clinic ceased operations in 2014.*

Women who are newly insured, as well as those who are not knowledgeable about breast cancer and the importance of screening, need to be reached. This will be accomplished in a variety of ways:

- Huntington Hospital has developed an informational card to be disseminated throughout the community, particularly targeting the underserved. The card presents a brief but impactful message empowering women to be screened for breast cancer, and provides the names and contact information for the three healthcare providers in Pasadena where they can see a physician to discuss their options and receive appropriate referrals. (see attached)
- Huntington Community Outreach nurses have developed a class called "An Ounce of Prevention," which addresses the various cancer screenings recommended for adults, including breast cancer.
- Community Outreach nurses work closely with partnering organizations in Greater Pasadena to identify opportunities to reach the underserved population. Services include education, counseling, referral, and problem-solving assistance in both English and Spanish. Currently, nurses are working with Villa Parke, Pasadena Unified School District, and other locations where women gather in the community, to offer education about women's health issues, including breast health and cancer prevention.
- Community Outreach nurses will partner with Villa Parke Community Center and the American Cancer Society to provide education and screening information to women who attend VPCC activities, and spread the message through a well-establish informal community network.
- HH's Breast Center physicians and nurse navigators conduct several community education events throughout the year. In addition, a quarterly e-newsletter, written by Dr. Jeannie Shen was initiated in 2014, providing information, recommendations, illustrations and videos, such as demonstration of self-breast examination. Frequent mailings go out to 40+ women in the community.
- Huntington Hospital Breast Center staff provide education, services and support to women in the Chinese Community at Herald Cancer Center in Rowland Heights.
- A partnership between the hospital and Pasadena Fire Department raised funds during Breast Cancer Awareness Month to support free mammograms for underserved women.
- In 2013 ChapCare entered into a relationship with Occidental College to bring a Health Leads-type program to its Pasadena clinic. Based on recommendations "prescribed" by physicians, students assist patients to obtain the health and psychosocial services they need to support positive health outcomes. Students follow-up on physician recommendations and maintain contact with patients between medical appointments to promote follow-up. This additional support system provides reinforcement to physician-initiated medical interventions, education and referrals.

BASELINE DATA COLLECTION YEAR ONE

ChapCare reported the number of patients whose mammograms were performed by the mobile imaging provider (354), Planned Parenthood reported the number of patients who received screening mammograms at White Memorial Hospital (179), and Huntington-Hill reported the number of screening mammograms performed on women 40 and older (28,261) in 2014 totaling **28,794**.

Immunization: Influenza Vaccination

According to the Centers for Disease Control and Prevention, it has been widely recognized for many years that people 65 years and older are at greater risk of serious complications from the flu compared to young, healthy adults. Influenza is a viral infection that attacks the respiratory system —the nose, throat and lungs, often leading to pneumonia in older adults. Older adults tend to have more medical co-morbidities and are at higher risk for complications. In fact, influenza and its complications can be deadly for people 65 years and older.

It is estimated that 90 percent of seasonal flu-related deaths, and more than 60 percent of seasonal flu-related hospitalizations in the United States each year occur in older adults.

The best way to prevent the flu is with a flu vaccination. The CDC recommends that everyone 6 months of age and older be vaccinated annually as vaccine becomes available in the community. Flu vaccine protects against flu viruses that research anticipates will be most common during a particular flu season. The vaccine is updated annually. Immunity sets in within approximately two weeks after being vaccinated. Immunity wanes over the course of a year, therefore annual vaccination is recommended.

Education is an essential component in persuading people to get vaccinated. Receiving this information from a trusted healthcare provider is often key to positively influencing reluctant patients.

AVAILABILITY OF VACCINE

Huntington Hospital has offered free flu shots to the public for many years. Formal, pre-scheduled flu shot clinics at multiple community locations were introduced in 2007. This took the service out into the community to reach people in places they frequent in the course of daily activities. Flu shot clinic sites include senior and community centers, senior housing, public libraries, faith-based organizations, and health fairs. Over the years the number of flu clinics has grown to over 30 sites with over 2,000 flu shots administered annually. Community outreach orders vaccine through the HH pharmacy department each December for the following flu season. During the 2014 flu season HH Community Outreach nurses offered the quadrivalent* vaccine at 32 community flu clinics and vaccinated 2,505 individuals, 26 percent of which was given to adults 65 and older.

Flu shots are provided in other ambulatory service departments of Huntington Hospital including the HH Ambulatory Care Center and the Medication Therapy Management Clinic.

Flu shots are also given to hospitalized patients who have not been vaccinated prior to admission, in line with best practices which dictate that patients' immunization record be reviewed at the time of admission and vaccination be offered as indicated.

Pasadena Public Health Department receives an annual supply of influenza vaccine from the Los Angeles County Health Department. PPHD public health nurses offer free flu shots at senior centers, schools in the Pasadena Public School District, health fairs, farmers' markets and other community locations. HH Community Outreach nurses work closely with PPHD nurses to coordinate efforts to maximize the vaccine supply and avoid duplication of efforts. HH CO nurses assist PPHD nurses to administer flu shots at one or more of their scheduled flu clinic locations each year. The health department offered trivalent vaccine during the 2014 flu season. PPHD administered 887 vaccinations in 2014, 18 percent of which were to adults 65 and older.

ChapCare, a Federally Qualified Health Clinic, provides flu shots to its patients of all ages. Patients' physicians recommend the influenza vaccine to patients at the time of their visits, and other methods of reminding patients are employed as well. A total of 2,093 ChapCare patients received vaccinations this flu season, 5 percent of which were adults 65 and older.

A great number of older adults living in Pasadena are Medicare beneficiaries and receive the annual flu shot during a visit to their healthcare provider or at retail clinics. A segment of the older adult population do not have a medical home because they are residually uninsured and are unaware of no cost services. Some elect not to visit a provider.

A segment of the older adult population subscribe to various beliefs and misinformation such as:

- Regarding oneself as healthy, active and independent, thus not needing vaccination
- Believing they are not at risk from dying from influenza even though they recognized it could be fatal for particular groups of people
- Influenza vaccine is unsafe
- Influenza vaccine is not effective in older people
- Side-effects are problematic
- Being vaccinated can give you the flu or make you sick

Older adults should be encouraged to accept vaccination against this vaccine-preventable disease. To increase the rate of immunization of seniors in our community and track progress, our approach will include:

- Collect baseline data (number of flu shots provided to adults 65+ in 2014) by all healthcare provider partners, and continue to collect annual volume of flu shots provided to this population in 2015 and 2016 to determine progress by end of 2016 flu season.
  Continue to provide education about vaccination at physician visits, health fairs and other community events, screening/counseling sites, and by offering a specific class about vaccinations and screenings ("An Ounce of Prevention") at various community sites where seniors gather.
- Disseminate various brief, printed informational material in the community, including:
  - *Get the flu shot, not the flu.* (Produced by Huntington Hospital)
  - *No More Excuses: You Need a Flu Vaccine* (USDHHS-CDC)
  - *Influenza Vaccine-What You Need to Know* (USDHHS-CDC)

Community Outreach received calls from a few older adults inquiring whether the hospital provides Fluzone High-Dose vaccine which their physicians were recommending. Callers were informed that the hospital offers quadrivalent vaccine only. There has been debate in the field of immunology and public health around whether the* **higher dose vaccine produces a better immune response in adults 65 and older. *Data from clinical trials comparing regular Fluzone to Fluzone High-Dose among persons aged 65 years or older indicate that a stronger immune response (i.e., higher antibody levels) occurs after vaccination with Fluzone High-Dose. Whether or not the improved immune response leads to greater protection against influenza disease after vaccination is not yet known. An ongoing study designed to determine the effectiveness of Fluzone High-Dose in preventing illness from influenza compared to Fluzone is expected to be completed in 2014-2015.*

2013 COMMUNITY HEALTH NEEDS ASSESSMENT

YEAR TWO PROGRESS REPORT 2015

BACKGROUND

In 2013 Huntington Hospital conducted a triennial Community Health Needs Assessment, per federal requirements, reporting its findings to the Board of Directors of the hospital, the Community Benefits Committee, and the greater community. Findings were based on 1) community feedback gathered during the Community Health Improvement Plan (CHIP) process, conducted by the Pasadena Public Health Department, with participation of over fifty community partners familiar with the needs of uninsured, low-income, marginalized and other high needs groups in Pasadena, and 2) an analysis of secondary data through http://www.HealthyPasadena.org, which includes a comprehensive dashboard of over 100 community health and quality of life indicators covering over 20 topic areas.

Under the leadership of Cathi Chadwell, Executive Director of Public Affairs, a work group composed of Huntington leaders with specific community and clinical knowledge was established to prioritize the significant community needs based on criteria important to the hospital, including:

- Alignment with Huntington Hospital strengths, mission, and resources
- Opportunity for partnership
- Solutions that impact multiple problems
- Availability of feasibility-effective methods

Results were presented to the hospital's Executive Management Team which selected the following prioritized needs:

- Cancer, with a focus on breast cancer and screening
- Immunization, with a focus on vaccination

*(Please refer to **Year One Progress Report 2014** for activities/accomplishments in 2014.)*

ACCESS TO SERVICES:

Access to health care was identified as a significant community need in the 2013 CHNA process. Data available at that time indicated that 78.1% of adults residing in SPA 3, (San Gabriel Valley), had health insurance of some kind.

Access to health care means having the timely use of health services to achieve the best health outcomes. Health insurance facilitates entry into the health care system. Health insurance makes a difference in whether people get necessary medical care, where they get their care, and ultimately, how healthy people are. Uninsured adults are far more likely than those with insurance to postpone or forgo health care altogether due to the financial burden of paying for medical care and medications. The consequences can be serious, particularly when preventable conditions go undetected. Uninsured adults,

compared with those with coverage, are less likely to receive routine care and follow-up. Silent health problems, such as hypertension and diabetes, often go undetected without routine check-ups. Consequently, uninsured patients have increased risk of being diagnosed in later stages of diseases, including cancer, and have higher mortality rates than those who have health insurance and a medical home.

In October 2012, Jane Haderlein, Senior Vice President of External Affairs, proposed a 'Health Summit' to identify community needs, through a collaborative effort with community partner organizations. This lead to the formation of the Healthcare Access Committee, convened in April 2013 by Cathi Chadwell, Executive Director of Public Affairs. The committee included representatives from the following organizations: Pasadena Public Health Department, Young and Healthy, Community Health Alliance of Pasadena (Chap), Bill Moore Clinic, and Huntington Hospital. The work of the committee was:

1) To identify current and potential resources available to support a united effort to educate and enroll community residents who qualified for insurance, and determine who and how the residually uninsured would be cared for.

2) To operationalize efforts to provide easily accessible tracking of information, ensure consistent messaging and information to community residents, and efficient sharing of all information regarding enrollment activities related to enrollment and access to those who do not qualify for insurance.

Subsequent monthly meetings yielded the following:

- Public educational presentations explaining the Affordable Care Act (ACA) in lay terms, delivered by various members of the partnering organizations in the Fall of 2013, to prepare community members for the first enrollment period offered through the ACA.
- Local organization staff received formal training from Maternal Child Health Access to prepare for assisting with enrollment.
- Development, printing, and community-wide dissemination of an information card about Covered California, including locations and contact information for local providers available to assist with enrollment, in both English and Spanish. (Attached)
- Development, printing and dissemination of the Pasadena Health Safety Net Directory (Attached)
- Development and maintenance of an enrollment activities tracking tool.

These activities have resulted in the enrollment of **13,147 newly insured** adults and children over the past two years; approximately 70% are Medi-Cal beneficiaries, 15% are Covered California enrollees, and the remaining 15% are enrolled in other programs (see *Table 1* below). In addition, a total of 7,373 adults and children who do not qualify for any program, ("residually uninsured"), received care in our community, based on the efforts of the partnering organizations participating in the health care access group.

TABLE 1. HEALTHCARE ENROLLMENTS IN PASADENA, 2014-2015

COVERED PASADENA	2014	2015	OVERALL TOTAL
Medi-Cal enrollments-adults	7373	1109	8482
Medi-Cal enrollments-Kids	390	274	664
TOTAL MEDI-CAL	**7763**	**1383**	**9146**
Covered California with Subsidy-adults	1211	479	1690
Covered California without Subsidy-adults	117	52	169
Covered California with Subsidy-kids	75	50	125
Covered California without Subsidy-kids	32	15	47
TOTAL COVERED CALIFORNIA	**1435**	**596**	**2031**
Other Programs-Adults	39	1380	1419
Other Programs-kids	132	419	551
Total Other Programs	**171**	**1799**	**1970**
Residually Uninsured receiving Care-adults	1930	1942	3872
Residually Uninsured receiving Care-kids	2104	1397	3501
TOTAL RESIDUALLY UNINSURED RECEIVING CARE	**4034**	**3339**	**7373**
Total Insurance Enrollment	**9369**	**3778**	**13147**

Due to the delay in government posted data, it is difficult to definitively state the actual number of residents who are covered by health insurance. However, we can infer from data that is available that this group has grown. Data currently available (2013-2014) indicates that 80.2% of Greater Pasadena adult residents had health insurance-an increase of 2.1%.

ADULTS WITH HEALTH INSURANCE

80.1



80.2
percent

Measurement Period:
2013-2014

Service Planning Area (SPA): SPA 3 - San Gabriel

Data Source: California Health Interview Survey

Categories: Health / Access to Health Services

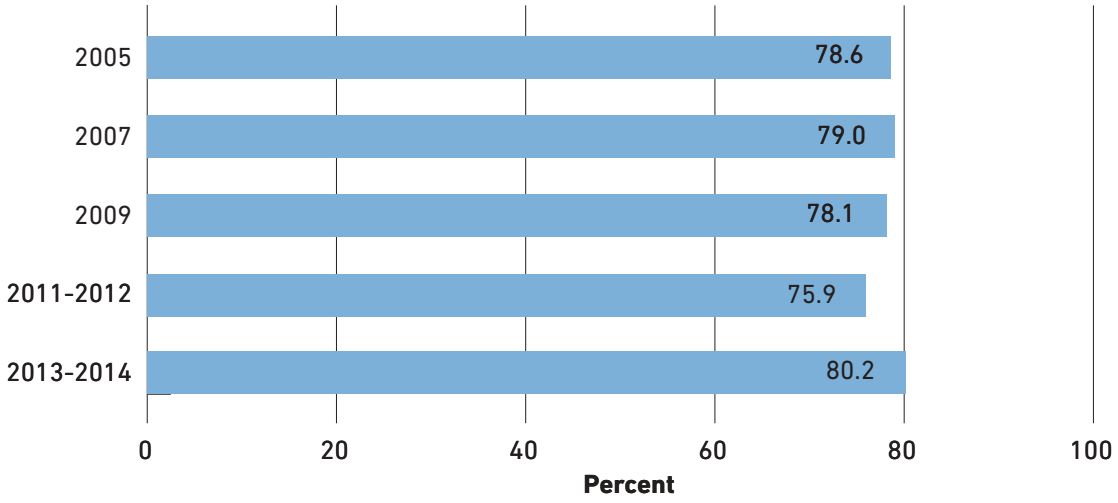
Technical Note: The regional value is compared to the California state value.

Maintained By: Healthy Communities Institute

Last Updated: November 2015

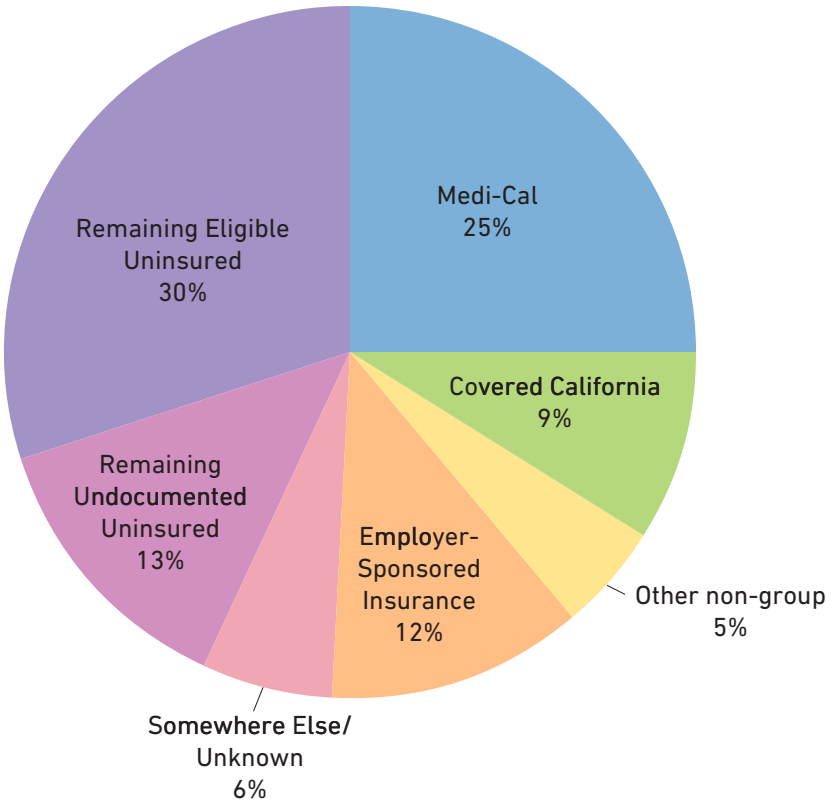
ZIP code specific data currently available (2014) reflects a disparity of as much as 9.7% among geographic areas of Pasadena, with ZIP code 91030 (South Pasadena) at 83.7% of adults having health insurance, while ZIP code 91103, (northwest Pasadena) at 74.0%. Once data for 2014 and 2015 is available, however, we are likely to see an overall increase in the percentage of residents with health insurance. Due to opportunities afforded by the ACA, we should see an even larger upward trend than in previous years, as illustrated in the graph and data below.

ADULTS WITH HEALTH INSURANCE: TIME SERIES



A majority of newly enrolled adults are Medi-Cal beneficiaries. In 2013, 8,605,691 adults in California were covered by Medi-Cal. That number increased to 12,549,540 by May, 2015. In the two year period 2014-2015, in addition to the new Medi-Cal beneficiaries, 1.4 million Californians were newly enrolled in Covered California. A majority of newly enrolled adults are Medi-Cal beneficiaries. California's population is estimated to be 39.8 million, with Los Angeles County at 10.1 million. Greater than 32% of Californians live in Los Angeles County. Pasadena's Medi-Cal beneficiaries is likely to have grown proportionately.

SOURCES OF COVERAGE AMONG CALIFORNIA'S PREVIOUSLY UNINSURED[37]



CHNA 2013 PRIORITIZED NEEDS

Cancer-Breast Cancer Screening

Huntington Hospital and its community partners continued to provide services and outreach to women 40 and older to provide information about breast cancer and the importance of having routine mammograms.

Women newly enrolled in various health insurance programs, as well as the residually uninsured, have access to services through the Huntington Ambulatory Care Center, ChapCare, and Planned Parenthood, as well as private providers in the community. Patients with medical homes are counseled by their physician about screening and are educated about risk factors for breast cancer based on their individual health and family history. Physicians refer appropriate patients to an imaging provider. Screening mammograms are provided as follows:

- ChapCare refers patients with insurance to Huntington-Hill Imaging Center, and utilizes a mobile provider at its clinic sites.
- Planned Parenthood of Pasadena partners with White Memorial Hospital.
- Huntington Ambulatory Care Center (HACC) refers women to Huntington–Hill Imaging Center. The HACC social worker assists women who are unable to pay for a mammogram to obtain services through funding made available by hospital donors.

Huntington-Hill offers a reduced rate to patients unable to pay for mammography.

Patients in the community are educated about resources by outreach workers from the various organizations in Pasadena. In addition, community health workers, such as Huntington Hospital's Community Outreach nurses, provide education, counseling, and referrals at their regularly scheduled Health Counseling and Screening sites. Information about the location and schedule of community screening sites is posted on the Hospital website, shared with local partner organizations, etc.

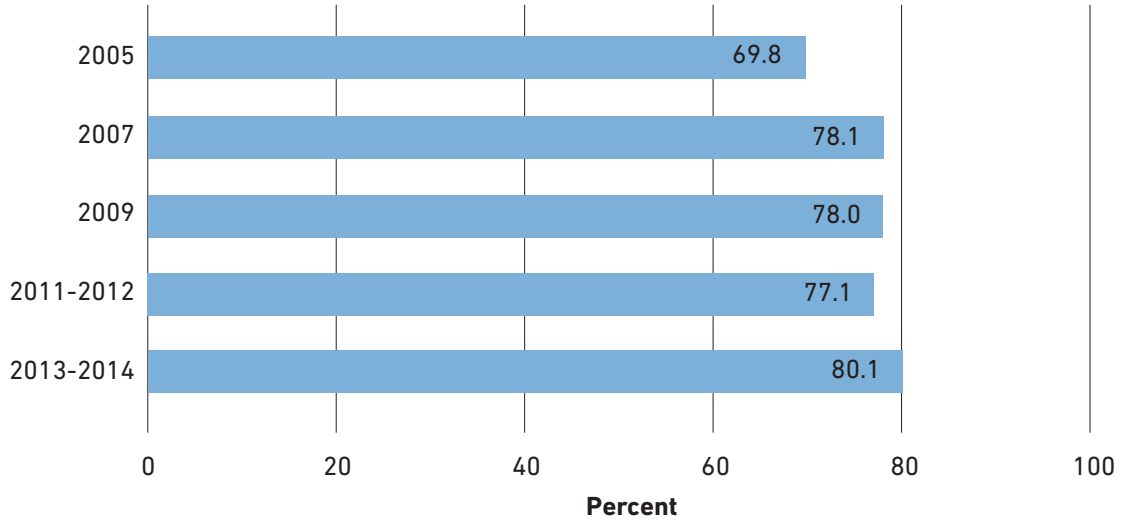
Women who are newly insured, as well as those who are residually uninsured and are not knowledgeable about breast cancer and the importance of screening, need to be reached. This is accomplished in a variety of w ys:

- Huntington Hospital Community Outreach nurses have been disseminating the informational card that was developed for this purpose throughout the community, particularly targeting the underserved. The card presents a brief but impactful message empowering women to be screened for breast cancer, and provides the names and contact information for the three healthcare providers in Pasadena where they can see a physician to discuss their options and receive appropriate referrals (see attached).
- Huntington Community Outreach nurses have developed a class called "An Ounce of Prevention," which addresses the various cancer screenings recommended for adults, including breast cancer.
- Community Outreach nurses work closely with partnering organizations in Greater Pasadena to identify opportunities to reach the underserved population. Services include education, counseling, referral, and problem-solving assistance in both English and Spanish. New health counseling and screening sites at Pasadena Unified School District elementary schools were initiated in 2015 to reach women as they drop their children off at school. The nurses continue to visit other locations where women tend to gather in the community to offer education about women's health issues, including breast health and cancer prevention.
- Community Outreach nurses partner with Villa Parke Community Center to share information and spread the message to women who attend VPCC activities through a well-established informal community network.
- HH's Breast Center physicians and nurse navigators conduct several community education events throughout the year.
- Dr. Jeannie Shen authors a quarterly e-newsletter, providing information, recommendations, illustrations and videos, such as demonstration of self-breast examination. Frequent mailings go out to 40+ women in the community.
- Huntington breast surgeons, Dr. Jeannie Shen, Dr. Ruth Williamson, and colleagues conduct annual events including a Breast Health Panel Discussion and the Pink Ribbon Conference to raise awareness and provide education about breast cancer.
- Dr. Shen has been particularly instrumental through outreach to the Chinese community.
- Huntington Hospital Breast Center staff provide education, services, and support to women in the Chinese Community at Herald Cancer Center in Rowland Heights.

- The Hospital partnered with the Pasadena Fire Department and California Pizza Kitchen to raise funds to support free mammograms for underserved women during Breast Cancer Awareness Month, and sponsored The Rose Bowl Walk and Barbecue for this purpose.
- At the time of clinic visits, ChapCare patients are educated about breast cancer and the appropriate time to have a screening mammogram, based on their age and family history. ChapCare refers patients with insurance to Huntington-Hill Imaging Center, and utilizes a mobile imaging provider at its clinic sites for women without coverage.
- Planned Parenthood of Pasadena partners with White Memorial Hospital to provide mammograms.
- Huntington Ambulatory Care Center (HACC) refers women to Huntington–Hill Imaging Center. The HACC social worker assists women who are unable to pay for a mammogram to obtain services through funding made available by hospital donors.
- Huntington-Hill offers a reduced rate to patients unable to pay for mammography.
- ChapCare continues to train student interns from Occidental College in its Health Leads type program to assist patients of the clinic. Based on recommendations 'prescribed' by physicians, students assist patients to obtain health and psychosocial services they need to support positive health outcomes. Students follow up on physician recommendations and maintain contact with patients between medical appointments to intervene or assist. This additional support system provides reinforcement to physician-initiated medical interventions, including health screenings such as mammograms.

At the time of the 2013 CHNA, data available (2008-2010) indicated that the mortality rate due to breast cancer was 23.9 deaths/100,000. More current data (2011-2013) reflects a decrease in deaths caused by breast cancer, with the mortality rate for this time period being 21.3 deaths/100,000-an improvement of 2.6 less lives taken. The graph below (healthypasadena.org) illustrates the upward trend in women reporting having had a screening mammogram.

MAMMOGRAM HISTORY: TIME SERIES



Considering this data, along with the decreasing death rate due to breast cancer, we should see a similar trend in Greater Pasadena over the next few years. While our assumption was that we would see a greater volume of mammograms among women receiving services from our three participating organizations, (ChapCare, PPP, and Huntington Hill Imaging Center), as a result of the various efforts we initiated to educate and provide resources to the women in our community. This is not the case, as illustrated in *Table 2* below.

TABLE 2. VOLUME OF MAMMOGRAMS 2014 AND 2015

ORGANIZATION	2014	2015
ChapCare	354	311
Huntington Hill Imaging Center	28,261	27,654
Planned Parenthood of Pasadena	179	160
Total	**28,794**	**28,125**

These results, though not what we had anticipated, may be attributed to factors which influence where women are receiving their mammograms, such as referrals by physicians to other providers than those we are tracking. Anecdotally, for example, nurses out in the community are reporting that almost all women they speak with at their clinic sites are aware of the importance of being screened for breast cancer, and report having had a screening mammogram. This is a major change from past years.

Immunization: Influenza Vaccination

According to the Centers for Disease Control and Prevention, it is widely recognized that people 65 years and older, as compared to young, healthy adults, are at greater risk of serious complications from the flu. Influenza is a viral infection that attacks the respiratory system, often leading to pneumonia. Older adults tend to have more medical co-morbidities and are at higher risk for complications. Influenza and its complications can be deadly for people 65 years and older.

It is estimated that 90 percent of seasonal flu-related deaths, and more than 60 percent of seasonal flu-related hospitalizations in the United States each year occur in older adults. The best way to avoid contracting the flu is with a flu vaccination. The CDC recommends that everyone 6 months of age and older be vaccinated annually. Each season a flu vaccine protects against the three or four viruses that research suggests will be most common. Once vaccinated, immunity sets in within approximately two weeks. Getting a flu shot earlier in the season is recommended for maximum protection.

Education is an essential component in persuading people to get vaccinated. Receiving this information from a trusted healthcare provider is often key to positively influencing reluctant patients.

2015 EFFORTS AND AVAILABILITY OF VACCINE

In anticipation of the 2015 flu season, Huntington Hospital and community partners conducted the following activities to boost immunization against influenza:

- During encounters at the various Health Counseling and Screening Clinics throughout Pasadena and South Pasadena, Community Outreach nurses encouraged clients to be vaccinated by providing information about the risks associated with influenza, and addressing fears and myths related to vaccination.
- "An Ounce of Prevention," a class developed by the Community Outreach nurses which provides information about various health screenings and preventive measures recommended for adults, was offered at various community sites.
- An informational card developed by Huntington Hospital and its community partners, and printed in both English and Spanish, was disseminated throughout the community. The card contains a brief but impactful message explaining the importance of being vaccinated, and provides the various locations where flu shots are available in Pasadena.
- Huntington Hospital continues to offer free flu shots to the public each fall. Flu shot clinic sites include senior and community centers, senior housing, public libraries, faith based organizations, and health fairs. During the 2015 flu season Huntington Hospital Community Outreach nurses offered the quadrivalent vaccine at 37 community flu clinics, vaccinating 2,259 individuals, 23 percent of whom were adults 65 and older.
- Flu shots are provided in other ambulatory service departments of Huntington Hospital including the Huntington Ambulatory Care Center and the Medication Therapy Management Clinic.
- Hospitalized patients' immunization records are reviewed at the time of admission and vaccinations are provided to those patients who have not been vaccinated prior to admission.

Table 3 illustrates flu vaccination efforts by Huntington Hospital and participating partners, ChapCare, Huntington ACO, and Pasadena Public Health Department, for the 2014 and 2015 flu seasons:

TABLE 3. FLU VACCINATIONS 2014 AND 2015 FLU SEASONS

	2014		2015	
	TOTAL #	65+	TOTAL #	65+
ChapCare	2,093	95 (5%)	2,635	79(3%)
Huntington Hospital	2,505	648 (23%)	2,259	517 (23%)
HH ACO	5,182	3,126 (60%)	8,488	4,867 (57%)
PPHD	887	164 (18%)	742	114 (15%)
Total	**10,667**	**4,033 (38%)**	**14,124**	**5,577 (39%)**

The Huntington Care Network **Accountable Care Organization (ACO)** was established to participate in the Medicare Shared Savings Program (MSSP), which is an enhanced patient centered care model that focuses on high quality, coordinated services and medical care. As such, a larger percentage of its patients are 65 and older. Its physicians educate patients about the risks of contracting flu, recommend and offer vaccine to their patients. As *Table 3* reflects, 60 per cent of the 5,182 flu shots given to ACO patients in 2014 were to patients 65 and older. In 2015, 57 per cent of the 8,488 flu shots given were to patients 65 and older.

Pasadena Public Health Department receives an annual supply of influenza vaccine from the Los Angeles County Health Department. The health department issues public service announcements encouraging people to be vaccinated. An annual information piece is contained in the Fall edition of its quarterly newsletter. PPHD public health nurses offer free flu shots at six community sites, including Villa Parke Community Center, Jackie Robinson Center, Pasadena Senior Center, Allendale, Santa Catalina, and La Pintoresca Public Libraries. HH Community Outreach nurses work closely with PPHD nurses to coordinate efforts to maximize the vaccine supply and avoid duplication of efforts. During flu season 2015-2016, PPHD administered a total of 742 flu shots, 15 per cent of which were to seniors.

ChapCare, a Federally Qualified Health Clinic, provides flu shots to patients of all ages. Patients' physicians recommend the influenza vaccine during clinic visits. Additional methods, such as telephonic and postal notices are employed to remind patients to get their annual flu shot as well.

Overall, the percentage of flu shots given to patients 65 years and older increased by 1% in 2015.

Many older adults living in Pasadena are Medicare beneficiaries, receiving their annual flu shot during a visit to their healthcare provider, or at retail clinics. A segment of the older adult population do not have a medical home because they are residually uninsured and are unaware of no cost services. Some elect not to visit a provider. A segment of the older adult population subscribe to various beliefs and misinformation about vaccination, including:

- Regarding oneself as healthy, active and independent, thus not needing vaccination
- Believing they are not at risk from dying from influenza, despite learning that flu could be fatal for particular groups of people, including the elderly
- Believing influenza vaccine is unsafe
- Believing influenza vaccine is not effective in older people
- Wanting to avoid potential side-effects
- Believing being vaccinated can give you the flu or make you sick

Older adults should be educated and encouraged to be immunized against this vaccine-preventable disease. Huntington Hospital and its community partners will continue our efforts to do so.

APPENDIX B:
HEALTHY COMMUNITIES INSTITUTE DATA ANALYSIS METHODS

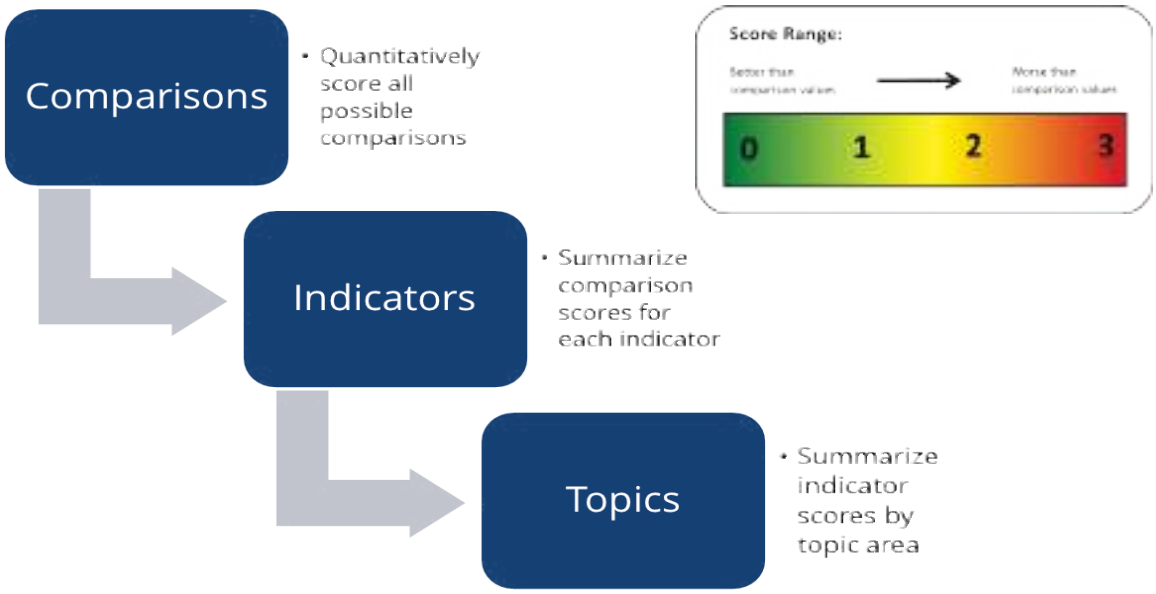
Indicators from the Community Dashboard were systematically summarized based on multiple comparisons using Healthy Communities Institute's methodology called Data Scoring. When all quantitative data was queried on June 8, 2016, 97 indicators were available for data scoring. Of these 97 total, 40 indicators contained Pasadena City-level data, 31 indicators contained Greater Pasadena-level data, and the remaining 26 indicators contained SPA 3 San Gabriel Valley-level data.

SCORING METHOD

For each indicator, the community value (either the city of Pasadena, Greater Pasadena, or SPA 3, San Gabriel Valley) was assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the that the local value (Greater Pasadena, Pasadena city, or SPA 3) is better than the comparison values and 3 indicates that the local value is worse than the comparison values. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time. Each indicator was assigned a score and compared against standards such as: California counties, California state, the U.S., a Healthy People 2020 target, and/or trend over time.

Indicators were categorized into 29 topic areas and each topic area received a score. Indicators may be categorized in more than one topic area. Topic scores were determined by the comparisons of all indicators within the topic.

HCI DATA SCORING OVERVIEW



If fewer than three indicators were available for a given topic area, the topic did not receive a score due to stability concerns and was removed from quantitative analysis. Ten topics contained indicators that were limited to the Los Angeles County region and therefore did not meet the minimum requirements of three or more sub-county indicators in order to be included in the scoring process: Disabilities, Education, Environment, Family Planning, Food Safety, Men's Health, Oral Health, Other Chronic Diseases, Public Safety, and Wellness and Lifestyle.

Dashboard Indicators

For ease of interpretation and analysis, indicator data from Greater Pasadena, city of Pasadena, and SPA 3 San Gabriel Valley geographic regions are displayed on the Healthy Pasadena Community Dashboard and feature a green-yellow-red gauge that shows how the Pasadena community is faring relative to comparison values. A distribution is created by comparing against standards within the state or nation for example, and dividing them into three groups (green, yellow, red). For all value comparisons, the scoring depends on whether the community value is better or worse than the comparison value, as well as how close the community value is to the target value. Indicators with the worst comparisons ("in the red") scored high, whereas indicators with better comparisons ("in the green") scored low.



HCI PLATFORM COUNTY DISTRIBUTION GAUGE

Trend Over Time

The Mann-Kendall statistical test for trend was used to assess whether the community value is increasing over time or decreasing over time, and whether the trend is statistically significant. The trend comparison used the four most recent comparable values for the community, and statistical significance is determined at the 90% confidence level. For each indicator with values available for four time periods, scoring was determined by direction of the trend and statistical significance.

Missing Values

Indicator scores were calculated using the comparison standard when there was an available data source. When information was unknown due to lack of comparable data, the neutral value assumed that the missing comparison score was neither good nor bad. Indicators with less than two out of five possible comparisons available due to limited data availability were removed from the analysis. Finally, non-directional indicators (e.g. where a high community value isn't considered 'good' or 'bad') were not included in the topic score.

Weighting of Comparison Scores

The five possible comparison standards were given a weight based on data availability across all indicators. California counties and California state value were each given 35% of the total weight, the U.S. value was given 10% of the weight, trending over time was given 15%, and Healthy People 2020 targets were given the remaining 5% of the weight. A weighted average of comparison scores was used to assign a score to each indicator.

Indicator Scoring

Indicator scores were averaged by topic area to calculate topic scores. Each indicator was included in up to three topic areas if appropriate. Resulting scores range from 0-3, where a higher score indicates a greater level of need as evidenced by the data.

A topic score was only calculated if it included at least three indicators. The 3 different geographic areas (city of Pasadena, Greater Pasadena, and SPA 3 San Gabriel Valley) were given equal weight for topic scoring. These scores were used to categorize the topics as red (score $\geq$1.5), yellow (1.25$\leq$ score <0.1.5), or green (score <1.25).

DISPARITIES ANALYSIS

To identify indicators with the largest disparities by gender or race/ethnicity, the Index of Disparity[38] measure was used to calculate the average of the absolute differences between rates for each sub-population and the overall community rate, divided by the community rate. The Index of Disparity summarizes disparities across groups within a population that can be applied across indicators with varying units of measure. The Index of Disparity measure is expressed as a percentage. Across all indicators, an Index of Disparity score that ranked in the top 25% of all disparities scores–in either gender or ace/ethnicity category–was identified as having a high disparity.

APPENDIX C: **COMMUNITY RESOURCES**

The following are resources available to Pasadena residents to respond to the health needs in the community. These were originally collected in a joint effort by Huntington Hospital and the Pasadena Public Health Department in May 2013. For the **2016 Community Health Needs Assessment of Greater Pasadena**, this list was revised and updated by both parties.

ACCESS TO HEALTH SERVICES

Armenian Relief Society Social Services. 740 E. Washington Blvd. Pasadena, CA 91104. (626) 797-6187. http://www.arswestusa.org.
Social services: low-income families with language barriers.

Community Health Alliance of Pasadena (ChapCare). 1855 N. Fair Oaks Ave. Pasadena, CA 91103. (626) 398-6300. http://www.chapcare.org.
Clinic: primary care, dental, behavioral, children and adults.

Convalescent Aid Society. 3255 E. Foothill Blvd. Pasadena, CA 91107. (626) 793-1696. http://www.cas1.org.
Medical equipment: free loan of medical equipment.

H.E.A.R. Center. 301 E. Del Mar Blvd. Pasadena, CA 91101. (626) 796-2016. http://www.hearcenter.org.
Testing center: hearing, speech/language evaluations, screenings.

Huntington Ambulatory Care Center. 711 S. Fairmount Ave. Pasadena, CA 91105. (626) 397-2631. http://www.huntingtonhospital.com.
Clinic: primary care, specialty care, social services.

Huntington Hospital. 100 W. California Blvd. Pasadena, CA 91105. (626) 397-5000. http://www.huntingtonhospital.com.
Hospital: medical care, emergency care, Trauma Center.

Huntington Hospital Community Asthma Program. 100 W. California Blvd. Pasadena, CA 91105. (626) 397-8637 or (626) 397-8636 (Spanish). http://www.huntingtonhospital.com.
Clinic: children/youth, asthma management, education.

Huntington Hospital Community Outreach. 100 W. California Blvd. Pasadena, CA 91105. (626) 397-2581. http://www.huntingtonhospital.com/Main/CommunityOutreach.aspx.
Community-based health screenings and counseling, information and referral, health classes, flu shots.

Huntington Health Physicians. 133 N. Altadena Dr. Pasadena, CA 91107. (626) 397-8300. https://huntingtonhealthphysicians.org/
Medical group: primary care, urgent care, children and adults.

Los Angeles County Department of Social Services. 955 N. Lake Ave. Pasadena, CA 91104. (626) 569-1399. http://www.ladpss.org.
Social services: low-income, public programs.

Pasadena Community Urgent Care. 3160 E. Del Mar Blvd. Pasadena, CA 91107. (626) 270-2400. http://www.PasadenaUrgentCare.com.
Clinic: urgent care.

Young and Healthy. 1905 Lincoln Avenue, Pasadena, CA 91103. (626) 795-5166. http://yhpasadena.org.
Social services: children/youth, medical, dental, behavioral health, assistance with obtaining health insurance.

CANCER

American Cancer Society. 50 N. Hill Ave., #200 Pasadena, CA 91106. (626) 795-7774. http://www.cancer.org.
Education: cancer, resource/referrals, advocacy.

Huntington Hospital Cancer Center. The Huntington Pavilion, 625 South Fair Oaks Avenue, Suite 100, Pasadena, CA 91105, (626) 397-2524. http://www.huntingtonhospital.com/Main/CancerCenter.aspx

Cancer Support Community Pasadena (CSCP): 76 East Del Mar Blvd., Suite 215, Pasadena, CA 91005, (626) 796-1083. http://www.cscpasadena.org/

CHILDREN'S HEALTH

Bienvenidos. 255 N. San Gabriel Blvd. Pasadena, CA 91107. (626) 696-1270. http://www.bienvenidos.org.
Social Services: children/youth, behavioral health, foster care.

Community Health Alliance of Pasadena (ChapCare). 1855 N. Fair Oaks Ave. Pasadena, CA 91103. (626) 398-6300. http://www.chapcare.org.
Clinic: primary care, dental, behavioral, children and adults.

Hathaway-Sycamores Child and Family Services. 210 S. DeLacey Ave. #110 Pasadena, CA 91105. (626) 395-7100. http://www.hathaway-sycamores.org.
Foster Care Agency: children/youth, social services, education.

Pasadena Public Health Department - Child Health & Disability Prevention Program. 1845 N. Fair Oaks Ave., #2137 Pasadena, CA 91103. (626) 744-6168. http://www.cityofpasadena.net/publichealth.
Health Screening: children/youth, social services.

Pasadena Public Health Department - Childhood Lead Poisoning Prevention Program. 1845 N. Fair Oaks Ave. Pasadena, CA 91109. (626) 744-6089. http://www.cityofpasadena.net/publichealth.
Case Management: children/youth, lead poisoning prevention, education.

Pasadena Unified School District - Health Programs. 351 S. Hudson Ave. Pasadena, CA 91109. (626) 396-3600 x88240.
Clinic: children/youth, school-based programs.

Pasadena Unified School District Primary Health Care Clinic. 351 S. Hudson Ave., #130 Pasadena, CA 91109. (626) 396-3600 x88180
Clinic: children/youth, medical services, screenings.

Young and Healthy. 1905 Lincoln Avenue, Building D, Pasadena, CA 91103. http://yhpasadena.org/
Social and Clinical Services: children/youth, dental, mental health, trauma, eye care, clinical care.

DISABILITIES

Ability First. 201 S. Kinneloa Ave. Pasadena, CA 91107. (626) 449-5661. http://www.abilityfirst.org.
Disabled Center: children/youth, adults.

Adaptive Recreation - City of Pasadena. 2575 Paloma St. Pasadena, CA 91107. (626) 744-7257. http://www.cityofpasadena.net/HumanServices/AdaptiveRecreation.
Disabled Center: adults, recreation, referrals.

California Department of Rehabilitation. 150 S. Los Robles Ave., #300 Pasadena, CA 91101. (626) 304-8300. http://www.dor.ca.gov.
Disabled Center: adults, counseling, vocational services.

Eastern Los Angeles Regional Center. 1000 S. Fremont Ave. Alhambra, CA 91802. (626) 299-4700. http://www.elarc.org.
Disabled Center: adults, children/youth, community -based services.

Frank D. Lanterman Regional Center. 3303 Wilshire Blvd., #700 Los Angeles, CA 90010. (213) 383-1300. http://www.lanterman.org.
Disabled Center: adults, children/youth, community-based services.

MERCI (Mentally & Educationally Retarded Citizens, Inc.). 525 N. Chandler Ave. Monterey Park, CA 91754. (626) 289-8817. http://www.merci.org.
Disabled Center: adults, vocational training, education.

Villa Esperanza Services. 2060 E. Villa St. Pasadena, CA 91107. (626) 449-2919. http://www.villaesperanzaservices.org.
Disabled Center: adults, children/youth.

ECONOMY

24-hour City Job Line. (626) 744-4600.
Hotline: employment.

Flintridge Center. 236 West Mountain Street, Suite 106, Pasadena, CA 91103. (626) 449-0839. info@Flintridge.org.
Development programs for youth and assistance with career opportunities and other reentry issues for previously incarcerated individuals.

Foothill Employment and Training Center. 1207 E. Green St. Pasadena, CA 91106. (626) 796-5627. http://www.foothilletc.org.
Career Center: employment, resources.

Ideal Youth. 83 E. Orange Grove Blvd. #2 Pasadena, CA 91103.
(626) 796-7164 x 16. http://www.idealyouth.org.
Career Center: teens, employment, vocational training.

Pasadena Community Job Center. 500 N. Lake Ave. Pasadena, CA 91101.
(626) 440-0112. http://pasadenajobcenter.com.
Day Laborer Site: employment, education.

Sources Career Development. 825 E. Orange Grove Blvd. Pasadena, CA 91104.
(626) 240-4591. http://www.unionstation.org/sources.html.
Career Center: employment, adults.

Women at Work. 3871 E. Colorado Blvd. Pasadena, CA 91107.
(626) 796-6870. http://www.womenatwork.org.
Career Center: employment, resources, women.

EDUCATION

American Cancer Society. 50 N. Hill Ave. #200 Pasadena, CA 91106.
(626) 795-7774. http://www.cancer.org/.
Education.

AspiresWest Pasadena. 119 E. Washington Blvd. Pasadena, CA 91103.
(626) 797-0789. http://www.aspireswestpasadena.com.
Education: children/youth, parenting, mentoring.

Boys & Girls Club of Pasadena. 3230 E. Del Mar Blvd. Pasadena, CA 91107 Pasadena, CA 91107. (626) 449-9100. http://www.bgcpasadena.org.
Education: children/youth, recreation, tutoring.

Cancer Support Community. 200 E. Del Mar Ave. Pasadena, CA 91105.
(626) 796-1083. http://www.cscpasadena.org/.
Education.

Continuing and Community Education. 3035 E. Foothill Blvd. Pasadena, CA 91107.
(626) 585-3000. http://pasadena.edu/academics/continuing-education.php.
Education: adults, parenting, vocational training.

Give The Streets Back!. P.O. Box 92733 Pasadena, CA 91109.
(626) 791-1855. http://www.givethestreetsback.org.
Education: children/youth, gang prevention, substance abuse.

Huntington Community Health Library. 100 W. California Blvd. Pasadena, CA 91105.
(626) 397-5161. http://www.huntingtonhospital.com.
Library: medical information.

Huntington Hospital Community Outreach. 100 W. California Blvd. Pasadena, CA 91105.
(626) 397-2581. http://www.huntingtonhospital.com.
Health classes.

Huntington Hospital HELP (Healthy Eating Lifestyle Program). 100 W. California Blvd. Pasadena, CA 91105. (626) 397-5000. http://www.huntingtonhospital.com.
Education: obesity prevention, diabetes management, cardiovascular health.

Huntington Hospital Perinatal Health Education. 100 W. California Blvd. Pasadena, CA 91105. (626) 397-5000. http://www.huntingtonhospital.com.
Education: women, pre-natal, parenting.

Jackie Robinson Community Center. 1020 N. Fair Oaks Ave. Pasadena, CA 91103. (626) 744-7300. http://www.cityofpasadena.net.
Community Center: education, social services, recreation.

Lake Avenue Community Foundation. 712 E. Villa St. Pasadena, CA 91101. (626) 449-4960. http://www.lakeavefoundation.org/
Education: children/youth, tutoring, referrals, health services.

Los Angeles County Human Services. 211. http://www.infoline-la.org.
Hotline: resource and referral, health and human services.

Mother's Club Learning Center 980 N. Fair Oaks Ave. Pasadena, CA 91103. (626) 792-2687. http://www.mothersclub.org.
Education: parent education, literacy.

Mustangs on the Move. 1905 Lincoln Ave. Pasadena, CA 91103. (626) 396-5600.
Education: children/youth, tutoring, test preparation.

Neighbors Acting Together Helping All (NATHA). 456 W. Montana St. Pasadena, CA 91103. (626) 794-5889. http://www.natha.org.
Education: children/youth, tutoring, community development.

Neighborhood Connections. 1020 N. Fair Oaks Ave. Pasadena, CA 91103. (626) 744-7290. http://www.cityofpasadena.net/NeighborhoodConnections/
Info And Referral: community development.

Pasadena YMCA. 2844 E. Foothill Blvd. Pasadena, CA 91107. (626) 432-5880. http://www.ymcala.org/pasadena.
Education: children/youth, after-school programs, recreation.

Pasadena LEARNs After School Program. 351 S. Hudson Ave. Pasadena, CA 91109. (626) 396-3614. http://www.gopusd.com/learns/ or http://www.pusd.us/domain/95
Education: children/youth, after-school programs.

Pasadena Unified School District — Child Development Program. 2046 N. Allen Ave. Pasadena, CA 91101. (626) 396-5900. http://www.pusd.us.
Childcare: children/youth, pre-school.

Victory Park Community Center. 2575 Paloma St. Pasadena, CA 91107. (626) 744-7500. http://www.cityofpasadena.net.
Community Center: education, social services, recreation.

Villa-Parke Community Center. 363 E. Villa St. Pasadena, CA 91101. (626) 744-6530. http://www.cityofpasadena.net
Community Center: education, social services, recreation.

YWCA Pasadena-Foothill Valley. 1200 N. Fair Oaks Ave., #9 Pasadena, CA 91103. (626) 296-8433. http://www.YWCA-Pasadena.org.
Education: women, children/youth, parenting, mammograms.

EXERCISE, NUTRITION & WEIGHT

Huntington Hospital Community Outreach. 100 W. California Blvd. Pasadena, CA 91105. (626) 397-2581. http://www.huntingtonhospital.com.
Chair yoga classes.

FAMILY PLANNING

Pasadena Public Health Department — Maternal, Child and Adolescent Health Outreach. 1845 N. Fair Oaks Ave., 2nd floor Pasadena, CA 91103. (800) 304-0015. http://www.cityofpasadena.net/publichealth.
Education: family planning, life course, STD/Pregnancy classes.

Planned Parenthood of Pasadena and San Gabriel Valley. 1045 N. Lake Ave. Pasadena, CA 91104. (626) 798-0706. http://www.plannedparenthood.org/pasadena.
Clinic: family planning, reproductive health, sex education.

IMMUNIZATIONS & INFECTIOUS DISEASES

Huntington Hospital Phil Simon Clinic. 711 Fairmount Ave. Pasadena, CA 91105. (626) 397-5480. http://www.thephilsimonclinic.org
Clinic: HIV/AIDS medical care, case management, social services.

Wesley Health Centers (Pasadena) — Andrew Escajeda Comprehensive Care Services. 1845 N. Fair Oaks Ave., Pasadena, CA 91103, (562) 867-7999. http://jwchinstitute.org/primary-medical-care/wesley-health-centers-pasadena/.
Clinic: HIV/AIDS medical care, testing, care coordination, behavioral health, food pantry, dental care

Pasadena Public Health Department — Immunization Clinic. 1845 N. Fair Oaks Ave. #122 Pasadena, CA 91103. (626) 744-6121. http://www.cityofpasadena.net/publichealth.
Clinic: immunizations.

Healthy Traveler Clinic. 1250 E. Green St., Pasadena, CA 91106. (626) 584-1200. http://www.healthytraveler.com. Clinic: immunizations.

MATERNAL, FETAL & INFANT HEALTH

Elizabeth House. P.O. Box 94077 Pasadena, CA 91109. (626) 577-4434. http://www.elizabethhouse.net.
Shelter: women, children, shelter.

Pasadena Public Health Department — Women, Infants and Children (WIC). 363 East Villa Street (Villa Parke Community Center), Pasadena, CA 91101. (626) 744-6005. http://cityofpasadena.net/publichealth/WIC.
Education: nutrition education, food checks, breastfeeding support.

Pasadena Public Health Department — Black Infant Health Program.
1845 N. Fair Oaks Ave., 2nd floor Pasadena, CA 91103. (626) 744-6155.
http://www.cityofpasadena.net/publichealth.
Case Management: at-risk pregnant and parenting African-American women, support services, education.

Pasadena Public Health Department — Maternal, Child and Adolescent Health Outreach. 1845 N. Fair Oaks Ave., 2nd floor Pasadena, CA 91103.
(800) 304-0015. http://www.cityofpasadena.net/publichealth.
Info and Referral: women, children/youth.

MENTAL HEALTH

Arcadia Mental Health Center / Los Angeles County Department of Mental Health.
330 E. Live Oak Ave. Arcadia, CA 91006. (626) 821-5858.
Info and Referral: mental health, adults.

Aurora Las Encinas Hospital. 2900 E. Del Mar Ave. Pasadena, CA 91107.
(626) 795-9901. http://www.lasencinashospital.com.
Hospital: mental health, chemical dependency.

D'Veal Family and Youth Services. 1855 N. Orange Grove Blvd. Pasadena, CA 91103.
(626) 796-3453. http://www.dveal.com.
Social Services: behavioral health, at-risk youth, drug and gang prevention, job training.

Foothill Family Service. 2500 E. Foothill Blvd. Pasadena, CA 91107.
(626) 564-1613. http://www.foothillfamily.org.
Social Services: behavioral health, children, adults.

Fuller Psychological and Family Services. 180 N. Oakland Ave. Pasadena, CA 91101.
(626) 584-5555.
Counseling Center: mental health.

Huntington Hospital Della Martin Center. 100 W. California Blvd. Pasadena, CA 91105.
(626) 397-2329. http://www.huntingtonhospital.com.
Hospital: mental health, chemical dependency.

Pacific Clinics. 2471 E. Walnut St. Pasadena, CA 91107.
(877) 722-2737. http://www.pacificclinics.org.
Social Services: behavioral health, outpatient treatment, substance abuse.

Pacific Clinics — Child & Family Specialty Services. 2550 E. Foothill Blvd. Pasadena, CA 91107. (626) 744-5230. http://www.pacificclinics.org.
Counseling Center: mental health, children/youth.

Pacific Clinics — Hudson Family Services. 70 N. Hudson St. Pasadena, CA 91101.
(626) 795-8471. http://www.pacificclinics.org.
Counseling Center: mental health, children/youth, adults.

Pacific Clinics — Pasadena Family Services. 66 Hurlbut St. Pasadena, CA 91105.
(626) 441-4221. http://www.pacificclinics.org.
Counseling Center: mental health, case management, education.

Pasadena Mental Health Center. 1495 N. Lake Ave. Pasadena, CA 91104.
(626) 798-0907. http://www.pmhc.org.
Counseling Center: mental health, education.

Rose City Center. 595 E. Colorado Blvd. #418 Pasadena, CA 91101.
(626) 793-8609. http://www.rosecitycenter.org.
Counseling Center: mental health.

Westminster Center. 867 E. Atchison Pasadena, CA 91104.
(626) 798-0915. http://www.westminstercenter.org.
Counseling Center: mental health.

OLDER ADULTS & AGING

Altadena Senior Center. 560 E. Mariposa Altadena, CA 91001. (626) 798-0505.
Senior Center: seniors, education, recreation.

Hart Park House Senior Center. 222 W. Sierra Madre Blvd. Sierra Madre, CA 91024.
(626) 355-7394. http://www.cityofsierramadre.com.
Senior Center: education, recreation.

Hospice of Grace. 351 E. Foothill Blvd. Arcadia, CA 91006.
(888) 769-7444. http://www.hospiceofgrace.com
Hospice Care.

Huntington Senior Care Network. 837 S. Fair Oaks Ave. Pasadena, CA 91105.
(626) 397-3110. http://www.huntingtonhospital.com/SCN.
Information, referral, care coordination, caregiver support.

National Association for Hispanic Elderly. 234 E. Colorado Blvd., #300 Pasadena, CA 91101. (626) 564-1988. http://www.anppm.org.
Social Services: seniors, job training.

Pasadena Senior Center. 85 E. Holly St. Pasadena, CA 91103.
(626) 795-4331. http://www.pasadenaseniorcenter.org.
Senior Center: seniors, education, recreation.

South Pasadena Senior Center. 1102 Oxley St. South Pasadena, CA 91030.
(626) 403-7360.
Senior Center: seniors, education, recreation.

PREVENTION & SAFETY

Pasadena Public Health Department. 1845 N Fair Oaks Ave., Pasadena, CA 91103.
(626) 744-6005. http://cityofpasadena.net/publichealth.
Prevention: tobacco and AOD prevention, environmental health, disease investigation, emergency preparedness/bioterrorism, immunization, HIV testing, physical activity and nutrition, WIC.

Pasadena Public Health Department — Tuberculosis Clinic. 1845 N. Fair Oaks Ave., #122 Pasadena, CA 91103. (626) 744-6024. http://www.cityofpasadena.net/publichealth.
Clinic: TB testing, case management.

SOCIAL ENVIRONMENT

Casa Maria — URDC Human Services Corporation. 691 E. Washington Blvd. Pasadena, CA 91104. (626) 296-8689. http://www.urdchsc.org/casamaria.html.
Shelter: women, transitional housing, support services.

Child Care Information Services (CCIS). 2465 E. Walnut St. Pasadena, CA 91107. (626) 449-8221.
Childcare: children/youth, referrals, GAIN, CalWorks.

Food for Faith — Pasadena Church. 404 E. Washington Blvd. Pasadena, CA 91104. (626) 794-2951. http://www.pasadenachurch.com.
Food Bank: homeless, low-income.

Foothill Unity Center. 191 N. Oak Ave. Pasadena, CA 91107. (626) 584-7420. http://www.foothillunitycenter.org.
Food Bank: homeless, social services.

Friends in Deed. 444 E. Washington Blvd. Pasadena, CA 91104. (626) 797-2402. http://www.friendsindeedpas.org.
Food Bank: homeless, bad weather shelter, women's daytime shelter.

Grace Center. P.O. Box 40250 Pasadena, CA 91114. (626) 355-4545. http://www.grace-center.org.
Shelter: women, domestic violence, support services.

Haven House. P.O. Box 50007 Pasadena, CA 91115. (323) 681-2626. http://www.jfsla.org/havenhouse.
Shelter: women, domestic violence, support services.

Holy Family Giving Bank. 1524 Fremont Ave. South Pasadena, CA 91030. (626) 403-6140. http://holyfamily.org/giving-bank/
Food Bank: homeless.

Housing Works. 1277 N. Wilcox Ave. Los Angeles, CA 90038. (323) 466-0042. http://www.housingworksca.org.
Social Services: homeless, behavioral health, case management.

Meals on Wheels, Pasadena. 54 N. Oakland Ave. Pasadena, CA 91101. (626) 449-6815.
Food Delivery: seniors.

Pasadena Public Health Department — Women, Infants and Children (WIC) Program. 363 East Villa Street (Villa Parke Community Center), Pasadena, CA 91101. (626) 744-6005. http://cityofpasadena.net/publichealth/WIC.
Education: nutrition education, food checks, breastfeeding support.

Los Angeles Rape & Battering Hotline. (626) 793-3385. http://www.peaceoverviolence.org.
Hotline: domestic violence, sexual assault.

Salvation Army Social Services. 960 E. Walnut St. Pasadena, CA 91106. (626) 773-4400. http://pasadena.salvationarmy.org.
Food Bank: homeless.

Shepherd's Door Domestic Violence Resource Center. P.O. Box 40441 Pasadena, CA 91114. (626) 765-9967. http://shepherddoor.org.
Shelter: domestic violence, women, children/youth.

Union Station. 825 E. Orange Grove Blvd. Pasadena, CA 91104. (626) 240-4550. http://www.unionstationfoundation.org.
Shelter: homeless, social services, housing assistance, health services.

SUBSTANCE ABUSE

Casa Treatment Center. (626) 792-2770. https://www.casatreatmentcenter.org.
Treatment Center: substance abuse, support services.

CHOICES — URDC Human Services Corporation. 1460 N. Lake Ave., #105 Pasadena, CA 91104. (626) 398-3796. http://www.urdchs.org/choices.html.
Treatment Center: women, substance abuse, perinatal.

IMPACT. 1680 N. Fair Oaks Ave. Pasadena, CA 91103. (626) 798-0884. http://www.impacthouse.com.
Treatment Center: substance abuse, support services.

Pasadena Council on Alcoholism and Drug Dependence (PCADD). 1245 E. Walnut St., #117 Pasadena, CA 91106. (626) 795-9127. http://www.socialmodel.com.
Treatment Center: outpatient, substance abuse, screenings, referrals.

Passageways Multi-Service Center. 1020 S. Arroyo Parkway Pasadena, CA 91105. (626) 403-4888.
Shelter: homeless, substance abuse, behavioral health.

The Walter Hoving Home. 127 S. El Molino Ave. Pasadena, CA 91101. (626) 405-0950. http://www.walterhovinghome.com.
Treatment Center: substance abuse.

TEEN & ADOLESCENT HEALTH

Day One. 175 N. Euclid Ave. Pasadena, CA 91101. (626) 229-9750. http://www.godayone.org.
Education: substance abuse, parenting.

La Pintoresca Teen Education Center. 1415 N. Raymond Ave., Pasadena, CA 91103. (626) 792-5101, ext. 111. http://www.ci.pasadena.ca.us/LPTEC. Community Center: computer lab, tutoring, activity center, teens, adolescents.

TRANSPORTATION

Dial-A-Ride. 221 E. Walnut St., #199 Pasadena, CA 91101. (626) 744-4094. http://www.cityofpasadena.net/DAR.
Transportation: seniors, disabled.

References

1. Association for Community Health Improvement. Assessment Process Map. Accessed online at http://www.assesstoolkit.org/assesstoolkit/introassessment.jsp on September 7, 2016.
2. Nielsen Claritas, 2016.
3. United States Census Bureau. American Community Survey, 2011-2015.
4. Center for Women's Welfare. Self-Sufficiency Standard for Connecticut, 2015. p. 11 Accessed online at http://depts.washington.edu/selfsuff/docs/CT2015_SSS.pdf on September 30, 2016.
5. Healthy Communities Institute. Socioneeds Index, 2016. Accessed online at www.healthypasadena.org/socioneeds on May 1, 2016.
6. United States Census Bureau. American Community Survey data for Pasadena city, 2015. Map created by the City of Pasadena Department of Information Technology (DoIT), GIS Unit using ArcGIS.
7. Pasadena Homeless Count. Accessed on June 1, 2016.
8. California Department of Education. Pasadena Unified School District data, 2014-2015. Accessed online at http://dq.cde.ca.gov/dataquest/ on September 1, 2016.
9. California Department of Education. Pasadena Unified School District data, 2012-2013. Accessed online at http://dq.cde.ca.gov/dataquest/ on September 1, 2016.
10. California Department of Education. Pasadena Unified School District data, 2013. Accessed online at http://dq.cde.ca.gov/dataquest/ on September 1, 2016.
11. California Health Interview Survey (CHIS). SPA 3 San Gabriel Valley data, 2014. Accessed online at http://ask.chis.ucla.edu/ on November 5, 2015.
12. South Coast Air Quality Management District (SQAMD), 2006-2014. Accessed online at http://www.aqmd.gov/home/library/air-quality-data-studies/historical-data-by-year on September 7, 2016.
13. CalEnviroScreen Pollution Burden Scores, updated August 1, 2014. Accessed online at http://www.arcgis.com/home/webmap/viewer.html?webmap=bdebc81d41f14742a1d62aa046359292 on September 15, 2016.
14. California Water Science Center. USGS, 2014. Accessed online at http://ca.water.usgs.gov/data/drought/ on September 8, 2016.
15. City of Pasadena Water and Power. Urban Water Management Plan, 2015, Accessed online at http://www.cityofpasadena.net/waterandpower/UWMP/ on September 1, 2016.
16. City of Pasadena Police Department. Monthly Statistical Reports, 2008-2015. Accessed online at http://www.ci.pasadena.ca.us/Police/Crime_Statistics/ on September 7, 2016.
17. City of Pasadena Police Department. Reported Shooting Events (Cases), 2012-2015.
18. City of Pasadena Public Health Department. Vital Record Business Intelligence System (VRBIS) Mortality Data, 2015.
19. U.S. Department of Health and Human Services, Healthy People 2020 Goals and Objectives. Accessed online at https://www.healthypeople.gov/2020/topics-objectives on May 1, 2016.
20. City of Pasadena Public Health Department. Youth Master Plan Survey Results, 2014.

21. California Highway Patrol. Statewide Integrated Traffic Records System, 2015. Accessed online at http://iswitrs.chp.ca.gov/ on October 1, 2016.
22. California Health Interview Survey (CHIS). SPA 3 San Gabriel Valley data, 2013-2014. Accessed online at http://ask.chis.ucla.edu/ on November 5, 2015.
23. City of Pasadena Public Health Department. Birth and Communicable Disease Results, 2016.
24. Centers for Disease Control and Prevention, 2012-2014. Accessed online at https://wonder.cdc.gov/ on October 31, 2016.
25. California Health Interview Survey (CHIS). SPA 3 San Gabriel Valley data, 2007. Accessed online at http://ask.chis.ucla.edu/ on September 1, 2012.
26. California Office of Statewide Health Planning and Development (OSHPD). Greater Pasadena Hospitalization and ER Admissions, 2011-2013. Accessed on April 10, 2015.
27. California Health Interview Survey (CHIS). SPA 3 San Gabriel Valley data, 2009. Accessed online at http://ask.chis.ucla.edu/ on September 1, 2012.
28. California Department of Public Health. Prenatal Care in Pasadena, 2012. Accessed online at http://informaticsportal.cdph.ca.gov/CHSI/VSQS/Default.aspx on July 1, 2015.
29. City of Pasadena Public Health Department. Environmental Health Division, 2016. Map created by the City of Pasadena Department of Information Technology (DoIT), GIS Unit using ArcGIS.
30. California Health Interview Survey (CHIS). SPA 3 San Gabriel Valley data, 2011-2012. Accessed online at http://ask.chis.ucla.edu/ on April 1, 2014.
31. Pasadena Unified School District, 2014-2015. Accessed on September 1, 2016.
32. City of Pasadena Public Health Department, 2011-2013.
33. California Department of Public Health. Sexually Transmitted Diseases (STDs) in Pasadena, 2014. Accessed online at http://www.cdph.ca.gov/data/statistics/Pages/STDDataTables.aspx on October 22, 2014.
34. California Department of Public Health. County Health Status Profiles, 2012. Accessed online at http://www.cdph.ca.gov/pubsforms/Pubs/OHIRProfiles2012.pdf on October 31, 2016.
35. California Department of Education. California Healthy Kids Survey for Pasadena Unified School District, 2014-2015. Accessed online at http://chks.wested.org/query-chks/ on September 1, 2016.
36. National Association of County & City Health Officials. First Things First: Prioritizing Health Problems. Accessed online at http://archived.naccho.org/topics/infrastructure/accreditation/upload/Prioritization-Summaries-and-Examples.pdf on June 17, 2016.
37. Where are California's Uninsured Now? Wave 2 of the Kaiser Family Foundation California Longitudinal Panel Survey. Accessed online at http://kff.org/health-reform/report/where-are-californias-uninsured-now-wave-2-of-the-kaiser-family-foundation-california-longitudinal-panel-survey/ on October 20, 2016.
38. Pearcy, J., Keppel, K. A Summary Measure of Health Disparity. Public Health Reports, May-June 2002, Volume 117.

Suggested Citation: Huntington Hospital, Pasadena Public Health Department.
2016 Greater Pasadena Community Health Needs Assessment. December 2016.

To download a copy, please visit: http://www.healthypasadena.org/2016chna

Huntington Hospital

PASADENA PUBLIC HEALTH DEPARTMENT

#16

Title 11, California Code of Regulations, § 999.5(d)(5)(B)

A description of all charity care provided in the last five years by each health facility that is a subject of the agreement or transaction

PHA is dedicated to making healthcare services accessible to its patients and to working with those in its community who are unable to afford charges associated with the cost of their medical care. To this end, PHA provides financial assistance for qualifying patients who receive emergency or other medically necessary care at Huntington Hospital.

Huntington Hospital's financial assistance program helps low-income, uninsured or underinsured patients who need help paying for all or part of their medical care. Patients are eligible for financial assistance when their family income is at or below 350% of the federal poverty guidelines. The specific discount amount is determined based on a sliding scale, with patients whose income and monetary assets are below 200% of the federal poverty level receiving a 100% discount (one end of the scale) and those whose income is between 300% and 350% of the federal poverty level receiving a 25% discount (the other end of the scale), with gradations in between. In no event are patients who are eligible for financial assistance charged more than amounts generally billed for comparable care to patients with insurance.

For additional information regarding Huntington Hospital's financial assistance program, see the copies of Huntington Hospital's Financial Assistance Policy and Financial Assistance Application attached to this Section 999.5(d)(5)(B) as **Exhibit 16-A** and **Exhibit 16-B**, respectively. For information regarding the amounts of charity care provided at Huntington Hospital in the last five years, see the charts attached to this Section 999.5(d)(5)(B) as **Exhibit 16-C**.

In addition to its financial assistance program, Huntington Hospital also has a self-pay policy, an uninsured discount policy, and makes financial counselors and other resources available to its patients to help them evaluate their eligibility for various assistance programs. For more information regarding Huntington Hospital's efforts in this regard, see its website regarding patient financial resources, available here: https://www.huntingtonhospital.org/patients/cost-of-care/#financial-assistance.

Exhibit 16-A

Huntington Hospital's Financial Assistance Policy

HUNTINGTON HOSPITAL
ADMINISTRATIVE POLICY & PROCEDURE

SUBJECT: FINANCIAL ASSISTANCE, PREVIOUSLY REFERRED TO AS "CHARITY CARE"	POLICY NO: 329	PAGE 1 of 14
AUTHORIZED APPROVAL:	EFFECTIVE DATE: 01/01/2019	SUPERCEDES/REPLACES 01/01/2016

PURPOSE

The purpose of this policy is to establish the criteria by which patients can apply for financial assistance and the process and guidelines used in that process in compliance with applicable financial assistance regulations.

POLICY

Huntington Hospital provides a reasonable amount of its services without charge to financially eligible patients who cannot afford to pay for care. All emergency and medically necessary services as defined by Medicare as services or items reasonable and necessary for the diagnosis or treatment of illness or injury, except for elective cosmetic procedures, can be considered for financial assistance. Financial assistance discounts will be written off based on a determination under this policy that the patient/other responsible party has demonstrated an inability to pay. However, in cases where it is determined that the account has not been paid and no demonstrated hardship under this policy has been provided, such accounts will be characterized as "bad debts" and collection of such accounts will be pursued, including referrals of such accounts to a collection agency.

DEFINITIONS

I. FINANCIAL ASSISTANCE previously referred to as CHARITY CARE, IS DEFINED AS FOLLOWS:

Financial Assistance is financial aid to a patient or responsible party and does not include discounts normally given to insurance policy holders, contract prices that are negotiated with insurance companies or other adjustments once the final bill has been created. When the patient is able to pay part of their bill, consideration will be given to writing off a portion of that account as partial financial assistance. Financial Assistance may also include assistance to patients who have incurred high medical costs as defined as yearly healthcare costs greater than 10% of household income.

Financial Assistance is not to be considered a substitute for personal responsibility and patients are expected to cooperate with Huntington Hospital's procedure for applying for Financial Assistance, and to contribute to the cost of their care based on their individual ability to pay.

REASONSABLE PAYMENT PLAN: means monthly payments that are not more than 10 percent of the patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means expenses of any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

If after a payment plan is established and there is a period of 90 days of no payment, the payment plan will be deemed to be no longer operative.

II. FINANCIAL ASSISTANCE PATIENTS ARE DEFINED AS FOLLOWS:

A. Uninsured patients (those without third party insurance, Medicare, Medicaid, or with injuries or conditions qualifying for coverage worker's compensation or automobile insurance for injuries) who do not have the ability to pay based on criteria described in the Eligibility section below.
B. Insured patients whose insurance coverage and ability to pay are inadequate to cover their out of pocket expenses.
C. Insured patient unable to pay for portion of the bill due to uncollected co-payments, deductibles and non-covered services. .
D. An insured or uninsured patient with high medical costs, whose household income does not exceed 350% of the federal poverty level, but whose out-of-pocket medical costs or expenses exceed 10% of their income for the prior year.
E. Any patient who demonstrates an inability to pay, versus bad debt, which is the unwillingness of the patient to pay.

III. AMOUNTS GENERALLY BILLED

The AGB, (Amounts Generally Billed) is defined as the maximum amount a patient who qualifies under the financial assistance policy for a discount which is equal to the average amounts historically allowed as a percentage of billed charges for all services provided under the Medicare program for a 12-month look back period calculated in accordance with IRC 501(r). Please see appendix A for the AGB calculation.

IV. COVERED ENTITIES

Only Huntington Hospital, which includes all services and areas listed on our license from the state of California including but not limited to inpatient and outpatient services, medication management clinic, Huntington Ambulatory Care Clinic, and the Senior Care Network, is covered under this financial assistance policy. Any ancillary physician billing that may be generated during a patient's stay, i.e. pathology, radiology, anesthesia services are not covered under this policy.

Emergency Room physicians are not covered under this financial assistance policy but have their own financial assistance policy per Health and Safety Code Sections 127450-127462. Please see appendix B for a list of providers that provide emergency and medically necessary services at Huntington Hospital.

PROCEDURES

I. NOTICE TO PATIENTS

A. Communication and notification of the availability of the financial assistance policy within the community of each hospital shall be in accordance with AB774, SB350, SB1276 and the federal PPACA.
B. The hospital will post notices informing patients of the hospital's financial assistance program. The notice will be posted in inpatient and outpatient areas of the hospital, including the

emergency department, billing office, patient admissions and registration offices and outpatient settings. The notice will include contact information on how a patient may obtain more information on the financial assistance program.

C. All patients will be informed of the hospital's financial assistance program at the time of admission or registration and will be offered a copy of the plain language version of the policy as well as an application for assistance.
D. The hospital will provide the financial assistance policy and application translated into the language spoken by the patient consistent with section 12693.30 of the Insurance Code and Health and Safety Code Section 127410(a).
E. All printed statements of accounts to the patient will include a summary of the financial assistance policy with contact information on how to obtain an application for assistance and the copy of the complete policy. A summary of the FAP, the application for assistance with instructions will be sent out with the first two statements of account to the guarantor.
F. The financial assistance policy and the plain language summary are available on the hospital's web site and/or the on-line patient portal.

II. ELIGIBILITY DETERMINATION:

A. Gross income should fall within established standards for determination of the federal poverty level, considering family or household size, geographic area and other pertinent factors. (See grid in Section IV).
B. The term "income" shall mean the annual family or household earnings and cash benefits from all sources before taxes, less payment made for alimony and child support. Proof of earnings may be determined by annualizing year-to-date family or household income. (see II E below for definition of Family or household)
C. Financial assets will be considered to the extent allowed by financial assistance regulations.
D. Employment status will be considered along with the projected availability of future earnings sufficient to meet the obligation within a reasonable period of time.
E. Family or household size will be considered. For this purpose, "Family or Household" for an adult patient is defined as spouse, domestic partner, dependent children under the age of 21, whether living at home or not and anyone else claimed as a dependent on the patient's federal tax return. For patients under the age of 18, "Family or household" is defined as the patient's parent(s) and/or caretaker relatives, other children under 21 years of age of the parent or caretaker relative and anyone else claimed as a dependent on the patient's federal tax return.
F. Other financial obligations, including living expenses and other items of a reasonable and necessary nature will be analyzed.
G. Patients whose out-of-pocket medical expenses exceed 10% of their prior year income and whose household income is 350% or below of the federal poverty level are eligible for financial assistance.
H. For financial assistance consideration, (charity care policy), monetary assets are included in determining eligibility. The first ten thousand dollars ($10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000) be counted in determining eligibility. Discounts under other financial discount policies do not count monetary assets in determining eligibility.
I. A letter is requested to be submitted, along with the other documentation, detailing the patient's need for financial assistance and stating a request for aid.
J. The amount(s) and frequency of the hospital bill(s) in relation to all of the factors outlined above will be considered.

K. There will be a credit report run to verify financial and related information that will assist in making a determination about the patient's eligibility for financial assistance.
L. Before making any determination of whether all or part of an account qualifies for financial assistance treatment and the amount of any write-off that should be applied, the patient shall be required to assist the Hospital in obtaining payment from and helping to assure that all other resources will be first applied, including Medi-Cal, welfare and other third-party sources.
M. Patients that are eligible for Government sponsored low–income assistance programs (e.g. Medi-Cal /Medicaid, Healthy Families, California Children's Services and any other applicable state or local low-income programs) to be automatically eligible for full financial assistance when payment is not made by the governmental program. For example, patients who qualify for Medi-Cal/Medicaid as well as other programs serving the needs of low-income patients (e.g. CHDP, Healthy Families, and some CCS) where the program does not make payment for all services or days during a hospital stay are eligible for Financial Assistance coverage. Under Huntington Hospital's financial assistance policy, these types of non-reimbursed patient account balances are eligible for full write-off as financial assistance. Specifically, included as financial assistance are charges related to denied stays or denied days of care. All Treatment Authorization Request (TAR) denials provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, and other denials (e.g. restricted coverage) are to be classified as Financial Assistance.
N. In cases where the patient is non-responsive and/or other sources of information are readily available to perform an individual assessment of financial need, i.e., existing eligibility for Medicaid or PARO score, these sources of information can be used to support and/or validate the decision for qualifying a patient for full financial assistance.
Unless a patient is informed otherwise, Financial Assistance provided under this Policy shall be valid for one full year beginning on the first day of the month of the screening. However, Huntington Hospital reserves the right to reevaluate a patient's eligibility for Financial Assistance during that one year time period if there is any change in the patient's financial status. Additionally, financial assistance provided to non-responsive patients based on other sources of information will not be valid for the full year, and will only be applicable for the eligible retroactive dates of service.

O. Patients will be notified in writing of the financial assistance approval amount. If a full discount was not approved the notification will indicate why and what additional steps if any that could be taken to obtain additional coverage.
P. The business office has the final authority to determine if reasonable efforts have been made to determine FAP eligibility.
Q. Patients completing Financial Assistance Applications are responsible for making reasonable effort to supply the information needed to make a determination. Failure to provide that information may result in a denial of the Financial Assistance Application.
R. To the extent the patient is determined to not be FAP eligible or at least not determined to be eligible at the time of the charge, (i.e. billing was issued prior to submitting a completed application), the patient may be charged in excess of the AGB.
S. Under no circumstances will a FAP application be considered in excess of 240 days from the date of first billing.

Financial Assistance status will be determined after the time of discharge by the Business Office after all required documentation is submitted by the patient or responsible party (see Section III.B.). There may be some instances where, because of complications unforeseen at the time of admission, the hospital charges turn out to be considerably greater than anticipated or estimated, and the patient is unable to pay the full amount. A patient may request a financial assistance

application form from a financial counselor at any time. If the patient is unable to complete the form, the patient's surrogate decision maker may assist in completing the form, or the patient may ask for assistance from the financial counselor.

Once the account is settled, the information used for determination will be kept on file in the Business Office.

Patients who are not eligible for financial assistance or are eligible to receive partial assistance which leaves them owing a balance due to the Hospital may request a payment plan from the Business Office.

In the event of non-payment of a discounted amount due under this financial assistance policy the hospital may engage in further collection activity. The details of the further collection actions can be found in the Billing and Collection policy. A copy of this policy can be obtained by contacting the business office.

III. FINANCIAL ASSISTANCE AND OTHER DISCOUNTS:

A. General Relief

General Relief patients usually do not qualify for Medi-Cal, because they are normally single, have no children, are unemployed and homeless. General Relief patients are considered financial assistance eligible patients.

B. Financial Assistance (full and partial)

To be eligible for financial assistance, a patient's or responsible family member's income must be at or below 350% of the federal poverty level. The patient or responsible family member must complete the financial assistance form and include the documentation as stated in Section IV.

- Patients whose income and monetary assets are below 200% of the federal poverty level will receive financial assistance equal to 100% of the Amounts Generally Billed as defined in Section III above.
- Patients whose income is between 200% and 250% of the federal poverty level will receive a financial assistance discount equal to 75% of the Amounts Generally Billed as defined in Section III above.
- Patients whose income is between 250% and 300% of the federal poverty level will receive a financial assistance discount equal to 50% of the Amounts Generally Billed as defined in Section III above.
- Patients whose income is between 300% and 350% of the federal poverty level will receive a financial assistance discount equal to 25% of the Amounts Generally Billed as defined in Section III above.

The remaining balance, for patients qualifying for partial financial assistance, may be paid in interest-free installments as mutually agreed upon between the patient and Huntington Hospital. If a payment plan cannot be agreed upon mutually, the "Reasonable Payment Plan" as defined will be applied. Payment will not be considered delinquent, nor will further collection activity occur, as long as any payments made pursuant to a payment plan are not more than 90 days delinquent under the terms of that plan. If an outside collection agency is utilized to

collect the unpaid debt, the agency agrees to abide by the requirements of this policy and will not garnish wages or place a lien on a principal residence.

C. Presumptive Eligibility for Financial Assistance

Huntington Hospital understands that certain patients may be non-responsive to the financial assistance application process. Under these circumstances, Huntington Hospital may utilize other sources of information to make an individual assessment of financial need. This information will enable Huntington Hospital to make an informed decision on the financial need of non- responsive patients utilizing the best estimates available in the absence of information provided directly by the patient.

Huntington Hospital will utilize a third-party (PARO) to conduct an electronic review of patient information to assess financial need. This review utilizes a healthcare industry-recognized model that is based on public record databases. This predictive model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets and liquidity. The model is designed to assess each patient to the same standards and is calibrated against historical approvals for Huntington Hospital's financial assistance under the traditional application process.

The electronic technology will be deployed prior to bad debt assignment after in-house collection efforts and all other eligibility and payment sources have been exhausted. This allows Huntington Hospital to screen all patients for financial assistance prior to pursuing any extraordinary collection actions. The data returned from this electronic eligibility review will constitute adequate documentation of financial need under this policy and will include:

- PARO Financial Assistance Score – Score rank from 0 to 999. A lower score indicates a lower socioeconomic status, suggesting that the guarantor is more likely to require financial assistance. A higher score indicates a higher socioeconomic status suggesting that the guarantor is less likely to require financial assistance. The score is calculated from a series of index values used to define factors relating to liquidity, asset level, socio-economic standing and poverty. Based on historical approvals this score will be less than or equal to 554, as calculated by PARO.
- Federal Poverty Level (FPL**)** – The estimated income to household ratio compared to income thresholds determined by the US Department of Health and Human Services. This is used as a measure to determine if a person or family is eligible for assistance through hospital financial assistance programs, as well as various federal programs. This estimate is used as the secondary rule for qualification as it adds another level of likely liquidity. Based on historical approvals, this score will be less than or equal to 200% FPL, as reported by PARO.
- Residence Status – An indication of the guarantor's property ownership status. This estimate is used as the secondary rule for qualification as it adds another level of likely liquidity.

When electronic enrollment is used as the basis for presumptive eligibility, the highest discount levels will be granted for eligible services for retrospective dates of service only. If a patient does not qualify under the electronic enrollment process, the patient may still be considered under the traditional financial assistance application process.

Patient accounts granted presumptive eligibility will be reclassified under the financial assistance policy. They will not be sent to collection, will not be subject to further collection actions, will not be notified of their qualification and will not be included in the hospital's bad debt expense.

D. Self-Pay/Uninsured Patient Discount

Huntington Hospital provides discount options for our self-pay/uninsured patient financial needs.

Uninsured patients will automatically be given a self-pay discount on charges for hospital based medical services. The amount of the discount is similar to Medicare rates. This discount is applied automatically at the time of billing.

- This discount is not available on elective pre-paid procedures which must be paid in full prior to the time of service (i.e. cosmetic procedures, bariatric procedures).
- This discount is not available if some form of insurance or third-party payer may be responsible for paying for the care provided (i.e. worker's compensation, third party liability company). The difference between amount received and total charges for patients with coverage from entities that have no contractual relationship with the hospital (out of network) and qualify for financial assistance under this policy shall be considered as uncompensated care. In addition, non-covered or denied services to insured patients who otherwise would qualify for financial assistance shall be considered as uncompensated care.

E. Prompt Pay Discount

Huntington Hospital also offers patients a 10% prompt pay discount, upon request, when the patient is willing to pay the entire outstanding balance of their bill. Prompt pay discounts are not applied to accounts which have a payment plan set-up. Prompt payment must be made within 30 days of the bill date.

IV. ELIGIBILITY STANDARDS:

A. Eligibility is based on the current years' Federal Poverty Guidelines which are issued annually by the Federal Register by the Department of Health and Human Services (HHS) https://aspe.hhs.gov/poverty-guidelines

V. OTHER FUNDING

A. Patient Services Assistance (Huntington Hospital Ambulatory Care Clinic (HACC) only)

When a patient receiving services from HACC cannot pay the bill, they may qualify for patient services funding. To qualify, the patient must:

- Live in the immediate area (i.e., Alhambra, Altadena, Arcadia, Duarte, Eagle Rock, Glendale, Monrovia, Pasadena, South Pasadena, Temple City)
- Apply for financial assistance as stated in Part II of this policy.

Funds donated to the hospital and restricted for financial assistance care purposes will be used to cover all or part of the self-pay obligation of patients who meet the donated fund qualifications.

B. Trauma Patients

To obtain trauma funds, Patient Financial Services must have the following:

- The Trauma Service County Eligibility (TSCE) form must be filled out and signed by the patient or responsible relative/party.
- If the patient is medically unable to sign and there is no family member available, the "Certificate when Patient Unable to Cooperate" form will be filled out by a financial counselor. The reason why the TSCE form could not be signed will be recorded. The preparer must sign their name on the line for Hospital Reviewer.

C. Victims of Crime (VOC)

Patients who are a victim of a crime could be eligible for State of California funding from the VOC program. The patient can apply at the District Attorney's office at the courthouse in Pasadena. The patient will not qualify if:

- There is insurance involved
- He/she initiated the crime
- He/she expires

VI. ITEMIZED BILLS

The final bill will be produced within ten days after discharge. The Business Office will automatically send the itemized bill. If a bill is not received, one can be obtained by calling the Business Office at (626) 397-5324.

If the patient wishes to request an itemized bill while still a patient in the hospital, they may do so by calling (626) 397-5324 or by asking a financial counselor. The patient should keep in mind that an itemized bill requested during their stay will be incomplete and only list charges that have been put in the system through midnight of the previous day.

VII. FINANCIAL ASSISTANCE FORM

The financial assistance form is located at the end of this policy.

Instructions:

Please print and complete the form. Attach your most recent paycheck stub or your previous year's tax form. In addition, please write a letter stating your circumstances and request for financial assistance. Then, mail the form, letter, and supporting documents to:

Huntington Hospital
Attn: Patient Financial Services, Customer Service
100 W. California Boulevard
P.O. Box 7013
Pasadena, CA 91109-7013

For questions regarding this form, please call: (626) 397-5324 from 8:00am-4:00pm M-F. Assistance completing the application, obtaining copies of this policy, or answering any related financial assistance questions can be obtained at the Help Hub in the lobby of the main hospital 8:00am-4:00pm M-F.

The approved application and any discounts can be applied to any subsequent hospital visits in the same calendar year the application was first approved.

The application and accompanying documents must be returned to business office within 10 days. If an additional time is needed to complete the application please call the business office.

Copies of all the financial assistance policies and the application can be found on our website www.huntingtonhospital.com

The polices are also available translated into the following languages: Spanish, Chinese, Armenian, Korean, Arabic, Vietnamese, Russian, Czech, and Farsi.

VIII. FINANCIAL ASSISTANCE APPLICATION REVIEW/APPROVAL PROCESS

a. A Financial Assistance Application will be reviewed by a business office financial counselor. If gross income is at or below 250% of FPG, the counselor may approve the financial assistance application, based on the information submitted with the application (proof of income required). If the gross income is more than 250% but less than 350% of FPG, an assessment for qualification of partial financial assistance based on income, assets, and medical debt load will be made by the financial counselor.
b. Financial Assistance Applications will be reviewed and approved, denied or returned to the patient with a request for additional information within ten (10) business days of receipt.
c. Collection agency requests for financial assistance or Financial Assistance Applications received from a collections agency shall be reviewed by a RBO Financial Counselor. The counselor shall follow the review process described in (b) above in determining ability to pay and approving partial, total or no financial assistance. Standard transaction approval levels will apply.
d. An approved financial assistance determination is applicable to all services referenced in the application AND services provided up to the end of the calendar year within which the

services were rendered, provided there is no change in the applications financial status that would warrant a reevaluation.

e. If financial assistance is approved at 100%, any patient deposits paid toward accounts approved for financial assistance must be refunded to the account guarantor. This does NOT apply to any third-party payments, including casualty insurance payments or settlements paid from attorney trust accounts. Those payments will be retained and financial assistance will be granted for the difference between gross charges and the sum of those excluded payments. Refunds under this provision will include interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure. In the event the refund is $5 or less, no monies will be refunded.

VIII. DISPUTE RESOLUTION

In the event of a dispute, a patient may seek review from the Business Office Manager by calling (626) 397-5324.

SOURCES

Patient Financial Services
Compliance & Internal Audit Services

Financial Assistance Policy Summary

Huntington Hospital is dedicated to making healthcare services accessible to our patients and acknowledges the financial needs of our community who are unable to afford the charges associated with the cost of their medical care. Huntington Hospital provides Financial Assistance for qualifying patients who receive emergency or medically necessary care. Patients must complete an application, submit verification documents and meet the eligibility requirements listed below. This policy does not cover any other providers of service except Huntington Hospital.

Who is eligible for financial assistance?

Our program helps low-income, uninsured or underinsured patients who need help paying for all or part of their medical care. Patients are eligible for Financial Assistance when their family income is at or below 350% of the Federal Poverty Guidelines (FPG). Additional information may be requested and ultimately may affect the hospital's decision.

Patients who are eligible for Financial Assistance will not be charged more than amounts generally billed (AGB) for emergency or other medically necessary care to patients with insurance. (AGB as defined by IRS Section 501(r)). See appendix A in Financial Assistance Policy.

What does the program cover?

The Financial Assistance program covers medically necessary care provided at Huntington Hospital. Elective cosmetic services are not covered under this policy.

What will I need to provide to submit an application?

1) Previous year's income tax return
2) Current paycheck stubs for the last 2 months (Self/Spouse if applicable)
3) Letter of hardship (Description supporting your financial needs)

You must provide information about your family's income. Income verification is required to determine financial assistance. All family members 18 years or older in the household must provide their income. **There are detailed explanations on the financial assistance application.**

Who can I contact if I have questions filling out the application?

For Assistance on completing the application or to request a copy of the policy you may receive help at any of the following sources:

- At any inpatient, outpatient or emergency department patient intake areas.
- Call the business office at (626) 397-5324 between the hours 8:00am to 4:00PM M-F, (leave a message after hours). Live translation services are available
- The Help Hub in the main lobby of the hospital, M-F 8:00am – 4:00pm
- By mail at the address shown below
- Or you can download an application and copy of polices at www.huntingtonhospital.com

Is there language assistance available?

The policy and application forms are available in most languages spoken in our community and are available at the above mentioned locations. Interpreter services are also available.

Huntington Hospital
100 W. California Blvd.
PO Box 7013 Pasadena, Ca 91109-7013
Attention: Business Office

Reviewed and Updated Quarterly

APPENDIX A
CALCULATION OF AMOUNT GENERALLY OWED BY INDIVIDUALS
ELIGIBLE FOR FINANCIAL ASSISTANCE

The hospital limits the amount owed by individuals eligible under this Financial Assistance Policy who received services except for cosmetic and elective procedures to an Amount Generally Billed (AGB) to patients covered by Medicare. In addition, the hospital also limits the eligible patient's financial responsibility to less than total charges. The hospital shall periodically, at least once a year, update the AGB calculation and re-evaluate the method used. The AGB shall be based on all services provided to Medicare patients fully adjudicated as of the end of a recent 12-month look back period ending no more than 120 days prior to the effective date of the policy or every January 1st thereafter. The calculation of the current AGB is as follows:

Total Medicare Expected Reimbursement / Total Medicare Gross Charges = AGB Percentage
(current AGB is 15% effective January 1, 2019)

The eligible individual's financial responsibility is calculated as follows and applied to the patient liability only (excluding any portion assumed or paid by insurance or other entities on behalf of the patient):

Total Gross Charges for the Services Rendered X AGB Percentage = Patient Financial Responsibility

FAP Eligibility Percentage and the latest published Federal Poverty Level (FPL) Guideline

Annual Income is	FAP Eligibility %
Below 200% of FPL	100% or FREE
200% to less than 250% of FPL	75%
250% to less than 300% of FPL	50%
300% to 350%	25%
Greater than 350%	0%

Persons in Family or Household	100% Poverty Level Annual Income	200% Poverty Level Annual Income	250% Poverty Level Annual Income	300% Poverty Level Annual Income	350% Poverty Level Annual Income
1	$12,140	$24280	$30,350	$36,420	$42,490
2	$16,460	$32,920	$41,150	$49,380	$57,610
3	$20,780	$41,560	$51,950	$62,340	$72,730
4	$25,100	$50,200	$62,750	$75,300	$87,850
5	$29,420	$58,840	$73,550	$88,260	$102,970
6	$33,740	$67,480	$84,350	$101,220	$118,090
7	$38,060	$76,120	$95,150	$114,180	$133,210
8	$42,380	$84,760	$105,950	$127,140	$148,330
For families with more than 8 persons, add for each additional person	$4,320	$8,640	$10,800	$12,960	$15,120

SOURCE: Federal Register, Vol. 83, No. 12, pp. 2642-2644

The AGB will apply to services received from the hospital inpatient and outpatient departments.

Appendix B

Dear Patients:

Huntington Hospital is very pleased that you and your primary care physician have shown such confidence in us as evidenced by this admission to the hospital. We realized that there are many options open to you in a free society and we are especially gratified that you considered us your care provider of choice.

In that spirit and to avoid possible future confusion we would like to advise you that although Huntington and your primary care physician may be contracted with your insurance carrier, there may be other "hospital-based" physicians (Anesthesiologist, Emergency, Hospitalists, Intensivists, Lab/Pathologist, Pediatrics, Radiologist) who may not be contracted with your carrier and from whom you may receive balance due statements separate from the hospital's statements to you.

If you should receive billing from the Anesthesiology, Emergency, Hospitalists, Intensivists, Pathology, Pediatrics, and/or Radiology groups and if you have any questions regarding their billings, we encourage you to contact them directly at the telephone numbers listed below. They will be able to explain all of the aspects of their billing methods and contractual relations (if any) with your carrier.

Anesthesiology

ABC Billing
8905 SW Nimbus Ave Ste 300
Beaverton, OR 97008
(800) 275 2152

Emergency Physicians

HMH Emergency Med Grp
PO BOX 60259
Los Angeles, CA 90060
(877) 346 2455

Hospitalists

Academic Hospitalists Med Grp
50 Bellefontaine St Ste 307
Pasadena, CA 91105
(626) 352 1444

Intensivists

Huntington Pulmonary MG
39 Congress St
Pasadena, CA 91105
(626) 486 0181

Lab/Pathology

Huntington Pathology Med Grp
5700 Southwyck Blvd
Toledo, OH 43614-1509
(800) 536 1197

OB Hospitalists

OBHG California PC
PO Box 6127
Greenville, SC 29606
(800) 967 2289

Pediatrics

CA Med Business Serv
PO Box 60049
Arcadia, CA 91066
(626) 821 1411

Radiation Oncology

Huntington Rad Onc Med Grp
PO Box 67808
Los Angeles, CA 90067
(310) 273 7365

Radiology

CA Med Business Serv
PO Box 60049
Arcadia, CA 91066
(626) 821 1411

Reviewed and Updated Quarterly

Exhibit 16-B

Hospital's Financial Assistance Application

Huntington Hospital

Huntington Hospital Financial Assistance/Charity Care Application

Please fill out all of the information completely

Disclaimer

We cannot guarantee that you will qualify, even if you apply. A written response will be provided to all patients supporting approval/denial after we receive your completed application and documentation. The Financial Assistance Policy covers medically necessary care provided at Huntington Hospital. Elective cosmetic services and any other providers of service except Huntington Hospital are not covered under this program.

FAILURE TO SUPPLY ALL REQUIRED INFORMATION WILL RESULT IN DENIAL.

Screening Questions

Does the patient have health insurance?	☐ **Yes**	☐ **No**
Has the patient applied for Medi-Cal/Welfare Public Assistance?	☐ **Yes**	☐ **No** **If YES, which one?**
Is the patient currently homeless?	☐ **Yes**	☐ **No**
Is the patient currently employed?	☐ **Yes**	☐ **No**
Is the patient's medical care related to a car accident or a work injury?	☐ **Yes**	☐ **No**

Patient Information

Patient Account #:	**Statement #:**	
Patient Last Name:	**Patient First Name:**	**Patient Middle Name:**
Patient Date of Birth:	**Social Security Number:**	☐ **Male** ☐ **Female**

Guarantor / Responsible payer Information

Person Responsible for Paying Bill:	**Relationship to Patient:**	**Date of Birth:**	**Social Security Number:**
Mailing Address: _____ _____ **City** **State** **Zip Code**			**Contact Information:** ***Home*** **:** _____ ***Cell:*** _____ ***Email*** **:** _____

Employment status of person responsible for paying bill: ☐ **Employed** ☐ **Unemployed** ☐ **Self Employed**

☐ **Retired** ☐ **Student** ☐ **Disabled** ☐ **Other:** _____

Spouse / Domestic Partner Information

Spouse Last Name:	**Spouse First Name:**	**Spouse Middle Name:**
Spouse Date of Birth:	**Spouse Social Security Number:**	☐ **Male** ☐ **Female**
Spouse Mailing Address (if different from Patient): _____ _____ **City** **State** **Zip Code**		**Spouse Contact Information:** ***Home*** **:** _____ ***Cell:*** _____ ***Email*** **:** _____

Spouse Employment Status: ☐ **Employed** ☐ **Unemployed** ☐ **Self Employed** ☐ **Retired**

☐ **Student** ☐ **Disabled** ☐ **Other:** _____

Family Information

Please list the family members in your household, including yourself. You must be able to provide proof of the number of people you support in your Federal Tax Returns. Family includes anyone related by birth, marriage, or adoption who live with you. If the family member is 18 years or older, please answer columns 4 and 5 below. ***Examples of sources of income include: Wages, Self-Employment, Unemployment, Disability, Child/Spousal Support, Pension, SSI, Work Study Programs (students), Retirement Accounts, etc.***

 # OF PEOPLE IN FAMILY: _____

1. Name:	2. Date of Birth:	3. Relationship to Patient:	4. Employer Name/Source of Income:	5. Total Gross Monthly Income (before taxes):	6. Minor Also Applying for Financial Assistance? (separate application needs to be completed)
					☐Yes ☐ No Account # _____
					☐Yes ☐ No Account # _____
					☐Yes ☐ No Account # _____
					☐Yes ☐ No Account # _____
					☐Yes ☐ No Account # _____
					☐Yes ☐ No Account # _____

If you need to enter additional family members, please attach an another page

Huntington Hospital Financial Assistance/Charity Care Form - *Continued*

Income Information - PROOF REQUIRED

You must provide the following information about your family's income. Income verification is required to determine financial assistance. All family members 18 years or older must provide their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income:

YOU MUST PROVIDE THE FOLLOWING INFORMATION:

1) Previous year's income tax return (Complete Tax Report)

2) Current paycheck stubs for the last 2 months (Self/Spouse/ Domestic Partner if applicable) if unable to supply paycheck stubs, you are required to provide 2 months of bank statements.

3) Letter of hardship (Description supporting your financial needs)

If you are unable to provide your tax return information due to delay in tax filing, temporary disability or unemployment, please provide your non-filing tax form and the last 2 months of your bank account statements.** ***You can obtain a copy by calling 1-800-908-9946 or visit www.irs.gov/individuals/get-transcript (use form 4506-T or 4506T-EZ)

*** Permanently Disabled/Retired applicants need to provide a copy of their Social Security Award Letter. (If not available please provide last 2 months of your bank account statements).**

*** If you are a student on financial aid, please provide a copy or letter of approval of your school financial aid and/or student loan information with your application.**

***Upon receipt of application, a credit report will be processed (will include spouse).**

Expense Information

In circumstances where you qualify for partial financial assistance, providing the information below will help establish a reasonable payment plan for the remainder of your balance.

Please enter your MONTHLY expenses:

Rent/Mortgage: $ _____
Insurance Premiums: $ _____
Other Debt/Expenses: $ _____
Medical/ Dental Expenses: $ _____
Childcare/School: $ _____
Groceries: $ _____
Utilities: $ _____
Child/Spousal Support: $ _____
Transportation/Car: $ _____
Clothing/Other Misc. $ _____

Sources of Income/Asset Information

What are your sources of income? Please specify monthly or yearly for all that apply.

	Monthly	Yearly		Monthly	Yearly
Job Income:	$ _____	$_____	**Interest/Dividend Income:**	$ _____	$_____
Spouse Job Income :	$ _____	$_____	**Social Security Income:**	$ _____	$_____
Business Income:	$ _____	$_____	**Alimony/Support Income:**	$ _____	$_____
Rental Income:	$ _____	$_____	**Other Income:**	$ _____	$_____

Total Income: $ _____
Current Checking Account Balance: $ _____
Current Savings Account Balance: $ _____

Does your family have other assets? Please check all that apply:

☐ **Stocks** ☐ **Bonds** ☐ **401K** ☐ **Health Savings Account(s)** ☐ **Trust(s)**

☐ **Property (including primary residence)** ☐ **Own a Business**

Patient Agreement

I understand Huntington Hospital may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.
I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services rendered. FAILURE TO SUPPLY ALL REQUIRED INFORMATION WITHIN 10 DAYS WILL RESULT IN DENIAL.

_____ _____
Signature of Person Applying for Financial Assistance **Date**

Financial Assistance Policy Summary

Huntington Hospital is dedicated to making healthcare services accessible to our patients and acknowledges the financial needs of our communit who are unable to afford the charges associated with the cost of their medical care. Huntington Hospital provides Financial Assistance for qualif ing patients who receive emergenc or medicall necessar care. Patients must complete an application, submit verification documents and meet the eligibilit requirements listed below. This polic does not cover an other providers of service except Huntington Hospital.

Who is eligible for financial assistance?

Our program helps low-income, uninsured or underinsured patients who need help pa ing for all or part of their medical care. Patients are eligible for Financial Assistance when their famil income is at or below 350% of the Federal Povert Guidelines (FPG). Additional information ma be requested and ultimatel ma affect the hospital's decision.

Patients who are eligible for Financial Assistance will not be charged more than amounts generall billed (AGB) for emergenc or other medicall necessar care to patients with insurance. (AGB as defined b IRS Section 501(r)). See appendix A in Financial Assistance Polic .

What does the program cover?

The Financial Assistance program covers medicall necessar care provided at Huntington Hospital. **Elective cosmetic services are not covered under this policy.**

What will I need to provide to submit an application?

1) Previous ear's income tax return (**complete tax report**)

2) Current pa check stubs for the last 2 months (Self/Spouse/ Domestic Partner if applicable) if unable to suppl pa check stubs, ou are required to provide 2 months of bank statements.

3) Letter of hardship (Description supporting our financial needs).

You must provide information about our famil 's income. Income verification is required to determine financial assistance. All famil members 18 ears or older in the household must provide their income. **There are detailed explanations on the financial assistance application.**

Who can I contact if I have questions filling out the application?

For Assistance on completing the application or to request a cop of the application polic Summar ou ma receive help at an of the following sources:

- Call the business office at (626) 397-5324 between the hours 8:30am to 4:00PM M-F, messages left after hours will be returned within 24 hours.
- B mail at the address listed below
- Download an application and cop of Summar polic at https://www.huntingtonhospital.org/Targeted-Search.aspx?C=financial%20assistance#~75H8i71

Is there language assistance available?

The polic and application forms are available in most languages spoken in our communit and are available at the above mentioned locations. Interpreter services are also available.

Huntington Hospital
100 W. California Blvd.
PO Box 845656 Los Angeles, CA 90084-5656
Attention: Business Office

Exhibit 16-C

Amounts of Charity Care

Huntington Hospital

Inpatient / Outpatient Charity Patients Volume Financial Trend

Inpatient

	2019				2018				2017				2016				2015			
Payor	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)
MediCal FFS	168	801,066	2,323,418	(1,522,352)	192	756,135	2,743,587	(1,987,451)	189	1,163,405	4,791,068	(3,627,659)	166	849,581	3,270,001	(2,420,418)	195	1,064,051	3,643,155	(2,579,105)
MediCal Mgd Care	6	39,328	50,148	(10,820)	7	123,501	184,189	(60,688)	5	24,593	78,403	(53,809)	3	8,738	24,167	(15,429)				
MediCal Pending	11	37,374	93,583	(56,209)	10	14,805	68,777	(53,971)	67	167,119	545,253	(378,134)	5	8,278	26,624	(18,345)	36	163,241	558,644	(395,403)
Medicare Cost Based	7	56,404	101,105	(44,702)	5	319,325	717,892	(398,568)	2	4,642	12,285	(7,643)					2	12,483	19,060	(6,576)
Medicare Part B	5	78,448	142,730	(64,282)	2	6,436	19,764	(13,328)	2	3,314	28,785	(25,470)	2	10,911	17,554	(6,643)	8	171,787	438,970	(267,183)
Medicare PPS	64	1,014,476	1,233,001	(218,524)	88	1,227,040	1,886,563	(659,522)	51	510,443	719,510	(209,066)	40	573,911	801,963	(228,052)	37	432,415	494,183	(61,768)
Self/Other	108	96,067	1,045,528	(949,460)	148	48,291	1,397,702	(1,349,409)	193	80,546	1,803,939	(1,723,391)	40	7,414	353,092	(345,678)	68	26,191	908,831	(882,640)
Senior HMO	26	473,428	560,011	(86,583)	26	581,790	594,168	(12,378)	22	317,463	580,625	(263,162)	24	422,348	470,296	(47,948)	28	422,168	419,846	2,322
Grand Total	**395**	**2,596,589**	**5,549,525**	**(2,952,933)**	**478**	**3,077,323**	**7,612,642**	**(4,535,314)**	**531**	**2,271,527**	**8,559,867**	**(6,288,334)**	**280**	**1,881,181**	**4,963,698**	**(3,082,513)**	**374**	**2,292,336**	**6,482,690**	**(4,190,353)**

Outpatient

	2019				2018				2017				2016				2015			
Payor	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)
MediCal FFS	236	52,812	178,752	(125,939)	376	72,883	287,803	(214,915)	218	42,230	208,695	(166,462)	74	9,948	51,495	(41,546)	9	1,618	6,147	(4,528)
MediCal Mgd Care	1	53	683	(631)	22	2,435	7,192	(4,756)	7	545	2,601	(2,056)	2	0	2,668	(2,668)	5	842	3,232	(2,390)
MediCal Pending					3	934	4,955	(4,021)	42	53,618	66,437	(12,818)	8	11,308	11,314	(6)	5	4,731	4,727	3
Medicare Part B	2	2,215	5,061	(2,846)	5	2,355	8,556	(6,201)									1	270	642	(372)
Medicare PPS	190	233,768	426,857	(193,087)	238	270,457	429,918	(159,457)	61	61,246	164,334	(103,087)	64	126,490	274,691	(148,200)	32	110,338	112,056	(1,718)
Self/Other	1,657	48,033	1,083,110	(1,035,056)	2,601	163,281	1,480,660	(1,317,342)	4,828	156,433	2,785,840	(2,629,389)	573	6,974	349,743	(342,760)	776	100,254	474,227	(373,972)
Senior HMO	161	413,177	253,296	159,883	103	167,189	179,462	(12,271)	36	69,806	54,089	15,718	39	71,584	81,451	(9,867)	35	113,906	95,938	17,969
Grand Total	**2,247**	**750,057**	**1,947,759**	**(1,197,676)**	**3,348**	**679,535**	**2,398,547**	**(1,718,963)**	**5,192**	**383,878**	**3,281,996**	**(2,898,093)**	**760**	**226,304**	**771,362**	**(545,046)**	**863**	**331,959**	**696,968**	**(365,009)**

Huntington Hospital

Inpatient / Outpatient Charity Patients Volume Financial Trend - EMERGENT ONLY

Inpatient

	2019				2018				2017				2016				2015			
Payor	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)
MediCal FFS	144	722,484	2,059,227	(1,336,743)	170	606,490	2,314,501	(1,708,010)	171	829,869	3,941,182	(3,111,309)	162	846,491	3,246,295	(2,399,802)	179	1,007,832	3,412,334	(2,404,503)
MediCal Mgd Care	5	30,453	39,559	(9,106)	6	25,243	47,650	(22,407)	5	24,593	78,403	(53,809)	2	0	12,086	(12,086)				
MediCal Pending	11	37,374	93,583	(56,209)	10	14,805	68,777	(53,971)	64	165,396	529,165	(363,768)	5	8,278	26,624	(18,345)	35	163,241	530,206	(366,965)
Medicare Cost Based	6	52,443	92,672	(40,229)	5	319,325	717,892	(398,568)	2	4,642	12,285	(7,643)					1	4,392	8,674	(4,282)
Medicare Part B	5	78,448	142,730	(64,282)	2	6,436	19,764	(13,328)	2	3,314	28,785	(25,470)	2	10,911	17,554	(6,643)	8	171,787	438,970	(267,183)
Medicare PPS	56	862,745	1,034,143	(171,397)	77	1,053,045	1,686,206	(633,160)	42	416,001	551,971	(135,969)	38	498,662	709,150	(210,488)	29	288,561	332,592	(44,031)
Self/Other	102	92,318	986,927	(894,609)	141	45,959	1,354,580	(1,308,619)	183	67,148	1,686,692	(1,619,542)	40	7,414	353,092	(345,678)	62	23,578	684,952	(661,374)
Senior HMO	19	312,626	445,935	(133,309)	20	478,451	455,638	22,813	14	234,308	447,360	(213,052)	19	350,393	404,378	(53,985)	23	268,004	241,601	26,403
Grand Total	**348**	**2,188,890**	**4,894,776**	**(2,705,883)**	**431**	**2,549,753**	**6,665,008**	**(4,115,251)**	**483**	**1,745,273**	**7,275,842**	**(5,530,563)**	**268**	**1,722,149**	**4,769,178**	**(3,047,026)**	**337**	**1,927,394**	**5,649,329**	**(3,721,935)**

Outpatient

	2019				2018				2017				2016				2015			
Payor	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)
MediCal FFS	231	52,312	175,032	(122,719)	363	71,620	278,970	(207,345)	216	42,207	194,384	(152,173)	72	9,948	51,170	(41,221)	9	1,618	6,147	(4,528)
MediCal Mgd Care					21	2,398	6,828	(4,430)	6	542	2,110	(1,568)	2	0	2,668	(2,668)	5	842	3,232	(2,390)
MediCal Pending					3	934	4,955	(4,021)	41	53,510	66,250	(12,740)	8	11,308	11,314	(6)	4	4,715	4,268	448
Medicare Part B	2	2,215	5,061	(2,846)	3	1,647	4,342	(2,694)									1	270	642	(372)
Medicare PPS	108	88,532	189,940	(101,407)	121	71,525	131,309	(59,782)	14	19,387	45,083	(25,696)	25	13,875	38,465	(24,590)	15	9,642	14,915	(5,273)
Self/Other	1,449	46,834	941,642	(894,789)	2,399	160,398	1,353,965	(1,193,531)	4,494	154,682	2,609,787	(2,455,088)	540	6,917	314,396	(307,471)	729	99,475	450,057	(350,581)
Senior HMO	145	254,880	154,586	100,297	72	124,034	127,226	(3,191)	31	63,975	51,547	12,428	31	42,740	56,503	(13,762)	23	61,611	30,327	31,284
Grand Total	**1,935**	**444,773**	**1,466,261**	**(1,021,465)**	**2,982**	**432,557**	**1,907,595**	**(1,474,994)**	**4,802**	**334,302**	**2,969,161**	**(2,634,837)**	**678**	**84,788**	**474,516**	**(389,718)**	**786**	**178,174**	**509,587**	**(331,412)**

Huntington Hospital

Inpatient / Outpatient Charity Patients Volume Financial Trend - NON EMERGENT ONLY

Inpatient

	2019				2018				2017				2016				2015			
Payor	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)
MediCal FFS	24	78,582	264,191	(185,609)	22	149,645	429,086	(279,441)	18	333,536	849,886	(516,350)	4	3,090	23,707	(20,617)	16	56,219	230,821	(174,602)
MediCal Mgd Care	1	8,874	10,589	(1,715)	1	98,259	136,539	(38,280)					1	8,738	12,082	(3,343)				
MediCal Pending									3	1,723	16,088	(14,365)					1	0	28,438	(28,438)
Medicare Cost Based	1	3,961	8,433	(4,473)													1	8,092	10,385	(2,294)
Medicare PPS	8	151,731	198,859	(47,127)	11	173,994	200,357	(26,362)	9	94,442	167,539	(73,097)	2	75,249	92,813	(17,564)	8	143,854	161,591	(17,737)
Self/Other	6	3,749	58,600	(54,851)	7	2,332	43,121	(40,789)	10	13,398	117,247	(103,849)					6	2,613	223,879	(221,266)
Senior HMO	7	160,802	114,077	46,725	6	103,339	138,530	(35,191)	8	83,155	133,265	(50,110)	5	71,955	65,918	6,037	5	154,164	178,245	(24,081)
Grand Total	**47**	**407,699**	**654,749**	**(247,050)**	**47**	**527,570**	**947,633**	**(420,063)**	**48**	**526,254**	**1,284,025**	**(757,771)**	**12**	**159,032**	**194,520**	**(35,487)**	**37**	**364,942**	**833,361**	**(468,418)**

Outpatient

	2019				2018				2017				2016				2015			
Payor	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)
MediCal FFS	5	501	3,721	(3,220)	13	1,263	8,833	(7,570)	2	23	14,311	(14,288)	2	0	325	(325)				
MediCal Mgd Care	1	53	683	(631)	1	37	364	(327)	1	4	491	(488)								
MediCal Pending									1	109	187	(78)					1	15	460	(445)
Medicare Part B					2	708	4,214	(3,507)												
Medicare PPS	82	145,236	236,917	(91,680)	117	198,933	298,609	(99,674)	47	41,860	119,251	(77,391)	39	112,615	236,226	(123,610)	17	100,696	97,141	3,555
Self/Other	208	1,198	141,468	(140,267)	202	2,882	126,695	(123,810)	334	1,751	176,053	(174,301)	33	57	35,347	(35,289)	47	779	24,170	(23,391)
Senior HMO	16	158,296	98,710	59,587	31	43,155	52,236	(9,080)	5	5,831	2,542	3,290	8	28,844	24,948	3,896	12	52,295	65,611	(13,316)
Grand Total	**312**	**305,284**	**481,498**	**(176,211)**	**366**	**246,977**	**490,951**	**(243,969)**	**390**	**49,576**	**312,835**	**(263,256)**	**82**	**141,517**	**296,846**	**(155,328)**	**77**	**153,785**	**187,382**	**(33,596)**

#17

Title 11, California Code of Regulations, § 999.5(d)(5)(C)

A description of all services provided by each health facility that is the subject of the transaction in the past five years to Medi-Cal patients, county indigent patients, and other classes of patients

Huntington Hospital is a licensed general acute care hospital located in Pasadena, California. Huntington Hospital offers a full complement of acute medical care and community services, ranging from general medicine to specialized programs in cardiovascular services, oncology, and the neurosciences. Huntington Hospital has the only trauma center in the region as well as the only Level III Neonatal Intensive Care Unit. In addition, Huntington Hospital offers women's and children's services, state-of-the-art orthopedic surgery, in- and outpatient psychiatric services, senior care and ambulatory care.

For further information, please see the tables attached to this Section 999.5(d)(5)(C) as **Exhibit 17-A** that detail inpatient and outpatient services provided by Huntington Hospital by payor, gender, and age.

Exhibit 17-A

Inpatient and Outpatient Services

Huntington Hospital

Inpatient and Outpatient Volume Financial Trend By Payor

Inpatient

	2019				2018				2017				2016				2015			
Payor	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)
Comm HMO	4,944	95,546,652	76,106,889	19,439,762	5,070	88,028,500	73,448,881	14,579,619	5,525	98,367,176	81,683,786	16,683,500	5,463	97,773,310	78,949,049	18,824,261	4,709	82,989,855	63,427,616	19,562,238
Comm Indemnity	60	1,699,606	901,258	798,347	75	2,273,068	1,789,669	483,399	88	1,711,582	1,305,255	406,329	65	1,299,019	698,815	600,204	78	1,166,908	962,284	204,624
Comm PPO/EPO	7,244	120,268,335	90,667,673	29,600,662	7,702	126,669,092	93,603,710	33,065,383	8,188	127,785,753	98,719,513	29,066,403	8,392	127,112,375	100,699,456	26,412,920	7,910	117,565,708	90,118,959	27,446,748
MediCal FFS	2,386	23,256,979	37,343,298	(14,086,319)	2,449	21,476,067	35,844,474	(14,368,406)	2,426	21,068,059	37,348,473	(16,280,366)	2,696	22,007,566	40,923,492	(18,915,927)	3,046	20,708,626	38,642,053	(17,933,427)
MediCal Mgd Care	3,276	29,584,612	41,683,896	(12,099,284)	3,317	26,815,870	41,198,258	(14,382,388)	2,987	26,693,438	40,567,501	(13,874,003)	2,543	21,260,741	33,370,533	(12,109,792)	1,778	13,976,135	23,017,810	(9,041,675)
MediCal Pending	114	364,980	1,102,210	(737,230)	115	432,136	1,299,353	(867,217)	94	493,529	954,134	(460,604)	73	207,123	764,736	(557,613)	108	278,401	1,156,648	(878,247)
Medicare Cost Based	261	4,983,883	6,511,032	(1,527,148)	233	4,413,488	5,858,002	(1,444,515)	281	5,388,956	7,172,109	(1,783,147)	293	4,636,285	6,249,281	(1,612,997)	278	4,448,546	6,137,947	(1,689,401)
Medicare Part B	218	2,575,653	4,167,060	(1,591,407)	224	2,959,060	5,419,303	(2,460,243)	239	2,806,171	4,559,536	(1,753,360)	207	2,550,259	3,984,870	(1,434,611)	275	3,575,816	5,514,695	(1,938,879)
Medicare PPS	6,836	113,137,477	132,112,306	(18,974,829)	7,099	106,574,589	132,674,927	(26,100,338)	7,289	102,129,769	132,579,634	(30,449,720)	7,390	106,714,266	133,902,934	(27,188,668)	7,187	97,896,773	120,828,050	(22,931,278)
Self/Other	706	3,327,257	7,073,092	(3,745,835)	710	2,760,524	8,913,375	(6,152,851)	768	3,018,610	7,255,533	(4,236,908)	741	2,496,120	7,118,687	(4,622,567)	570	2,481,977	5,838,870	(3,356,893)
Senior HMO	4,561	93,299,818	89,670,727	3,629,090	4,169	85,433,089	85,711,255	(278,166)	4,362	83,313,786	83,980,830	(666,957)	4,155	77,498,733	78,090,473	(591,740)	3,417	62,875,778	62,127,415	748,363
Work Comp	246	8,093,872	5,527,665	2,566,208	280	8,504,949	6,153,489	2,351,460	279	8,267,491	6,313,574	1,953,923	243	6,910,941	5,925,830	985,111	218	5,305,167	4,361,326	943,842
Grand Total	**30,852**	**496,139,124**	**492,867,106**	**3,272,017**	**31,443**	**476,340,430**	**491,914,695**	**(15,574,265)**	**32,526**	**481,044,320**	**502,439,878**	**(21,394,910)**	**32,261**	**470,466,737**	**490,678,156**	**(20,211,418)**	**29,574**	**413,269,690**	**422,133,673**	**(8,863,982)**

Outpatient

	2019				2018				2017				2016				2015			
Payor	Visits	Net Revenue	Total Costs	Gain / (Loss)	Visits	Net Revenue	Total Costs	Gain / (Loss)	Visits	Net Revenue	Total Costs	Gain / (Loss)	Visits	Net Revenue	Total Costs	Gain / (Loss)	Visits	Net Revenue	Total Costs	Gain / (Loss)
Comm HMO	30,450	32,388,354	23,589,031	8,799,323	23,489	29,280,346	20,643,390	8,636,955	19,002	29,520,930	18,469,933	11,051,291	17,376	28,602,627	17,412,523	11,190,104	16,654	26,935,022	15,954,340	10,980,682
Comm Indemnity	370	730,254	278,129	452,126	417	571,293	285,274	286,019	500	649,405	330,719	318,695	576	648,174	349,521	298,653	461	677,373	299,197	378,176
Comm PPO/EPO	52,029	44,655,573	33,716,498	10,939,075	50,150	41,319,258	32,103,687	9,215,571	51,810	38,081,345	32,055,603	6,026,491	50,394	35,553,461	28,489,331	7,064,130	47,286	31,730,123	26,010,183	5,719,939
MediCal FFS	5,672	1,150,277	3,958,352	(2,808,075)	5,623	1,100,910	3,870,614	(2,769,704)	5,995	912,915	4,331,270	(3,418,240)	6,968	1,190,130	4,686,672	(3,496,542)	8,081	1,247,006	5,560,067	(4,313,060)
MediCal Mgd Care	18,481	6,756,084	14,322,441	(7,566,357)	18,403	4,758,818	13,281,417	(8,522,599)	17,614	3,980,216	12,032,205	(8,051,640)	15,801	3,396,941	10,304,050	(6,907,109)	15,011	3,138,821	9,331,949	(6,193,128)
MediCal Pending	25	51,007	129,404	(78,397)	18	10,925	27,009	(16,085)	12	32,833	17,578	15,255	12	29,857	20,195	9,662	153	109,163	180,009	(70,846)
Medicare Part B	668	476,799	723,767	(246,968)	630	389,034	638,984	(249,951)	721	352,878	712,097	(359,206)	704	373,752	684,204	(310,452)	824	477,692	732,678	(254,986)
Medicare PPS	37,676	23,843,153	33,259,912	(9,416,759)	38,115	22,046,377	33,188,168	(11,141,791)	39,330	19,920,171	32,297,966	(12,377,287)	39,108	19,760,000	31,710,333	(11,950,333)	39,542	19,566,229	28,111,814	(8,545,585)
Self/Other	11,416	1,752,419	5,453,905	(3,701,486)	11,105	1,813,274	5,698,852	(3,885,577)	10,040	1,391,908	5,736,942	(4,344,842)	10,080	1,242,192	5,889,327	(4,647,136)	9,547	1,203,550	4,671,717	(3,468,167)
Senior HMO	23,733	22,341,500	25,491,787	(3,150,287)	19,025	19,700,406	22,290,471	(2,590,065)	13,073	17,587,826	19,182,243	(1,594,219)	10,953	15,888,077	17,222,510	(1,334,434)	9,976	14,454,810	14,821,213	(366,402)
Work Comp	1,635	1,032,303	1,263,865	(231,562)	2,900	1,291,646	1,934,514	(642,868)	2,936	1,157,464	1,906,514	(749,008)	2,892	1,047,270	1,750,329	(703,059)	3,333	806,595	1,535,537	(728,942)
Grand Total	**182,155**	**135,177,723**	**142,187,091**	**(7,009,368)**	**169,875**	**122,282,286**	**133,962,381**	**(11,680,095)**	**161,033**	**113,587,891**	**127,073,068**	**(13,482,710)**	**154,864**	**107,732,480**	**118,518,996**	**(10,786,516)**	**150,868**	**100,346,384**	**107,208,704**	**(6,862,319)**

Huntington Hospital

Inpatient and Outpatient Volume Financial Trend By Gender

Inpatient

	2019				2018				2017				2016				2015			
Gender	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)
F	17,621	260,247,690	256,685,806	3,561,884	17,967	256,842,267	262,609,060	(5,766,793)	18,906	260,521,879	270,059,846	(9,537,590)	18,361	244,481,798	255,052,274	(10,570,476)	17,132	224,825,062	226,282,685	(1,457,623)
M	13,228	235,847,429	236,147,692	(300,263)	13,475	219,477,642	229,291,359	(9,813,718)	13,619	220,510,581	232,372,406	(11,861,553)	13,899	225,976,428	235,619,767	(9,643,338)	12,441	188,444,628	195,846,122	(7,401,494)
Unknown	3	44,005	33,608	10,396	1	20,522	14,277	6,245	1	11,860	7,627	4,233	1	8,511	6,115	2,396	1	0	4,866	(4,866)
Grand Total	**30,852**	**496,139,124**	**492,867,106**	**3,272,017**	**31,443**	**476,340,430**	**491,914,695**	**(15,574,265)**	**32,526**	**481,044,320**	**502,439,878**	**(21,394,910)**	**32,261**	**470,466,737**	**490,678,156**	**(20,211,418)**	**29,574**	**413,269,690**	**422,133,673**	**(8,863,982)**

Outpatient

	2019				2018				2017				2016				2015			
Gender	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)
F	79,885	74,474,671	79,979,848	(5,505,177)	74,027	65,800,133	74,073,549	(8,273,416)	71,744	61,096,830	69,291,918	(8,193,674)	67,937	57,514,460	63,897,768	(6,383,308)	66,750	52,584,735	57,833,205	(5,248,471)
M	58,363	60,642,194	61,902,427	(1,260,233)	55,852	56,475,756	59,675,898	(3,200,142)	52,980	52,482,616	57,770,812	(5,287,143)	51,470	50,201,128	54,356,556	(4,155,428)	50,020	47,760,389	49,374,583	(1,614,194)
Unknown	40	60,858	304,817	(243,959)	14	6,397	212,934	(206,537)	13	8,445	10,338	(1,893)	11	16,893	264,673	(247,780)	6	1,261	916	345
Grand Total	**138,288**	**135,177,723**	**142,187,091**	**(7,009,368)**	**129,893**	**122,282,286**	**133,962,381**	**(11,680,095)**	**124,737**	**113,587,891**	**127,073,068**	**(13,482,710)**	**119,418**	**107,732,480**	**118,518,996**	**(10,786,516)**	**116,776**	**100,346,384**	**107,208,704**	**(6,862,319)**

Huntington Hospital

Inpatient Volume Financial Trend By Age Group

Inpatient

	2019				2018				2017				2016				2015			
Age Group	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)	Cases	Net Revenue	Total Costs	Gain / (Loss)
00_04	3,995	47,101,922	42,961,851	4,140,071	4,174	47,612,919	40,675,126	6,937,794	4,236	47,799,911	42,630,970	5,169,025	4,150	42,110,233	41,019,042	1,091,191	4,130	39,262,278	37,335,239	1,927,039
05_09	179	1,876,694	2,705,434	(828,739)	206	2,399,962	2,884,394	(484,432)	212	2,575,697	3,743,652	(1,167,951)	250	2,565,321	3,769,302	(1,203,981)	235	2,103,435	2,734,546	(631,110)
10_14	175	2,157,526	3,682,936	(1,525,410)	225	4,329,126	5,787,668	(1,458,543)	235	4,413,185	4,729,777	(316,587)	231	3,207,279	4,763,580	(1,556,301)	231	3,970,953	4,121,255	(150,302)
15_19	385	5,253,398	5,961,367	(707,969)	410	5,833,411	6,546,653	(713,242)	423	5,819,423	6,482,638	(663,206)	441	6,589,092	7,427,808	(838,716)	366	4,343,714	4,513,922	(170,207)
20_24	785	9,190,693	9,713,149	(522,456)	868	9,697,652	10,001,386	(303,735)	965	11,456,736	10,817,544	639,211	932	10,715,769	10,403,368	312,401	955	11,084,847	10,590,900	493,947
25_29	1,452	16,396,948	15,923,711	473,237	1,523	15,626,711	15,443,598	183,113	1,582	17,334,869	17,219,908	114,992	1,603	17,472,673	16,965,787	506,886	1,376	13,248,825	13,593,243	(344,418)
30_34	2,141	26,912,457	24,344,090	2,568,368	2,276	26,894,524	23,081,152	3,813,372	2,265	28,035,409	24,660,193	3,375,261	2,227	24,391,763	22,747,390	1,644,372	1,968	20,874,040	18,411,298	2,462,742
35_39	1,997	26,079,706	23,001,377	3,078,329	2,080	26,135,835	23,028,808	3,107,027	2,058	25,787,765	22,790,443	2,997,363	2,060	24,423,132	23,375,964	1,047,168	1,854	22,554,391	18,760,687	3,793,704
40_44	1,370	22,849,712	19,658,796	3,190,915	1,323	19,177,929	18,888,684	289,245	1,381	18,821,966	18,118,440	703,554	1,301	20,426,949	18,138,678	2,288,271	1,264	18,959,062	17,827,888	1,131,174
45_49	1,335	20,922,291	19,794,411	1,127,880	1,398	21,344,800	21,585,937	(241,137)	1,477	20,807,340	21,206,236	(398,867)	1,535	21,772,941	21,877,958	(105,017)	1,336	19,135,038	18,164,791	970,248
50_54	1,530	27,016,002	25,742,745	1,273,258	1,529	25,284,414	26,317,260	(1,032,846)	1,770	28,902,722	29,143,641	(240,885)	1,811	30,826,848	30,508,611	318,238	1,633	27,706,427	26,973,390	733,037
55_59	1,766	33,465,921	32,619,463	846,458	1,886	32,933,225	32,702,553	230,673	1,934	33,653,979	35,597,599	(1,943,581)	2,014	34,638,721	35,049,736	(411,015)	1,717	29,616,131	28,540,797	1,075,334
60_64	2,055	40,314,869	38,394,517	1,920,352	2,121	40,110,217	39,765,140	345,077	2,164	39,877,355	41,535,552	(1,658,154)	2,207	41,177,375	40,688,689	488,686	1,991	35,856,438	35,909,275	(52,838)
65_69	2,336	44,128,944	46,502,979	(2,374,035)	2,283	43,692,649	47,666,628	(3,973,980)	2,535	45,784,010	50,700,189	(4,916,128)	2,507	45,038,229	49,683,783	(4,645,554)	2,144	37,024,161	40,444,523	(3,420,363)
70_74	2,380	46,785,475	49,093,033	(2,307,558)	2,232	42,201,367	48,071,627	(5,870,260)	2,214	39,523,885	44,901,677	(5,377,747)	2,221	38,899,699	44,784,105	(5,884,406)	2,053	35,176,997	39,721,222	(4,544,225)
75_79	2,165	42,714,843	45,427,063	(2,712,219)	2,089	36,088,672	41,551,906	(5,463,234)	2,102	35,277,666	41,498,738	(6,221,029)	1,878	31,861,181	35,919,403	(4,058,223)	1,727	28,114,364	31,960,192	(3,845,828)
80_84	1,807	33,731,324	35,479,744	(1,748,419)	1,737	30,646,439	35,855,410	(5,208,972)	1,886	30,924,263	36,740,666	(5,816,366)	1,822	30,367,944	34,181,477	(3,813,533)	1,773	26,764,827	31,029,934	(4,265,107)
85+	2,999	49,240,398	51,860,442	(2,620,045)	3,083	46,330,579	52,060,765	(5,730,186)	3,087	44,248,140	49,922,017	(5,673,815)	3,071	43,981,590	49,373,475	(5,391,885)	2,821	37,473,763	41,500,572	(4,026,809)
Grand Total	**30,852**	**496,139,124**	**492,867,106**	**3,272,017**	**31,443**	**476,340,430**	**491,914,695**	**(15,574,265)**	**32,526**	**481,044,320**	**502,439,878**	**(21,394,910)**	**32,261**	**470,466,737**	**490,678,156**	**(20,211,418)**	**29,574**	**413,269,690**	**422,133,673**	**(8,863,982)**

Huntington Hospital

Outpatient Volume Financial Trend By Age Group

Outpatient

	2019				2018				2017				2016				2015			
Age Group	Visits	Net Revenue	Total Costs	Gain / (Loss)	Visits	Net Revenue	Total Costs	Gain / (Loss)	Visits	Net Revenue	Total Costs	Gain / (Loss)	Visits	Net Revenue	Total Costs	Gain / (Loss)	Visits	Net Revenue	Total Costs	Gain / (Loss)
00_04	5,626	3,234,276	2,180,127	1,054,149	6,013	2,983,583	2,483,503	500,080	6,278	3,165,481	2,497,345	668,259	6,156	2,787,783	2,457,235	330,548	6,082	2,335,686	1,907,917	427,769
05_09	2,323	1,632,607	1,237,669	394,939	2,361	1,428,382	1,086,256	342,126	2,779	1,627,635	1,285,286	342,405	2,692	1,429,474	1,108,016	321,457	2,709	1,232,958	962,072	270,886
10_14	2,525	1,835,029	1,334,678	500,351	2,435	1,510,200	1,314,356	195,844	2,766	1,683,927	1,331,520	352,460	2,593	1,628,532	1,249,035	379,497	2,465	1,415,301	1,016,940	398,361
15_19	4,067	3,170,789	2,707,212	463,576	4,021	2,901,804	2,606,335	295,470	4,146	3,182,691	2,528,325	654,444	4,012	2,940,819	2,408,656	532,163	3,881	2,823,726	2,334,012	489,714
20_24	5,824	4,730,724	4,453,008	277,716	6,187	4,698,744	4,343,865	354,880	6,434	4,912,057	4,581,921	330,256	6,205	4,794,184	4,344,997	449,188	6,243	4,432,496	4,240,005	192,491
25_29	7,972	5,999,682	5,939,899	59,783	8,190	5,485,388	5,726,886	(241,497)	8,104	5,078,186	5,623,484	(545,150)	7,655	4,759,166	5,014,929	(255,763)	7,584	4,405,744	4,932,829	(527,085)
30_34	9,622	7,020,537	6,892,208	128,329	9,383	6,554,830	6,334,342	220,488	8,933	6,649,450	6,478,744	170,857	8,732	5,539,008	5,635,691	(96,684)	8,310	5,255,732	5,522,455	(266,723)
35_39	10,283	7,629,800	7,284,145	345,655	9,641	7,105,209	6,779,577	325,632	8,726	6,396,983	6,225,708	171,419	8,705	6,044,079	5,861,373	182,705	8,337	5,421,998	5,386,876	35,122
40_44	9,435	7,983,387	7,773,608	209,778	8,836	6,563,393	7,024,548	(461,156)	8,324	6,235,243	6,175,718	59,662	8,187	6,132,710	5,983,508	149,202	8,386	6,000,884	5,888,447	112,437
45_49	10,525	8,533,758	8,019,512	514,246	10,671	7,980,603	8,518,523	(537,921)	9,588	7,055,910	7,627,356	(571,298)	9,977	7,208,859	7,470,862	(262,004)	9,811	6,501,957	6,925,126	(423,168)
50_54	13,050	10,034,921	10,324,095	(289,174)	11,875	8,745,042	8,813,583	(68,542)	11,777	8,649,732	8,919,943	(270,035)	11,823	8,599,019	9,036,051	(437,032)	11,314	8,188,027	8,140,824	47,203
55_59	14,263	10,932,443	10,975,017	(42,574)	13,707	10,769,891	10,628,679	141,212	13,445	9,510,024	10,376,160	(865,941)	12,802	8,898,269	9,150,662	(252,393)	12,874	8,518,772	8,645,026	(126,254)
60_64	16,189	12,360,727	11,846,973	513,754	14,812	11,581,879	11,526,515	55,364	14,009	9,841,083	10,484,762	(643,486)	13,701	10,188,019	10,577,075	(389,056)	12,633	9,219,478	8,958,560	260,918
65_69	18,713	12,650,613	15,237,349	(2,586,736)	16,152	10,719,414	13,619,381	(2,899,967)	15,332	10,367,773	13,230,869	(2,862,894)	14,720	9,704,990	12,418,353	(2,713,363)	14,035	8,664,981	10,341,600	(1,676,619)
70_74	17,662	11,855,147	14,204,425	(2,349,278)	14,993	10,337,779	12,711,747	(2,373,968)	13,335	8,814,558	11,550,728	(2,735,999)	12,187	8,016,965	10,457,684	(2,440,720)	11,536	7,883,374	9,580,379	(1,697,005)
75_79	14,010	9,916,549	12,093,430	(2,176,880)	12,112	8,506,808	10,808,500	(2,301,692)	10,201	7,326,728	10,656,708	(3,329,845)	9,071	6,378,724	8,449,432	(2,070,708)	8,909	5,953,847	7,474,808	(1,520,961)
80_84	9,567	6,882,866	8,489,250	(1,606,384)	8,643	6,385,749	8,386,561	(2,000,811)	8,049	6,196,176	8,402,839	(2,206,557)	7,426	5,791,858	7,846,476	(2,054,618)	7,611	5,813,827	7,139,326	(1,325,499)
85+	10,499	8,773,870	11,194,489	(2,420,619)	9,843	8,023,588	11,249,225	(3,225,637)	8,807	6,894,255	9,095,652	(2,201,267)	8,220	6,890,024	9,048,960	(2,158,935)	8,148	6,277,595	7,811,501	(1,533,906)
Grand Total	**182,155**	**135,177,723**	**142,187,091**	**(7,009,368)**	**169,875**	**122,282,286**	**133,962,381**	**(11,680,095)**	**161,033**	**113,587,891**	**127,073,068**	**(13,482,710)**	**154,864**	**107,732,480**	**118,518,996**	**(10,786,516)**	**150,868**	**100,346,384**	**107,208,704**	**(6,862,319)**

#18

Title 11, California Code of Regulations, § 999.5(d)(5)(D)

A description of any community benefit program provided by the health facilities that are the subject of the agreement or transaction during the past five years with an annual cost of at least $10,000 and the annual cost of each program for the past five years

PHA is committed to caring for the physical, mental, and social well-being of its community. As part of these efforts, Huntington Hospital has a robust community benefit program and engages in a variety of activities aimed at addressing the health needs of its community, including its efforts to:

- Access to Healthcare Services – increase access to healthcare for uninsured and underinsured residents of its community. These efforts include providing navigation assistance to patients to help them obtain health insurance, offering affordable, high-qualify primary and specialty healthcare to underserved populations, and operating periodic medical clinics in the community.

- Heart Disease and Stroke – improve outcomes due to cardiovascular disease, stroke, and diabetes through increased awareness, education, and patient support.

- Child and Adolescent Health – mitigate the effects of stress and trauma and improve overall health and well-being of all children in its community.

- Older Adults and Aging – provide low-income and underserved older adults with the services and support required to meet their particular needs.

PHA also engages in a variety of health education, training, and research activities, such as providing free health clinics and offering clinical education for nurses, pharmacists, respiratory and physical therapists, dieticians and others.

For more information regarding Huntington Hospital's recent community benefit activities, see the community benefit reports Huntington Hospital filed with the California Office of Statewide Health Planning and Development for its 2017 and 2018 fiscal years, copies of which are attached to this Section 999.5(d)(5)(D) as **Exhibit 18-A** and **Exhibit 18-B**, respectively. For information regarding the estimated economic value of Huntington Hospital's community benefits for each of the last five fiscal years, including breakdowns by category of community benefit, see the charts attached to this Section 999.5(d)(5)(D) as **Exhibit 18-C**.

Exhibit 18-A

2017 Community Benefit Reports



Huntington Hospital Community Benefits Plan Fiscal Year 2017

For Submittal by May 31, 2018 to:
Office of Statewide Health Planning and Development
Accounting and Reporting Systems Section
2020 West El Camino Avenue, Suite 1100
Sacramento, CA 95833
Email: CommunityBenefit@oshpd.ca.gov

Huntington Hospital

Preface

In accordance with Senate Bill 697, Community Benefits Legislation, Huntington Hospital, a private not-for-profit hospital, submits this Community Benefits Plan for Fiscal Year 2017.[a] Senate Bill 697 requires a not-for profit hospital in California to complete the following activities:

- Review and reaffirm its mission statement to ensure that its policies integrate and reflect the public interest in meeting its responsibilities as a not-for-profit organization

- Complete and update a needs assessment every three years, evaluating the health needs of the community served by the hospital

- Adopt and file a community benefits plan annually, documenting activities that the hospital has undertaken to address community health needs within its mission and financial capacity; and to the extent practicable, assign and report the economic value of community benefits provided in furtherance of its plan

[a] Huntington Hospital fiscal year is from January 1 to December 31.

Introduction to Huntington Hospital

2017 marked a historic milestone: Huntington Hospital's 125th year of serving our community. Founded in 1892, Huntington Hospital is committed to providing excellent patient care delivered with compassion and respect. Huntington Hospital is a 619-bed, not-for-profit community hospital located in Pasadena, California. The hospital offers a full complement of acute medical care and community services, ranging from general medicine to the foremost specialized programs in cardiovascular services, oncology, and the neurosciences. The hospital has the only trauma center in the region. In addition, Huntington Hospital offers women's and children's services, state-of-the art orthopedic surgery, in- and outpatient psychiatric services, Huntington Hospital Senior Care Network, and Huntington Ambulatory Care Center.

Through an ongoing partnership between Huntington Hospital and Shriners Hospitals for Children – Southern California, inpatient surgical and medical services for pediatric patients are available at Huntington Hospital and the medical team provides advanced post-surgical care. A new Shriners for Children Medical Center (located across the street from the hospital campus) offers specialty care services for pediatric patients in the region. In 2017, Huntington Hospital and Providence St. Joseph Health entered into an agreement to further expand access to quality care. Providence St. Joseph Health, which includes 12 medical institutions across Los Angeles and Orange Counties, will now contract exclusively with Huntington Hospital in the San Gabriel Valley for all acute care hospital and outpatient clinical services. Huntington Hospital also partners with University of Southern California (USC) Institute for Maternal-Fetal Health to offer a Fetal Surgery Program in Pasadena – encompassing high-risk perinatal care, surgery and a neonatal intensive care unit (NICU) expertise.

As a teaching facility affiliated with the Keck School of Medicine of USC, Huntington Hospital supported 25 internal medicine and 17 general surgery residents in 2017. More than one-third of these residents remain in the area to practice, providing a seamless transition through generations of care.

Recently, Huntington Hospital received numerous awards, recognitions, and certifications:

- Full hospital-wide accreditation from The Joint Commission for achieving national standards for health care quality and safety
- Accredited as a Pediatric Medical Center (PMC)

- Gold Seal of Approval™ from The Joint Commission for stroke care
- Gold Seal of Approval™ from The Joint Commission for total knee and hip replacement program
- Certified as a Comprehensive Stroke Center from The Joint Commission, one of the first hospitals in Los Angeles County to earn this designation
- Named to Target: Stroke Honor Roll Elite by the American Heart Association/American Stroke Association and also received the American Stroke Association's Get With the Guidelines – Stroke Gold Plus Performance Achievement Award in recognition of the hospital's high quality, best practice stroke care
- Designation as a STEMI (ST Segment Elevation Myocardial Infarction) Receiving Center where emergency medical service personnel give patients having possible myocardial infarctions a 12-lead EKG in the field and a hospital team is ready when a patient arrives in the Emergency Department
- Magnet® designation by American Nurses Credentialing Center. Magnet® designation represents the highest level of national recognition to health care organizations that demonstrate sustained excellence in nursing care in a healthy, collaborative, and professional work environment. Only six percent of all acute care health care organizations have obtained this prestigious recognition.
- Maximum five-year accreditation from the Accreditation Council for Graduate Medical Education (ACGME)
- Hospital Compare 5-Star by the Centers for Medicare & Medicaid Services (CMS), the highest possible CMS rating for overall excellence
- Huntington Hospital Trauma Center has been recertified as a Level II trauma center by the Verification Review Committee (VRC), an ad hoc committee of the Committee on Trauma (COT) of the American College of Surgeons (ACS)
- Emergency Department Approved for Pediatrics (EDAP)
- Level III Neonatal Intensive Care Use with California Children's Services (CCS) Certification
- Huntington Hospital received Leapfrog Safety Grade of "A" for 2017-2018, one of 832 hospitals in the nation to receive the highest possible grade, based on 27 measures of publicly available hospital safety data

- Recognized by *U.S. News and World Report* for Best Hospital Rankings 2017-2018, #9 Hospital in California, #4 Hospital in Los Angeles Metro Area, ranked among the best in the country in gynecology and urology, and recognized as Best Regional Hospital in 15 types of care with recognition as "High Performing" in seven adult specialties and in eight common adult procedures and conditions
- The Cheers Award – bestowed by the Institute for Safe Medication Practices – honors organizations that have set a "superlative standard of excellence" in the prevention of medication errors
- Recipient of ECRI Institute 2017 Healthcare Supply Chain Achievement Award for demonstrating excellence in overall spend management and in adopting best practice solutions in its supply chain processes
- Huntington Hospital Cancer Center recently received a full three-year accreditation from the American College of Surgeons' Commission on Cancer
- Jim and Eleanor Randall Breast Center received a full three-year accreditation from the National Accreditation Program for Breast Centers (NAPBC), one of only three hospitals in Los Angeles County to achieve this level of accreditation
- Jim and Eleanor Randall Breast Center recognized as a Breast Imaging Center of Excellence by the American College of Radiology
- The American College of Radiology Commission on Quality and Safety has accredited Huntington Hospital's Toshiba Aquilion One 320 for computer tomography and Toshiba 2005 Vantage for magnetic resonance imaging services
- Accredited facility for Adult Transthoracic by the Intersocietal Accreditation Commission (IAC)
- Huntington Hospital awarded the Baby-Friendly® designation from Baby-Friendly USA, a credentialing program for hospitals that is part of an international initiative led by the World Health Organization (WHO) and the United Nations Children Fund (UNICEF). The designation is considered the gold standard of care and demonstrates our Women's and Children's Services commitment to patient and family-centered care.
- Huntington Hospital was accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)
- Centers of Distinction for bariatric surgery, spinal surgery, knee and hip replacement, heart and vascular services and cardiac care by the Blue Cross Blue Shield Association

- Huntington Hospital became a participant of the American Joint Replacement Registry (AJRR), a central registry for data on total hip and knee arthroplasties at the hospital and other participating sites throughout the country
- Neurophysiology Intraoperative Monitoring Laboratories and Epilepsy Accreditation from the Lab Accreditation Board of ABRET
- Named a 2017 Most Wired hospital by College of Healthcare Information Management Executives. The designation recognizes future-ready hospitals that use technology to improve communication, safety and patient-provider relationships.
- Recognized at the highest possible level by the Healthcare Information and Management Systems Society (HMSS) for the adoption and utilization of electronic medical record (EMR) systems at hospitals around the world

Huntington Hospital also offers continuing education and learning for the public, employees, medical staff, and other health care professionals, through the availability of health science and community libraries. With social media transforming the way that people communicate, Huntington Hospital has extended its reach into the web community using familiar sites like Facebook, Instagram, Twitter, and YouTube.

Contents

Section	Description	Page
	Preface	i
	Introduction to Huntington Hospital	ii
1	Executive Summary	1
2	Our Mission, Vision, Core Values and Commitment	4
3	2016 Community Health Needs Assessment Summary	5
	Our Community: Greater Pasadena	5
	Prioritized Health Needs	6
	Selected Areas of Focus	7
	Unaddressed Needs and Additional Community Benefit Activities	8
	Implementation Strategy	8
	2017 – 2019 Implementation Strategy: Goals and Strategies	9
4	Community Benefits Planning Process	11
5	Community Benefits Plan Update	13
	Access to Health Care Services	13
	Heart Disease and Stroke	17
	Child and Adolescent Health	20
	Older Adults and Aging	22
	Cancer	24
	Health Education, Training and Research	25
6	Economic Value of Community Benefits	28
Appendices		
A	Community Collaborations	30
B	Educational Affiliations	34

Section 1: Executive Summary

Mission Statement

At Huntington Hospital, our mission is to provide excellent health care and compassionate service to each person by bringing together outstanding physicians, caring nurses, professional staff and advanced technologies. Our vision, mission, and core values guide our organization's commitment to serving our community.

Definition of Community

Huntington Hospital's service area is defined as Greater Pasadena, which comprises the following communities and ZIP codes: Altadena (ZIP code 91001), South Pasadena (91030), Pasadena (91101, 91103, 91104, 91105, 91106, and 91107), and San Marino (91108).

2016 Community Health Needs Assessment (CHNA)

The 2016 Community Health Needs Assessment methodology included:

- An analysis of secondary data
- Primary data collection through key informant interviews coupled with input from approximately fifty individuals representing the interests of underserved groups in the Greater Pasadena region
- Synthesis of primary and secondary data
- Prioritization of preliminary data and screening out health problems based on feasibility factors

Based on the results of the prioritization and screening processes, a Huntington Hospital CHNA workgroup and the Executive Management Team determined that the Hospital's four priorities for the next three years, 2017-2019, will be:

- Access to Health Care Services
- Heart Disease and Stroke
- Child and Adolescent Health
- Older Adults and Aging

2017 – 2019 Implementation Strategy Goals

Huntington Hospital and its partners will address the following these health needs through the implementation of various strategies and programs. Our overall goals are:

Access to Health Care Services: Improve access to health care for uninsured and underserved residents of Greater Pasadena.

Heart Disease and Stroke: Improve outcomes due to cardiovascular disease, stroke, and diabetes through increased awareness, education, and patient support.

Child and Adolescent Health: To improve the ability of children and adolescents with asthma to manage their condition.

To mitigate the effects of stress and trauma and improve overall health and well-being of all children in the community.

Older Adults and Aging: Low-income and underserved older adults will have the services and support required to meet their needs.

Community Benefits Plan Programs and Activities

In Fiscal Year 2017, some of the activities Huntington Hospital conducted in support of these health needs included the following: providing navigation assistance to obtain health insurance or services available and linkages to providers; offering Huntington Ambulatory Care Center (HACC) to serve underinsured and uninsured persons, providing community health education, screening and support programs for numerous health conditions – including heart disease and diabetes – through a dedicated Community Outreach Department; providing no-cost asthma education and management services through Huntington Hospital Community Asthma Program; offering specialized programs and services to address elderly and disabled care and independence through Senior Care Network; and providing health information – in multiple formats and languages – for professionals, service agencies, and the general public. Huntington Hospital also conducted programs and services in response to the other community needs, including: providing specialized services related to cancer prevention, awareness and support; and collaborating with educational institutions to provide graduate medical education programs for general surgery and internal medicine residents, pharmacy residents, nursing students, and other health care professionals.

In addition, Huntington Hospital continued to provide charity care for patients without the ability to pay for necessary treatment, absorbed the unpaid costs of care for patients with Medi-Cal and

Medicare, and operated other medical programs in support of the community, such as an emergency and trauma center, neonatal nursery, high-risk perinatal program.

Economic Value of Community Benefits Provided

The economic value of community benefits provided by Huntington Hospital in Fiscal Year 2017 is estimated at **$129,780,381** (economic value includes Medicare Program Shortfall of $45,559,700).

Section 2: Our Mission, Vision, Core Values and Commitment

Huntington Hospital's Mission, Vision, Core Values and Our Commitment to You follow. These guide our organization in serving our community.

Mission Statement

To provide excellent health care and compassionate service to each person by bringing together outstanding physicians, caring nurses, professional staff and advanced technologies.

Vision Statement

To be the leader in creating community well-being through world-class health care delivered with kindness and dignity.

Core Values

Respect • Integrity • Stewardship • Excellence • Collaboration

Our Commitment to You

Thank you for allowing us to care for you. We take every step to exceed your expectation, and we encourage you to play an active role in your care. As part of our commitment to you, we will:

- Treat you with courtesy and respect.
- Listen carefully.
- Explain things in ways you understand.
- Address your needs.
- Answer your questions to keep you informed.
- Respond to your concerns.
- Provide a safe and clean environment.
- Include you and your family in your care.
- Be sensitive to your cultural needs.
- Work together as a team to care for you.

Approved by Board of Directors, 2016

Section 3: 2016 Community Health Needs Assessment Summary

Huntington Hospital's 2016 Community Health Needs Assessment and Implementation Strategy are available at www.huntingtonhospital.org and www.healthypasadena.org

In 2016, Huntington Hospital and the Pasadena Public Health Department partnered to conduct the first joint Community Health Needs Assessment (CHNA) of Greater Pasadena, in accordance with California Senate Bill 697[1] and the Patient Protection and Affordable Care Act (ACA)[2]. The resulting CHNA report describes findings from a year-long, systematic process that was conducted to provide insight into the health status and needs of the residents of the Greater Pasadena area. Data presented in the report span a wide range of indicators that affect community well-being, including disease rates, risk factors for disease and death, health behaviors, and social determinants of health. The CHNA serves as a tool for effectively planning the allocation of community benefits to improve the health of the community.

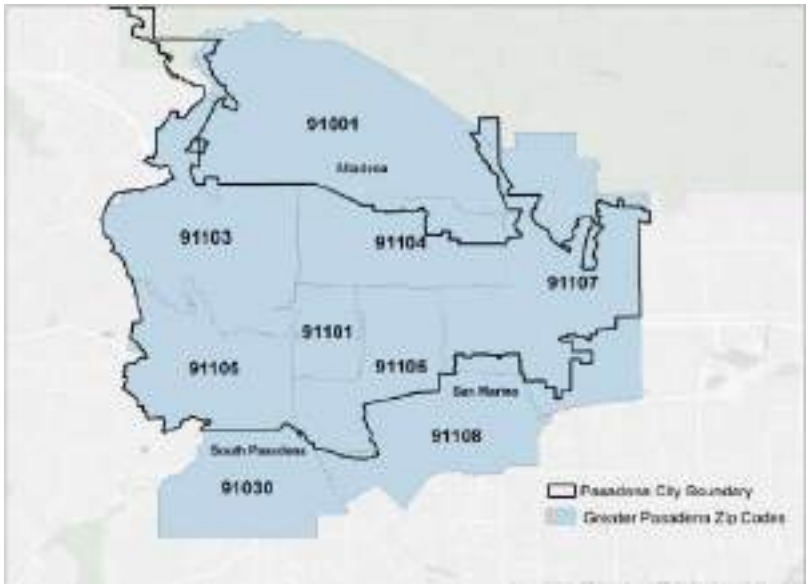
Our Community: Greater Pasadena

The 2016 CHNA focuses on the geographic area of Greater Pasadena, which includes Pasadena, Altadena, South Pasadena, and San Marino, and is comprised of nine contiguous ZIP Codes.

The total population of Greater Pasadena is 236,423 persons, approximately 2.3% of the entire population of Los Angeles County. In many respects, Greater Pasadena is a resource-rich community. For example, compared to California and/or Los Angeles County, the median household income rate is higher, the dropout rate is lower, the percentage of residents with a Bachelor's degree is much higher, the percentage of single-parent households is lower, and the ability to access care is slightly better. On the other hand, a single ZIP Code emerges within the geographic area with the highest level of socioeconomic need: ZIP Code 91103, northwest

[1] California Senate Bill 697 (SB 697) since its implementation in 1994, requires tax-exempt hospitals to document activities undertaken to address community health needs.
[2] The Patient Protection and Affordable Care Act (ACA), enacted in 2010, included in IRS Section 501(r), directs tax-exempt hospitals to conduct a Community Health Needs Assessment and develop an Implementation Strategy every three years.

Pasadena, has higher relative needs than the County overall, as evidenced by the highest rate of families living in poverty, the lowest median household income, and the highest rate of unemployment. Therefore, helping the residents of this area will be a priority in planning community benefit activities.



Prioritized Health Needs

The CHNA process included:

- An analysis of secondary data
- Primary data collection through key informant interviews coupled with input from approximately fifty individuals representing the interests of underserved groups in the Greater Pasadena region
- Synthesis of primary and secondary data
- Prioritization of preliminary data using the HANLON METHOD, rating each health need with a score of 0-10 based on the following three criteria: size of the health problem, seriousness of the health problem, and effectiveness of interventions
- Eliminating health problems using the 'PEARL' Test for the following feasibility factors (Yes/No):

  Proprietary – Does an appropriate program exist to address the health problem?

  Economics – Does it make economic sense to address the problem?

Acceptability – Will the community accept or want the program?

Resources – Is funding available or potentially available for a program?

Legality – Do current laws allow program activities to be implemented?

- Health problems which received a response of "No" to any of the above factors were eliminated.
- Priority scores were calculated for the remaining problems and rank was assigned accordingly.

Selected Areas of Focus

Based on the results of the prioritization process, the Huntington Hospital CHNA workgroup and the Executive Management Team determined that the Hospital's four priorities for the next three years, 2017-2019, will be:

- **Access to Care**, with a focus on improving access to primary and specialty care services, and strengthening the continuum of care
- **Heart Disease and Stroke**, with a focus on increasing awareness through education and patient support
- **Child and Adolescent Health**, with a focus on providing outpatient asthma specialty care, and addressing the effects of trauma on lifelong health
- **Older Adults and Aging**, with a focus on supporting independence

These four areas were selected because approaches to their improvement are compatible with the Hospital's mission, values, strengths, and resources, providing the best opportunity to positively impact the community.

While diabetes was not identified as a priority health need, data indicated that the prevalence of the condition is higher in the San Gabriel Valley (12.0%) than either Los Angeles County (10.0%) or California (8.9%). Additionally, both the age-adjusted hospitalization rate due to uncontrolled diabetes and the age-adjusted death rate due to diabetes are higher than Healthy People 2020 targets. Exercise, nutrition, and weight was ranked sixth highest health need and will be incorporated into the strategies to address Heart Disease and Stroke, through lifestyle practices, raising awareness, and education.

Unaddressed Needs and Additional Community Benefit Activities

Huntington Hospital's strategic approach is to allocate community benefit resources where impact will be maximized. With this idea guiding our selection of health needs to be addressed, we defer to our various community partners to directly address mental and dental health needs. Resources currently exist in Greater Pasadena, through community organizations that are specifically funded, and employ professionally trained staff offering an array of specialized programs and services in the realms of mental health and dental care.

Though mental health will not be an area of focus in the Implementation Strategy, Huntington Hospital provides adult behavioral health services through the highly regarded Della Martin Center for Behavioral Health. Services available include: Psychiatric Acute Treatment Program, Chemical Dependency Recovery Center, Partial Hospitalization Program, Intensive Outpatient Program, and Maternal Wellness Program.

Implementation Strategy

The Implementation Strategy summarizes the rationale for each health need, the goals, strategies and programs the hospital will employ to address the four identified priority health needs over the next three years. The components of this plan are not meant to include an exhaustive account of the various actions Huntington Hospital brings to bear, year in and year out, to address community health and wellness.

For each identified priority health need, the Implementation Strategy includes the following:

- Description – Summary and rationale regarding its importance
- Goal – What we hope to ultimately achieve
- Strategies and Programs – Resources that will be employed to address the priority health need
- Anticipated Impact/Metrics – Short-term objectives
- Potential Partnerships – Community Partners that may be engaged in joint efforts to address the priority health need

2017 – 2019 Implementation Strategy: Goals and Strategies

In 2017 through 2019, Huntington Hospital and its partners will focus efforts on the following goals and strategies through the implementation of various programs and services.

Health Need 1: Access to Health Care Services

Goal: Improve access to health care for uninsured and underinsured residents of Greater Pasadena

Strategies to Meet Need:

- Provide navigation assistance to obtain health insurance or services available
- Provide healthcare outreach
- Offer affordable, high-quality primary and specialty healthcare to the under-served population
- Bring periodic medical clinics into the community to supplement existing services to reach adult underserved residents
- Enable shared access of Electronic Health Record (EHR) via Health Information Exchange (HIE)

Health Need 2: Heart Disease and Stroke

Goal: Improve outcomes due to cardiovascular disease, stroke, and diabetes through increased awareness, education, and patient support

Strategies to Meet Need:

- Provide health education and support in the community
- Expand awareness of cardiovascular disease and stroke through activities and events in the community
- Expand education and support to patients with diabetes
- Expand dietary education

Health Need 3: Child and Adolescent Health

Goals: To improve the ability of children and adolescents with asthma to manage their condition

To mitigate the effects of stress and trauma and improve overall health and well-being of all children in the community.

Strategies to Meet Need:

- Continue to provide no-cost services through Huntington Hospital Community Asthma

Program

- Obtain grant funding to institute programming in the Pasadena Public School District to teach children and their caregivers tools to cope with stressors, based on health research done on trauma, and the Trauma Informed Care approach

Health Need 4: Older Adults and Aging

Goal: Low-income and underserved older adults will have the services and support required to meet their needs

Strategies to Meet Need:

- Provide older adults and their family caregivers with services, information, education, and support
- Support patients with chronic diseases, limited resources, and psycho-social issues which lead to hospitalization and threaten independence

Section 4: Community Benefits Planning Process

In compliance with Senate Bill 697, Huntington Hospital prepared this community benefits plan based on its 2016 Community Health Needs Assessment and in consideration of the Hospital's strengths, mission and resources, opportunities for partnership, solutions impact multiple community health needs, and effective methods are available.

A Manager of Community Outreach and Community Benefit participates in the planning and development of organizational community initiatives, represents Huntington Hospital in promoting the total health of the community through partnerships and collaborative efforts with local community organizations and individuals to improve quality of life and achieve Healthy People 2020 objectives, collects data that captures hospital-wide community benefits activities, and, in collaboration with the hospital's Strategic Financial Analysis team, ensures compliance with regulatory requirements pertaining to not-for-profit hospitals.

In Fiscal Year 2017, Huntington Hospital again supplemented its annual community benefits reporting process with the use of Lyon Software's CBISA Plus™ (Community Benefit Inventory for Social Accountability) software. The software uses key modules – needs, goals, partnerships, programs and statistics, indicators, narratives and outcomes – to capture quantitative and qualitative information for the hospital's fiscal year. Community benefit activity/program information was entered for many hospital departments, including: Administration, Ambulatory/Physician Information Systems, Blood Donor Center, Cancer Center, Cardiology, Cardiac Rehabilitation, Care Coordination, Clinical Laboratory, Clinical Education and Practice, Community Outreach, Emergency Department/Trauma Services, Employer Relations, Food and Nutrition Services, Health Navigation, Health Sciences Library, Huntington Ambulatory Care Center (HACC), Huntington Hospital Community Asthma Program (HHCAP), Huntington Collection, Integrative Oncology, Medical Post-Graduate Education, Neonatal Intensive Care Unit (NICU), Neurosciences, Non-Invasive Cardiology, Nursing Research, Occupational Therapy, Outpatient Rehabilitation, Parking, Patient Experience, Pediatrics, Pharmacy, Philanthropy, Physical Therapy, Public Relations, Radiology, Respiratory Care Services, Senior Care Network, Social Work Services, Speech-Language Pathology, Volunteer Services, and Workforce Development. To accurately report the economic value of community benefits, Finance reported information on the

unreimbursed costs of many programs and services, including charity care, shortfalls in government-sponsored programs, and other programs operated by the Department of Community Outreach, Senior Care Network, Huntington Ambulatory Care Center, Graduate Medical Education (GME), Health Sciences Library, Clinical Research, Perinatal Education, Palliative Care, and Health Navigation.

On an annual basis, Huntington Hospital will monitor and report measures of plan progress (metrics). In addition, staff at Huntington Hospital reports information to a Community Benefits Committee, comprised of representatives from approximately twenty health and social service organizations and interested citizens.

Section 5: Community Benefits Plan Update

This section includes a description of programs and services provided by Huntington Hospital and key measurements of outcomes accomplished (metrics) in Fiscal Year 2017. Programs and services are organized in response to the four significant health needs identified in the 2016 Community Health Needs Assessment. In addition, due our strengths in cancer prevention, awareness and support and health education and training, summary descriptions of key programs and services are also included. See **Appendix A** for a listing of the hospital's collaborations among organizations, service agencies, government and private providers in the San Gabriel Valley.

Access to Health Care Services

Programs and Services Offered:

- Huntington Hospital offered multiple programs to provide navigation assistance to obtain health insurance or services available including:
    - An on-site Medi-Cal Eligibility Worker was available at the hospital to assist patients who qualified to enroll for health insurance coverage
    - Throughout the year, registered nurses from the Community Outreach Department attended community health fairs and events, providing information on enrollment in health insurance options
    - Community members telephoned a dedicated number or visited the Hospital's website for free physician, service or facility referrals (14,085 telephone calls and chats handled in Fiscal Year 2017)
    - Huntington Hospital's Senior Care Network Resource Center served the community through the following programs and services:
        - Offering a free 50+ Health Connection Membership program (9,075 members)
        - Responding to 4,720 telephone inquiries by and 74 walk-in consultations
        - Assisting 1,379 patients identified by the Resource Center with post-discharge follow-up and as-needed assistance with care transitions
        - Visiting 155 50+ Health Connection members admitted to Huntington Hospital

  - Offering 20 Noon-Hour lectures on topics such as Medicare, heart health, stroke prevention, nutritional strategies for preventing and managing Type II diabetes, memory, reducing risk of colon cancer, reducing skin cancer risk, managing back pain through movement, orthopedics, addressing prostate cancer risks, managing breast health and cancer detection, fall prevention strategies, planning for the contingencies of illness or accident, and organizing your house to better enjoy your life (attended by 846 persons)
  - Distributing two *50+ Health Connection* newsletters, including information and advice about aging and disease management as well as an events calendar and description of ongoing programs
  - Attending ten Pasadena Senior Commission meetings
  - Attending nine End-of-Life Care Coalition meetings
- To empower members of the community to enjoy the healthiest lifestyles possible, registered nurses from the Community Outreach Department conducted free two-hour health screenings and counseling at 16 different screening clinics on alternating days each month, screening 1,962 persons. These screening clinic locations included: Pasadena Senior Center, Altadena Senior Center, South Pasadena Senior Center, Jackie Robinson Community Center, Villa Parke Community Center, Villa Parke Farmer's Market, Foothill Unity Center, Pasadena Central Library, Crowell Public Library, Cleveland Elementary School, Jackson Elementary School, Madison Elementary School, Roosevelt Elementary School, Washington Middle School, Friends In Deed, and Pacific Clinics.
- Throughout the year, registered nurses from the Community Outreach Department attended community health fairs and events, providing a variety of services including blood glucose screenings, blood pressure screenings, and Body Mass Index (BMI) measurements. In Fiscal Year 2017, 198 persons were screened and counseled at seven health fairs.
- In Fiscal Year 2017, Community Outreach Department nurses offered 17 health-related classes in English and eight classes in Spanish, serving 442 persons. Topics covered included: Ageless Benefits of Exercise, Diabetes in the Mirror, Diabetes Nutrition Tips, Emotional Fitness, Stress Management, Is it Flu or a Cold, First Aid at Home, Seeing is Believing: Vision, Preventing Falls, Pain, Medication Education, Healthy Heart 101, Journey

Inside Your Body, Part 1 and Part 2, and Brain Attack: Principles of Stroke. In addition, 49 yoga classes were offered, serving 536 persons.

- On November 18, 2017, Huntington Hospital partnered with Villa Parke Community Center, through Mejor Salud, Mejor Vida (Better Health, Better Life). At this annual health fair, local residents received care and information in a safe, welcoming environment. Many of the participants were low-income residents who face significant barriers in accessing regular health services. The team included community outreach nurses, nursing students, Graduate Medical Education (GME) staff, a pharmacist, Huntington Ambulatory Care Center (HACC) manager and social worker, as well as translators from PALS for Health, and mental health services from Pacific Clinics. Other partners were Pasadena Public Health Department, City of Pasadena Parks and Recreation, and City of Hope National Medical Center. They offered educational information, discussed insurance options, administered medical exams to 31 persons and arranged for follow-up visits through HACC (19 persons served by HACC).
- Huntington Ambulatory Care Clinic, staffed by the hospital's internal medicine residents, provided primary and specialty care for uninsured and underinsured residents, providing 5,113 visits in Fiscal Year 2017)
- Huntington Hospital's Emergency and Trauma Center is the sole provider of emergency services in Pasadena, providing 75,680 visits in Fiscal Year 2017
- Huntington Hospital continued to support and maintain Pasadena Community Urgent Care – a collaboration among Huntington Hospital, the City of Pasadena, Huntington Health Physicians, and ChapCare – through numerous outreach and marketing efforts. Pasadena Community Urgent Care also helps identify patients with chronic illnesses who don't have a primary care physician and makes the proper referrals for ongoing care. In 2017, hours of operation changed to seven days a week, 9 am to 9 pm.
- To assist local employers with keeping their workforce healthy, Huntington Hospital offered an onsite employee wellness program featuring health screenings and assessments for blood glucose and blood pressure, distribution of FIT kits for at-home colorectal screenings, DermaScan to screen for sun damage and potential skin cancers, development of customized programs based on assessments, educational sessions taught by physicians and other health care professionals, and maintenance of onsite information kiosks. In Fiscal 2017, approximately 7,000 persons were served through 97 events.

- On May 19, 2017, also known as National Hepatitis Testing Day, Huntington Hospital partnered with Hep B Free-Los Angeles and the Hepatitis C Task Force of Los Angeles County to host a day-long conference that helped raise awareness of this hidden epidemic. Nearly 100 health advocates, along with community and religious leaders, were on hand to learn more about viral hepatitis.
- In partnership with area hospitals, clinics and other health care organizations, the City of Pasadena, fire and law enforcement agencies, County Emergency Medical Services, and utility companies, a Huntington Hospital team attended ongoing monthly meetings to improve disaster preparedness in the community and provides ongoing education on personal preparedness to hospital staff
- Service providers and the public accessed the hospital-sponsored Healthy Pasadena website for data and information about community health status (includes health, economy, education, environment, government and politics, public safety, social environment, and transportation), tools and resources, community, priorities, and promising practices
- Community members accessed the hospital's website for pertinent health information and news, patient and visitor information, details about upcoming events and education classes, and a physician directory (with selection criteria including specialty, gender, location, insurance accepted and language spoken)
- To facilitate communication between hospital caregivers and patients, the Department of Patient Experience at Huntington Hospital offered three specialty services for interpretation in 22 languages and sign language: Language Line (3,089 calls and 32,663 minutes), Video Interpretation (4,918 records and 67,018 minutes), and Life Signs for Hearing Impaired (38 service calls)
- The continued availability of Health eConnect offered consumer education and patient involvement in their health care, a vehicle for improving quality and safety of patient care by reducing medical and medication errors, and provided caregivers with clinical decision support tools for more effective care and treatment. In addition, in Fiscal Year 2017, Huntington Hospital began the rollout of its Health Information Exchange (HIE) to ChapCare, a local federally qualified health center, with six active users.

Heart Disease and Stroke

Programs and Services Offered:

- To empower members of the community to enjoy the healthiest lifestyles possible, registered nurses from the Community Outreach Department conducted free two-hour health screenings and counseling – for blood pressure and blood glucose – at 16 different screening clinics on alternating days each month, screening 1,962 persons. These screening clinic locations included: Pasadena Senior Center, Altadena Senior Center, South Pasadena Senior Center, Jackie Robinson Community Center, Villa Parke Community Center, Villa Parke Farmer's Market, Foothill Unity Center, Pasadena Central Library, Crowell Public Library, Cleveland Elementary School, Jackson Elementary School, Madison Elementary School, Roosevelt Elementary School, Washington Middle School, Friends In Deed, and Pacific Clinics.[1]
- Throughout the year, registered nurses from the Community Outreach Department attended community health fairs and events, providing a variety of services including blood glucose screenings, blood pressure screenings, and Body Mass Index (BMI) measurements. In Fiscal Year 2017, 198 persons were screened and counseled at seven health fairs.[1]
- A Nurse Practitioner/Tobacco Treatment Specialist, with specialized training and expertise in tobacco cessation products, provided counseling, motivational and behavior change skills and techniques to assist individuals with overcoming nicotine addiction (eight persons served). An informative Tobacco Cessation pamphlet, detailing common myths and excuses, facts, and benefits of quitting tobacco, is readily available on the hospital's website.
- In February (National Heart Awareness Month), in partnership with the American Heart Association, Huntington Hospital celebrated Heart Month with a variety of activities. Throughout February, every baby born at the hospital received a free red onesie, to highlight the importance of heart health, from the very first moments of life. On Friday, February 3, hospital employees, volunteers, physicians and friends gathered in the hospital lobby for Wear Red Day, uniting with millions of people across the country to help raise awareness about heart disease in women. On February 14, a hospital chef demonstrated several healthy recipes, with samples and corresponding recipe cards distributed to participants.

[1] Programs and services presented under health need: Access to Health Care Services.

- A variety of lectures were delivered by physicians and dietitians throughout the year, including: Cardiology Updates, with Q&A sessions on February 21; Exercise and Diet: Heart Health as We Age on February 22; Modern Mediterranean Diet for Stroke Prevention on May 10; and Nutritional Strategies for Preventing and Managing Type II Diabetes on November 1.
- In May (National Stroke Awareness Month), Huntington Hospital's eighth annual gold instruction event took place at the Brookside Golf Course on May 24, 2017. "Saving Strokes," a rehabilitation-through-golf program of the American Heart/American Stroke Association offered stroke survivors the opportunity to add golf as a mental, physical, and emotional rehabilitation tool in their journey to recovery. Sixty participants spent the morning working with golf pros and later enjoyed a luncheon with fellow stroke survivors, physical therapists and other members of the Huntington Hospital Stroke Center team. On May 10, over 100 people attended a Stroke Awareness Health Fair at the hospital – supported by a multidisciplinary team comprised of nurses, physical therapists, speech language pathologists, and pharmacists. Huntington Hospital supported the annual Go Red for Women luncheon held on May 17 in Hollywood. The half-day event, attending by over 200 persons, featured break-out sessions and a heart healthy lunch.
- On June 1, 2017, Huntington Hospital collaborated with the Pasadena Fire Department to hold a free CPR pop-up training event at Paseo Colorado Shopping Mall in Pasadena. In less than five minutes per demonstration, CPR instructors taught the basic and proper techniques of Hands-Only CPR – done to the beat of the famous song "Stayin' Alive" – to over 100 local residents. On a weekly basis, Huntington Hospital NICU offers free Infant CPR classes, giving parents and caregivers additional confidence when infants are discharged from the unit.
- In partnership with the American Heart Association, Huntington Hospital participated in the Heart Walk at the Rose Bowl in Pasadena. During July through September, fifteen hospital team captain volunteers recruited walkers and raised money for the American Heart Association. On the day of the event – September 23 – hospital registered nurses provided blood pressure screenings and distributed information on heart disease.
- "Stop the Bleed" is a national initiative launched by the White House in 2015 to provide bystanders with tools and knowledge to stop life-threatening bleeding. Severe bleeding can result in death within minutes before Emergency Medical Services or other public safety providers arrive; the person closest to you may be the only one who can "stop the bleed."

Huntington Hospital Trauma Services conducted a training session on October 13 at the Pasadena Unified School District for 42 school nurses and provided QuikClot Bleeding Control supplies to all Pasadena Unified School District campuses. Trauma Services also conducted a training session on November 27 at Southern California Edison Company for 29 Safety Staff employees, demonstrating the appropriate application of tourniquets and appropriate packing and compression of actively bleeding areas of injury.

- In Fiscal Year 2017, Huntington Hospital completed an analysis of patient specific data that revealed approximately 20 percent of patients had a secondary diagnosis of diabetes, with increases in diabetes patients and diabetes visits over the past four years. Data analysis also revealed that the average length of stay of patients with a secondary diagnosis of diabetes is approximately 1.5 days longer than patients without diabetes. As a result, strategies were developed for insulin administration; standardized, evidence-based patient education (e.g., to assist patients in preparation for discharge); and coordination of delivery of meal trays by Food and Nutrition Services with insulin administration and blood glucose testing. Future plans include ongoing education of nursing staff and development of a comprehensive outpatient diabetes management program (including those offered by HACC).
- Huntington Hospital Heart and Vascular Center and Stroke Center offer state-of-the-art medical care to patients. The Heart and Vascular Center is a recognized leader in cardiac care, offering a full spectrum of services, including screening and diagnostic tests, advanced medical and surgical treatments, cardiac rehabilitation, and education programs. Huntington Hospital's Stroke Center offers 24-hour emergent diagnostic and treatment services to patients, a dedicated 12-bed stroke unit, a continuum of care that includes a 24-bed inpatient rehabilitation unit and an outpatient rehabilitation program, and support programs for stroke patients and their families. New programs addressing heart disease and stroke include the addition of a Leapfrog Group-compliant Intensivist Program and the availability of the CardioMEMS Heart Failure System, a new miniaturized, wireless monitoring sensor that is implanted in patients to manage heart failure.
- In Fiscal Year 2017, free, monthly meetings were held for Stroke Survivor Support Group (served 12 to 20 persons each month), Stroke Family/Caregiver Support Group (a self-directed group run by the participants), and Stroke Survivor Aphasia Speech Group (served 303

persons). A Senior Exercise Class held twice a week – led by physical therapists – assisted 638 persons in Fiscal Year 2017.

- Supplemental information on heart disease and stroke is also available on the hospital website. This information addresses many different aspects of these health conditions, including risk factors, heart disease in women, diet, herbs and alternative medicine, smoking cessation, and other heart resources.

Child and Adolescent Health

Programs and Services Offered:

- To help children, adolescents and adults better understand their asthma needs and decrease emergency room visits, hospitalizations and missing school or work, Huntington Hospital continued to offer asthma education and management classes (HHCAP). In Fiscal Year 2017, 228 persons participated in 143 asthma education and management sessions. In addition to these specialized classes, Huntington Hospital offered 28 asthma clinics, where allergists evaluated and treated 273 medically underserved children and adults. Based on statistics for the most recent full year available (2016), 94% of asthma education participants experienced decreased emergency department visits or hospitalizations six months to one year after education sessions.
- In Fiscal Year 2017, Huntington Hospital, along with collaborating partners – Pasadena Unified School District (PUSD) and Young & Healthy – requested grant funding from UniHealth Foundation for a new initiative, the Pasadena Trauma-Informed Care Initiative. The program seeks to enhance the well-being of local residents through a community-wide effort to reduce the prevalence and impacts of trauma, which is increasingly recognized as a health care epidemic. Over the three-year grant period, some of the activities Huntington Hospital plans to conduct include: providing training sessions to approximately 200 community professionals annually, on-campus trauma-informed care training for approximately 80 PUSD teachers annually, preparing approximately 182 teachers each year to implement mindfulness techniques for students in their classrooms, educating at least 100 local parents and families annually, and providing trauma-informed care education to more than 100 area medical professionals.

- "Stop the Bleed" is a national initiative launched by the White House in 2015 to provide bystanders with tools and knowledge to stop life-threatening bleeding. Severe bleeding can result in death within minutes before Emergency Medical Services or other public safety providers arrive; the person closest to you may be the only one who can "stop the bleed." Huntington Hospital Trauma Services conducted a training session on October 13 at the Pasadena Unified School District for 42 school nurses and provided QuikClot Bleeding Control supplies to all Pasadena Unified School District campuses.[1]
- Huntington Hospital offered childbirth and parenting classes for community members as well as specialized services for parents with an infant in the hospital's NICU. In Fiscal Year 2017, Huntington Hospital offered classes on a variety of topics such as childbirth preparation, infant care, breastfeeding basics, CPR, and Mommy and Me as well as online virtual maternity tours and weekly maternity orientation sessions, including small group tours of Labor and Delivery and Maternity. Under the supervision of a lactation specialist, Huntington Hospital hosted a weekly Breastfeeding Support Group, serving 3,500 persons in Fiscal Year 2017. A child life specialist conducted parent child workshops at local libraries, presenting various health topics for discussion and education (200 persons served in Fiscal Year 2017). On a regular basis, Huntington Hospital hosted events for families of NICU infants, including: Infant CPR Class (held weekly; 75 persons served), NICU Orientation (held weekly; 110 persons served), Parent Connection Coffee Break (biweekly support groups; 150 persons served), Parent Connection Pizza Night (held monthly; 75 persons served), Parent Connection Baby Shower (held three times; 80 persons served), and Walk for Kids, an annual event to benefit for the Ronald McDonald House in Pasadena.

[1] Program and services presented under health need: Access to Health Care Services.

Older Adults and Aging

Programs and Services Offered:

- Huntington Hospital Senior Care Network (SCN) is a nationally recognized not-for profit program that has helped older adults and adults with disabilities and their families remain healthy and independent since 1984. Care coordination programs – provided by expertly trained Bachelor's and Master's degree social workers and nurses – offer assistance with solving care problems, help connect to resources such as personal care and meals, coordinate service delivery and monitor progress, educate about managing hospital stays and returning home, assist with changes in living arrangements when needed, and serve as a representative for out-of-area families. In Fiscal Year 2017, SCN programs – including the Multipurpose Senior Services Program (MSSP) and Assisted Living Waiver (ALW) Program – served an average of 575 clients each month.
- Moving to a new location on the hospital campus, SCN continued its efforts to be more accessible to everyone who needs the program, including walk-ins, referrals from hospital staff, calls from people regarding an aging family member. In addition to the new space being larger, it can accommodate individuals with mobility limitations and includes private meeting space for talking with clients about sensitive and confidential concerns. Further enhancing access to SCN services, special ambassadors from this Huntington Hospital department are deployed to serve at the front desk in our main lobby, where they help direct visitors and respond to questions. In addition, SCN staff collaborate extensively with other community care providers. In 2017, Huntington Hospital expanded its assistance to vulnerable seniors who are returning home after receiving inpatient care. Experts from Senior Care Network worked with discharge staff across the hospital, to help improve patient safety and outcomes during and after the transition home.
- In Fiscal Year 2017, registered nurses from Huntington Hospital administered 2,045 free flu shots on 27 different occasions during the three-month period from late September to November. Nurses conducted flu shot clinics at a variety of locations, including: senior centers, area churches, service agencies and centers in the community, Huntington Ambulatory Care Center, hospital cafeteria, public libraries, public schools, community centers, community events, and farmer's markets. To maximize the vaccine supply and avoid duplication of efforts,

registered nurses from Huntington Hospital Community Outreach coordinated dates and sites with Pasadena Public Health Department.

- A group of nurse navigators and a community navigator assisted patients in improving their hospital experiences and ensuring safe and successful transitions to their homes following hospitalization. These navigators assisted older patients in the management of conditions such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), cardiac surgery, stroke, and joint replacements. Navigators collaborated with other medical personnel, families, and service centers; clearly communicated patients' needs to other health care personnel; assisted with information about medical conditions, treatments, and services; explored patients' goals, any barriers, and needs in self-management; and assisted with setting up appointments, obtaining transportation and medications and linking patients with community resources. In Fiscal Year 2017, nurse and community navigators assisted 4,990 unique patients. A Geriatric Certified Nurse Specialist performed approximately 200 comprehensive geriatric assessments and rounded on 165 patients in Fiscal Year 2017.
- With the support of funding from UniHealth Foundation, Huntington Hospital, along with three other magnet hospitals – Cedars-Sinai Medical Center, UCLA Ronald Reagan Medical Center, and Torrance Memorial Medical Center – participated in a demonstration and evaluation project on a Systems Addressing Frail Elders (SAFE™) Care. A multidisciplinary team including nurses, pharmacists, physicians, social work, information systems, and administration worked on the project in Fiscal Year 2017, implementing the SAFE™ Care Program on the intervention unit and collecting data on patients 65 years and older from the implementation and comparison units. Outcomes expected are decreased lengths of stay, reduced complications and adverse events, and fewer intensive care unit days. The study completed data collection in September 2017. Analysis of data is currently in progress.
- To help patients overcome transportation-related barriers to care, Huntington Hospital provided 24-hour transportation assistance – via Uber/Lyft, taxi, wheelchair or other van – to 1,053 persons in Fiscal Year 2017. Of the total, Ridewith24 arranged on-demand Uber/Lyft driver-partners to assist 161 patients to their homes.

Cancer

Programs and Services Offered:

- On an ongoing basis throughout the year, Huntington Hospital Cancer Center offered numerous community events with partners such as American Cancer Society, Herald Cancer Association, Pasadena Unified School District, Pasadena Fire Department, Altadena Guild, and Huntington Senior Care Network.
- Huntington Hospital Cancer Center offered support groups helping patients and their families cope with their diseases. In Fiscal Year 2017, these offerings included: Transitions: Grief and Loss Support Group (offered four times), lung cancer (offered second Wednesday of 11 months), newly diagnosed breast cancer (offered first Thursday of ten months), prostate cancer (offered first Thursday of ten months), gynecological cancer support group (offered ten times in 2017), lymphedema (offered monthly), ostomy (offered eight times), and Cantonese-speaking Chinese Cancer support group (offered monthly;).
- To enhance the care of oncology patients, Huntington Hospital's cancer nurse navigators helped coordinate the many aspects of care for patients, provided information for patients and their families, and helped patients navigate the often complex system, from appointment scheduling to insurance coverage, to complementary therapies. In Fiscal Year 2017, nurse navigators served 1,390 patients with cancer diagnoses (including 922 patients with breast cancer, 154 patients with prostate cancer, 120 patients with colorectal cancer, 61 patients with lung cancer, 54 patients with gynecologic cancer, 54 patients with head/neck cancer, and 25 patients with kidney cancer).
- At the Constance G. Zahorik Appearance Center at Huntington Hospital, a licensed cosmetologist helped clients manage the cosmetic side effects of cancer treatment, including the use of wigs, makeup, scarves and hats, and sun protective clothing; referrals for breast prosthesis and bra fittings were also provided. In partnership with the American Cancer Society, Huntington Hospital offered Look Better, Feel Better classes, under supervision of licensed cosmetologist and nurse navigators. In Fiscal Year 2017, 364 patients were served at the Appearance Center.
- Integrating complementary therapies with current standard cancer treatments, Huntington Hospital's Integrative Oncology program offered acupuncture and therapeutic yoga sessions.

- To raise funds to support free mammograms, Huntington Hospital partnered with the Pasadena Fire Department and California Pizza Kitchen during Breast Cancer Awareness Month (October) with several Pasadena Goes Pink events.

Health Education, Training and Research

Programs and Services Offered:

- In Fiscal Year 2017, Huntington Hospital continued to collaborate in the education and training of general surgery and internal medicine residents, pharmacy interns and residents, other health care professionals such as nurses, technicians, physical and occupational therapists, respiratory therapy practitioners, and social workers. See **Appendix B** for a listing of schools affiliated with Huntington Hospital. Among the highlights in Fiscal Year 2017:
    - 25 internal medicine residents completed various aspects of a three-year training program
    - 17 general surgery residents completed various aspects of a five-year training program
    - 2 pharmacy residents completed various aspects of a one-year postgraduate program
    - 11 pharmacy interns
    - 881 nursing students
    - 18 social work interns (includes 10 social work interns at Senior Care Network)
    - 15 respiratory therapy interns
    - 14 radiology technology interns
    - 11 physical therapy interns
    - 7 occupational therapy interns
    - 3 speech pathology interns
    - 2 clinical laboratory scientist interns
    - 2 echocardiography technology interns
- In Fiscal Year 2017, an Evidence-based Practice Fellowship Program for nurses at Huntington Hospital was established, providing an opportunity for nurses to conduct meaningful research and synthesize findings. In 2017, three nurses were selected to participate in the fellowship program and collaborated on research regarding nurse-to-nurse communications.

- Based on an actual newborn experience at the hospital, Neonatal Intensive Care Unit (NICU) nurses first worked with the Pasadena Fire Department on the development of a newborn care training class the emphasizes the significance of temperature regulation and expanded this educational program to three additional fire departments in the region. This followed with invitations to present information about the program and its results at annual conferences for both the Association of California Nurse Leaders and the National Association of Neonatal Nurses.
- As a base station for the region, nurses with experience in emergency medicine and a special certification in advanced mobile intensive care worked closely with paramedics in the field, helping make it possible for patients with serious medical needs to begin receiving care even before arriving at the hospital. Throughout the year, Emergency Department staff provided several continuing education classes for emergency medical technicians, paramedics and mobile intensive care nurses from across Los Angeles County. In addition, on January 18, a pre-hospital care coordinator and social services director invited area skilled nursing facilities staff to a summit at the hospital for an educational session on end-of-life forms, interactions with Emergency Medical Services and collaboration in patient care.
- Through partnerships with Blair Health Careers Academy and Pasadena Unified School District Center for Independent Study, Medical Arts Program, 60 high school students from these two schools interned at the hospital for various health-related careers. The Health Careers Academy prepares students for advanced careers in the physical and mental health fields through a four-year course of study ending in a 180-hour internship which provides hands-on training in patient skill areas, specialized topics such as medical terminology, knowledge of health care issues and the health care delivery system, and career planning. Huntington Hospital's supervisor attended Advisory Board meetings and educational summits, arranged tours and guests speakers, evaluated senior projects, interviewed, trained and placed students for volunteer work as well as internships, facilitated mentoring of students by health care professionals, provided review and input on course curriculum, and prepared and trained students for competitions at state and national level.
- Through a collaboration between Pasadena Chamber of Commerce and Civic Association, and the departments of Volunteer Services and Food and Nutrition Services, three students from

Blair High School Culinary Arts and Hospitality Academy completed their internship in the hospital's Food Service Kitchen.

- Huntington Hospital's Health Sciences Library provided reference, database and internet searching, document delivery and inter-library loans, access to references and point of care from mobile devices and desktop computers, and the assistance of professional librarians for employees, medical staff, patients, and hospital visitors. Huntington Hospital's Community Health Library professional librarians and trained volunteers provided assistance to the community by offering approximately 690 consumer health related books, 70 electronic books/reports, 11 consumer health newsletters and journals, and over 600 online videos for patients and their families and Huntington Hospital staff.

Section 6: Economic Value of Community Benefits

In Fiscal Year 2017, the economic value of community benefits provided by Huntington Hospital is estimated at **$129,780,381** (economic value includes Medicare Program Shortfall of $45,559,700).

Table 6.1 summarizes the unreimbursed costs of these community benefits according to the framework specifically identified by Senate Bill 697:

- Medical care services
- Other benefits for vulnerable populations
- Other benefits for the broader community
- Health research, education, and training programs

Table 6.1: Estimated Economic Value of Community Benefits Provided by Huntington Hospital
Fiscal Year 2017

Senate Bill 697 Category	Programs and Services Included	Unreimbursed Cost[1]
Medical Care Services	Medicare Program Shortfall[2]	$45,559,700
	Medi-Cal Program Shortfall[2]	$36,668,000
	Charity Care[3]	$9,258,300
	Other Direct Services: Palliative Care Program and Health Navigation[4]	$2,176,182
Other Benefits for Vulnerable Populations	Senior Care Network Services, Huntington Ambulatory Care Center, Community Outreach Services, Huntington Hospital Community Asthma Program, Assistance to Patients Needing Resources, Assistance with Medi-Cal Eligibility, and Donations to Non-Profit Organizations Serving the Needy	$6,262,733
Other Benefits for the Broader Community	Health Information Exchange, Health Information and Education, Health Screenings, Community Health Fairs and Events, Nurse Navigators, Support Groups, Physician Referral Services, Meeting Space for Use by Community and Groups, and Donations to Non-Profit Organizations Serving the Broader Community	$6,171,747
Health Research, Education, and Training Programs	Education and Training of Health Care Professionals and Students, Graduate Medical Education Program, Clinical Research Program, Health Sciences Library, and Donations to Non-Profit Organizations for Health Research, Education and Training Programs	$23,683,719
-	**SUBTOTAL, EXCLUDING MEDICARE SHORTFALL**	$84,220,681
-	**GRAND TOTAL**	**$129,780,381**

[1] Unreimbursed costs for the Senate Bill 697 categories - other benefits for vulnerable populations, other benefits for the broader community and health research, education and training programs - may include an hourly rate for labor (plus benefits), other expenses such as purchased services, food, supplies, other direct expenses and rooms.
[2] Medical care services provided to Medicare and Medi-Cal beneficiaries result in shortfalls for the hospital. The method for determining these shortfalls is based on actual costs as calculated by a cost accounting system. The costs are subtracted from the payments received from Medicare or Medi-Cal.
[3] Costs are also calculated by a cost accounting system. Actual cost is subtracted from any payments received from either public or private insurance payors or patients.
[4] Other direct services costs based on expenses associated with the activity including some hospital standard indirect expenses.

Appendix A: Community Collaborations

Huntington Hospital collaborated with the following community organizations and agencies in Fiscal Year 2017. Organizations are listed alphabetically.

- Adelante Youth Alliance
- Altadena Guild
- Altadena Senior Center
- Alzheimer's Association
- American Cancer Society
- American Heart Association
- American Red Cross
- American Stroke Association
- Association of California Nurse Leaders
- Blair Health Academy
- Blair High School Culinary Arts and Hospitality Academy
- Calvary Bargain Center
- Cancer Support Community
- CAUSE
- ChapCare
- City of Pasadena
- Chinese Christian Herald Crusades
- City of Hope National Medical Center
- Club 21 Learning and Resource Center
- Community Women Vital Voice
- Convalescent Aid Society
- First Presbyterian Church
- Flintridge Center
- Flintridge La Canada Guild
- Foothill Unity Center

- Friends In Deed
- Health Impact
- Holliston Methodist Church (Dream Church)
- Healthy Pasadena
- Holy Family Church
- Housing Works
- Huntington Health Physicians
- Huntington Medical Research Institute
- Jackie Robinson Community Center
- Justice in Aging
- Jet Propulsion Laboratory (JPL)
- KKLA – FM
- Los Angeles County Arboretum and Botanic Garden Foundation
- MAPS (Mission to Assist and Provide for Seniors) Charities
- Monte Vista Grove Homes
- NAACP – Pasadena Branch
- National Association of Neonatal Nurses
- National Charity League
- Organization for Healthcare Educators
- Pacific Clinics
- PALS for Health
- Partners in Care Foundation
- Pasadena Chamber of Commerce and Civic Association
- Pasadena Community Foundation
- Pasadena Community Urgent Care Pasadena Farmers' Market
- Pasadena Educational Foundation
- Pasadena Fire Department
- Pasadena Jewish Temple and Center
- Pasadena Parks and Recreation
- Pasadena Police Department

- Pasadena Presbyterian Church
- Pasadena Public Health Department
- Pasadena Public Libraries
- Pasadena Respiratory Health Foundation
- Pasadena Senior Center
- Pasadena Unified School District
- Pasadena Village
- Phil Simon Tanzania Project
- Pilgrim Towers
- Planned Parenthood of Pasadena
- Professional Child Development Association (PCDA)
- Regency Park
- Ronald McDonald House – Pasadena
- Rose Bowl Aquatic Center
- Rose Bowl Booster Club
- Rotary Club of Sierra Madre
- Rotary International – Pasadena Rotary Club
- Sacred Heart Catholic Church
- Saint Barnabas Senior Center of Los Angeles
- Salvation Army
- San Gabriel Valley End-of-Life Care Coalition
- San Gabriel Valley Pride Inc.
- San Marino Guild
- San Marino Motor Classic
- Sheriff's Support Group
- South Pasadena Senior Center
- St. Barnabas Senior Center of Los Angeles
- St. Elizabeth Catholic Church
- Union Station
- Urban Land Institute

- USC Family Caregiver Support
- Villa Esperanza Services
- Villa Parke Community Center
- Westminster Presbyterian Church
- Young and Healthy

Appendix B: Educational Affiliations

Huntington Hospital partnered with the following educational entities for education and training of health care professionals in Fiscal Year 2017. Organizations are listed in alphabetical order.

- Azusa Pacific University
- Biola University
- California Baptist University
- California State University – Dominguez Hills
- California State University – Fullerton
- California State University – Long Beach
- California State University – Los Angeles
- California State University – Northridge
- California State University – San Marcos
- Cerritos College
- Chapman University
- Citrus College
- Cypress College
- El Camino College
- Eastern New Mexico University
- Fuller Theological Seminary School of Psychology
- Glendale Career College
- Glendale Community College
- Grand Canyon University
- Institute of Health Sciences
- Laboure College
- Loma Linda University
- Maryville University
- McCook Community College
- Metropolitan University

- Mount St. Mary's University
- Mt. San Antonio College
- Oakwood University
- Pasadena City College
- Regis University (Loretto Heights School of Nursing)
- Saint Louis University
- Saint Xavier University
- San Joaquin Valley College
- San Jose State University
- Shepard University
- University of California – Los Angeles
- University of California – San Diego
- University of California Extension – Los Angeles
- University of San Francisco
- University of Southern California (USC)
- Vanguard University
- West Coast College
- Western Governors University
- Western University of Health Sciences
- Wilkes University

Exhibit 18-B

2018 Community Benefit Reports



Huntington Hospital Community Benefits Plan Fiscal Year 2018

For Submittal by May 31, 2019 to:
Office of Statewide Health Planning and Development
Accounting and Reporting Systems Section
2020 West El Camino Avenue, Suite 1100
Sacramento, CA 95833
Email: CommunityBenefit@oshpd.ca.gov

Huntington Hospital

Preface

In accordance with Senate Bill 697, Community Benefits Legislation, Huntington Hospital, a private not-for-profit hospital, submits this Community Benefits Plan for Fiscal Year 2018.[a] Senate Bill 697 requires a not-for profit hospital in California to complete the following activities:

- Review and reaffirm its mission statement to ensure that its policies integrate and reflect the public interest in meeting its responsibilities as a not-for-profit organization

- Complete and update a needs assessment every three years, evaluating the health needs of the community served by the hospital

- Adopt and file a community benefits plan annually, documenting activities that the hospital has undertaken to address community health needs within its mission and financial capacity; and to the extent practicable, assign and report the economic value of community benefits provided in furtherance of its plan

[a] Huntington Hospital fiscal year is from January 1 to December 31.

Introduction to Huntington Hospital

Founded in 1892, Huntington Hospital is committed to providing excellent patient care delivered with compassion and respect. Huntington Hospital is a 619-bed, not-for-profit community hospital located in Pasadena, California. The hospital offers a full complement of acute medical care and community services, ranging from general medicine to the foremost specialized programs in cardiovascular services, oncology, and the neurosciences. The hospital has the only trauma center in the region as well as the only Level III Neonatal Intensive Care Unit (NICU). In addition, Huntington Hospital offers women's and children's services, state-of-the art orthopedic surgery, in- and outpatient psychiatric services, Huntington Hospital Senior Care Network, and Huntington Ambulatory Care Center.

Through an ongoing partnership between Huntington Hospital and Shriners Hospitals for Children – Southern California, inpatient surgical and medical services for pediatric patients are available at Huntington Hospital and the medical team provides advanced post-surgical care. A new Shriners for Children Medical Center (located across the street from the hospital campus) offers specialty care services for pediatric patients in the region. In 2018, Huntington Hospital and Providence St. Joseph Health entered into an agreement to further expand access to quality care. Providence St. Joseph Health, which includes 12 medical institutions across Los Angeles and Orange Counties, will now contract exclusively with Huntington Hospital in the San Gabriel Valley for all acute care hospital and outpatient clinical services. Huntington Hospital also partners with University of Southern California (USC) Institute for Maternal-Fetal Health to offer a Fetal Surgery Program in Pasadena – encompassing high-risk perinatal care, surgery and NICU expertise.

As a teaching facility affiliated with the Keck School of Medicine of USC, Huntington Hospital supported 25 internal medicine and 17 general surgery residents in 2018. More than one-third of these residents remain in the area to practice, providing a seamless transition through generations of care.

Recently, Huntington Hospital received numerous awards, recognitions, and certifications:

- Full hospital-wide accreditation from The Joint Commission for achieving national standards for health care quality and safety
- Accredited as a Pediatric Medical Center (PMC)
- Gold Seal of Approval® from The Joint Commission for stroke care

- Gold Seal of Approval® from The Joint Commission for total knee and hip replacement program
- Heart-Check Mark® for Advanced Certification for Comprehensive Stroke Center from the American Heart Association/American Stroke Association
- Designation as a STEMI (ST Segment Elevation Myocardial Infarction) Receiving Center where emergency medical service personnel give patients having possible myocardial infarctions a 12-lead EKG in the field and a hospital team is ready when a patient arrives in the Emergency Department
- Magnet® designation by American Nurses Credentialing Center. Magnet® designation represents the highest level of national recognition to health care organizations that demonstrate sustained excellence in nursing care in a healthy, collaborative, and professional work environment. Only seven percent of all acute care health care organizations have obtained this prestigious recognition.
- Maximum five-year accreditation from the Accreditation Council for Graduate Medical Education (ACGME)
- Hospital Compare 5-Star by the Centers for Medicare & Medicaid Services (CMS), the highest possible CMS rating for overall excellence
- Huntington Hospital Trauma Center is certified as a Level II Trauma Center by the Verification Review Committee (VRC), an ad hoc committee of the Committee on Trauma (COT) of the American College of Surgeons (ACS)
- Emergency Department Approved for Pediatrics (EDAP)
- Level III Neonatal Intensive Care Use with California Children's Services (CCS) Certification
- Huntington Hospital received Leapfrog Safety Grade of "A" for Spring 2018 and Fall 2018, one of 855 hospitals in the nation to receive the highest possible grade, based on 27 measures of publicly available hospital safety data
- Recognized by *U.S. News and World Report* for Best Hospital Rankings 2018-19, #10 Best Hospital in California, #5 Hospital in Los Angeles Metro Area, ranked among the best in the country in gynecology and urology, and recognized as Best Regional Hospital in 14 types of care with recognition as "High Performing" in seven adult specialties and in seven common adult procedures and conditions

- Huntington Hospital Cancer Center received full three-year accreditation from the American College of Surgeons' Commission on Cancer
- Jim and Eleanor Randall Breast Center received a full three-year accreditation from the National Accreditation Program for Breast Centers (NAPBC), one of only three hospitals in Los Angeles County to achieve this level of accreditation
- Jim and Eleanor Randall Breast Center recognized as a Breast Imaging Center of Excellence by the American College of Radiology
- Accredited facility for Adult Transthoracic Echocardiography by the Intersocietal Accreditation Commission (IAC)
- Huntington Hospital awarded the Baby-Friendly® designation from Baby-Friendly USA, a credentialing program for hospitals that is part of an international initiative led by the World Health Organization (WHO) and the United Nations Children Fund (UNICEF). The designation is considered the gold standard of care and demonstrates our Women's and Children's Services commitment to patient and family-centered care.
- Huntington Hospital was accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)
- Blue Cross Blue Shield Association Centers of Distinction for bariatric surgery, cardiac care, and spinal surgery
- Huntington Hospital became a participant of the American Joint Replacement Registry (AJRR), a central registry for data on total hip and knee arthroplasties at the hospital and other participating sites throughout the country
- Neurophysiology Intraoperative Monitoring Laboratories and Epilepsy Accreditation from the Lab Accreditation Board of ABRET
- Recognized at the highest possible level by the Healthcare Information and Management Systems Society (HMSS) for the adoption and utilization of electronic medical record (EMR) systems at hospitals around the world

Huntington Hospital also offers continuing education and learning for the public, employees, medical staff, and other health care professionals, through the availability of health science and community libraries. With social media transforming the way that people communicate, Huntington

Hospital has extended its reach into the web community using familiar sites like Facebook, Instagram, Twitter, and YouTube.

Contents

Section	Description	Page
	Preface	i
	Introduction to Huntington Hospital	ii
1	Executive Summary	1
2	Our Mission, Vision, Core Values and Commitment	4
3	2016 Community Health Needs Assessment Summary	5
	Our Community: Greater Pasadena	5
	Prioritized Health Needs	6
	Selected Areas of Focus	7
	Unaddressed Needs and Additional Community Benefit Activities	8
	Implementation Strategy	8
	2017 – 2019 Implementation Strategy: Goals and Strategies	9
4	Community Benefits Planning Process	11
5	Community Benefits Plan Update	13
	Access to Health Care Services	13
	Heart Disease and Stroke	17
	Child and Adolescent Health	20
	Older Adults and Aging	22
	Cancer	24
	Health Education, Training and Research	26
6	Economic Value of Community Benefits	28
7	Process for 2019 Community Health Needs Assessment	30

Appendices

A Community Collaborations 32

B Educational Affiliations 36

Section 1: Executive Summary

Mission Statement

At Huntington Hospital, our mission is to provide excellent health care and compassionate service to each person by bringing together outstanding physicians, caring nurses, professional staff and advanced technologies. Our vision, mission, and core values guide our organization's commitment to serving our community.

Definition of Community

Huntington Hospital's service area is defined as Greater Pasadena, which comprises the following communities and ZIP codes: Altadena (ZIP code 91001), South Pasadena (91030), Pasadena (91101, 91103, 91104, 91105, 91106, and 91107), and San Marino (91108).

2016 Community Health Needs Assessment (CHNA)

The 2016 Community Health Needs Assessment methodology included:

- An analysis of secondary data
- Primary data collection through key informant interviews coupled with input from approximately fifty individuals representing the interests of underserved groups in the Greater Pasadena region
- Synthesis of primary and secondary data
- Prioritization of preliminary data and screening out health problems based on feasibility factors

Based on the results of the prioritization and screening processes, a Huntington Hospital CHNA workgroup and the Executive Management Team determined that the Hospital's four priorities for the next three years, 2017-2019, will be:

- Access to Health Care Services
- Heart Disease and Stroke
- Child and Adolescent Health
- Older Adults and Aging

2017 – 2019 Implementation Strategy Goals

Huntington Hospital and its partners will address the following these health needs through the implementation of various strategies and programs. Our overall goals are:

Access to Health Care Services: Improve access to health care for uninsured and underserved residents of Greater Pasadena.

Heart Disease and Stroke: Improve outcomes due to cardiovascular disease, stroke, and diabetes through increased awareness, education, and patient support.

Child and Adolescent Health: To improve the ability of children and adolescents with asthma to manage their condition.

To mitigate the effects of stress and trauma and improve overall health and well-being of all children in the community.

Older Adults and Aging: Low-income and underserved older adults will have the services and support required to meet their needs.

Community Benefits Plan Programs and Activities

In Fiscal Year 2018, some of the activities Huntington Hospital conducted in support of these health needs included the following: providing navigation assistance to obtain health insurance or services available and linkages to providers; offering Huntington Ambulatory Care Center (HACC) to serve underinsured and uninsured persons, offering community health clinics throughout the year, providing community health education, screening and support programs for numerous health conditions – including heart disease and diabetes – through a dedicated Community Outreach Department; providing no-cost asthma education and management services through Huntington Hospital Community Asthma Program; offering specialized programs and services to address elderly and disabled care and independence through Senior Care Network; and providing health information – in multiple formats and languages – for professionals, service agencies, and the general public. Huntington Hospital also conducted programs and services in response to the other community needs, including: providing specialized services related to cancer prevention, awareness and support; and collaborating with educational institutions to provide graduate medical education programs for general surgery and internal medicine residents, pharmacy residents, nursing students, and other health care professionals.

In addition, Huntington Hospital continued to provide charity care for patients without the ability to pay for necessary treatment, absorbed the unpaid costs of care for patients with Medi-Cal and

Medicare, and operated other medical programs in support of the community, such as an emergency and trauma center, neonatal nursery, high-risk perinatal program.

Economic Value of Community Benefits Provided

The economic value of community benefits provided by Huntington Hospital in Fiscal Year 2018 is estimated at **$120,533,094** (economic value includes Medicare Program Shortfall of $39,024,800).

Section 2: Our Mission, Vision, Core Values and Commitment

Huntington Hospital's Mission, Vision, Core Values and Our Commitment to You follow. These guide our organization in serving our community.

Mission Statement

To provide excellent health care and compassionate service to each person by bringing together outstanding physicians, caring nurses, professional staff and advanced technologies.

Vision Statement

To be the leader in creating community well-being through world-class health care delivered with kindness and dignity.

Core Values

Respect • Integrity • Stewardship • Excellence • Collaboration

Our Commitment to You

Thank you for allowing us to care for you. We take every step to exceed your expectation, and we encourage you to play an active role in your care. As part of our commitment to you, we will:

- Treat you with courtesy and respect.
- Listen carefully.
- Explain things in ways you understand.
- Address your needs.
- Answer your questions to keep you informed.
- Respond to your concerns.
- Provide a safe and clean environment.
- Include you and your family in your care.
- Be sensitive to your cultural needs.
- Work together as a team to care for you.

Approved by Board of Directors, 2016

Section 3: 2016 Community Health Needs Assessment Summary

Huntington Hospital's 2016 Community Health Needs Assessment and Implementation Strategy are available at www.huntingtonhospital.org and www.healthypasadena.org

In 2016, Huntington Hospital and the Pasadena Public Health Department partnered to conduct the first joint Community Health Needs Assessment (CHNA) of Greater Pasadena, in accordance with California Senate Bill 697[1] and the Patient Protection and Affordable Care Act (ACA)[2]. The resulting CHNA report describes findings from a year-long, systematic process that was conducted to provide insight into the health status and needs of the residents of the Greater Pasadena area. Data presented in the report span a wide range of indicators that affect community well-being, including disease rates, risk factors for disease and death, health behaviors, and social determinants of health. The CHNA serves as a tool for effectively planning the allocation of community benefits to improve the health of the community.

Our Community: Greater Pasadena

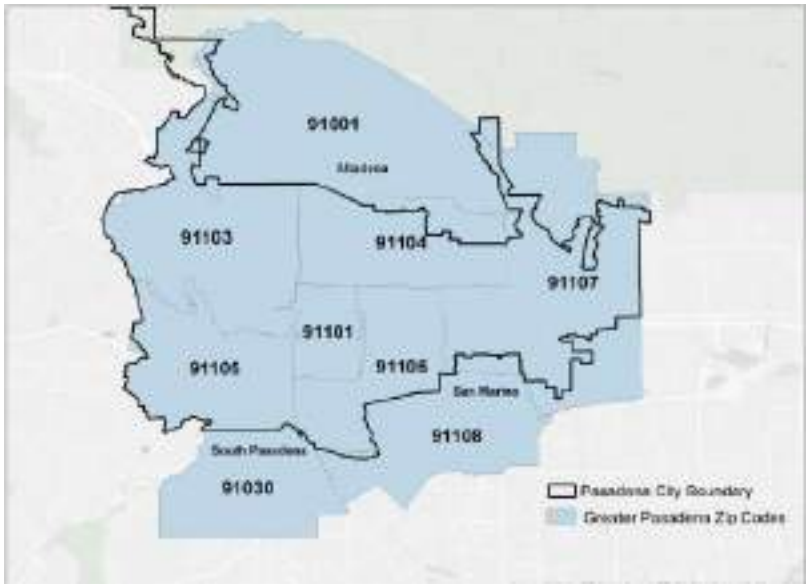
The 2016 CHNA focuses on the geographic area of Greater Pasadena, which includes Pasadena, Altadena, South Pasadena, and San Marino, and is comprised of nine contiguous ZIP Codes.

The total population of Greater Pasadena is 236,423 persons, approximately 2.3% of the entire population of Los Angeles County. In many respects, Greater Pasadena is a resource-rich community. For example, compared to California and/or Los Angeles County, the median household income rate is higher, the dropout rate is lower, the percentage of residents with a Bachelor's degree is much higher, the percentage of single-parent households is lower, and the ability to access care is slightly better. On the other hand, a single ZIP Code emerges within the geographic area with the highest level of socioeconomic need: ZIP Code 91103, northwest

---

[1] California Senate Bill 697 (SB 697) since its implementation in 1994, requires tax-exempt hospitals to document activities undertaken to address community health needs.
[2] The Patient Protection and Affordable Care Act (ACA), enacted in 2010, included in IRS Section 501(r), directs tax-exempt hospitals to conduct a Community Health Needs Assessment and develop an Implementation Strategy every three years.

Pasadena, has higher relative needs than the County overall, as evidenced by the highest rate of families living in poverty, the lowest median household income, and the highest rate of unemployment. Therefore, helping the residents of this area will be a priority in planning community benefit activities.



Prioritized Health Needs

The CHNA process included:

- An analysis of secondary data
- Primary data collection through key informant interviews coupled with input from approximately fifty individuals representing the interests of underserved groups in the Greater Pasadena region
- Synthesis of primary and secondary data
- Prioritization of preliminary data using the HANLON METHOD, rating each health need with a score of 0-10 based on the following three criteria: size of the health problem, seriousness of the health problem, and effectiveness of interventions
- Eliminating health problems using the 'PEARL' Test for the following feasibility factors (Yes/No):
  Proprietary – Does an appropriate program exist to address the health problem?
  Economics – Does it make economic sense to address the problem?

Acceptability – Will the community accept or want the program?

Resources – Is funding available or potentially available for a program?

Legality – Do current laws allow program activities to be implemented?

- Health problems which received a response of "No" to any of the above factors were eliminated.
- Priority scores were calculated for the remaining problems and rank was assigned accordingly.

Selected Areas of Focus

Based on the results of the prioritization process, the Huntington Hospital CHNA workgroup and the Executive Management Team determined that the Hospital's four priorities for the next three years, 2017-2019, will be:

- **Access to Care**, with a focus on improving access to primary and specialty care services, and strengthening the continuum of care
- **Heart Disease and Stroke**, with a focus on increasing awareness through education and patient support
- **Child and Adolescent Health**, with a focus on providing outpatient asthma specialty care, and addressing the effects of trauma on lifelong health
- **Older Adults and Aging**, with a focus on supporting independence

These four areas were selected because approaches to their improvement are compatible with the Hospital's mission, values, strengths, and resources, providing the best opportunity to positively impact the community.

While diabetes was not identified as a priority health need, data indicated that the prevalence of the condition is higher in the San Gabriel Valley (12.0%) than either Los Angeles County (10.0%) or California (8.9%). Additionally, both the age-adjusted hospitalization rate due to uncontrolled diabetes and the age-adjusted death rate due to diabetes are higher than Healthy People 2020 targets. Exercise, nutrition, and weight was ranked sixth highest health need and will be incorporated into the strategies to address Heart Disease and Stroke, through lifestyle practices, raising awareness, and education.

Unaddressed Needs and Additional Community Benefit Activities

Huntington Hospital's strategic approach is to allocate community benefit resources where impact will be maximized. With this idea guiding our selection of health needs to be addressed, we defer to our various community partners to directly address mental and dental health needs. Resources currently exist in Greater Pasadena, through community organizations that are specifically funded, and employ professionally trained staff offering an array of specialized programs and services in the realms of mental health and dental care.

Though mental health will not be an area of focus in the Implementation Strategy, Huntington Hospital provides adult behavioral health services through the highly regarded Della Martin Center for Behavioral Health. Services available include: Psychiatric Acute Treatment Program, Chemical Dependency Recovery Center, Partial Hospitalization Program, Intensive Outpatient Program, and Maternal Wellness Program.

Implementation Strategy

The Implementation Strategy summarizes the rationale for each health need, the goals, strategies and programs the hospital will employ to address the four identified priority health needs over the next three years. The components of this plan are not meant to include an exhaustive account of the various actions Huntington Hospital brings to bear, year in and year out, to address community health and wellness.

For each identified priority health need, the Implementation Strategy includes the following:

- Description – Summary and rationale regarding its importance
- Goal – What we hope to ultimately achieve
- Strategies and Programs – Resources that will be employed to address the priority health need
- Anticipated Impact/Metrics – Short-term objectives
- Potential Partnerships – Community Partners that may be engaged in joint efforts to address the priority health need

2017 – 2019 Implementation Strategy: Goals and Strategies

In 2017 through 2019, Huntington Hospital and its partners will focus efforts on the following goals and strategies through the implementation of various programs and services.

Health Need 1: Access to Health Care Services

Goal: Improve access to health care for uninsured and underinsured residents of Greater Pasadena

Strategies to Meet Need:

- Provide navigation assistance to obtain health insurance or services available
- Provide healthcare outreach
- Offer affordable, high-quality primary and specialty healthcare to the under-served population
- Bring periodic medical clinics into the community to supplement existing services to reach adult underserved residents
- Enable shared access of Electronic Health Record (EHR) via Health Information Exchange (HIE)

Health Need 2: Heart Disease and Stroke

Goal: Improve outcomes due to cardiovascular disease, stroke, and diabetes through increased awareness, education, and patient support

Strategies to Meet Need:

- Provide health education and support in the community
- Expand awareness of cardiovascular disease and stroke through activities and events in the community
- Expand education and support to patients with diabetes
- Expand dietary education

Health Need 3: Child and Adolescent Health

Goals: To improve the ability of children and adolescents with asthma to manage their condition

To mitigate the effects of stress and trauma and improve overall health and well-being of all children in the community.

Strategies to Meet Need:

- Continue to provide no-cost services through Huntington Hospital Community Asthma

Program

- Obtain grant funding to institute programming in the Pasadena Public School District to teach children and their caregivers tools to cope with stressors, based on health research done on trauma, and the Trauma Informed Care approach

Health Need 4: Older Adults and Aging

Goal: Low-income and underserved older adults will have the services and support required to meet their needs

Strategies to Meet Need:

- Provide older adults and their family caregivers with services, information, education, and support
- Support patients with chronic diseases, limited resources, and psycho-social issues which lead to hospitalization and threaten independence

Section 4: Community Benefits Planning Process

In compliance with Senate Bill 697, Huntington Hospital prepared this community benefits plan based on its 2016 Community Health Needs Assessment and in consideration of the Hospital's strengths, mission and resources, opportunities for partnership, solutions impact multiple community health needs, and effective methods are available.

The Executive Director, Philanthropy and Public Affairs and a Manager of Community Outreach and Community Benefits participate in the planning and development of organizational community initiatives, represent Huntington Hospital in promoting the total health of the community through partnerships and collaborative efforts with local community organizations and individuals to improve quality of life and achieve Healthy People 2020 objectives, and collect data that captures hospital-wide community benefits activities, and, in collaboration with the hospital's Strategic Financial Analysis team, ensures compliance with regulatory requirements pertaining to not-for-profit hospitals.

In Fiscal Year 2018, Huntington Hospital again supplemented its annual community benefits reporting process with the use of Lyon Software's CBISA Plus™ (Community Benefit Inventory for Social Accountability) software. The software uses key modules – needs, goals, partnerships, programs and statistics, indicators, narratives and outcomes – to capture quantitative and qualitative information for the hospital's fiscal year. Community benefit activity/program information was entered for many hospital departments, including: Administration, Ambulatory/Physician Information Systems, Blood Donor Center, Cancer Center, Cardiology, Cardiac Rehabilitation, Care Coordination, Center for Health Evidence, Clinical Laboratory, Clinical Education and Practice, Community Outreach, Disaster Preparation, Emergency Department/Trauma Services, Food and Nutrition Services, Health Navigation, Huntington Ambulatory Care Center (HACC), Huntington Hospital Community Asthma Program (HHCAP), Huntington Collection, Integrative Oncology, Labor and Delivery, Medical Post-Graduate Education, Neonatal Intensive Care Unit (NICU), Neurosciences, Non-Invasive Cardiology, Nursing Research, Occupational Therapy, Outpatient Rehabilitation, Parking, Patient Experience, Pediatrics, Perinatal Health Education, Pharmacy, Philanthropy, Physical Therapy, Public Relations, Radiology, Respiratory Care Services, Senior Care Network, Social Work Services, Speech-Language Pathology, Stroke

Program, Volunteer Services, and Workforce Development. To accurately report the economic value of community benefits, Finance reported information on the unreimbursed costs of many programs and services, including charity care, shortfalls in government-sponsored programs, and other programs operated by the Department of Community Outreach, Senior Care Network, Huntington Ambulatory Care Center, Graduate Medical Education (GME), Center for Health Evidence, Clinical Research, Perinatal Education, Palliative Care, and Health Navigation.

On an annual basis, Huntington Hospital will monitor and report measures of plan progress (metrics). In addition, staff at Huntington Hospital reports information to a Community Benefits Committee, comprised of representatives from approximately twenty health and social service organizations and interested citizens.

Section 5: Community Benefits Plan Update

This section includes a description of programs and services provided by Huntington Hospital and key measurements of outcomes accomplished (metrics) in Fiscal Year 2018. Programs and services are organized in response to the four significant health needs identified in the 2016 Community Health Needs Assessment. In addition, due our strengths in cancer prevention, awareness and support and health education and training, summary descriptions of key programs and services are also included. See **Appendix A** for a listing of the hospital's collaborations among organizations, service agencies, government and private providers in the San Gabriel Valley.

Access to Health Care Services

Programs and Services Offered:

- Huntington Hospital offered multiple programs to provide navigation assistance to obtain health insurance or services available including:
  - An on-site Medi-Cal Eligibility Worker was available to assist patients who qualified to enroll for health insurance coverage
  - Throughout the year, registered nurses from the Community Outreach Department attended community health fairs and events, providing information on enrollment in health insurance options
  - Community members telephoned a dedicated number or visited the Hospital's website for free physician, service or facility referrals (15,396 telephone calls and chats handled in Fiscal Year 2018)
  - Huntington Hospital's Senior Care Network Resource Center served the community through the following programs and services:
    - Offering a free 50+ Health Connection Membership program (9,317 members)
    - Responding to 2,772 telephone inquiries by and 62 walk-in consultations
    - Assisting 1,845 patients identified by the Resource Center Hospital Liaison and other staff with post-discharge follow-up and as-needed assistance with care transitions
    - Offering 21 Noon-Hour lectures on topics such as earthquake readiness, mindfulness and gratitude, getting a good night's sleep, wisdom and freedom of aging, reducing

risks for conditions such as heart disease, breast cancer, and colon cancer; solutions to hearing problems, attention to our sight, advances in stroke care, memory, update on Alzheimer's disease research and treatment, staying active at any age, ankle pain in the active individual, keeping your feet happy and healthy, oral health, movement disorders, pain management and opioid abuse, and hair loss (attended by 895 persons).

- Distributing two *50+ Health Connection* newsletters, including information and advice about aging and disease management as well as an events calendar and description of ongoing programs and a separate events calendar
- Attending ten Pasadena Senior Commission meetings
- Attending eight San Gabriel Valley End-of-Life Care Coalition meetings

- To empower members of the community to enjoy the healthiest lifestyles possible, registered nurses from the Community Outreach Department conducted free two-hour health screenings and counseling at 17 different screening clinics on alternating days each month, screening 1,750 persons. These health screenings/counseling locations included: Pasadena Senior Center, Altadena Senior Center, South Pasadena Senior Center, Jackie Robinson Community Center, Villa Parke Community Center, Villa Parke Farmer's Market, Foothill Unity Center – Pasadena and Monrovia, Pasadena Central Library, Crowell Public Library, Cleveland Elementary School, Madison Elementary School, Roosevelt Elementary School, Washington STEAM Magnet Academy, South Pasadena High School, Harambee Ministries School, Art Center College of Design, Operating Engineers Trust Fund, Pilgrim Towers Senior Apartments, Concord Senior Apartments, Cavalry Presbyterian Church, Friends In Deed, and Pacific Clinics. Schedules of these free health counseling and screenings by registered nurses were published in English, Spanish and Chinese.
- Throughout the year, registered nurses from the Community Outreach Department attended community health fairs and events, providing a variety of services including blood glucose screenings, blood pressure screenings, and Body Mass Index (BMI) measurements. In Fiscal Year 2018, 130 persons were screened and counseled at four health fairs.
- In Fiscal Year 2018, Community Outreach Department nurses offered 12 health-related classes in English, serving 190 persons. Topics covered (with dates and community locations) included: Ageless Benefits of Exercise and Chair Yoga Class (offered January 17 at Crowell

Library), The Scoop on Poop – Constipation (offered January 31 at Pilgrim Towers North), Healthy Heart (offered February 1 at Pasadena Senior Center, February 28 at Crowell Library, and April 18 at South Pasadena Senior Center), Food for Thought (offered March 15 at Pacific Clinics), Flu Busters – Seasonal Influenza (offered March 21 at Calvary Presbyterian Church, June 29 at Jackie Robinson Community Center, August 28 at Pilgrim Towers North, and September 27 at Crowell Library), Hypertension: The Silent Killer (offered April 10 at Huntington Hospital-Stroke Department and July 12 at Pasadena Senior Center). In addition, 44 chair yoga classes were offered at various community locations throughout the year, serving 501 persons.

- In Fiscal Year 2018, Huntington Hospital held eight community clinics – at local schools, food pantries and community centers. Clinics were offered in March, April (three different dates and locations), May, June, September and November, serving 61 persons in Fiscal Year 2018. During each of these clinics, Community Outreach team members – in partnership with HACC and the Graduate Medical Exam program – conducted medical exams and tests (including blood pressure and blood glucose), provided vital health education, discussed health insurance options, and arranged for patients to obtain follow-up care at HACC.
- Huntington Ambulatory Care Clinic, staffed by the hospital's internal medicine residents, provided primary and specialty care for uninsured and underinsured residents, providing 5,876 visits in Fiscal Year 2018
- For patients' urgent care needs, Huntington Hospital affiliated with Exer More Than Urgent Care Pasadena. Staffed by the same physicians who work in the hospital's Emergency Room Exer Pasadena offers advanced urgent care including on-site laboratory, imaging and pharmacy services.
- Huntington Hospital's Emergency and Trauma Center is the sole provider of emergency services in Pasadena, providing 75,866 visits in Fiscal Year 2018
- In partnership with community providers, Huntington Hospital Disaster/Emergency Preparedness Program provided an all hazards approach to disaster preparedness for patients, visitors, staff, physicians, and community members. Disaster Team members attended ongoing meetings to improve disaster preparedness in the community, provided staff education and drills, and educated employees with regard to personal preparedness at home and at work, and participated in annual Preparedness Fair.

- Service providers and the public accessed the hospital-sponsored Healthy Pasadena website for data and information about community health status (includes health, economy, education, environment, government and politics, public safety, social environment, and transportation), tools and resources, community, priorities, and promising practices
- Community members accessed the hospital's website for pertinent health information and news, patient and visitor information, details about upcoming events and education classes, and a physician directory (with selection criteria including specialty, gender, location, insurance accepted and language spoken)
- To facilitate communication between hospital caregivers and patients, the Department of Patient Experience at Huntington Hospital offered three specialty services for interpretation in 22 languages and sign language: Language Line, Video Interpretation, and Life Signs for Hearing Impaired, serving over 9,000 persons in Fiscal Year 2018.
- The continued availability of Health eConnect offered consumer education and patient involvement in their health care, a vehicle for improving quality and safety of patient care by reducing medical and medication errors, and provided caregivers with clinical decision support tools for more effective care and treatment. In Fiscal Year 2018, Health eConnect was broadly used at Huntington Hospital and in community physician offices to view patient records by the hospital, Hill Radiology Centers, and approximately 12 physician offices that contributed data to the exchange (each month, over 800 unique users accessed patient records). ChapCare, a local federally qualified health center, maintained six active users of Health eConnect.
  In addition, in the fourth quarter, Huntington Hospital implemented EDIE – Emergency Department Information Exchange – to assist emergency physicians in care of patients.

Heart Disease and Stroke

Programs and Services Offered:

- To empower members of the community to enjoy the healthiest lifestyles possible, registered nurses from the Community Outreach Department conducted free two-hour health screenings and counseling – for blood pressure and blood glucose – at 17 different screening clinics on alternating days each month, screening 1,750 persons. Pasadena Senior Center, Altadena Senior Center, South Pasadena Senior Center, Jackie Robinson Community Center, Villa Parke Community Center, Villa Parke Farmer's Market, Foothill Unity Center – Pasadena and Monrovia, Pasadena Central Library, Crowell Public Library, Cleveland Elementary School, Madison Elementary School, Roosevelt Elementary School, Washington STEAM Magnet Academy, South Pasadena High School, Harambee Ministries School, Art Center College of Design, Operating Engineers Trust Fund, Pilgrim Towers Senior Apartments, Concord Senior Apartments, Cavalry Presbyterian Church, Friends In Deed, and Pacific Clinics.[1]
- Throughout the year, registered nurses from the Community Outreach Department attended community health fairs and events, providing a variety of services including blood glucose screenings, blood pressure screenings, and Body Mass Index (BMI) measurements. In Fiscal Year 2018, 130 persons were screened and counseled at four health fairs.[1]
- A Nurse Practitioner/Tobacco Treatment Specialist, with specialized training and expertise in tobacco cessation products, provided counseling, motivational and behavior change skills and techniques to assist individuals with overcoming nicotine addiction. An informative Tobacco Cessation pamphlet, detailing common myths and excuses, facts, and benefits of quitting tobacco, is readily available on the hospital's website.
- In partnership with the American Heart Association, Huntington Hospital celebrated National Heart Awareness Month with a variety of activities. Throughout February, every baby born at the hospital received a free red cap and onesie, to highlight the importance of heart health, from the very first moments of life. Parents and family members received educational materials and education on CPR for infants. On Friday, February 2, hospital employees, volunteers, physicians and friends gathered at the hospital entrance for National Wear Red Day®, uniting

[1] Programs and services presented under health need: Access to Health Care Services.

with millions of people across the country to help raise awareness about heart disease in women.

- A variety of lectures were delivered by physicians and dietitians throughout the year, including: Cardiology Updates, with Q&A sessions on February 15 (100 persons served); Beating Heart Disease on February 21 (62 persons served); Advances in Stroke Care/Time is Brain on May 23 (39 persons served); and Staying Active at Any Age on June 20 (46 persons served).
- In May (National Stroke Awareness Month), Huntington Hospital's ninth annual gold instruction event took place at the Brookside Golf Course on May 16, 2018. "Saving Strokes," a rehabilitation-through-golf program of the American Heart/American Stroke Association offered stroke survivors the opportunity to add golf as a mental, physical, and emotional rehabilitation tool in their journey to recovery. Sixty participants spent the morning working with golf pros and later enjoyed a luncheon with fellow stroke survivors, physical therapists and other members of the Huntington Hospital Stroke Center team. On May 10, over 100 people attended a Stroke Awareness Health Fair at the hospital – supported by a multidisciplinary team comprised of nurses, physical therapists, speech language pathologists, and pharmacists. Huntington Hospital supported the annual Go Red for Women/Rock the Red Event luncheon held on May 17 at the Avalon in Hollywood. The half-day event, attending by over 200 persons, featured guest speakers, entertainment, and a heart healthy lunch.
- On June 6, 2018, Huntington Hospital partnered with the Pasadena Fire Department and the American Heart Association to hold a free CPR pop-up training event at the Paseo Colorado Shopping Mall in Pasadena. In less than five minutes per demonstration, CPR instructors taught the basic and proper techniques of Hands-Only CPR to 285 local residents.
- In partnership with the American Heart Association, Huntington Hospital participated in the Heart Walk at the Rose Bowl in Pasadena. During July through September, fifteen hospital team captain volunteers recruited walkers and raised money for the American Heart Association. On the day of the event – September 29 – hospital registered nurses provided blood pressure screenings and distributed information on heart disease.
- "Stop the Bleed" is a national initiative launched by the White House in 2015 to provide bystanders with tools and knowledge to stop life-threatening bleeding. Severe bleeding can result in death within minutes before Emergency Medical Services or other public safety providers arrive; the person closest to you may be the only one who can "stop the bleed."

Huntington Hospital Trauma Services conducted a training session on April 20 at the Los Angeles County Office of Education for 72 school nurses. The session provided hands-on demonstrations and information about how to use tourniquets and control bleeding in traumatic injuries. Trauma Services also conducted training sessions on November 7 at Heritage Square Senior Apartments for 42 persons and Holy Family Catholic Church in South Pasadena on March 2 and June 12 for 56 persons.

- Huntington Hospital statistics revealed approximately 20 percent of patients had a secondary diagnosis of diabetes and that the average length of stay of patients with a secondary diagnosis of diabetes is approximately 1.5 days longer than patients without diabetes. As a result, strategies were developed for insulin administration; standardized, evidence-based patient education (e.g., to assist patients in preparation for discharge); and coordination of delivery of meal trays by Food and Nutrition Services with insulin administration and blood glucose testing. Future plans include ongoing education and training of hospital staff, development of care protocols, further intradepartmental development of a comprehensive outpatient diabetes management program titled Diabetes Empowerment, Education and Prevention (D.E.E.P.), and a diabetes management support group.
- Huntington Hospital Heart and Vascular Center and Stroke Center offer state-of-the-art medical care to patients. The Heart and Vascular Center is a recognized leader in cardiac care, offering a full spectrum of services, including screening and diagnostic tests, advanced medical and surgical treatments, cardiac rehabilitation, and education programs. Huntington Hospital's Stroke Center offers 24-hour emergent diagnostic and treatment services to patients, a dedicated 12-bed stroke unit, a continuum of care that includes a 24-bed inpatient rehabilitation unit and an outpatient rehabilitation program, and support programs for stroke patients and their families. New programs addressing heart disease and stroke include the addition of a Leapfrog Group-compliant Intensivist Program, the availability of the CardioMEMS Heart Failure System (a new miniaturized, wireless monitoring sensor that is implanted in patients to manage heart failure), the availability of the WATCHMAN™ implant for patients with a heart condition known as non-valvular AFib .
- In Fiscal Year 2018, free meetings were held for Stroke Survivor Support Group (served 165 persons in 11 monthly meetings), Stroke Family/Caregiver Support Group (a self-directed group run by the participants meets every Friday), Stroke Survivor Aphasia Speech Group

(served 337 persons in weekly Friday meetings). A Senior Exercise Class held twice a week – led by physical therapists – assisted 792 persons in Fiscal Year 2018.

- Supplemental information on heart disease and stroke is also available on the hospital website. This information addresses many different aspects of these health conditions, including risk factors, heart disease in women, diet, herbs and alternative medicine, smoking cessation, and other heart resources.

Child and Adolescent Health

Programs and Services Offered:

- To help children, adolescents and adults better understand their asthma needs and decrease emergency room visits, hospitalizations and missing school or work, Huntington Hospital continued to offer asthma education and management classes (HHCAP). In Fiscal Year 2018, 119 persons participated in 78 asthma education and management sessions. In addition to these specialized classes, Huntington Hospital offered 29 asthma clinics, where allergists evaluated and treated 249 medically underserved children and adults. Based on statistics for the most recent full year available (2017), 95% of asthma education participants experienced decreased emergency department visits or hospitalizations six months to one year after education sessions.
- In Fiscal Year 2018, Huntington Hospital, along with collaborating partners – Pasadena Unified School District (PUSD) and Young & Healthy – received grant funding from UniHealth Foundation for a new initiative, the Pasadena Trauma-Informed Care Initiative. In its first year of the three-year grant, some of the activities accomplished included: training of 226 community professionals – three community education courses of six hours each – to use a trauma-informed approach in their work with children and families; training of 83 PUSD teachers/staff to learn more about working with children in ways that help prevent or address trauma and mindfulness; reaching 4,760 students, based on teacher/staff attendance at these training sessions; providing training sessions for 386 parents of school-age children; and conducting one-hour educational sessions for 1,266 community members regarding trauma informed care at locations throughout the community. Huntington Hospital's five Community Outreach nurses received supplemental training regarding trauma-informed care and are

incorporating trauma-informed practice into their work throughout the community. These nurses continue to serve parents and families at two high-risk PUSD schools via monthly health screenings, helping to identify trauma-related care needs and provide appropriate assistance to other resources, as needed.

- "Stop the Bleed" is a national initiative launched by the White House in 2015 to provide bystanders with tools and knowledge to stop life-threatening bleeding. Severe bleeding can result in death within minutes before Emergency Medical Services or other public safety providers arrive; the person closest to you may be the only one who can "stop the bleed." Huntington Hospital Trauma Services conducted a training session on April 20 at the Los Angeles County Office of Education for 72 school nurses. The session provided hands-on demonstrations and information about how to use tourniquets and control bleeding in traumatic injuries.[1]
- Huntington Hospital offered childbirth and parenting classes for community members as well as specialized services for parents with an infant in the hospital's NICU. In Fiscal Year 2018, Huntington Hospital offered classes on a variety of topics such as childbirth preparation, infant care, breastfeeding basics, CPR: Infant and Child, and Baby and Me as well as online virtual maternity tours and weekly maternity orientation sessions, including small group tours of Labor and Delivery and Maternity. Under the supervision of a lactation specialist, Huntington Hospital hosted a weekly Breastfeeding Support Group, serving 3,120 persons in Fiscal Year 2018. A child life specialist conducted four family parent child workshops at community libraries, presenting various health topics for discussion and education (200 persons served). On a regular basis, Huntington Hospital hosted events for families of NICU infants, including: Infant CPR Class (held weekly; 128 persons served), NICU Orientation (held weekly; 160 persons served), Parent Connection Coffee Breaks (biweekly support groups; 158 persons served), Parent Connection Pizza Night (held monthly; 96 persons served), Parent Connection Baby Shower (held quarterly; 120 persons served), and Walk for Kids, an annual event to benefit for the Ronald McDonald House in Pasadena. Two unique events were held in 2018 for NICU families – a biannual NICU Reunion on April 21, serving 400 families, with entertainment, a luncheon, and opportunities to reconnect with staff; and a holiday crafts workshop on

[1] Program and services presented under health need: Access to Health Care Services.

December 13, serving 30 persons, with opportunities to celebrate their infants' first Christmas, while enjoying the company of other parents and staff.

Older Adults and Aging

Programs and Services Offered:

- Huntington Hospital Senior Care Network (SCN) is a nationally recognized not-for profit program that has helped older adults and adults with disabilities and their families remain healthy and independent since 1984. Care coordination programs – provided by expertly trained Bachelor's and Master's degree social workers and nurses – offer assistance with solving care problems, help connect to resources such as personal care and meals, coordinate service delivery and monitor progress, educate about managing hospital stays and returning home, assist with changes in living arrangements when needed, and serve as a representative for out-of-area families. In Fiscal Year 2018, SCN programs – including the Multipurpose Senior Services Program (MSSP) and Assisted Living Waiver (ALW) Program – served approximately 750 unduplicated clients.
- In its new location on the hospital campus, SCN continued its efforts to be more accessible to everyone who needs the program, including walk-ins, referrals from hospital staff, calls from people regarding an aging family member. In addition to the new space being larger, it can accommodate individuals with mobility limitations and includes private meeting space for talking with clients about sensitive and confidential concerns. Further enhancing access to SCN services, special ambassadors from this Huntington Hospital department are deployed to serve at the front desk in our main lobby, where they help direct visitors and respond to questions. In addition, SCN staff collaborate extensively with other community care providers. In 2018, Huntington Hospital expanded its assistance to vulnerable seniors who are returning home after receiving inpatient care. Experts from Senior Care Network worked with discharge staff across the hospital, to help improve patient safety and outcomes during and after the transition home.
- In Fiscal Year 2018, registered nurses from Huntington Hospital administered 1,862 free flu shots on 19 different occasions during October through November. Nurses conducted flu shot clinics at a variety of locations, including: senior centers, area churches, schools, service

agencies and centers in the community, Huntington Ambulatory Care Center, hospital cafeteria, public libraries, public schools, community centers, community events, and farmer's markets. To maximize the vaccine supply and avoid duplication of efforts, registered nurses from Huntington Hospital Community Outreach coordinated dates and sites with Pasadena Public Health Department.

- A group of nurse navigators and a community navigator assisted patients in improving their hospital experiences and ensuring safe and successful transitions to their homes following hospitalization. These navigators assisted patients hospital-wide, based on nursing units and health conditions. Navigators collaborated with other medical personnel, families, and service centers; clearly communicated patients' needs to other health care personnel; assisted with information about medical conditions, treatments, and services; explored patients' goals, any barriers, and needs in self-management; and assisted with setting up appointments, obtaining transportation and medications and linking patients with community resources. In Fiscal Year 2018, nurse and community navigators assisted 4,559 unique patients. A Geriatric Certified Nurse Specialist and rounded on 246 patients in Fiscal Year 2018.
- With the support of funding from UniHealth Foundation, Huntington Hospital, along with three other magnet hospitals – Cedars-Sinai Medical Center, UCLA Ronald Reagan Medical Center, and Torrance Memorial Medical Center – participated in a demonstration and evaluation project on a Systems Addressing Frail Elders (SAFE™) Care. Based on the positive findings of a multidisciplinary team, implementation of the SAFE™ Care Program was continued at Huntington Hospital. Final analysis of data is currently in progress.
- To help patients overcome transportation-related barriers to care, Huntington Hospital provided 24-hour transportation assistance – via Uber/Lyft, taxi, wheelchair or other van – to 897 persons in Fiscal Year 2018.

Cancer

Programs and Services Offered:

- On an ongoing basis throughout the year, Huntington Hospital Cancer Center offered numerous community events with partners such as American Cancer Society, Herald Cancer Association, Church of Nazarene in Pasadena, Pasadena Unified School District, Pasadena Fire Department, Altadena Guild, and Huntington Senior Care Network.
- To enhance the care of oncology patients, Huntington Hospital's cancer nurse navigators helped coordinate the many aspects of care for patients, provided information for patients and their families, and helped patients navigate the often complex system, from appointment scheduling to insurance coverage, to complementary therapies. In Fiscal Year 2018, nurse navigators served 1,188 patients with cancer diagnoses (including 651 patients with breast cancer, 161 patients with prostate cancer, 155 patients with lung and esophageal cancer, 114 patients with colorectal cancer, 55 patients with gynecologic cancer, 50 patients with head/neck cancer, and 2 patients with kidney cancer).
- Huntington Hospital Cancer Center offered education and support groups helping patients and their families cope with their diseases. In Fiscal Year 2018, these offerings included: Transitions: Grief and Loss Support Group (six-week course offered four times), nutrition class for cancer survivors (offered second Tuesday of 12 months), lung cancer (offered second Wednesday of 12 months), newly diagnosed breast cancer (offered first Thursday of ten months), prostate cancer (offered first Thursday of ten months), gynecological cancer support group (offered first Wednesday of eight in 2018), lymphedema (offered second Wednesday of the month), wound ostomy (offered third Thursday for first five months of the year), and Cantonese-speaking Chinese Cancer support group (offered for first six months of the year).
- At the Constance G. Zahorik Appearance Center at Huntington Hospital, a licensed cosmetologist helped clients manage the cosmetic side effects of cancer treatment, including the use of wigs, makeup, scarves and hats, and sun protective clothing; referrals for breast prosthesis and bra fittings were also provided. In partnership with the American Cancer Society, Huntington Hospital offered Look Better, Feel Better classes, under supervision of licensed cosmetologist and nurse navigators. In Fiscal Year 2018, 358 persons were served at the Appearance Center.

- Integrating complementary therapies with current standard cancer treatments, Huntington Hospital's Integrative Oncology program services included acupuncture, massage therapy, hypnotherapy, therapeutic yoga, food and fitness, and therapeutic drum circle. Beat Cancer Thru Drumming is a Beat the Odds® drum circle program offered at Huntington Hospital for cancer patients and cancer survivors to cultivate emotional resilience and mental focus. Five-week sessions were held during the periods from May 7 through June 11 and September 26 through October 24 and served 24 persons. On a monthly basis (second Tuesday of each month), Huntington Hospital offered nutrition classes for cancer survivors –education and support sessions for cancer patients and their families on how to eat well during and after cancer treatment.
- On January 20, Huntington Hospital Cancer Center participated in the KKLA Health Fair and offered free health screenings for colorectal cancer awareness, based on American Cancer Society guidelines. Over 200 persons were in attendance at this event held at Church of Nazarene, in Pasadena.
- On June 3, 2018, Huntington Cancer Center hosted its third annual open house to celebrate National Cancer Survivors Day (held in collaboration with Commission on Cancer and National Accreditation Program for Breast Centers). Over eighty guests enjoyed food, music therapy, stress-relieving activities, and informative break-out sessions — and reconnected with physicians and staff who had guided them through their cancer treatment. Participants were also encouraged to create personal messages of hope and strength to share with new cancer patients here.
- On October 13, Huntington Hospital, in partnership with Chinese Herald Cancer Association, hosted a Pink Ribbon Conference for Chinese breast cancer survivors, friends and family members. In addition to presentations from the breast cancer medical director and manager of Integrative Oncology, the event featured exercises by breast cancer navigator. The event served 183 persons.
- To raise funds to support free mammograms, Huntington Hospital partnered with the Pasadena Fire Department and California Pizza Kitchen during Breast Cancer Awareness Month (October) with several Pasadena Goes Pink events.

Health Education, Training and Research

Programs and Services Offered:

- In Fiscal Year 2018, Huntington Hospital continued to collaborate in the education and training of general surgery and internal medicine residents, pharmacy interns and residents, other health care professionals such as nurses, technicians, physical and occupational therapists, respiratory therapy practitioners, and social workers. See **Appendix B** for a listing of schools affiliated with Huntington Hospital. Among the highlights in Fiscal Year 2018:
    - 25 internal medicine residents completed various aspects of a three-year training program
    - 17 general surgery residents completed various aspects of a five-year training program
    - 4 pharmacy residents completed various aspects of a one-year postgraduate program
    - 12 pharmacy interns
    - 20 clinical pharmacy students (six-week advanced rotation program)
    - 813 nursing students
    - 36 social work interns (includes 8 social work interns at Senior Care Network)
    - 18 respiratory therapy interns
    - 14 radiology technology interns
    - 11 physical therapy interns
    - 4 occupational therapy interns
    - 4 echocardiography technology interns
    - 2 clinical laboratory scientist interns
    - 1 inpatient speech language pathology intern
    - 1 dietetic intern
- In Fiscal Year 2018, the recently established Huntington Hospital Evidence-based Practice/Nursing Research Council sponsored an inaugural Annual Nursing Research Conference titled *Improving Care Delivery* on March 7, 2018. The conference disseminated science-based knowledge through collegial exchange and explored approaches to research in nursing, evidence-based practice, quality improvement, and innovation. The conference served 180 persons – including RNs, nurse managers, educators, clinical nurse specialists, nurse scientists – from Huntington Hospital as well as hospitals and healthcare organizations, colleges and universities in the Southern California area.

- As a base station for the region, nurses with experience in emergency medicine and a special certification in advanced mobile intensive care worked closely with paramedics in the field, helping make it possible for patients with serious medical needs to begin receiving care even before arriving at the hospital. Throughout the year, Emergency Department staff provided multiple continuing education classes for emergency medical technicians, paramedics and mobile intensive care nurses from the adjacent areas of Pasadena, South Pasadena and San Marino as well as throughout Los Angeles County.
- Through partnerships with Blair Health Careers Academy and Pasadena Unified School District Center for Independent Study, Medical Arts Program, 59 high school students from these two schools interned at the hospital for various health-related careers. The Health Careers Academy prepares students for advanced careers in the physical and mental health fields through a four-year course of study ending in a 180-hour internship which provides hands-on training in patient skill areas, specialized topics such as medical terminology, knowledge of health care issues and the health care delivery system, and career planning. Huntington Hospital's supervisor attended Advisory Board meetings and educational summits, arranged tours and guests speakers, evaluated senior projects, interviewed, trained and placed students for volunteer work as well as internships, facilitated mentoring of students by health care professionals, provided review and input on course curriculum, and prepared and trained students for competitions at state and national level.
- Huntington Hospital's Center for Health Evidence provided reference, database and internet searching, document delivery and inter-library loans, access to references and point of care from mobile devices and desktop computers, and the assistance of professional librarians for employees, medical staff, patients, and hospital visitors. Huntington Hospital's Community Health Library professional librarians and trained volunteers provided assistance to the community by offering approximately consumer health related books, electronic books/reports, consumer health newsletters and journals, and online videos for patients and their families and Huntington Hospital staff.

Section 6: Economic Value of Community Benefits

In Fiscal Year 2018, the economic value of community benefits provided by Huntington Hospital is estimated at **$120,533,094** (economic value includes Medicare Program Shortfall of $39,024,800).

Table 6.1 summarizes the unreimbursed costs of these community benefits according to the framework specifically identified by Senate Bill 697:

- Medical care services
- Other benefits for vulnerable populations
- Other benefits for the broader community
- Health research, education, and training programs

Table 6.1: Estimated Economic Value of Community Benefits Provided by Huntington Hospital
Fiscal Year 2018

Senate Bill 697 Category	Programs and Services Included	Unreimbursed Cost[1]
Medical Care Services	Medicare Program Shortfall[2]	$39,024,800
	Medi-Cal Program Shortfall[2]	$35,043,500
	Charity Care[3]	$6,952,300
	Other Direct Services: Palliative Care Program and Health Navigation[4]	$2,277,660
Other Benefits for Vulnerable Populations	Senior Care Network Services, Huntington Ambulatory Care Center, Community Outreach Services, Huntington Hospital Community Asthma Program, Assistance to Patients Needing Resources, Medi-Cal Eligibility Worker, and Donations to Non-Profit Organizations Serving the Needy	$5,110,953
Other Benefits for the Broader Community	Health Information Exchange, Health Information and Education, Health Screenings, Community Health Fairs and Events, Nurse Navigators, Support Groups, Physician Referral Services, Meeting Space for Use by Community and Groups, and Donations to Non-Profit Organizations Serving the Broader Community	$5,369,330
Health Research, Education, and Training Programs	Education and Training of Health Care Professionals and Students, Graduate Medical Education Program, Clinical Research Program, Center for Health Evidence, and Donations to Non-Profit Organizations for Health Research, Education and Training Programs	$26,754,551
-	**SUBTOTAL, EXCLUDING MEDICARE SHORTFALL**	$81,508,294
-	**GRAND TOTAL**	**$120,533,094**

[1] Unreimbursed costs for the Senate Bill 697 categories - other benefits for vulnerable populations, other benefits for the broader community and health research, education and training programs - may include an hourly rate for labor (plus benefits), other expenses such as purchased services, food, supplies, other direct expenses and rooms.
[2] Medical care services provided to Medicare and Medi-Cal beneficiaries result in shortfalls for the hospital. The method for determining these shortfalls is based on actual costs as calculated by a cost accounting system. The costs are subtracted from the payments received from Medicare or Medi-Cal.
[3] Costs are also calculated by a cost accounting system. Actual cost is subtracted from any payments received from either public or private insurance payors or patients.
[4] Other direct services costs based on expenses associated with the activity including some hospital standard indirect expenses.

Section 7: Process for 2019 Community Health Needs Assessment

The 2010 Patient Protection and Affordable Care Act, commonly known as the Affordable Care Act (ACA), requires non-profit, tax exempt hospitals to conduct a Community Health Needs Assessment (CHNA) every three years to analyze and identify the health needs of their communities and to develop an implementation strategy to meet priority identified health needs. In addition, Senate Bill 697, Community Benefits legislation, requires California non-profit hospitals to conduct a community needs assessment every three years and prepare and adopt an annual community benefits plan, in response to identified health needs. Huntington Hospital's Executive Team is responsible for overseeing the 2019 CHNA, including the following:

- Establish an Assessment Infrastructure, in conjunction with members of Huntington Hospital Community Benefits Committee
- Work collaboratively with the City of Pasadena Public Health Department
- Actively participate in Service Planning Area 3 – San Gabriel Valley Hospital Collaborative to share data resources and potentially align efforts along one area of need in the region
- Define goals, objectives and timeline
- Confirm Greater Pasadena – communities of Pasadena, Altadena, South Pasadena, and San Marino – as the geographic service area for purposes of the CHNA
- Analyze secondary data for the Greater Pasadena area and/or Service Planning Area 3 – San Gabriel Valley
- Collect and analyze primary data through key informant interviews and focus groups
- Prepare/update a directory of available resources in the community to address health needs
- Establish a group of health and social service professionals with specific clinical and community knowledge to prioritize the significant community needs identified based on criteria reflecting the hospital's mission, values, strengths, and resources
- Presentations of 2019 CHNA to Community Benefits Committee, Executive or Leadership Team, and Board of Directors
- Prepare a three-year Implementation Strategy (2020 – 2022), including goals, strategies and programs, anticipated impact/metrics, and potential partnerships

- Post the 2019 CHNA (including directory of community resources) and 2020 – 2022 Implementation Strategy on website for public review and comments

Appendix A: Community Collaborations

Huntington Hospital collaborated with the following community organizations and agencies in Fiscal Year 2018. Organizations are listed alphabetically.

- Adelante Youth Alliance
- Altadena Guild
- Altadena Senior Center
- Alzheimer's Association
- American Cancer Society
- American Diabetes Association
- American Heart Association
- American Red Cross
- American Stroke Association
- Association of California Nurse Leaders
- Blair High School Health Careers Academy
- Calvary Bargain Center
- Cancer Support Community
- CAUSE
- ChapCare
- City of Pasadena
- Chinese Christian Herald Crusades
- City of Hope National Medical Center
- Club 21 Learning and Resource Center
- Community Center of La Canada Flintridge
- Community Services Resource
- Community Women Vital Voice
- Convalescent Aid Society
- Crowell Library
- First Presbyterian Church

- Flintridge Center
- Flintridge La Canada Guild
- Foothill Unity Center
- Friends In Deed
- Health Impact
- Holliston Methodist Church (Dream Church)
- Healthy Pasadena
- Holy Family Church
- Housing Works
- Huntington Health Physicians
- Huntington Medical Research Institute
- Jackie Robinson Community Center
- Justice in Aging
- Jet Propulsion Laboratory (JPL)
- KKLA – FM
- Kidspace Children's Museum
- Los Angeles County Arboretum and Botanic Garden Foundation
- MAPS (Mission to Assist and Provide for Seniors) Charities
- Monte Vista Grove Homes
- NAACP – Pasadena Branch
- National Association of Neonatal Nurses
- National Charity League
- Organization for Healthcare Educators
- Pacific Clinics
- PALS for Health
- Partners in Care Foundation
- Pasadena Chamber of Commerce and Civic Association
- Pasadena Community Foundation
- Pasadena Community Urgent Care Pasadena Farmers' Market
- Pasadena Educational Foundation

- Pasadena Farmers' Market
- Pasadena Fire Department
- Pasadena Jewish Temple and Center
- Pasadena Parks and Recreation
- Pasadena Police Department
- Pasadena Presbyterian Church
- Pasadena Public Health Department
- Pasadena Public Libraries
- Pasadena Respiratory Health Foundation
- Pasadena Senior Center
- Pasadena Unified School District
- Pasadena Village
- Phil Simon Tanzania Project
- Pilgrim Towers
- Planned Parenthood of Pasadena
- Professional Child Development Association (PCDA)
- Regency Park
- Ronald McDonald House – Pasadena
- Rose Bowl Booster Club
- Rotary Club of Sierra Madre
- Rotary International – Pasadena Rotary Club
- Sacred Heart Catholic Church
- Saint Barnabas Senior Center of Los Angeles
- Salvation Army
- San Gabriel Valley End-of-Life Care Coalition
- San Gabriel Valley Pride Inc.
- San Marino Guild
- San Marino Motor Classic
- Sheriff's Support Group
- South Pasadena Senior Center

- St. Barnabas Senior Center of Los Angeles
- St. Elizabeth Catholic Church
- Union Station
- Urban Land Institute
- USC Family Caregiver Support
- Villa Esperanza Services
- Villa Parke Community Center
- Westminster Presbyterian Church
- Yoga House
- Young and Healthy

Appendix B: Educational Affiliations

Huntington Hospital partnered with the following educational entities for education and training of health care professionals in Fiscal Year 2018. Organizations are listed in alphabetical order.

- Azusa Pacific University
- Biola University
- California Baptist University
- California State University – Dominguez Hills
- California State University – Fullerton
- California State University – Long Beach
- California State University – Los Angeles
- California State University – Northridge
- Cerritos College
- Chapman University
- Cypress College
- Eastern New Mexico University
- El Camino College
- Fuller Theological Seminary School of Psychology
- Glendale Community College
- Grand Canyon University
- Institute of Health Sciences
- Laboure College
- Loma Linda University
- Maryville University
- McCook Community College
- Metropolitan University
- Mount St. Mary's University
- Mt. San Antonio College
- Oakwood University

- Pasadena City College
- Regis University Loretto Heights School of Nursing
- Saint Louis University
- Saint Xavier University
- San Joaquin Valley College
- San Jose State University
- Shepard University
- University of California – Los Angeles (UCLA)
- UCLA Extension
- UCLA Center for Prehospital Care
- UCLA Luskin School of Public Affairs
- UCLA School of Nursing
- University of California – San Diego
- University of San Francisco
- University of Southern California (USC)
- Walden University
- West Coast University
- Western Governors University
- Western University of Health Sciences
- Wilkes University

Exhibit 18-C

Estimated Economic Value of Huntington Hospital's Community Benefits

Table 6.1: Estimated Economic Value of Community Benefits Provided by Huntington Hospital
Fiscal Year 2014

Senate Bill 697 Category	Programs and Services Included	Unreimbursed Cost
Medical Care Services	Medicare Program Shortfall[2]	$34,977,200
	Medi-Cal Program Shortfall[2]	$32,901,700
	Charity Care[3]	$10,719,300
	Other Direct Services: Geriatric Psychiatric Program and Palliative Care Program	$1,049,623
Other Benefits for Vulnerable Populations	Huntington Ambulatory Care Center, Senior Care Network Services, Community Outreach Services, Assistance to Patients Needing Resources, Assistance with Medi-Cal Eligibility, Physician Referral Services for Medi-Cal and Uninsured Patients, and Donations to Non-Profit Organizations Serving the Needy	$3,893,692
Other Benefits for the Broader Community	Health Information Exchange, Nurse Navigators, Health Information and Education, Health Screenings, Community Health Fairs and Events, Support Groups, Meeting Space for Use by Community and Groups, and Donations to Non-Profit Organizations Serving the Broader Community	$6,015,537
Health Research, Education, and Training Programs	Graduate Medical Education, Education and Training of Health Care Professionals and Students, Clinical Research Program, and Health Sciences Library	$17,620,946
-	**SUBTOTAL, EXCLUDING MEDICARE SHORTFALL**	$72,200,998
-	**GRAND TOTAL**	**$107,178,198**

[1] Unreimbursed costs for the Senate Bill 697 categories - other benefits for vulnerable populations, other benefits for the broader community and health research, education and training programs - may include an hourly rate for labor (plus benefits), other expenses such as purchased services, food, supplies, other direct expenses and rooms.

[2] Medical care services provided to Medicare and Medi-Cal beneficiaries result in shortfalls for the hospital. The method for determining these shortfalls is based on actual costs as calculated by a cost accounting system. The costs are subtracted from the payments received from Medicare or Medi-Cal.

[3] Costs are also calculated by a cost accounting system. Actual cost is subtracted from any payments received from either public or private insurance payors or patients.

Table 6.1: Estimated Economic Value of Community Benefits Provided by Huntington Hospital
Fiscal Year 2015

Senate Bill 697 Category	Programs and Services Included	Unreimbursed Cost
Medical Care Services	Medicare Program Shortfall[2]	$34,269,900
	Medi-Cal Program Shortfall[2]	$32,859,300
	Charity Care[3]	$5,038,800
	Other Direct Service: Palliative Care Program[4]	$511,956
Other Benefits for Vulnerable Populations	Senior Care Network Services, Huntington Ambulatory Care Center, Community Outreach Services, Assistance to Patients Needing Resources, Assistance with Medi-Cal Eligibility, and Donations to Non-Profit Organizations Serving the Needy	$4,621,038
Other Benefits for the Broader Community	Health Information Exchange, Nurse Navigators, Health Information and Education, Health Screenings, Community Health Fairs and Events, Support Groups, Physician Referral Services, Meeting Space for Use by Community and Groups, and Donations to Non-Profit Organizations Serving the Broader Community	$5,394,855
Health Research, Education, and Training Programs	Education and Training of Health Care Professionals and Students, Graduate Medical Education Program, Clinical Research Program, and Health Sciences Library	$19,000,736
-	**SUBTOTAL, EXCLUDING MEDICARE SHORTFALL**	$67,426,885
-	**GRAND TOTAL**	**$101,696,585**

[1] Unreimbursed costs for the Senate Bill 697 categories - other benefits for vulnerable populations, other benefits for the broader community and health research, education and training programs - may include an hourly rate for labor (plus benefits), other expenses such as purchased services, food, supplies, other direct expenses and rooms.

[2] Medical care services provided to Medicare and Medi-Cal beneficiaries result in shortfalls for the hospital. The method for determining these shortfalls is based on actual costs as calculated by a cost accounting system. The costs are subtracted from the payments received from Medicare or Medi-Cal.

[3] Costs are also calculated by a cost accounting system. Actual cost is subtracted from any payments received from either public or private insurance payors or patients.

[4] Other direct service cost based on expenses associated with the activity including some hospital standard indirect expenses.

Table 6.1: Estimated Economic Value of Community Benefits Provided by Huntington Hospital
Fiscal Year 2016

Senate Bill 697 Category	Programs and Services Included	Dollar Unreimbursed Cost
Medical Care Services	Medicare Program Shortfall[2]	$41,021,200
	Medi-Cal Program Shortfall[2]	$28,513,600
	Charity Care[3]	$5,096,442
	Other Direct Service: Palliative Care Program[4]	$523,253
Other Benefits for Vulnerable Populations	Senior Care Network Services, Huntington Ambulatory Care Center, Community Outreach Services, Assistance to Patients Needing Resources, Assistance with Medi-Cal Eligibility, and Donations to Non-Profit Organizations Serving the Needy	$6,446,001
Other Benefits for the Broader Community	Health Information Exchange, Nurse Navigators, Health Information and Education, Health Screenings, Community Health Fairs and Events, Support Groups, Physician Referral Services, Meeting Space for Use by Community and Groups, and Donations to Non-Profit Organizations Serving the Broader Community	$4,863,485
Health Research, Education, and Training Programs	Education and Training of Health Care Professionals and Students, Graduate Medical Education Program, Clinical Research Program, and Health Sciences Library	$22,105,991
-	**SUBTOTAL, EXCLUDING MEDICARE SHORTFALL**	$67,548,772
-	**GRAND TOTAL**	**$196,569,972**

[1] Unreimbursed costs for the Senate Bill 697 categories - other benefits for vulnerable populations, other benefits for the broader community and health research, education and training programs - may include an hourly rate for labor (plus benefits), other expenses such as purchased services, food, supplies, other direct expenses and rooms.
[2] Medical care services provided to Medicare and Medi-Cal beneficiaries result in shortfalls for the hospital. The method for determining these shortfalls is based on actual costs as calculated by a cost accounting system. The costs are subtracted from the payments received from Medicare or Medi-Cal.
[3] Costs are also calculated by a cost accounting system. Actual cost is subtracted from any payments received from either public or private insurance payors or patients.
[4] Other direct service cost based on expenses associated with the activity including some hospital standard indirect expenses.

Table 6.1: Estimated Economic Value of Community Benefits Provided by Huntington Hospital
Fiscal Year 2017

Senate Bill 697 Category	Programs and Services Included	Unreimbursed Cost[1]
Medical Care Services	Medicare Program Shortfall[2]	$45,559,700
	Medi-Cal Program Shortfall[2]	$36,666,000
	Charity Care[3]	$9,256,300
	Other Direct Services: Palliative Care Program and Health Navigation[4]	$2,176,182
Other Benefits for Vulnerable Populations	Senior Care Network Services, Huntington Ambulatory Care Center, Community Outreach Services, Huntington Hospital Community Asthma Program, Assistance to Patients Needing Resources, Assistance with Medi-Cal Eligibility, and Donations to Non-Profit Organizations Serving the Needy	$6,262,733
Other Benefits for the Broader Community	Health Information Exchange, Health Information and Education, Health Screenings, Community Health Fairs and Events, Nurse Navigators, Support Groups, Physician Referral Services, Meeting Space for Use by Community and Groups, and Donations to Non-Profit Organizations Serving the Broader Community	$6,171,747
Health Research, Education, and Training Programs	Education and Training of Health Care Professionals and Students, Graduate Medical Education Program, Clinical Research Program, Health Sciences Library, and Donations to Non-Profit Organizations for Health Research, Education and Training Programs	$23,683,719
-	**SUBTOTAL, EXCLUDING MEDICARE SHORTFALL**	$84,220,681
-	**GRAND TOTAL**	**$129,780,381**

[1] Unreimbursed costs for the Senate Bill 697 categories - other benefits for vulnerable populations, other benefits for the broader community and health research, education and training programs - may include an hourly rate for labor (plus benefits), other expenses such as purchased services, food, supplies, other direct expenses and rooms.

[2] Medical care services provided to Medicare and Medi-Cal beneficiaries result in shortfalls for the hospital. The method for determining these shortfalls is based on actual costs as calculated by a cost accounting system. The costs are subtracted from the payments received from Medicare or Medi-Cal.

[3] Costs are also calculated by a cost accounting system. Actual cost is subtracted from any payments received from either public or private insurance payors or patients.

[4] Other direct services costs based on expenses associated with the activity including some hospital standard indirect expenses.

Table 6.1: Estimated Economic Value of Community Benefits Provided by Huntington Hospital
Fiscal Year 2018

Senate Bill 697 Category	Programs and Services Included	Unreimbursed Cost
Medical Care Services	Medicare Program Shortfall[2]	$39,024,800
	Medi-Cal Program Shortfall[2]	$35,043,500
	Charity Care[3]	$6,952,300
	Other Direct Services: Palliative Care Program and Health Navigation[4]	$2,277,660
Other Benefits for Vulnerable Populations	Senior Care Network Services, Huntington Ambulatory Care Center, Community Outreach Services, Huntington Hospital Community Asthma Program, Assistance to Patients Needing Resources, Medi-Cal Eligibility Worker, and Donations to Non-Profit Organizations Serving the Needy	$5,110,953
Other Benefits for the Broader Community	Health Information Exchange, Health Information and Education, Health Screenings, Community Health Fairs and Events, Nurse Navigators, Support Groups, Physician Referral Services, Meeting Space for Use by Community and Groups, and Donations to Non-Profit Organizations Serving the Broader Community	$5,369,330
Health Research, Education, and Training Programs	Education and Training of Health Care Professionals and Students, Graduate Medical Education Program, Clinical Research Program, Center for Health Evidence, and Donations to Non-Profit Organizations for Health Research, Education and Training Programs	$26,754,551
-	**SUBTOTAL, EXCLUDING MEDICARE SHORTFALL**	$81,508,294
-	**GRAND TOTAL**	$120,533,094

[1] Unreimbursed costs for the Senate Bill 697 categories - other benefits for vulnerable populations, other benefits for the broader community and health research, education and training programs - may include an hourly rate for labor (plus benefits), other expenses such as purchased services, food, supplies, other direct expenses and rooms.

[2] Medical care services provided to Medicare and Medi-Cal beneficiaries result in shortfalls for the hospital. The method for determining these shortfalls is based on actual costs as calculated by a cost accounting system. The costs are subtracted from the payments received from Medicare or Medi-Cal.

[3] Costs are also calculated by a cost accounting system. Actual cost is subtracted from any payments received from either public or private insurance payors or patients.

[4] Other direct services costs based on expenses associated with the activity including some hospital standard indirect expenses.

#19

Title 11, California Code of Regulations, § 999.5(d)(5)(E)

For each health facility that is the subject of the agreement or transaction, a description of the current policies and procedures regarding staffing for patient care areas; employee input on health quality and staffing issues; and employee wages, salaries, benefits, working conditions and employment protections

Staffing for Patient Care Areas and Employee Input on Health Quality and Staffing Issues

PHA has established policies and procedures to ensure that its medical staff and multidisciplinary patient care teams provide care to its patients that is appropriate, individualized, and planned along a continuum of care. Each department has a formalized staffing plan, which is reviewed at least annually based on a variety of criteria, such as performance assessment and improvement activities and mandated staffing ratios and patient acuity. These policies also ensure that PHA's medical staff and other healthcare providers have the opportunity to provide input on health quality and staffing issue through such mechanisms as department leadership meetings, staff meetings, forums, and newsletters.

These policies are:

- Hospital Plan for the Provision of Patient Care Services
- Staffing Plan
- Staffing Scheduling Floating Cancellation of Staff
- Extra Shift Differential
- Agency Personnel
- Acuity Patient Classification System
- Assignment of Patient Care

Employee Wages, Salaries, Benefits, Working Conditions and Employment Protections

PHA has the following established human resource policies and procedures that address employee wages, salaries, benefits, working conditions and employment protections:

- Absence and Attendance
- Alcohol and Drug Policy
- At-Will Employment
- Benefits: Workers' Compensation
- Bereavement Leave
- Callback Pay
- Code of Conduct
- Competency Assessment
- Cultural Diversity and Sensitivity
- Discipline
- Dress Code

- Education Meetings
- Employee Classification
- Employee Conduct: Discrimination and Harassment
- Employee Events Awards and Prizes
- Employee Introductory Period
- Employee Rehire / Reinstatement
- Employment Background Checks
- Employment of Relatives and Personal Relationships
- Equal Employment Opportunity
- Exempt Employee Pay
- Flexing / Required Time Off
- Grievance
- Health Screen
- Hiring Incentives
- Holiday Premium Pay
- Jury Duty Pay
- Just Culture
- Leave of Absence
- Licensure, Certification or Registration Verification
- Long Services Award Program
- Meal and Rest Periods
- New Hire Employment
- Overtime Pay
- Payment of Wages
- Performance Evaluation / Merit Increase
- Reduction in Force
- Relocation Expense Reimbursement
- Reporting Time Pay
- Secondary Position
- Shift Differential Pay
- Sick Time (CA Paid Sick Leave, PHA Sick, and Extended Illness Reserve)
- Social Media Policy
- Solicitation and Distribution
- Special Productivity Award
- Standby Pay
- Temporary Modified / Alternate Work Program
- Termination Pay
- Transfers and Promotions
- Travel Time
- Vacation / Holiday Cash-Out Option
- Vacation and Holiday (Formerly Paid Time Off)
- Wage and Salary Administration
- Work Period Definitions

#20

Title 11, California Code of Regulations, § 999.5(d)(5)(F)

For each health facility that is the subject of the agreement or transaction, all existing documents setting forth any guarantees made by any entity that would be taking over operation or control of the health facilities subject to the transaction relating to employee job security and retraining, or the continuation of current staffing levels and policies, employee wages, salaries, benefits, working conditions and employment protections

Pursuant to the Affiliation Agreement, Cedars-Sinai will become the sole member of PHA, with PHA retaining all of its assets and liabilities. These assets and liabilities include contractual arrangements PHA has in place with officers, employees, doctors, and medical groups to provide administrative, professional and coverage services to PHA. Therefore, all PHA employee rights and obligations, including employee wages, salaries, benefits, working conditions and employment protections will remain intact as a result of the Affiliation. Additionally, the parties do not anticipate that the Affiliation will negatively impact the employment status of any PHA employees, and Cedars-Sinai has expressly agreed to certain employee-related protections in Section 13.9 of the Affiliation Agreement.

In addition, please see the response to Section 999.5(d)(3)(A) for information about the PHA retention plan.

#21

Title 11, California Code of Regulations, § 999.5(d)(5)(G)

If the transaction will have any impact on reproductive healthcare services provided by any facility that is the subject of transaction, or any impact on the availability or accessibility of reproductive healthcare services, a description of all reproductive healthcare services provided in the last five years by each health facility that is the subject of the transaction

The parties do not anticipate that the proposed Affiliation will have any negative effect on PHA's provision of reproductive healthcare services. The Affiliation Agreement in no way limits or modifies PHA's current provision of healthcare services and, as a general matter, the parties intend for PHA to continue to provide the same types and levels of services post-Affiliation as it did prior to the Affiliation. In addition, under Section 13.14 of the Affiliation Agreement, Cedars-Sinai commits to PHA providing women's health services at levels as required by the California Attorney General, among other healthcare services.

#22

Title 11, California Code of Regulations, § 999.5(d)(5)(H)

Statement describing all effects that the proposed agreement or transaction may have on healthcare services provided by the facility including, but not limited to, any changes in the types or levels of medical services that may be provided at the facility and a statement of how the proposed transaction may affect the availability and accessibility of healthcare in the affected communities

The proposed Affiliation provides for Cedars-Sinai to become the sole member of PHA, and is not intended to have any adverse impact on the availability or accessibility of health care services to the affected community, nor do the parties anticipate that the Affiliation will result in any adverse changes to Huntington Hospital's day-to-day operations. Additionally, under Section 13.14 of the Affiliation Agreement, Cedars-Sinai commits to PHA continuing important aspects of its healthcare operations as and for the periods determined by the California Attorney General, including the following:

- Huntington Hospital will continue as a licensed general acute care hospital, including to the extent that Huntington is able to meet the requirements of applicable accreditation agencies, maintaining each of the following with the same types and levels of services as currently provided:

  Level II Trauma Center
  Level III Neonatal Intensive Care Unit
  Comprehensive Stroke Center
  STEMI Receiving Center
  Advanced Cardiology and Cardiovascular Surgery Programs
  Advanced Robotic Surgery
  Orthopedic Service Line
  Oncology Service Line
  Neurology Service Line
  GME programs
  Senior Care Network
  Women's Health Services
  End of Life Services

- Huntington Hospital will continue to participate in the Medi-Cal and Medicare programs.

- Any future sale or change in control of Huntington Hospital will require the prior approval of the California Attorney General.

- Huntington Hospital will use commercially reasonable efforts to maintain Magnet Status with substantially the same types and levels of services as currently provided.

Moreover, the parties intend for the Affiliation to strengthen PHA and its affiliates by giving them access to certain resources and services of Cedars-Sinai and thus anticipate that it will have a substantially positive effect on PHA's delivery of healthcare services and will improve the availability and accessibility of healthcare in the affected communities. For additional information regarding the resources and services Cedars-Sinai intends to make available to PHA, please see the response to Section 999.5(d)(2)(A).

#23

Title 11, California Code of Regulations, § 999.5(d)(5)(I)

Description and copy of all current contracts between the applicant and the city in which the applicant is located and current contracts between the applicant and the county in which the applicant is located for each health facility subject to the transaction

Agreements responsive to this Section 999.5(d)(5)(I) that are attached hereto as Exhibits are as follows:

- Trauma Center Service Agreement No. H-703481 dated July 1, 2008 between the County of Los Angeles and Pasadena Hospital Association Ltd, dba Huntington Memorial Hospital, as amended through Amendment No. 22 dated June 10, 2020, for the provision of trauma center designation services. **(Exhibit 23-A)**

- Master Agreement dated January 1, 2020 between the County of Los Angeles and Huntington Memorial Hospital for Specialty Care Center Designations. **(Exhibit 23-B)**

- Mental Health Services Agreement No. MH060087, Contract Allowable Rate - Fee For Service, Medi-Cal Acute Psychiatric Inpatient Hospital Services dated July 1, 2015 between the County of Los Angeles and Pasadena Hospital Association Ltd, dba Huntington Memorial Hospital for reimbursement of Psychiatric Inpatient Hospital Services for Medi-Cal beneficiaries, as amended through Amendment No. 3 dated June 9, 2020. **(Exhibit 23-C)**

- Master Agreement No. H-707421 dated January 8, 2018 between the County of Los Angeles and Huntington Memorial Hospital, as amended by Amendment No. 1, for Comprehensive Stroke System. **(Exhibit 23-D)**

- Master Agreement No. H-708207 dated July 1, 2019 between the County of Los Angeles and Huntington Memorial Hospital, as amended by Amendment No. 1, for Specialty Care Center Designations. **(Exhibit 23-E)**

- Social Program Agreement (Contract # CP-05-377) dated March 5, 2020 between the County of Los Angeles and Huntington Hospital, regarding $5,000 grant for health and social service initiatives and programs. **(Exhibit 23-F)**

- Contract No. 23,340 dated April 16, 2020 between the City of Pasadena and Pasadena Hospital Association Ltd, dba Huntington Memorial Hospital, for the COVID-19 pandemic. **(Exhibit 23-G)**

Exhibit 23-A

Trauma Center Service Agreement No. H-703481

#-703481

TRAUMA CENTER SERVICE AGREEMENT

BY AND BETWEEN

COUNTY OF LOS ANGELES

AND

PASADENA HOSPITAL ASSOCIATION LTD, DBA HUNTINGTON MEMORIAL HOSPITAL

EFFECTIVE

JULY 1, 2008 – JUNE 30, 2010

TRAUMA CENTER SERVICE AGREEMENT

TABLE OF CONTENTS

PARAGRAPH		PAGE #
1.	TERM:	- 2 -
2.	ADDITIONAL PROVISIONS:	- 5 -
3.	SPECIFIC RESPONSIBILITIES OF COUNTY'S DEPARTMENT OF HEALTH SERVICES (COUNTY'S LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY):	- 5 -
4.	SPECIFIC RESPONSIBILITIES OF CONTRACTOR:	- 10 -
5.	INDEMNIFICATION:	- 12 -
6.	GENERAL INSURANCE REQUIREMENTS:	- 13 -
7.	SPECIFIC INSURANCE COVERAGE REQUIREMENTS:	- 16 -
8.	WAIVERS:	- 18 -
9.	STANDARDS OF CARE:	- 19 -
10.	NUMBER OF PATIENTS TO BE TREATED:	- 20 -
11.	PATIENT TRANSFERS:	- 21 -
12.	TRAUMA CENTER SIGNS:	- 22 -
13.	TRAUMA TEAM:	- 22 -
14.	TRAUMA CENTER FEES:	- 22 -
15.	QUALITY IMPROVEMENT:	- 24 -
16.	DUE PROCESS:	- 25 -
17.	RESPONSIBILITY FOR INDIGENT PATIENTS:	- 30 -
18.	STATUS OF CONTRACTOR:	- 30 -
19.	INTERPRETERS:	- 31 -
20.	CONSUMER COMPLAINTS:	- 31 -
21.	NOTICES:	- 32 -

Contract #H-703481

TRAUMA CENTER SERVICE AGREEMENT

THIS AGREEMENT is made and entered into this 1st day of July, 2008,

by and between COUNTY OF LOS ANGELES (hereafter "County"),

and PASADENA HOSPITAL ASSOCIATION LTD, DBA HUNTINGTON MEMORIAL HOSPITAL (hereafter "Contractor").

WHEREAS, various general acute care hospitals located within Los Angeles County have been identified by County as hospitals which are uniquely staffed and equipped to provide appropriate care to emergency patients who suffer major trauma; and

WHEREAS, Contractor is willing to accept and care for trauma patients at hospital under County's advanced trauma system and in accordance with the terms and conditions which follow herein; and

WHEREAS, Contractor, by virtue of the parties' execution of this Agreement, is a County designated Trauma Center; and

WHEREAS, this Agreement establishes funding available to Contractor for certain services performed during the term of this Agreement for services to be performed by Contractor described herein in accordance with the terms and conditions under this Agreement; and

WHEREAS, Contractor has agreed to use its best efforts to maintain continuous participation as a County-designated Trauma

Center and Paramedic Base Hospital during the term of this Agreement; and

WHEREAS, the Agreement is authorized by Health and Safety Code Sections 1797.204, 1797.252, and 1798.170, Government Code Section 26227, as well as by provisions of Welfare and Institutions Code Section 16946.

NOW, THEREFORE, the parties agree as follows:

1. TERM:

A. This Agreement supersedes all other previous agreements entitled "Trauma Center Service Agreement" and shall commence effective July 1, 2008, and it shall remain in full force and effect until June 30, 2010, without further action of the parties. In any event, County may terminate this Agreement in accordance with the TERMINATION Paragraphs of the ADDITIONAL PROVISIONS hereunder.

B. Notwithstanding any other provision of this Agreement, Director of County's Department of Health Services or his duly authorized designee (jointly hereafter referred to as "Director") may immediately suspend this Agreement at any time if Contractor's license to operate basic or comprehensive emergency services is revoked or suspended. If such licensure, suspension, or revocation remains in effect for a period of at

least sixty (60) days, Director may terminate this Agreement upon giving at least thirty (30) days prior written notice to Contractor.

C. Notwithstanding any other provision hereof, Director may suspend this Agreement immediately upon giving written notice to Contractor, if Contractor, its agents, subcontractors, or employees at Contractor may be engaging in a continuing course of conduct which poses an imminent danger to the life or health of patients receiving or requesting medical care and services at Contractor. Any such action by Director shall be subject to the "due process" procedures established in Paragraph 16 hereinbelow.

D. Notwithstanding any other provision of this Agreement, in the event the County makes a final decision to implement a central hospital base station concept, Director may withdraw the requirement that Contractor maintain designation as a base hospital, furnish base hospital services, and meet all requirements set forth in Exhibit "F", Paramedic Base Hospital Requirements, attached hereto and incorporated herein by reference by giving Contractor at least one-hundred eighty (180) days prior written notice thereof. This provision shall not affect County's right to terminate this

Agreement for cause under Paragraph 37 of the Additional Provisions of the Agreement.

E. Notwithstanding any other provision of this Agreement, either party may terminate this Agreement with or without cause by giving the other party at least sixty (60) days prior written notice thereof. This provision shall not affect County's right to terminate this Agreement for cause under Paragraph 37 of the Additional Provisions of the Agreement.

F. If the State EMS Authority and the State EMS Commission disapprove for any reason the County's trauma system plan, County may terminate this Agreement by providing written notice to Contractor of the State's action, and by setting forth in the notice an effective date of termination which is no less than thirty (30) days from the date of the County's receipt of notification of the State's action, but which is no more than sixty (60) days from said date.

G. In accordance with this Agreement, Contractor may, during the term of this Agreement, submit claims for services provided to eligible indigent patients. In consideration for services to be performed by Contractor under this Agreement, these claims will be reimbursed at the all-inclusive rates set forth in

Exhibit B.

2. ADDITIONAL PROVISIONS: Attached hereto and incorporated herein by reference, is a document labeled "ADDITIONAL PROVISIONS". The terms and conditions therein contained are part of this Agreement.

3. SPECIFIC RESPONSIBILITIES OF COUNTY'S DEPARTMENT OF HEALTH SERVICES (COUNTY'S LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY):

A. The Department of Health Services ("Department") shall develop and monitor compliance with triage protocols and procedures for County's trauma system.

B. The Department shall be responsible for the development and ongoing evaluation and Performance Improvement of the trauma system.

C. The Department shall be responsible for periodic performance evaluations of the trauma system, which shall be conducted at least every three (3) years in conjunction with the American College of Surgeons review. The evaluation shall be based, in part, on requirements described in Exhibit "A.I", Level I Trauma Center Requirements, Exhibit "A.II", Level II Trauma Center Requirements, Exhibit "A.III", Level I Pediatric Trauma Center Requirements, and Exhibit "A.IV", Level II Pediatric Trauma Center Requirements, attached

hereto and incorporated herein by reference. Results of the trauma evaluation shall be made available to individual participants.

D. The Department shall implement policies and procedures for quality improvement in order to monitor the appropriateness and quality of care rendered to trauma patients in Los Angeles County as described under Paragraph 15 hereinbelow.

E. The Department shall be responsible for maintaining a source of reimbursement for eligible indigent patients described in Exhibit "B", Provisions For Reimbursement of Eligible Indigent Patients, attached hereto and incorporated herein by reference.

F. One or more individuals within the Department shall be designated by Director to liaise with all Los Angeles County designated Trauma Centers with respect to matters affecting County's advanced trauma system.

G. The Department shall be responsible for ensuring that Trauma Centers and other hospitals that treat trauma patients participate in the data and quality improvement process.

H. The Department shall be responsible for ensuring that patient inclusion in the data collection system is based on Exhibit "C", Patient Inclusion in the Trauma

Center Data System, attached hereto and incorporated herein by reference.

I. The Trauma Center data collection system requirements are described and set forth in Exhibit "D", Trauma Center Data Collection System, attached hereto and incorporated herein by reference. The Department shall comply with all Department responsibilities for the Trauma Center data collection system in Exhibit "D".

J. The Department, after consultation with and advice from the Emergency Medical Services Commission ("EMSC"), EMS Data Advisory Committee shall maintain a comprehensive Trauma Center data collection system. The composition of the EMS Data Advisory Committee, is described in Exhibit "E", Data Advisory Committee Membership, attached hereto and incorporated herein by reference.

K. The Department shall monitor the trauma patient catchment area defined for Contractor to ensure that trauma patients are triaged appropriately to Contractor. Contractor acknowledges receipt of a map defining its catchment area as of the date of execution of this Agreement.

L. The Department may modify trauma patient catchment areas from time to time to meet the needs of the advanced trauma system. In the event that a catchment

area is to be changed, then sixty (60) days prior to the effective date of the change, the Department shall give written notice to all designated Trauma Centers. All impacted Trauma Centers which are not County operated, including Contractor, shall be afforded the opportunity to provide written statements regarding the proposed change. If Contractor is adversely affected by the change of the catchment areas, Contractor shall be provided with "due process" as specified in Paragraph 16 hereinbelow prior to the change in the catchment areas.

M. In the event that an existing Trauma Center ceases to participate in the advanced trauma system, the Department shall first attempt to reconfigure the trauma patient catchment areas so as to provide coverage for the area no longer served by such hospital by utilizing existing Trauma Centers. If coverage cannot be provided by the use of existing Trauma Centers, the Director shall give written notice to Contractor and to all concerned designated Trauma Centers of any Department intention to seek a new hospital to provide the coverage. Contractor and all other concerned designated Trauma Centers shall have the opportunity to provide written statements to

Director within ten (10) days of receipt of such notification regarding the proposed change. If Contractor believes it would be adversely affected by the addition of a new Trauma Center in such circumstances, Contractor may present its complaint in accordance with the "due process" provisions specified in Paragraph 16 hereinbelow prior to County designation of the new Trauma Center.

N. Interim System Re-Configuration. The Department may, on an interim basis, restructure the trauma system as it deems necessary, in those instances when a Contractor gives notice that it is withdrawing from the system or when a Contractor is suspended or terminated from the prehospital care system. In the event that an interim restructuring occurs, any affected Contractor shall be given the opportunity to provide written and oral statements regarding the restructuring to the local EMS agency. The affected existing Contractors shall be provided with the "due process" procedures as specified in Paragraph 16 hereinbelow.

O. The Department shall follow the trauma system policy which addresses the coordination with all health care organizations within the trauma system to facilitate the transfer of an organization member in accordance

with the criteria set forth in Paragraph 11 hereinbelow.

4. SPECIFIC RESPONSIBILITIES OF CONTRACTOR:

A. Contractor shall furnish Trauma Center services to patients in need thereof who are delivered, or present themselves, to Contractor. In the provision of such services, Contractor shall comply at all times during the term of this Agreement with the staffing criteria and other requirements of applicable Exhibits "A.I" - "A.IV".

B. The Contractor shall comply with the reimbursement process for eligible indigent patients described in Exhibit "B", attached hereto and incorporated herein by reference.

C. The Contractor shall include only those patients that meet inclusion in the data collection system based on Exhibit "C", attached hereto and incorporated herein by reference.

D. The Contractor shall comply with all Contractor responsibilities for the Trauma Center data collection system in Exhibit "D", attached hereto and incorporated herein by reference.

E. It is understood and agreed that medical care furnished to patients pursuant to this Agreement shall be

provided by physicians duly licensed to practice medicine in the State of California, and the agreement by Contractor to arrange for the furnishing of such treatment at hospital is not to be construed as Contractor entering into the practice of medicine. This provision shall not limit the right of practitioners or nursing personnel affiliated with or employed by Contractor at hospital to render any and all services within the scope of their professional licensure or certification, as permitted by Contractor=s rules, regulations, and policies with respect thereto.

F. Contractor shall maintain designation as a base hospital, furnish base hospital services, and meet all requirements set forth in Exhibit "F", Paramedic Base Hospital Requirements, attached hereto and incorporated herein by reference. The foregoing base hospital requirement shall not apply to Childrens Hospital Los Angeles or to a Contractor that has lost its designation as a base hospital in accordance with Paragraph 1(D) of this Agreement.

5. INDEMNIFICATION: Contractor shall indemnify, defend, and hold harmless County, elected and appointed officers, employees, and agents from and against any and all

liability, including but not limited to demands, claims, actions, fees, costs, and expenses (including attorney and expert witness fees), arising from or connected with Contractor's acts and/or omissions arising from and/or relating to this Agreement.

County shall indemnify, defend, and hold harmless Contractor and its officers, employees and agents, from and against any and all liability, including but not limited to demands, claims, actions, fees, costs and expenses (including attorney and expert witness fees), arising from or connected with County's acts and/or omissions arising from and/or relating to this Agreement.

6. GENERAL INSURANCE REQUIREMENTS: Without limiting Contractor's indemnification of County, and during the term of this Agreement, Contractor shall provide and maintain, and shall require all of its subcontractors to maintain, the following programs of insurance specified in this Agreement. Such insurance shall be primary to and not contributing with any other insurance or self-insurance programs maintained by County, and such coverage shall be provided and maintained at Contractor's own expense.

A. Evidence of Insurance: Certificate(s) or other evidence of coverage satisfactory to County shall be delivered to County's Department of Health Services,

Contracts and Grants Division, 313 North Figueroa Street, Sixth Floor-East, Los Angeles, California 90012, prior to commencing services under this Agreement. Such certificates or other evidence shall:

(1) Specifically identify this Agreement.

(2) Clearly evidence all coverages required in this Agreement.

(3) Contain the express condition that Contractor will use best efforts to give County written notice by mail at least thirty (30) calendar days in advance of cancellation for all policies evidenced on the certificate of insurance. Should Contractor receive notice from insurer of a cancellation to take effect earlier than thirty (30) calendar days from such notice, Contractor shall use best efforts to notify County in writing of such cancellation on the next business day.

(4) Include copies of the additional insured endorsement to the commercial general liability policy, adding County of Los Angeles, its Special Districts, its officials, officers, and employees as insured for all activities arising from this Agreement.

(5) Identify any deductibles or self-insured

retentions for County=s approval. Contractor shall be responsible for all deductibles as they apply to any insurance coverage with respect to this Agreement.

B. Insurer Financial Ratings: Insurance is to be provided by an insurance company acceptable to County with an A.M. Best rating of not less than A: VII, unless otherwise approved by County.

C. Failure to Maintain Coverage: Failure by Contractor to maintain the required insurance, or to provide evidence of insurance coverage acceptable to County, shall constitute a material breach of contract upon which County may immediately terminate or suspend this Agreement. County, at its sole option, may obtain damages from Contractor resulting from said breach.

D. Notification of Incidents, Claims, or Suits: Contractor shall report to County:

(1) Any third party claim or lawsuit filed against Contractor arising from or related to services performed by Contractor under this Agreement.

(2) Any loss, disappearance, destruction, misuse, or theft of any kind whatsoever of County property, monies or securities entrusted to Contractor under the terms of this Agreement.

(3) Simultaneously, any injury, death or treatment of a patient provided services covered in this Agreement for which Contractor provides any report/notice to the Joint Commission on Accreditation of Hospital Organization (JCAHO), or any report/notice as required under Title 22, C.C.R.70737 (e.g., unusual occurrence). Such report to County shall only include the patient name, date, and treatment.

E. Insurance Coverage Requirements for Subcontractors: Except as set forth below, Contractor shall ensure that any and all non-physician subcontractors (e.g. pump technicians) performing medical care and treatment services under this Agreement shall meet the professional liability insurance requirements of this Agreement by either:

(1) Contractor providing evidence of insurance covering the activities of subcontractors, or

(2) Contractor providing evidence submitted by subcontractors evidencing that subcontractors maintain the required insurance coverage. County retains the right to obtain copies of evidence of subcontractor insurance coverage at any time. The amount of professional liability insurance

required in this Agreement for non-physician subcontractors would be an amount equal to that which the County routinely requires in its agreements with non-physician contractors providing similar medical care and treatment services to the County.

F. Insurance Coverage Requirements for Affiliate Physicians: Contractor shall ensure that any and all physicians, either individually, or by or through a related medical group, physician group, or independent physician association where appropriate, with privileges to perform or otherwise performing any services covered under this Agreement on premises of or used by Contractor maintain professional liability insurance covering liability arising from any error, omission, negligent, or wrongful act of such physician(s) with limits of not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) aggregate. The coverage also shall provide an extended two (2) year reporting period commencing upon the termination or cancellation of this Agreement, only if such coverage is consistent with the industry standard in California.

7. SPECIFIC INSURANCE COVERAGE REQUIREMENTS:

A. General Liability Insurance: (written on ISO policy

form CG 00 01 or its equivalent) with limits of not less than the following:

General Aggregate:	$2 Million
Personal and Advertising Injury:	$1 Million
Each Occurrence:	$1 Million

B. Automobile Liability Insurance: (written on ISO policy form CA 00 01 or its equivalent) with a limit of liability of not less than One Million Dollars ($1,000,000) for each accident. Such insurance shall include coverage for all "owned", "hired", and "non-owned" vehicles, or coverage for "any auto".

C. Workers' Compensation and Employers' Liability: Insurance providing workers' compensation benefits, as required by the Labor Code of the State of California or by any other state, and for which Contractor is responsible. If Contractor's employees will be engaged in maritime employment, coverage shall provide workers' compensation benefits as required by the U.S. Longshore and Harbor Worker's Compensation Act, Jones Act, or any other Federal law for which Contractor is responsible.

In all cases, the above insurance also shall include Employers' Liability coverage with limits of not less than the following:

Each Accident:	$1 Million

Disease - Policy Limit: $1 Million

Disease - Each Employee $1 Million

D. Professional Liability: Insurance maintained by Contractor covering liability arising from any error, omission, negligent or wrongful act of Contractor, its officers, or employees with limits of not less than Three Million Dollars ($3,000,000) per occurrence. The coverage also shall provide an extended two (2) year reporting period commencing upon the termination or cancellation of this Agreement.

6. WAIVERS: Director may waive trauma center criteria contained in Exhibits "A.I" - "A.IV", when it is determined that the conditions necessitating the waiver request will be in effect less than seventy-two (72) hours for any one occurrence and that procedures exist to ensure that patient care is not jeopardized. Waivers may, upon discretion of Director, include but not be limited to, the following instances:

A. Temporary inability of Contractor to meet staffing requirements with regard to trauma team or any in-house or on-call or second call physicians whose absence, as determined by Director, would not jeopardize the welfare of trauma patients.

B. Temporary loss of function or restricted capacity of

any of the special facilities, resources or capabilities of Contractor, if such loss or restriction would not jeopardize the welfare of trauma patients. County recognizes that routine servicing and subsequent temporary inoperability ("down time") of the Computerized Tomography (CT) scanner does not require invocation of a waiver.

Contractor shall direct its waiver request to Director's office. If a waiver is given, Contractor shall re-contact Director as soon as the temporary staffing or the equipment deficiency for which the waiver was given has been resolved. If a deficiency has not been corrected within the time deemed appropriate by Director, Director may temporarily suspend Contractor's designation as a Trauma Center. In this event, Contractor shall notify surrounding base hospitals and Trauma Centers, and paramedic provider agencies serving Contractor's area that it is on temporary bypass status. When the deficiency necessitating bypass status has been corrected, Director may lift the suspension, and Contractor shall immediately notify such surrounding hospitals.

9. STANDARDS OF CARE:

A. Contractor shall provide for supervision and monitoring

of care rendered under the terms of this Agreement in accordance with the recognized standards thereof through regular review of patient medical records by Contractor's appropriately designated medical staff committee(s) at hospital. In addition, Contractor shall provide for specific quality improvement activities as described in the QUALITY IMPROVEMENT Paragraph 15, hereinbelow.

B. Contractor shall:

(1) maintain Contractor's accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and be in conformance at hospital with the standards of the JCAHO which apply to the provision of emergency medical services.

(2) not subject trauma patients to avoidable delay in receiving necessary medical care at Contractor pending financial arrangements.

10. NUMBER OF PATIENTS TO BE TREATED: While the parties contemplate that persons suffering major trauma at locations near Contractor will normally be delivered to Contractor for care, the parties recognize that County can make no guarantee in this regard and further that County is unable to assure that any minimum number of trauma patients will be

delivered to Contractor during the term of this Agreement.

11. PATIENT TRANSFERS:

A. Patients to whom service is being provided hereunder may be transferred between and from trauma centers to other medical facilities, including County-operated facilities, in compliance with JCAHO standards, Title 22 of the California Administrative Code, Emergency Medical Treatment and Active Labor Act (EMTALA), and other laws and protocols governing such transfers, providing that:

(1) any transfer shall be, as determined by the trauma center surgeon of record, medically prudent; and

(2) in accordance with local EMS agency interfacility transfer policies; and

(3) the transfer may not be refused if the receiving facility has the capacity to accept.

B. Contractor agrees to continue to provide services hereunder until a patient is transferred.

C. Contractor shall have written transfer agreements with trauma centers. Contractor shall develop written criteria for consultation and transfer of patients needing a higher level of care.

D. To the extent that it is not contrary to, or inconsistent with, any Federal or State law, regulation

or policy, the County shall take the necessary steps to ensure that preference is given to Contractor seeking to effectuate a medically prudent transfer of a patient to a County owned facility.

E. Contractor or other responsible party shall be financially liable for transportation of patients for whom services are rendered hereunder and who are being transferred from Contractor to any other facility. Nothing herein shall prevent Contractor from billing the patient or other financially responsible party for such services.

12. TRAUMA CENTER SIGNS: Contractor may, at its own expense, identify itself as a Trauma Center by placing signs to that effect on Contractor's grounds. Such signs shall exclude any reference to the level of its County designation and shall otherwise conform to local government regulations.

13. TRAUMA TEAM: Contractor agrees to designate trauma teams, whose members must include the general surgeon, and other team members as appropriate to respond to all trauma codes called either from the field or from the hospital. Upon activation of the trauma code, appropriate team members shall be available as defined in regulations and shall assemble in the trauma resuscitation area.

14. TRAUMA CENTER FEES: By payment as set forth in this

paragraph, Contractor agrees to offset a portion of the cost of the data collection effort excluding new hardware, the data management system, and a portion of the County's administrative costs for the trauma system and base hospital operation. The annual Trauma Center/Base Hospital fee for Fiscal Years 2008-09 and 2009-10 shall be Fifty-One Thousand Two Hundred Twenty-Seven Dollars ($51,227) and Fifty-Two Thousand Seven Hundred and Eighty-Two Dollars ($52,782), respectively, for each Contractor and is due on or before August 31 of the fiscal year. Since the base hospital requirement does not apply to Childrens Hospital Los Angeles, as noted in Paragraph 4. SPECIFIC RESPONSIBILITIES OF CONTRACTOR, Section F., the annual Trauma Center fee for Childrens Hospital Los Angeles for Fiscal Years 2008-09 and 2009-10 shall be Thirty-Nine Thousand Six Hundred and Seventy Dollars ($39,670) and Forty-One Thousand and Twenty-Eight Dollars ($41,028), respectively, and is due on or before August 31 of the fiscal year.

If this Agreement is revoked, cancelled, or otherwise terminated on a date other than June 30, the amount reflected herein above for such term shall be prorated, and a reduced amount, based upon the actual number of days of such term that the Agreement is in effect, shall be due County hereunder. If the greater sum has already been paid

by Contractor, County shall refund the difference between that payment and the prorated amount.

If this Agreement is revoked, cancelled, or terminated because of Contractor's failure to maintain the trauma system criteria as described in applicable Exhibits "A.I" - "A.IV", or failure to maintain an acceptable level of trauma care as determined by community standards, Contractor shall not be eligible for any such refund.

In any event, County shall refund to Contractor its prorated share of remaining funds contributed by designated County Trauma Centers to the data collection system, if the total cost of such programs, as determined by the County's Auditor Controller and Director in accordance with standard auditing and accounting practices, is found to be less than the total amount contributed by designated Trauma Centers.

15. QUALITY IMPROVEMENT:

A. Specific rights of the Department:

(1) Director may from time to time review Contractor's policies and procedures regarding quality improvement as they pertain to care rendered under this Agreement.

(2) Director may request Contractor to verify that internal follow up is occurring by Contractor on a particular case under review by the Department.

Contractor shall respond in writing within fifteen (15) days of Director's written request.

B. Specific responsibilities of Contractor:

(1) Contractor shall conduct a detailed audit of:

(a) all trauma related deaths;

(b) all trauma patient transfers;

(c) all major complications.

(2) Contractor shall abide by the following requirements concerning case audit:

(a) Audit attendances must be documented by signature and rosters retained by Contractor;

(b) Audit minutes must be recorded and retained by Contractor.

(3) All such records shall be available to designees duly authorized by Director during the term of this Agreement and for a period of seven (7) years thereafter upon request of Director.

(4) Contractor shall further advise Director, upon request, what corrective action was taken on specific cases.

16. DUE PROCESS:

A. Notice of Proposed Adverse Action: In all cases in which the Director has the authority to, and pursuant to this authority, has taken any of the actions

constituting grounds for hearing as hereafter set forth in Subparagraph 16.B., Contractor shall promptly be given written notice of the specific charges and factual basis upon which the Director's action is based. With the exception of summary suspensions or summary suspension with intent to terminate, Contractor shall be afforded a right to request a hearing before implementation of any of the actions which constitute grounds for a hearing. Contractor shall have thirty (30) days following the receipt of such notice within which to file with Director a request for hearing before the EMSC.

B. Grounds for Hearing: Any one or more of the following actions constitute grounds for a hearing: summary suspension of Contractor as a Trauma Center; summary suspension with intent to terminate Agreement; Trauma Center operational and programmatic changes wherein Contractor has been given specific rights herein to request a hearing; modifications to Contractor's trauma patient catchment area; and the proposed addition of a new hospital as a Trauma Center when Contractor believes it would be adversely affected by such addition. Nothing in this paragraph 16 shall affect County's right to terminate Agreement under

subparagraph 1.D.

C. Summary Suspension or Summary Suspension with Intent To Terminate: In the case of summary suspensions or summary suspension with intent to terminate this Agreement, Contractor, at its election, shall have the right to request in writing that Director reconsider the summary suspension action. Director shall act on this request for reconsideration within ten (10) days after the receipt of the reconsideration request. Contractor representatives shall be given an opportunity to meet with Director to discuss the alleged basis for the summary action.

Within ten (10) days following the meeting with Director, or within ten (10) days following the summary suspension action, Director shall issue a written decision to Contractor regarding the summary suspension. This decision may be that the suspension be continued for a particular time or upon particular condition, that the summary suspension be terminated, that Agreement be terminated, that other conditions be imposed on Contractor, or such other action as may seem warranted. If Director takes any action other than full and immediate termination of the summary suspension, Contractor may request a hearing on the

summary suspension before the EMSC, as provided in this Paragraph. Such request shall be in writing and addressed to Director. Such request shall be delivered to Director within five (5) days of Director's delivery to Contractor of his/her written decision.

D. Time and Place of Hearing: Director shall, within fifteen (15) days of receipt of a request for hearing, file a request for the hearing with the EMSC. The EMSC shall give notice to Contractor of the time, place, and date of the hearing in accordance with EMSC rules and procedures. The date of commencement of the hearing shall be not less than thirty (30) days, nor more than ninety (90) days from the filing of the request for a hearing, subject to the convenience and approval of the EMSC; however, if the request is received from Contractor when Contractor is under a summary suspension then in effect, Director shall attempt to arrange a hearing before the EMSC as soon as possible.

E. Notice of Charges: As part of, or together with the notice of hearing, Director shall state in writing, in concise language, the acts or omissions with which Contractor is charged or reasons for substantial operational change or restructuring. If either party, by written notice, requests a list of individuals who

will appear on behalf of the other, then each party, within ten (10) days of such request, shall furnish to the other a list, in writing, of the names and addresses of the individuals, so far as is then reasonably known, who will give testimony or evidence in support of that party at the hearing.

F. Hearing Procedure: At the hearing, subject to the rules of the EMSC, both sides shall have the following rights: to call and examine witnesses, to introduce exhibits, and to rebut any evidence. The EMSC may question witnesses.

G. Memorandum of Points and Authorities: Subject to the rules of the EMSC, each party shall have the right to submit a memorandum of points and authorities to the EMSC.

H. Basis of Decision: Subject to the rules of the EMSC, the EMSC decision on a hearing under this Agreement shall be based upon the evidence produced at the hearing. The evidence may consist of the following:

(1) oral testimony of the parties' representatives;

(2) documentary evidence introduced at the hearing;

(3) briefs or memorandum of points and authorities presented in connection with the hearing;

(4) policies and procedures of the Department;

(5) all officially noticed matters.

I. Record of Hearing: The parties understand that the EMSC maintains a record of hearings by one or more of the following methods: a shorthand reporter, a tape or disc recording, or by its clerk's minutes of the proceedings. If a shorthand reporter is specifically requested in writing by Contractor or by Director, the cost of same shall be borne by such party.

J. Decision of the EMSC: The decision of the EMSC shall be effective and binding on the parties to the extent permitted and prescribed in County Code Section 3.20.070B.

17. RESPONSIBILITY FOR INDIGENT PATIENTS: Nothing contained in this Agreement is intended nor shall it be construed to affect either party's existing rights, obligations, and responsibilities with respect to care required by or provided to indigent patients.

18. STATUS OF CONTRACTOR: The parties hereto agree that Contractor, its officers, agents, and employees, including its professional and nonprofessional personnel, shall act in an independent capacity and not as officers, agents, or employees of County and shall not have the benefits of County employees. Except as may otherwise expressly be provided hereunder, Contractor shall furnish all personnel,

supplies, equipment, space, furniture, insurance, utilities, and telephone necessary for performance of Contractor's responsibilities set forth in this Agreement. This Paragraph shall not preclude or limit Contractor from seeking reimbursement, contributions, tuition, or other payments from the public or from non-County provider agencies for services provided by Contractor hereunder where entitlement thereto is permitted by law or by separate contract.

19. INTERPRETERS: If Contractor is located in an area where communication problems may exist because of a high concentration of non-English-speaking residents, Contractor shall provide interpreters in accordance with the requirements for such services established under Section 70721, Title 22 of the California Administrative Code.

20. CONSUMER COMPLAINTS:

A Contractor agrees to comply with all responsibilities and related requirements applicable under Section 70707, Title 22 of the California Administrative Code, to ensure that each patient receiving services hereunder at Contractor is made aware of the following information prior to discharge: the name, location, and telephone number of Contractor's representative responsible for handling patient complaints; means,

including forms, for submitting complaints in writing to that representative; a "Bill of Rights" defining patient prerogatives relative to matters on care, services, communication, and registry of complaints.

B. Contractor shall, on request, furnish to Director, copies of all trauma patient complaints, and the results of Contractor's investigation and action taken. All of Contractor's administrative files maintained on such complaints shall be open to inspection by Director. Such inspection rights shall not extend to reports of medical staff committees, nor to incident reports or other attorney-client communication or materials qualifying for the attorney-client privilege.

21. NOTICES: Any and all notices required, permitted, or desired to be given hereunder by one party to the other shall be in writing and shall be delivered to the other party personally or by United States mail, certified or registered postage prepaid return receipt requested, to the parties at the following addresses and to the attention of the persons named. County's Director shall have the authority to issue all notices which are required or permitted by County hereunder. Addresses and persons to be notified may be changed by a party by giving at least ten (10) calendar days prior written notice thereof to the

other.

A. Notices to County shall be addressed as follows:

(1) Department of Health Services
Emergency Medical Systems Division
5555 Ferguson Drive, Suite 220
Commerce, California 90022
Attention: Acting Director

(2) Department of Health Services
Contracts and Grants Division
313 North Figueroa Street
Sixth Floor - East
Los Angeles, California 90012
Attention: Division Chief

B. Notice to Contractor shall be addressed as follows:

Pasadena Hospital Association LTD. dba
Huntington Memorial Hospital
Administration
100 West California Boulevard
Pasadena, CA 91105-3097
Attention: Chief Executive Officer

IN WITNESS WHEREOP, the Board of Supervisors of the County of Los Angeles has caused this Agreement to be subscribed by its

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

Director of Health Services and Contractor has caused this Agreement to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By [REDACTED]

John F. Schuhhoff, Ph.D.
Interim Director of Health Services

Pasadena Hospital Association LTD, dba Huntington Memorial Hospital
Contractor

By [REDACTED]

Signature

Stephen A Ralph
Printed Name

President and CEO
Title

September 5, 2008
Date

(AFFIX CORPORATE SEAL HERE)

APPROVED AS TO FORM:
OFFICE OF THE COUNTY COUNSEL

APPROVED AS TO CONTRACT ADMINISTRATION:

DEPARTMENT OF HEALTH SERVICES
CONTRACTS AND GRANTS DIVISION

TRAUMA CENTER SERVICE AGREEMENT

TABLE OF CONTENTS

EXHIBIT I (BODY OF THE AGREEMENT)

ATTACHMENTS:

ADDITIONAL PROVISIONS

ATTACHMENT AP-1 Safely Surrender Notice (English)

ATTACHMENT AP-2 Safely Surrender Notice (Spanish)

EXHIBIT A.I LEVEL I TRAUMA CENTER REQUIREMENTS

EXHIBIT A.II LEVEL II TRAUMA CENTER REQUIREMENTS

EXHIBIT A.III LEVEL I PEDIATRIC TRAUMA CENTER REQUIREMENTS

EXHIBIT A.IV LEVEL II PEDIATRIC TRAUMA CENTER REQUIREMENTS

ATTACHMENT A-1 Emergency Department Approved for Pediatrics (EDAP) Standards

EXHIBIT B PROVISIONS FOR REIMBURSEMENT OF ELIGIBLE PATIENTS

ATTACHMENT B-1 Trauma Service County Eligibility Protocol

Attachment U-1 Trauma Service County Eligibility (TSCE) Agreement

Attachment U-2 Hospital Certification of Inability to Cooperate

ATTACHMENT B-2 Notice (English)

ATTACHMENT B-3 Notice (Spanish)

ATTACHMENT B-4 Instructions for Submission of Claims & Data Collection

ATTACHMENT B-5 Trauma Physician Services Program Packet

ATTACHMENT B-6 Trauma Center Payment Refund Form

EXHIBIT C PATIENT INCLUSION IN THE TRAUMA CENTER DATA SYSTEM

EXHIBIT D TRAUMA CENTER DATA COLLECTION SYSTEM

ATTACHMENT D-1 TEMIS Hospital Hardware & Software Specifications

ATTACHMENT D-2 Trauma Patient Summary (TPS) Form Pages 1 & 2

ATTACHMENT D-3 Hospital Employee Acknowledgment & Confidentiality Agreement

EXHIBIT E DATA ADVISORY COMMITTEE MEMBERSHIP

EXHIBIT F PARAMEDIC BASE HOSPITAL REQUIREMENTS

ATTACHMENT F-1 Communications Management Committee

ATTACHMENT F-2 Base Hospital Form Pages 1 & 2

ATTACHMENT F-3 Receiving Hospital Outcome Data

ATTACHMENT F-4 TEMIS Hospital Hardware & Software Specifications

ATTACHMENT F-5 Hospital Employee Acknowledgment & Confidentiality Agreement

ATTACHMENT F-6 Base Hospital Communication Equipment

ATTACHMENT F-7 Communication Equipment Maintenance Standards

TRAUMA CENTER SERVICE AGREEMENT

ADDITIONAL PROVISIONS

TABLE OF CONTENTS

PARAGRAPH		PAGE #
1.	ADMINISTRATION AND MONITORING:	- 1 -
2.	CONTRACT COMPLIANCE:	- 2 -
3.	LICENSES:	- 3 -
4.	CONFIDENTIALITY:	- 3 -
5.	RECORDS AND AUDITS:	- 4 -
6.	COUNTY'S QUALITY ASSURANCE PLAN:	- 7 -
7.	CONTRACTOR'S PERFORMANCE DURING CIVIL UNREST OR DISASTER:	-8 -
8.	INDEPENDENT CONTRACTOR STATUS:	- 8 -
9.	NONDISCRIMINATION IN SERVICES:	- 9 -
10.	NONDISCRIMINATION IN EMPLOYMENT:	- 9 -
11.	FAIR LABOR STANDARDS ACT:	- 10 -
12.	EMPLOYMENT ELIGIBILITY VERIFICATION:	- 10 -
13.	STAFF PERFORMANCE WHILE UNDER THE INFLUENCE:	- 11 -
14.	CONTRACTOR'S WILLINGNESS TO CONSIDER COUNTY'S EMPLOYEES FOR EMPLOYMENT:	- 11 -
15.	CONSIDERATION OF GREATER AVENUES FOR INDEPENDENCE ("GAIN") PROGRAM OR GENERAL RELIEF OPPORTUNITY FOR WORK ("GROW") PARTICIPANTS FOR EMPLOYMENT:	- 12 -
16.	TERMINATION FOR IMPROPER CONSIDERATION:	- 13 -
17.	RESTRICTIONS ON LOBBYING:	- 14 -

18. COUNTY LOBBYISTS: ..... - 14 -

19. UNLAWFUL SOLICITATION: ..... - 15 -

20. CONFLICT OF INTEREST: ..... - 15 -

21. PROHIBITION AGAINST ASSIGNMENT AND DELEGATION: ..... - 16 -

22. SERVICE DELIVERY SITE - MAINTENANCE STANDARDS: ..... - 18 -

23. CONFLICT OF TERMS: ..... - 19 -

24. MERGER PROVISION: ..... - 19 -

25. CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM: ..... - 19 -

26. TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM: ..... - 20 -

27. CONTRACTOR'S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM: ..... - 21 -

28. NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT: ..... - 22 -

29. CONTRACTOR RESPONSIBILITY AND DEBARMENT: ..... - 22 -

30. CERTIFICATION RSGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION: ..... - 25 -

31. SEVERABILITY: ..... - 26 -

32. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996: ..... - 27 -

33. COMPLIANCE WITH APPLICABLE LAWS: ..... - 28 -

34. COMPLIANCE WITH CIVIL RIGHTS LAWS: ..... - 29 -

35. GOVERNING LAW, JURISDICTION, AND VENUE: ..... - 30 -

36. SUBCONTRACTING: ..... - 30 -

37. TERMINATION FOR MATERIAL BREACH AND/OR ANTICIPATORY BREACH: ..... - 32 -

38. NO PAYMENT FOR SERVICES PROVIDED FOLLOWING EXPIRATION / TERMINATION OF AGREEMENT: ..... - 36 -

39. NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY LAW: ..... - 37 -

40. CONTRACTOR'S ACKNOWLEDGMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW: ..... - 37 -

41. RECYCLED BOND PAPER: ..... - 38 -

7. Department(s), division(s), service(s) or section(s) that include at least the following surgical specialties, which are staffed by qualified specialists with pediatric experience:
   a. Microsurgery/Reimplantation *(may be provided through a written transfer agreement with a hospital that has a department division service, or section that provides this service)*
   b. Neurologic
   c. Obstetric/Gynecologic *(may be provided through a written transfer agreement with a hospital that has a department, division, service, or section that provides this service)*
   d. Ophthalmologic
   e. Oral or Maxillofacial or Head/Neck
   f. Orthopaedic
   g. Pediatric
   h. Plastic
   i. Urologic

8. Department(s), division(s), service(s) or section(s) that include at least the following non-surgical specialties, which are staffed by qualified specialists with pediatric experience:
   a. Anesthesiology
   b. Cardiology
   c. Critical Care
   d. Emergency Medicine
   e. Gastroenterology
   f. General Pediatrics
   g. Hematology/Oncology
   h. Infectious Disease
   i. Neonatology
   j. Nephrology
   k. Neurology
   l. Pathology
   m. Psychiatry
   n. Pulmonology
   o. Radiology
   p. Rehabilitation/Physical Medicine. *(This requirement may be provided through a written agreement with a pediatric rehabilitation center.)*

9. Commitment by the hospital and its medical staff to treat and care for any pediatric patient presenting.

10. Demonstrated capacity and ability to care for pediatric trauma patients fourteen (14) years and younger, including surgical and intensive care unit capacities/capabilities.

11. Helipad with a permit issued by the State of California, Department of Transportation, Division of Aeronautics.

C. **PROFESSIONAL STAFF REQUIREMENTS**:

1. **SURGICAL**: Qualified surgical specialist(s) or specialty availability, which shall be available as follows:

a. Immediately Available:

(1) Pediatric Surgeon:
A pediatric surgeon capable of evaluating and treating pediatric trauma patients shall be in-house, immediately available, and dedicated to the facility for pediatric trauma patients twenty-four (24) hours per day. A pediatric surgeon capable of evaluating and treating pediatric trauma patients shall be promptly available for consultation.

(This requirement may be fulfilled by:
(a) a staff pediatric surgeon with experience in pediatric trauma care; or
(b) a staff trauma surgeon with experience in pediatric trauma care; or
(c) a senior general surgical resident who has completed at least three clinical years of surgical residency training and is capable of assessing emergent situations. When a senior resident is the responsible surgeon:
(i) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the pediatric patient, including initiating surgical care; and
(ii) a staff pediatric trauma surgeon *with experience in pediatric trauma care or a staff surgeon with experience in pediatric trauma care shall be on-call and promptly available; and*

(iii) a staff pediatric trauma surgeon or a staff surgeon with experience in pediatric trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

b. On-call and <u>Promptly Available</u> with pediatric experience:

(1) Cardiothoracic
(2) Pediatric Surgeon *(Pediatric Trauma Centers, Level I and Level II, shall ensure that a backup mechanism exists for a second pediatric surgeon.)*
(3) Hand
(4) Pediatric Neurologic *(Pediatric Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second neurological surgeon.)*
(5) Obstetric/Gynecologic *(This surgical service may be provided through a written transfer agreement.)*
(6) Pediatric Ophthalmic
(7) Pediatric Oral or Maxillofacial or Head/Neck
(8) Pediatric Orthopedic
(9) Plastic Surgeon
(10) Reimplantation/Microsurgery *(This surgical service may be provided through a written transfer agreement at Pediatric Level I and Level II Trauma Centers.)*
(11) Urologic
(12) Vascular *(Pediatric Trauma Centers, Level I and Level II, shall ensure the availability of a surgeon credentialed by the Trauma Center to perform vascular surgery.)*

(The above requirements may be fulfilled by a supervised senior resident as defined in Section A-14 of this Exhibit who are capable of assessing emergent situations in their respective specialties. When a senior resident is the

responsible surgeon:

(a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;

(b) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-11 of this Exhibit; and

(c) a staff pediatric trauma surgeon on a staff surgeon with experience in pediatric trauma care shall be advised of all pediatric trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

c. Available for Consultation:
Available for consultation or consultation and transfer agreements for pediatric trauma patients requiring the following surgical services:

(1) Burns

(2) Spinal Cord Injury

2. **NON-SURGICAL:** Qualified non-surgical specialist(s) or specialty availability, which shall be as follows:

a. Immediately Available:

(1) Emergency Medicine:
Emergency medicine, staffed with qualified specialist in emergency medicine with pediatric experience, who are in-house and immediately available at all times with a second physician on call.

(This requirement may be fulfilled by:

(a) a qualified specialist in pediatric emergency medicine; or

(b) a qualified specialist in emergency medicine with pediatric experience; or

(c) a subspecialty resident in emergency medicine who has completed at least one year of subspecialty residency education in pediatric emergency medicine with pediatric

experience. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialist in emergency medicine and are board certified in emergency medicine or pediatric emergency medicine shall not be required by the local EMS agency to complete an Advanced Trauma Life Support (ATLS) course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine. When a senior resident is the responsible emergency physician in house:

(i) a qualified specialist in pediatric emergency medicine or emergency medicine with pediatric experience shall be promptly available; and

(ii) the qualified specialist on-call shall be notified of all patients who require resuscitation, operative surgical intervention, or intensive care unit admission.]

(2) Pediatric Anesthesiologist:
Pediatric Anesthesiology, Level I shall be immediately available, with a second physician on call and dedicated to the facility.

(This requirement may be fulfilled by senior residents or certified registered nurse anesthetists with pediatric experience who are capable of assessing emergent situations in pediatric trauma patients and of providing any indicated treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist with pediatric experience on-call shall be advised about the patient, be promptly available at all times, and present for all operations.)

(3) Pediatric Critical Care:
Pediatric Critical Care, in-house and immediately

available.

(The in-house requirement may be fulfilled by:
(a) a qualified specialist in pediatric critical care medicine; or
(b) a qualified specialist in anesthesiology with experience in pediatric critical care; or
(c) a qualified surgeon with expertise in pediatric critical care; or
(d) a physician who has completed a least two years of residency in pediatrics. When a senior resident is the responsible pediatric critical care physician then:
(i) a qualified specialist in pediatric critical care medicine, or a qualified specialist in anesthesiology with experience in pediatric critical care, shall be on-call and promptly available; and
(ii) the qualified specialist on-call shall be advised about all patients who may require admission to the pediatric intensive care unit and shall participate in all major therapeutic decisions and interventions.

b. Promptly Available:
(1) Pediatric Anesthesiology (second call)
(2) Pediatric Emergency Medicine (second call)
(3) Pediatric Gastroenterology
(4) Pediatric Infectious Disease
(5) Pediatric Nephrology
(6) Pediatric Neurology
(7) Pediatric Pulmonology
(8) Pediatric Radiology

c. Available for Consultation:
(1) The following qualified specialist with pediatric experience **shall be on the hospital staff** and Available for Consultation:
(a) General Pediatrics
(b) Mental Health
(c) Neonatology
(d) Pathology

(e) Pediatric Cardiology
(f) Pediatric Hematology/Oncology
(g) Pediatric Infectious Disease

(2) The following qualified specialist with pediatric experience shall be Available for Consultation or provided through transfer agreement:
(a) Adolescent Medicine
(b) Child Development
(c) Genetics/Dysmorphology
(d) Neuroradiology
(e) Obstetrics
(f) Pediatric Allergy and Immunology
(g) Pediatric Dentistry
(h) Pediatric Endocrinology
(i) Pediatric Pulmonology
(j) Rehabilitation/Physical Medicine.

D. ADDITIONAL SERVICE CAPABILITIES:

1. Emergency Service:
Basic or comprehensive emergency service which has special permits issued pursuant to Chapter 1, Division 5 of Title 22. The emergency service shall:
a. designate an emergency physician to be a member of the pediatric trauma team;
b. provide emergency medical services to pediatric patients;
c. have appropriate pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director;
d. designate a trauma resuscitation area of adequate size to accommodate multi-system injured pediatric trauma patients and equipment; and
e. comply with the Emergency Department Approved for Pediatrics (EDAP) requirements (Attachment A-1).

2. Surgical Service:
A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:
a. operating staff who are immediately available unless operating on trauma patients and back-up personnel who are promptly available;
b. appropriate surgical equipment and supplies as

determined by the trauma program medical director;
c. cardiopulmonary bypass equipment; and
d. operating microscope.

3. **Pediatric Intensive Care Unit (PICU):**
   a. The PICU shall be approved by the State Department of Health Services' California Children Services (CCS);
   b. The PICU shall have appropriate equipment and supplies as determined by the physician responsible for the pediatric intensive care service and the pediatric trauma program medical director;
   c. The pediatric intensive care specialist shall be **immediately available**, advised about all patients who may require admission to the PICU, and shall participate in all major therapeutic decisions and interventions; and
   d. The qualified specialist in (c) above shall be a member of the trauma team.

4. **Radiological Service:**
   a. The radiological service shall have in-house and <u>immediately available</u> a radiological technician capable of performing:
      (1) plain films; and
      (2) computed tomography imaging (CT).
   b. A radiological service shall have the following additional services <u>promptly available</u> for children:
      (1) angiography; and
      (2) ultrasound.

5. **Clinical Laboratory Service:** A clinical laboratory service shall have:
   a. a comprehensive blood bank or access to a community central blood bank with adequate hospital storage facilities;
   b. capability of collecting and storing blood for emergency care; and
   c. clinical laboratory services immediately available with micro sampling capability.

6. **Nursing Services:** Nursing services that are staffed by qualified licensed nurses with education, experience, and demonstrated clinical competence in the care of critically ill and injured children.

B. <u>SUPPLEMENTAL SERVICES</u>:

Exhibit A.III

1. In addition to the special permit licensing services, a pediatric trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, the following approved supplemental services:
   a. Burn Center.
      (This service may be provided through written transfer agreement with a Burn Center. Patients requiring burn care may be presented to the County's Medical Alert Center for transfer to a burn center within Los Angeles County. Patients may be placed outside the Los Angeles County if resources within the County are unavailable. The Medical Alert Center will assist in facilitating the transfer of burn patients to appropriate facilities.)
   b. The following services shall have personnel trained in pediatrics and equipped for acute care of the critically injured child:
      (1) Physical Therapy Service
      (2) Rehabilitation Center *(This service may be provided through a written transfer agreement with a rehabilitation center.)*
      (3) Respiratory Care Service
      (4) Hemodialysis capabilities, with qualified personnel able to acutely hemodialyze trauma patients twenty-four (24) hours/day
      (5) Occupational Therapy Service
      (6) Speech Therapy Service
      (7) Social Service

2. A trauma center shall have the following services or programs that do not require a license or special permit:
   a. Post Anesthetic Recovery Room (PAR) shall meet the requirements of California Administrative Code. (Surgical Intensive Care Unit is acceptable.)
   b. Acute spinal cord injury management capability. *(This service may be provided through a written transfer agreement with a Rehabilitation Center.)*
   c. Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the California Health and Safety Code.
   d. An outreach program, to include:
      (1) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and

(2) trauma prevention for the general public; and
(3) public education and illness/injury prevention education.

e. Written inter-facility transfer agreements with referring and specialty hospitals.
f. Suspected child abuse and neglect team (SCAN).
g. Aeromedical transport plan.
h. Child Life Program.
i. Pediatric Trauma research program.
j. Maintain an educational rotation with an Accreditation Council on Graduate Medical Education (ACGME) approved and affiliated surgical residency program.

F. **QUALITY IMPROVEMENT PROCESS**:

Pediatric Trauma Centers shall have a quality improvement process to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition the process shall include:

1. A detailed audit of all trauma related deaths, major complications, and transfers (including interfacility transfers);

2. A multidisciplinary trauma peer review committee that includes all members of the trauma team;

3. Participation in the trauma system data management system;

4. Participation in the local EMS agency trauma quality improvement committee as outlined in the Prehospital Care Policy Manual Reference No. 615, Trauma Quality Improvement Subcommittee-Trauma Hospital Advisory Committee (THAC-QI) and Reference No. 616 Trauma Hospital Regional Quality Improvement Program;

5. Written system in place for patients, parents of minor children who are patients, legal guardians(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child; and

6. Following of applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality.

G. **CLINICAL EDUCATION AND RESEARCH:**

A Level I Pediatric Trauma Center shall include the following:

1. Multidisciplinary trauma conference including, but not limited to, the trauma team; held at least once a month to critique selected trauma cases.

2. Formal continuing education in pediatric trauma care. Continuing education in pediatric trauma care shall be provided for:
   a. staff physicians;
   b. staff nurses;
   c. staff allied health personnel;
   d. EMS personnel; and
   e. other community physicians and health care personnel.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.IV
PEDIATRIC LEVEL II TRAUMA CENTER REQUIREMENTS

TABLE OF CONTENTS

PARAGRAPH	PAGE
DEFINITIONS:	- 1 -
Abbreviated Injury Scale:	- 1 -
Available for Consultation:	- 1 -
Dedicated:	- 1 -
on-call physicians	- 1 -
in-house physicians	- 1 -
Emergency Department Approved for Pediatrics:	- 1 -
General Surgeon:	- 2 -
In-house:	- 2 -
Injury Severity Score:	- 2 -
Immediately Available:	- 2 -
On-Call:	- 2 -
Pediatric Experience:	- 2 -
Promptly Available:	- 3 -
Qualified Specialist:	- 3 -
Residency Program:	- 4 -
Senior Resident:	- 5 -
Trauma Center:	- 5 -
Trauma Resuscitation Area:	- 5 -
Trauma Service:	- 5 -
Trauma Team:	- 6 -
GENERAL REQUIREMENTS:	- 6 -
PROFESSIONAL STAFF REQUIREMENTS:	- 9 -
SURGICAL:	- 9 -
Immediately Available:	- 10 -
Promptly Available	- 11 -
Available for Consultation:	- 12 -
NON-SURGICAL:	- 12 -
Immediately Available:	- 12 -
Promptly Available	- 15 -
Available for Consultation	- 16 -
ADDITIONAL SERVICE CAPABILITIES:	- 16 -
Emergency Service:	- 16 -
Surgical Service:	- 17 -

Pediatric Intensive Care Unit (PICU): ..... - 17 -
Radiological Service: ..... - 17 -
Clinical Laboratory Service: ..... - 18 -

SUPPLEMENTAL SERVICES: ..... - 18 -

QUALITY IMPROVEMENT PROCESS: ..... - 19 -

CLINICAL EDUCATION AND RESEARCH: ..... - 20 -

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.IV
TRAUMA CENTER REQUIREMENTS
PEDIATRIC LEVEL II

A. **DEFINITIONS:**

1. Abbreviated Injury Scale:

"Abbreviated Injury Scale" or "AIS" is an anatomic severity scoring system. For the purposes of data sharing, the standard to be followed is AIS 90. For the purposes of volume performance measurement auditing, the standard to be followed is AIS 90, using AIS code derived or computer derived scoring.

2. Available for Consultation:

"Available for Consultation" means being physically available to the specified area of the Trauma Center within a period of time that is medically prudent, but not in excess of twenty-four (24) hours unless documented in the medical record that the consult does not need to respond in person.

3. Dedicated:

a. For on-call physicians, "Dedicated", means taking call at only one facility during the same time frame.
b. For in-house physicians, "Dedicated", means that their main responsibility is trauma.

4. Emergency Department Approved for Pediatrics:

"Emergency Department Approved for Pediatrics (EDAP)" means a licensed basic emergency department that has been confirmed by the Department of Health Services (DHS), and the American Academy of Pediatrics Chapter II, and the Los Angeles Pediatric Society as meeting specific service criteria to provide optimal emergency pediatric care.

5. General Surgeon:

"General Surgeon" for the purposes of this trauma

system, is a surgeon, credentialed by the facility and experienced in cardiovascular and organ repair.

6. In-house:

"In-house" means being within the actual confines of the Trauma Center.

7. Injury Severity Score:

"Injury Severity Score " or "ISS" means the sum of the square of the Abbreviated Injury Scale ("AIS") score of the three most severely injured body regions.

8. Immediately Available:

"Immediately available" means unencumbered by conflicting duties or responsibilities; responding without delay when notified; and being physically available to the specified area of the Trauma Center when the patient is delivered in accordance with local EMS Agency's policies and procedures.

9. On-Call:

"On-call" means agreeing to be available, according to a predetermined schedule, to respond to the Trauma Center in order to provide a defined service.

10. Pediatric Experience:

"Pediatric Experience" means a surgical or non-surgical physician specialty that has been approved to provide care to the pediatric trauma patient as defined by the Pediatric Trauma Director.

11. Promptly Available:

"Promptly available" means:

a. responding without delay when notified and requested to respond to the hospital;
b. being physically available to the specified area of the Trauma Center (trauma receiving area, emergency department, operating room, or other specified area of the trauma center) within a period of time that is medically prudent and in accordance with local EMS

agency policies and procedures; and

c. the interval between the delivery of the patient at the Trauma Center and the arrival of the respondent should not have a measurable harmful effect on the course of the patient's management or outcome.

When the term "promptly available" is used it is presumptively met if upon notification and request to respond to the hospital the physician is in-house within thirty (30) minutes of the request. Responses in excess of thirty (30) minutes will be reviewed on a case by case basis to determine whether the response was medically prudent and proportionate to the patient's clinical condition and whether the failure to respond within thirty (30) minutes had a measurable harmful effect on the course of the patient's management or outcome.

12. Qualified Specialist:

"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means:

a. A physician licensed in California who is <u>board certified</u> in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty.

b. A <u>non-board certified</u> physician may be recognized as a "qualified specialist" by the local EMS agency upon substantiation of need by a trauma center if:

(1) the physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education ("ACGME") or the Royal College of Physicians and Surgeons of Canada;

(2) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and

(3) the physician has successfully completed a

residency program.

13. Residency Program:

"Residency program" means a residency program of the trauma center or a residency program formally affiliated with a trauma center where senior residents can participate in educational rotations, which has been approved by the appropriate Residency Review Committee of the Accreditation Council on Graduate Medical Education.

14. Senior Resident:

"Senior resident" or "senior level resident" means a physician, licensed in the State of California, who has completed at least three (3) years of the residency or is in their last year of residency training and has the capability of initiating treatment and who is in training as a member of a residency program at the designated Trauma Center. Residents in general surgery shall have completed three (3) years of residency in order to be considered a senior resident.

15. Trauma Center:

"Trauma Center" or "designated Trauma Center" means a licensed general acute care hospital, accredited by the Joint Commission of Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV Trauma Center and/or Level I or II Pediatric Trauma Center by the local EMS agency and the Los Angeles County Board of Supervisors in accordance with Title 22.

16. Trauma Resuscitation Area:

"Trauma resuscitation area" means a designated area within a trauma center where trauma patients are evaluated upon arrival.

17. Trauma Service:

A "trauma service" is a clinical service established by the organized medical staff of a trauma center that has

oversight and responsibility of the care of the trauma patient. It includes, but is not limited to, direct patient care services, administration, and as needed, support functions to provide medical care to injured patients.

18. Trauma Team:

"Trauma team" means the multi-disciplinary group of personnel who have been designated to collectively render care for trauma patients at a designated Trauma Center. The trauma team consists of physicians, nurses, and allied health personnel. The composition of the trauma team may vary in relationship to trauma center designation level and the patient's severity of injury, but must include the trauma surgeon.

B. **GENERAL REQUIREMENTS**:

1. A licensed hospital which has been designated as a Level II pediatric Trauma Center by the EMS Agency.

2. ReddiNet System where geographically available.

3. A pediatric trauma program medical director who is a board certified surgeon with experience in pediatric trauma care (may also be trauma program medical director for adult trauma services), whose responsibilities include, but are not limited to, factors that affect all aspects of pediatric trauma care such as:
   a. recommending pediatric trauma team physician privileges;
   b. working with nursing and administration to support the needs of pediatric trauma patients;
   c. developing pediatric trauma treatment protocols;
   d. determining appropriate equipment and supplies for pediatric trauma care;
   e. ensuring the development of policies and procedures to manage domestic violence, elder and child abuse and neglect;
   f. having authority and accountability for the pediatric trauma quality improvement peer review process;
   g. correcting deficiencies in pediatric trauma care or excluding from trauma call those trauma team members who no longer meet standards;

h. coordinating pediatric trauma care with other hospital and professional services;
i. coordinating with local and State EMS agencies;
j. assisting in the coordination of the budgetary process for the trauma program; and
k. identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who have pediatric trauma care experience and who are qualified to be members of the pediatric trauma program.

4. A pediatric trauma nurse coordinator/manager who is a registered nurse with qualifications (may also be trauma nurse coordinator/manager for adult trauma services) including evidence of educational preparation and clinical experience in the care of pediatric trauma patients, knowledge of Trauma Center operations and local EMS Agency policies and regulations, administration ability, and responsibilities that include but are not limited to factors that affect all aspects of pediatric trauma care, including:
   a. organizing services and systems necessary for the multi-disciplinary approach to the care of the injured child;
   b. coordinating day-to-day clinical process and performance improvement as it pertains to pediatric trauma nursing and ancillary personnel;
   c. collaborating with the pediatric trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the pediatric trauma program; and
   d. ensuring compliance with policies, procedures, and protocols established by the EMS Agency.

5. A pediatric trauma service which can provide for the implementation of the requirements specified in this Agreement and provide for coordination with the local EMS Agency.

6. A pediatric trauma team, which is a multi-disciplinary team responsible for the initial resuscitation and management of the pediatric trauma patient.
   a. The pediatric trauma team leader shall be a surgeon with pediatric trauma experience as defined by the trauma program medical director; and
   b. the remainder of the team shall include physician,

nursing, and support personnel in sufficient numbers to evaluate, resuscitate, treat, and stabilize pediatric trauma patients.

7. Department(s), division(s), service(s) or section(s) that include at least the following surgical specialties, which are staffed by qualified specialists with pediatric experience:
   a. Microsurgery/Reimplantation *(may be provided through a written transfer agreement with a hospital that has a department division service, or section that provides this service)*
   b. Neurologic
   c. Obstetric/Gynecologic *(may be provided through a written transfer agreement with a hospital that has a department, division, service, or section that provides this service)*
   d. Ophthalmologic
   e. Oral or Maxillofacial or Head/Neck
   f. Orthopaedic
   g. Pediatric
   h. Plastic
   i. Urologic

8. Department(s), division(s), service(s) or section(s) that include at least the following non-surgical specialties, which are staffed by qualified specialists with pediatric experience:
   a. Anesthesiology
   b. Cardiology
   c. Critical Care
   d. Emergency Medicine
   e. Gastroenterology
   f. General Pediatrics
   g. Hematology/Oncology
   h. Infectious Disease
   i. Neonatology
   j. Nephrology
   k. Neurology
   l. Pathology
   m. Psychiatry
   n. Pulmonology
   o. Radiology
   p. Rehabilitation/Physical Medicine *(This requirement may be provided through a written agreement with a pediatric rehabilitation center.)*

9. Commitment by the hospital and its medical staff to treat and care for any pediatric patient presenting.

10. Demonstrated capacity and ability to care for pediatric trauma patients fourteen (14) years and younger, including surgical and intensive care unit capacities/capabilities.

11. Helipad with a permit issued by the State of California, Department of Transportation, Division of Aeronautics.

C. **PROFESSIONAL STAFF REQUIREMENTS**:

1. **SURGICAL**: Qualified surgical specialist(s) or specialty availability, which shall be available as follows:

a. Immediately Available:

(1) Pediatric Surgeon:
A pediatric surgeon capable of evaluating and treating pediatric trauma patients shall be in-house, immediately available, and dedicated to the facility for pediatric trauma patients twenty-four (24) hours per day. A pediatric surgeon capable of evaluating and treating pediatric trauma patients shall be promptly available for consultation.

(This requirement may be fulfilled by:
(a) a staff pediatric surgeon with experience in pediatric trauma care; or
(b) a staff trauma surgeon with experience in pediatric trauma care; or
(c) a senior general surgical resident who has completed at least three clinical years of surgical residency training and is capable of assessing emergent situations. When a senior resident is the responsible surgeon:
(i) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the pediatric patient, including initiating surgical care; and
(ii) a staff pediatric trauma surgeon with experience in pediatric trauma care or a staff surgeon with

experience in pediatric trauma care shall be on-call and promptly available; and

(iii) a staff pediatric trauma surgeon or a staff surgeon with experience in pediatric trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

b. On-call and <u>Promptly Available</u> with pediatric experience:

(1) Cardiothoracic
(2) Pediatric Surgeon *(Pediatric Trauma Centers, Level I and Level II, shall ensure that a backup mechanism exists for a second pediatric surgeon.)*
(3) Neurologic *(Pediatric Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second neurological surgeon.)*
(4) Obstetric/Gynecologic *(This surgical service may be provided through a written transfer agreement.)*
(5) Ophthalmic
(6) Oral or Maxillofacial or Head/Neck
(7) Orthopedic
(8) Plastic
(9) Reimplantation/Microsurgery *(This surgical service may be provided through a written transfer agreement at Pediatric Level I and Level II Trauma Centers.)*
(10) Urologic
(11) Vascular *(Pediatric Trauma Centers, Level I and Level II, shall ensure the availability of a surgeon credentialed by the Trauma Center to perform vascular surgery.)*

(The above requirements may be fulfilled by a supervised senior resident as defined in Section

A-14 of this Exhibit who are capable of assessing emergent situations in their respective specialties. When a senior resident is the responsible surgeon:

(a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;

(b) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-11 of this Exhibit; and

(c) a staff pediatric trauma *surgeon on a staff surgeon with experience in pediatric trauma care shall be advised of all pediatric trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)*

c. Available for Consultation:
Available for consultation or consultation and transfer agreements for pediatric trauma patients requiring the following surgical services:
(1) Burns
(2) Spinal Cord Injury

2. **NON-SURGICAL**: Qualified non-surgical specialist(s) or specialty availability, which shall be as follows:

a. Immediately Available:
(1) Emergency Medicine:
Emergency medicine, staffed with qualified specialist in emergency medicine with pediatric experience, who are in-house and immediately available at all times with a second physician on call.

(This requirement may be fulfilled by:
(a) a qualified specialist in pediatric emergency medicine; or
(b) a qualified specialist in emergency medicine with pediatric experience; or

(c) a subspecialty resident in emergency medicine who has completed at least one year of subspecialty residency education in pediatric emergency medicine with pediatric experience. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialist in emergency medicine and are board certified in emergency medicine or pediatric emergency medicine shall not be required by the local EMS agency to complete an Advanced Trauma Life Support (ATLS) course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine. When a senior resident is the responsible emergency physician in house:

(i) a qualified specialist in pediatric emergency medicine or emergency medicine with pediatric experience shall be promptly available; and

(ii) the qualified specialist on-call shall be notified of all patients who require resuscitation, operative surgical intervention, or intensive care unit admission.)

(2) Pediatric Critical Care:
Pediatric Critical Care, in-house and immediately available.

(The in-house requirement may be fulfilled by:

(a) a qualified specialist in pediatric critical care medicine; or

(b) a qualified specialist in anesthesiology with experience in pediatric critical care; or

(c) a qualified surgeon with expertise in pediatric critical care; or

(d) a physician who has completed a least two years of residency in pediatrics. When a senior resident is the responsible

pediatric critical care physician then:

(i) a qualified specialist in pediatric critical care medicine, or a qualified specialist in anesthesiology with experience in pediatric critical care, shall be on-call and promptly available; and

(ii) the qualified specialist on-call shall be advised about all patients who may require admission to the pediatric intensive care unit and shall participate in all major therapeutic decisions and interventions.

b. Promptly Available:

(1) Anesthesiologist:
Anesthesiology, Level II shall be promptly available with a mechanism established to ensure that the anesthesiologist is in the operating room when the patient arrives with a second physician on call and dedicated to the facility.

(This requirement may be fulfilled by senior residents or certified registered nurse anesthetists with pediatric experience who are capable of assessing emergent situations in pediatric trauma patients and of providing any indicated treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist with pediatric experience on-call shall be advised about the patient, be promptly available at all times, and present for all operations.)

(2) Radiologist

c. Available for Consultation:

(1) The following qualified specialist with pediatric experience **shall be on the hospital staff** and Available for Consultation:

(a) General Pediatrics
(b) Mental Health
(c) Neonatology
(d) Pathology
(e) Pediatric Cardiology

(f) Pediatric Gastroenterology
(g) Pediatric Hematology/Oncology
(h) Pediatric Infectious Disease
(i) Pediatric Neurology
(j) Pediatric Radiology

(2) The following qualified specialist with pediatric experience shall be Available for Consultation or provided through transfer agreement:
(a) Adolescent Medicine
(b) Child Development
(c) Genetics/Dysmorphology
(d) Neuroradiology
(e) Obstetrics;
(f) Pediatric Allergy and Immunology
(g) Pediatric Dentistry
(h) Pediatric Endocrinology
(i) Pediatric Pulmonology
(j) Rehabilitation/Physical Medicine.

D. **ADDITIONAL SERVICE CAPABILITIES**:

1. **Emergency Service**:
Basic or comprehensive emergency service which has special permits issued pursuant to Chapter 1, Division 5 of Title 22. The emergency service shall:
a. designate an emergency physician to be a member of the pediatric trauma team;
b. provide emergency medical services to pediatric patients;
c. have appropriate pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director;
d. designate a trauma resuscitation area of adequate size to accommodate multi-system injured pediatric trauma patients and equipment; and
e. comply with Emergency Department Approved for Pediatrics (EDAP) requirements (Attachment A-1).

2. **Surgical Service**:
A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:
a. operating staff who are promptly available unless operating on trauma patients and back-up personnel who

are promptly available; and

b. appropriate surgical equipment and supplies as determined by the trauma program medical director.

3. **Pediatric Intensive Care Unit (PICU):**
   a. The PICU shall be approved by the State Department of Health Services' California Children Services (CCS);
   b. The PICU shall have appropriate equipment and supplies as determined by the physician responsible for the pediatric intensive care service and the pediatric trauma program medical director;
   c. The peciatric intensive care specialist shall be promptly available to care for trauma patients in the intensive care unit; and
   d. The qualified specialist in (c) above shall be a member of the trauma team.

4. **Radiological Service:**
   a. The radiological service shall have in-house and immediately available a radiological technician capable of performing:
      (1) plain films; and
      (2) computed tomography imaging (CT).
   b. A radiological service shall have the following additional services promptly available for children:
      (1) angiography; and
      (2) ultrasound.

5. **Clinical Laboratory Service:** A clinical laboratory service shall have:
   a. a comprehensive blood bank or access to a community central blood bank with adequate hospital storage facilities;
   b. capability of collecting and storing blood for emergency care; and
   c. clinical laboratory services immediately available with micro sampling capability.

6. **Nursing Services:** Nursing services that are staffed by qualified licensed nurses with education, experience, and demonstrated clinical competence in the care of critically ill and injured children.

E. **SUPPLEMENTAL SERVICES:**

1. In addition to the special permit licensing services, a

pediatric trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, the following approved supplemental services:

a. Burn Center.
(This service may be provided through written transfer agreement with a Burn Center. Patients requiring burn care may be presented to the County's Medical Alert Center for transfer to a burn center within Los Angeles County. Patients may be placed outside the Los Angeles County if resources within the County are unavailable. The Medical Alert Center will assist in facilitating the transfer of burn patients to appropriate facilities.)

b. The following services shall have personnel trained in pediatrics and equipped for acute care of the critically injured child:
   (1) Physical Therapy Service
   (2) Rehabilitation Center *(This service may be provided through a written transfer agreement with a rehabilitation center.)*
   (3) Respiratory Care Service
   (4) Hemodialysis capabilities, with qualified personnel able to acutely hemodialyze trauma patients twenty-four (24) hours/day
   (5) Occupational Therapy Service
   (6) Speech Therapy Service
   (7) Social Service

2. A trauma center shall have the following services or programs that do not require a license or special permit:
   a. Post Anesthetic Recovery Room (PAR) shall meet the requirements of California Administrative Code.(Surgical Intensive Care Unit is acceptable.)
   b. Acute spinal cord injury management capability. *(This service may be provided through a written transfer agreement with a Rehabilitation Center.)*
   c. Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the California Health and Safety Code.
   d. An outreach program, to include:
      (1) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and
      (2) trauma prevention for the general public; and
      (3) public education and illness/injury prevention

education.

e. Written inter-facility transfer agreements with referring and specialty hospitals.
f. Suspected child abuse and neglect team (SCAN).
g. An aeromedical transport plan.
h. A Child Life Program.

F. **QUALITY IMPROVEMENT PROCESS**:

Pediatric Trauma Centers shall have a quality improvement process to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition the process shall include:

1. A detailed audit of all trauma related deaths, major complications, and transfers (including interfacility transfers);

2. A multidisciplinary trauma peer review committee that includes all members of the trauma team;

3. Participation in the trauma system data management system;

4. Participation in the local EMS agency trauma evaluation committee;

5. Written system in place for patients, parents of minor children who are patients, legal guardians(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child; and

6. Following of applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality.

G. **CLINICAL EDUCATION AND RESEARCH**:

A Level II Pediatric Trauma Center shall include the following:

1. Multidisciplinary trauma conference including, but not limited to, the trauma team; held at least once a month to critique selected trauma cases.

2. Formal continuing education in pediatric trauma care. Continuing education in pediatric trauma care shall be provided for:

a. staff physicians;
b. staff nurses;
c. staff allied health personnel;
d. EMS personnel; and
e. other community physicians and health care personnel.

TRAUMA CENTER SERVICE AGREEMENT

EMERGENCY DEPARTMENT APPROVED FOR PEDIATRICS (EDAP) STANDARDS 2005

INTRODUCTION:

Emergency Department Approved for Pediatrics (EDAP) Standards were developed as a concerted effort by the Committee on Pediatric Emergency Medicine, which is made up of representatives from the following organizations: Los Angeles Pediatric Society, Pediatric Liaison Nurses of Los Angeles County, California Chapter of the American College of Emergency Physicians, National EMSC Resource Alliance, California Chapter 2 of the American Academy of Pediatrics, Emergency Nurses Association, American College of Surgeons, and Los Angeles County Department of Health Services Emergency Medical Services Agency.

The Standards have been approved by The Hospital Association of Southern California and meet or exceed the standards established by the Emergency Medical Services for Children (EMSC) administration, personnel, and policy guidelines for the care of pediatric patients in the emergency department set forth by the California Emergency Medical Services Authority in 1995.

DEFINITIONS:

Board certified: Completed an approved educational training program and an evaluation process including an examination designed to assess the knowledge, skills, and experience necessary to provide quality patient care in that specialty.

Board prepared: Successful completion of a Board approved emergency medicine or pediatric residency training program and demonstrate active progression in the certifying process.

Emergency Department Approved for Pediatrics (EDAP): A licensed basic emergency department that is approved by the County of Los Angeles to receive pediatric patients from the 9-1-1 system. These emergency departments provide care to

pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies, procedures, and protocols.

Medical Pediatric Critical Care Center (MPCCC): A licensed acute care hospital that is approved by the County of Los Angeles to receive critically ill non-trauma pediatric patients from the 9-1-1 system.

Pediatric Trauma Center (PTC): A licensed acute care hospital that is designated by the County of Los Angeles to receive critically injured pediatric trauma patients from the 9-1-1 system.

Promptly available: Being in the emergency department within a period of time that is medically prudent and appropriate to the patient's clinical condition; and further, that the interval between the arrival of the patient to the emergency department and the arrival of the respondent should not have a measurably harmful effect on the course of patient management or outcome.

Qualified specialist: A physician licensed in the State of California who has: 1) taken special postgraduate medical training, or has met other specified requirements; and 2) active progression towards board certification in the corresponding specialty for those specialties that have board certification and are recognized by the American Board of Medical Specialties.

Senior resident: A physician licensed in the State of California who has completed at least two years of the residency under consideration and has the capability of initiating treatment when the clinical situation demands, and who is in training as a member of the residency program at the designated hospital.

I. ADMINISTRATION/COORDINATION

A. EDAP Medical Director

1. Qualifications:

a. Qualified specialist in Emergency Medicine or Pediatrics
b. Completion of eight hours of CME in topics related to pediatrics every two years
c. Current Pediatric Advanced Life Support Course (PALS) or American Academy of Pediatrics - American College of Emergency Physicians Advanced Pediatric Life Support Course (APLS) provider or instructor

2. Responsibilities:

a. Oversight of EDAP quality improvement (QI) program
b. Member of hospital emergency department committee and pediatric committee
c. Liaison with medical pediatric critical care centers (MPCCC), pediatric trauma centers (PTC), base hospitals, community hospitals, prehospital care providers, and the EMS Agency
d. Identify needs and facilitate pediatric education for emergency department physicians
e. Review, approve, and assist in the development of all pediatric policies and procedures

B. Designated Pediatric Consultant *

1. Qualifications:

a. Qualified specialist in pediatrics or subspecialty in pediatric emergency medicine

2. Responsibilities:

a. Member of hospital emergency department committee and pediatric committee
b. Participation with EDAP staff in developing and monitoring pediatric QI program, protocols, policies and procedures
c. Consult with EDAP Medical Director and Pediatric Liaison Nurse as needed

* Pediatric Consultant may also be the EDAP Medical Director

C. Pediatric Liaison Nurse (PdLN)

1. Qualifications:

a. At least two years experience in pediatrics or in an emergency department that sees pediatric patients, within the previous five years
b. Experience with QI programs is recommended
c. Current PALS or APLS provider /instructor
d. Completion of a two day pediatric emergency nursing course or ENPC course *
e. Completion of eight hours of Board of Registered Nursing (BRN) approved continuing education units (CEU) in pediatric topics every two years

2. Responsibilities:

a. Attend monthly meetings of the Pediatric Liaison Nurses of Los Angeles County
b. Participate in the development and maintenance of a pediatric QI program
c. Liaison with MPCCCs, PTCs, base hospitals, community hospitals, prehospital care providers, and the EMS Agency
d. Member of selected hospital based emergency department and/or pediatric committees
e. Notify the EMS Agency in writing of any change in status of the EDAP Medical Director, Pediatric Consultant, and Pediatric Liaison Nurse

* A two day pediatric emergency nursing course should include but not limited to a broad spectrum of topics including: injury prevention, resuscitation, surgical emergencies, apparent life threatening event (ALTE), death of a child to include sudden infant death syndrome (SIDS), trauma, medical conditions, submersions, respiratory emergencies, airway management, ingestion, child abuse and neglect, fever to include bacterial and viral infections, seizures, and neonatal emergencies.

II. PERSONNEL

A. Physicians-Qualifications/Education

1. Twenty four hour emergency department coverage shall be provided or directly supervised by physicians

functioning as emergency physicians or pediatricians experienced in emergency care. This includes senior residents practicing at their respective hospitals only.

2. At least 75% of the emergency department coverage shall be provided by physicians who are Board certified or demonstrate active progression in the certifying process towards emergency medicine or pediatrics.

3. Those emergency department physicians who are not board certified or board prepared shall be a current PALS or APLS provider or instructor.

B. Nurses-Qualifications/Education

1. At least 75% of the total RN staff and at least one RN per shift in the emergency department shall be a current PALS or APLS provider or instructor.

2. At least one RN per shift shall have completed a two day pediatric emergency nursing course (within the last 4 years).

NOTE: It is highly recommended that all nurses regularly assigned to the emergency department meet the above requirements.

3. All nurses assigned to the emergency department shall attend at a minimum: eight hours of pediatric BRN approved education every two years, which may include the two day pediatric emergency nursing course.

C. Pediatric physicians/Specialty services

1. There shall be a pediatric on call panel that allows for telephone consultation and a promptly available pediatrician to the emergency department twenty four hours per day. This pediatrician shall be board certified or board prepared.

2. A plan shall exist whereby other pediatric specialists may be consulted and available in at least the following specialties: surgery, orthopedics, anesthesia and neurosurgery. This requirement may be met by a written agreement with a MPCCC.

3. A plan shall exist whereby a second emergency physician

or pediatrician will be available within thirty minutes to serve as back-up for the emergency department in critical situations.

D. Physician Assistant-Qualifications/Education

1. Physician Assistant (PA) licensed by the State of California

2. PA working in the emergency department shall be a current PALS or APLS provider or instructor.

III. POLICIES, PROCEDURES, AND PROTOCOLS

A. Establish procedures and protocols for pediatric emergency patients to include but not limited to:

1. Triage and initial evaluation

2. Patient safety

3. Suspected child abuse and neglect

4. Transfers

5. Consents

6. Sedation/analgesia

7. Do-not-resuscitate (DNR)/Advanced Health Care Directives

8. Death to include SIDS and the care of the grieving family

9. Aeromedical transport to include landing procedure

10. Daily verification of proper location and functioning of equipment and supplies of the pediatric code cart.

11. Immunizations

12. Child abandonment to include a recent (within 72 hours) postpartum woman without evidence of a newborn

13. Family presence

B. Establish a written interfacility consult and transfer agreement with a MPCCC and PTC to facilitate transfers of

critically ill and injured pediatric patients. The consult shall be available twenty four hour a day for telephone consultation.

C. Establish a written interfacility consult and transfer agreement with a California Children Services (CCS) approved Level II or Level III Neonatal Intensive Care Unit (NICU).

IV. QUALITY IMPROVEMENT (QI)

A. A pediatric QI program shall be developed and monitored by the EDAP Medical Director and Pediatric Liaison Nurse with input from the Designated Pediatric Consultant as needed.

B. The program should include an interface with prehospital care, emergency department, trauma, pediatric critical care, pediatric in-patient, and hospital wide QI activities.

C. A mechanism shall be established to easily identify pediatric (14 years & under) visits to the emergency department.

D. The pediatric QI program should include identification of the indicators, methods to collect data, results and conclusions, recognition of improvement, action(s) taken, assessment of effectiveness of actions, and communication process for participants.

E. The pediatric QI program should include review of the following pediatric patients seen in the emergency department:

1. Deaths
2. Cardiopulmonary and/or respiratory arrests, including all pediatric intubations
3. Suspected child abuse or neglect
4. Transfers to and/or from another facility
5. Admissions from the ED to an adult ward or ICU
6. Selected return visits to the ED
7. Pediatric transports within the 9-1-1 system

F. A mechanism to document and monitor pediatric education of EDAP staff shall be established.

V. SUPPORT SERVICES

A. Respiratory Therapy

1. At least one respiratory therapist shall be in house twenty four hours per day.

2. Current PALS provider or instructor

B. Radiology

1. Radiologist on call and promptly available twenty four hours per day

2. Radiology technician in house twenty four hours per day with a back up technician on call and promptly available

3. CT scan technician on call and promptly available

C. Laboratory

1. Technician in house twenty four hours per day and a back up technician on call and promptly available

2. Clinical Laboratory capabilities in house:

a. Chemistry
b. Hematology
c. Blood bank
d. Arterial blood gas
e. Microbiology
f. Toxicology
g. Drug levels

NOTE: Toxicology and drug levels may be done offsite if routine tests are available within two hours.

VI. EQUIPMENT, SUPPLIES, AND MEDICATIONS

Pediatric equipment, supplies, and medications shall be easily accessible, labeled, and logically organized. EDAP staff shall be appropriately educated as to the locations of all items. Each EDAP shall have a method of daily verification of proper location and function of equipment and supplies. It is highly recommended that each EDAP have a mobile peciatric crash cart.

The following are requirements for equipment, supplies, and medications for an EDAP:

GENERAL EQUIPMENT

- Foley catheters (8-22fr)
- IV blood/fluid warmer
- Length and weight tape for determining pediatric resuscitation drug dosages
- Meconium Aspirator
- OB Kit
- Posted or readily available pediatric drug dosage reference material calculated on a dose per kilogram basis.
- Restraint device
- Weight scale in kilograms
- Warming device

MONITORING EQUIPMENT

- Blood pressure cuffs (infant, child, adult, and thigh)
- Doppler
- ECG monitor/defibrillator (0-400 Joules) with pediatric and adult paddles
- End tidal CO_2 monitor or detector, (adult and pediatric sizes)
- Hypothermia thermometer
- Pulse oximeter

RESPIRATORY EQUIPMENT

- Bag-valve-mask device, self inflating (pediatric size: 450-900ml and adult size: 1000-2000ml)
- Bag-valve, with clear masks (neonate, infant, child, and adult sizes)
- Endotracheal tubes (uncuffed: 2.5-5.5 and cuffed: 6.0-9.0)
- Laryngoscope (curved and straight: 0-3)
- Magill forceps (pediatric and adult)
- Nasal cannulae (infant, child, and adult)
- Nasopharyngeal airways (infant, child, adult)
- Nasogastric tubes (including 5 and 8fr feeding tubes)
- Oral airways (sizes 0-5)
- Clear oxygen masks (standard and non-rebreathing) for infant, child, and adult
- Stylets for endotracheal tubes
- Suction catheters (sizes 6-12fr)
- Tracheostomy tubes (sizes 0-6)
- Yankauer suction tips

VASCULAR ACCESS EQUIPMENT

Arm boards (infant, child, and adult)
Infusion devices to regulate rate and volume
Intraosseous needles
IV administration sets with calibrated chambers
IV catheters (14-26ga)
IV solutions (D5.2NS, D5.45NS, D5NS, D10W, and NS)
Stopcocks (3 way)
Umbilical vein catheters

FRACTURE MANAGEMENT DEVICES

Pediatric cervical spine immobilization devices
Pediatric femur splint
Spine board (long and short)

SPECIALIZED TRAYS OR KITS

Cricothyrotomy tray
Pediatric lumbar puncture tray
Pediatric tracheostomy tray
Thoracostomy tray
Chest tube (sizes 10-28fr)
Venous cutdown tray

PEDIATRIC SPECIFIC RESUSCITATION MEDICATIONS

Albuterol	Dobutamine
Amiodarone	Epinephrine (1:1,000 & 1:10,000)
Atropine	Lidocaine
Adenosine	Naloxone
Calcium chloride	Procainamide
Dextrose (25% & 50%)	Racemic epinephrine (inhalation)
Dopamine	Sodium Bicarbonate

NOTE: It is suggested that these drugs be immediately available in the resuscitation room and not locked in a computerized system.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT B
PROVISIONS FOR REIMBURSEMENT

TABLE OF CONTENTS

PARAGRAPH — PAGE #

I. ELIGIBLE INDIGENT CARE FUNDING

A. GENERAL REIMBURSEMENT CONDITIONS: ..... - 1 -

B. CONTINUED BILLING TO COUNTY: ..... - 5 -

C. PAYMENT FOR CONTRACTOR SERVICES: ..... - 5 -

D. CLAIMS-BASED FUNDING: ..... - 14 -

E. BILLING AND PAYMENT - PHYSICIAN SERVICES: ..... - 17 -

F. RECOVERY OF PAYMENT: ..... - 18 -

II. LUMP SUM FUNDING FOR CONTINUED ACCESS TO EMERGENCY CARE FOR MEDI-CAL BENEFICIARIES

A. FISCAL YEAR 2008-09: ..... - 20 -

B FISCAL YEAR 2009-10: ..... - 22 -

III. FUNDING FOR BASE HOSPITAL SERVICES FOR CONTINUED ACCESS TO EMERGENCY CARE FOR MEDI-CAL BENEFICIARIES

A. FISCAL YEAR 2008-09: ..... - 25 -

B. FISCAL YEAR 2009-10: ..... - 28 -

IV. FUNDING FOR PEDIATRIC TRAUMA CENTERS

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT B
PROVISIONS FOR REIMBURSEMENT

I. ELIGIBLE INDIGENT CARE FUNDING

A. GENERAL REIMBURSEMENT CONDITIONS: County has allocated certain monies as set forth herein to be used to pay Contractor for trauma care provided by them to eligible patients during the term of this Agreement. For the term of this Agreement, funds and Hospital Services Account funds shall be deposited to the County administered Special Revenue Funds referenced in Paragraph I.D.2. of Exhibit B. These deposits, together with other funds, which County may at its sole discretion allocate to the account from time to time, and any interest which the deposits may earn, shall be used to pay Contractor for trauma patient care.

Reimbursement to Contractor shall be provided from the Special Revenue Funds by County for the hospital component of treatment of trauma patients hereunder who are unable to pay for the treatment and for whom payment for such services has not been made and will not be made through private coverage or by any program funded in whole or in part by the federal government.

Contractor will determine and document persons who are eligible for services coverage hereunder. Only eligible patients (i.e., (1) those unable to pay for services, and (2) for whom there is no third-party coverage in part or in whole for trauma

services provided qualify under this funding program. No reimbursement shall be provided for patient care if the patient has the ability to pay for the service, but refuses or fails to pay for same. Nor is County responsible nor shall it pay for services hereunder if Contractor has failed to submit to any known third-party payer(s) for the patient, an accurate, complete, and timely billing, and for that reason has been denied payment by such payer(s). Nor shall reimbursement be due Contractor or paid by County hereunder for any patient care which is covered in, or the subject of reimbursement in, any other contract between Contractor and County.

To bill County, Contractor must at a minimum show that it has made reasonable efforts to secure payment from the patient by billing (at least monthly) for an additional period of not less than two (2) months after the date Contractor first billed the patient. Contractor must show that the person cannot afford to pay for the services provided by the Contractor; and, it must also show that payment for the services will not be covered by third-party coverage or by any program funded in whole or in part by the federal government; and, that Contractor has not received payment for any portion of the amount billed.

County reimbursement is limited to trauma patients without the ability to pay for the services and for whom Contractor has made a reasonable, good faith effort to determine if there is a responsible private or public third-party source of payment, and there is no source of payment.

Contractor will continue to determine and document persons who are eligible for trauma care coverage hereunder in accordance with the procedures set forth in Attachment "B-1", Trauma Service County Eligibility ("TSCE") Protocol, attached hereto and incorporated herein by reference.

Attachment "B-1", Trauma Service County Eligibility ("TSCE") Agreement form shall be utilized by Contractor as the sole means for determining each patient's eligibility for trauma care coverage during the term of this Agreement. The TSCE Agreement form must be completed and signed by the patient or the patient's responsible relative(s). If a TSCE Agreement form cannot be secured because the patient or the patient's responsible relative(s) is (are) unable to cooperate in providing the necessary financial information, then a Contractor certification to that effect (Attachment "B-2", Hospital Certification of Inability to Cooperate form) must be completed. The original of each such form must be maintained by Contractor as part of its

financial records. Contractor shall submit a copy of the applicable form to the County Emergency Medical Services Agency as stated in Attachment "B-4", Instructions for Submission of Claims and Data Collection.

Documentation to establish that Contractor has complied with the aforementioned patient eligibility requirements must be maintained by Contractor and made available upon request, pursuant to Paragraph 5. of the Additional Provisions Exhibit of this Agreement, to authorized County or State representatives for inspection, audit, and photocopying.

During the term of this Agreement, as required by Section 16818 of the Welfare and Institutions Code, Contractor shall continue to provide, at the time treatment is sought by a patient at its facility, individual notice of the availability of reduced cost hospital care under this Agreement. Additionally, Contractor shall post throughout such period, in conspicuous places in its emergency department and patient waiting rooms, notices of the procedures for applying for reduced cost hospital care hereunder. The language which must be used in such individual and public notices shall follow that prescribed by the State of California and as it may be revised from time to time. The State's currently approved "Notice" language is reflected in

English in Attachment "B-2" and in Spanish in Attachment "B-3".

B. CONTINUED BILLING TO COUNTY: In the event funding as set forth in Paragraph I.D. of Exhibit B is exhausted prior to the expiration or other termination of this Agreement, Contractor shall continue to bill County, for remaining period up to such expiration or earlier termination, in accordance with the terms of this Agreement.

C. PAYMENT FOR CONTRACTOR SERVICES:

1. County agrees under the following conditions to reimburse Contractor for the hospital component of trauma services to eligible trauma patients described in Paragraph I.A. of Exhibit B, within forty-five (45) days of receipt of a valid claim:

a. Reimbursement by County shall be limited to payment for the hospital component of trauma services provided to eligible indigent trauma patients for whom Contractor is required to complete a Trauma Patient Summary ("TPS") form, Attachment "D-2", of Agreement.

b. Contractor shall submit required reports as set forth in Attachment "B-4", Instructions for Submission of Claims and Data Collection, attached hereto and incorporated herein by reference to County's

Emergency Medical Services Agency, 5555 Ferguson Drive, Suite 220, Commerce, California 90022, for trauma care provided under the terms of this Agreement, and this care shall be reimbursed by County pursuant to subparagraphs I.C.1.d.and f. of Exhibit B.

c. Reimbursement by County shall be limited to the hospital component of trauma services provided to eligible indigent patients during the term of this Agreement. Reimbursement shall only be made on claims for which all required data is in the TEMIS and which has been submitted as required by reporting procedures reflected in Attachment "B-4". Reimbursement to Contractor and other County contract trauma service hospitals shall be made from the Special Revenue Funds (see infra.). All Contractor claims for reimbursement must be received by County within four (4) months after the close of the fiscal year during which services were provided, no later than the last working day of October for the prior fiscal year.

d. Following receipt of all of the required reports and billings from Contractor and other contract trauma service hospitals and subject to the funding

provision below, County payment hereunder for the hospital component of trauma services provided by Contractor to eligible trauma patients, as defined hereunder, shall be based on the following all-inclusive rates:

FY 2008-09	FY 2009-10	
$5949	$6425	per emergency department visit and assessment. (No such fee will be paid if the patient is admitted to the hospital as an inpatient from the emergency department.)
$11,547	$12,471	for the first inpatient day; and
$5,016	$5,417	for the second inpatient day; and
$3,966	$4,283	for the third inpatient day; and
$3,966	$4,283	for the fourth inpatient day;and
$2,799	$3,023	for each day thereafter.

These payments will be the maximum amounts payable to Contractor for care hereunder, with aggregate payment for all Contractors for services provided during the term of this Agreement until the funds set forth in Paragraph I.D. of Exhibit B are exhausted.

e. Once the medical condition of a trauma patient has stabilized, Contractor may contact the County's Medical Alert Center or other personnel as designated by County to request transfer of the trauma patient in accordance with County patient transfer procedures and priority criteria as approved by Director. Until the transfer occurs, County's responsibility for reimbursement to Contractor for medically necessary services shall continue as described herein.

f. Any and all payments received by Contractor from a trauma patient or from third-party payers, or both, for claims previously billed to the County, must be immediately reported to the County. If Contractor previously received payment from the County for such claims, the Contractor must immediately submit a refund of County's payment to the Special Revenue Funds Section, 313 North Figueroa Street, Room 531, Los Angeles, California 90012. A TRAUMA HOSPITAL PAYMENT REFUND FORM (Attachment B-6) must be completed and submitted for each refund. All such refunds received by County will be deposited to the Special Revenue Funds.

If Contractor has not received payment from the County for such claims, the Contractor must withdraw the claim by notifying the EMS Agency Reimbursement Coordinator at 5555 Ferguson Drive, Suite 220, Commerce, California 90022.

g. Director, at his/her discretion, may deduct from payments due to Contractor any prior overpayments made under this Agreement which were paid due to County's or to Contractor's clerical error or which resulted from Contractor's subsequent receipt of payment from the patient or third-party payer(s). County shall furnish Contractor with an itemization of such deductions, which will include the identity of the patient(s) for whose care overpayment was made, amounts of overpayment, and the basis for the finding of overpayment.

h. Upon payment of claim to Contractor by County for a trauma patient's care, and assignment and subrogation to County of any and all rights to collection as set forth herein, Contractor shall within 90 days of the receipt of those funds, cease all current and waive all future collection efforts, by itself and

by its contractors/agents, to obtain any payment from the patient.

Contractor shall pursue reimbursement from third party coverage such as Medi-Cal, Medicare, other government programs, or other health insurance if they become aware of coverage. Contractor shall, upon verification of such third party coverage, submit a bill for its services to the third party. As soon as payment is received, Contractor shall reimburse County any payment received under the Trauma Center Service Agreement (TCSA) for that patient. Contractor agrees to assign and subrogate all rights that they may have against any patient, his/her responsible relative, any third party tortfeasor for reimbursement as a result of care and services provided by Contractor for which a claim has been paid by County under the TCSA. At its sole discretion, County and/or its Contractor may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement up to the full amount of usual and customary fees, [including, for

example, billed charges) for patient care and services regardless of any amount the Contractor has received under the TCSA. In the event Contractor is contacted by other third party's representative (e.g., insurance claim adjuster) or a patient's attorney regarding pending litigation, Contractor shall indicate that the paid claim for services provided to their client is assigned and subrogated to the County and refer such representative to the designated County contact. Contractor shall reasonably cooperate with County in its collection efforts.

Examples of when these County collection efforts might occur would include, but not necessarily be limited to, situations where there are third-party tortfeasors responsible for a patient's medical expenses.

For trauma patients admitted to Contractor's facility prior to or on the last day during the term of this Agreement, and remaining in the hospital after that date, reports and billings to County shall be submitted only after patient has been discharged in the subsequent fiscal year (no partial billings). Payment by County to

Contractor for such patients shall be at the rates in effect on the date of admission. Said reports and billings shall be on forms, and completed in such detail and with such attachments in accordance with procedures prescribed in writing by Director in Attachment "B-4".

Contractor hereby acknowledges receipt of such forms, attachments, and procedures. Said reports shall be submitted to County's Emergency Medical Services Agency no later than within four (4) months after the close of the fiscal year during which services were provided, no later than the last working day of October for the prior fiscal year.

i. Any funds received by the County, pursuant to Paragraph I.C.1.h., shall be deposited into the Special Revenue Funds.

2. All required reports and billings submitted by Contractor shall be rendered in the name of Contractor as said name appears upon the upper portion of the first page of this Agreement.

3. Contractor shall maintain and make available to State or County representatives upon request records of all of the financial information referenced in this Paragraph,

including records of patient and third-party payer payments, all in accordance with Paragraph 5. of the Additional Provisions exhibit of the Agreement.

4. County may periodically conduct an audit of the Contractor's records. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a statistically random sample of claims from the adjudicated universe for a fiscal year. The scope of the audit shall include an examination of patient medical and financial records, patient/insurance billing records, and collection agency reports associated with the sampled claims.

Audited paid claims that do not comply with program requirements shall result in a refund to the Special Revenue Funds. Any audited claim which is in violation of the Contract terms and conditions shall result in the Contractor refunding to the County the claim amount plus a penalty of fifty percent (50%) of the amount paid for that claim. Audit results may be appealed to the EMS Agency Director, or his/her designee.

Audited unpaid claims that do not comply with program requirements shall result in an adjustment in hospital's

subsequent year's recommendations for Medi-Cal funding.

D. CLAIMS-BASED FUNDING: The parties have agreed to the following payment mechanisms for payment to the Contractors, with the maximum funding amount as set forth below to apply to the aggregate of payments made to the Contractor under the terms herein, and to payments made to all other trauma hospital Contractors under the terms of identical agreements with the County:

1. a. Funding (Claims Based) for FY 2008-09: County has allocated a maximum total amount of $12.1 million. The parties acknowledge that this funding is comprised in part by revenue generated by Measure B Trauma Property Assessment (TPA) Funds as allocated by the County Board of Supervisors. The parties further acknowledge that the Measure B TPA Funds may vary based on (1) a percentage change, if any, in the total revenue generated for FY 2008-09 as compared to FY 2006-07 (the base year); and/or (2) an adjustment by the cumulative increase, if any, to the medical component of the Western Urban Consumer Price Index from July 1, 2003, as established by the United States Bureau of Labor Statistics if set by the Board of Supervisors,

exclusively (Measure B Adjustment). As a result, the total maximum allocation may exceed the aggregate of $12.1 million, taking into account a Measure B Adjustment to the Measure B TPA Funds. The parties also agree that the amount resulting from any Measure B Adjustment applied to the Claims-Based Funding may be allocated, in whole or in part, to increase the maximum obligation for Lump-Sum Funding for (1) Continued Access to Emergency Care for Medi-Cal Beneficiaries and/or (2) funding for Base Hospital Services for Continued Access to Emergency Care for Medi-Cal Beneficiaries, as set forth below, rather than to the Claims-Based Funding maximum obligation.

b. Funding (Claims Based) for FY 2009-10: Except as set forth below, County has allocated a maximum total amount of $12.1 million. The parties acknowledge that this funding is comprised in part by revenue generated by Measure B Trauma Property Assessment (TPA) Funds as allocated by the County Board of Supervisors. The parties further acknowledge that the Measure B TPA Funds may vary based on (1) a percentage change, if any, in the total revenue

generated for FY 2009-10 as compared to FY 2008-09 (the base year); and/or (2) an adjustment by the cumulative increase, if any, to the medical component of the Western Urban Consumer Price Index from July 1, 2003, as established by the United States Bureau of Labor Statistics if set by the Board of Supervisors, exclusively (Measure B Adjustment). As a result, the total maximum allocation may exceed the aggregate of $12.1 million, taking into account a Measure B Adjustment to the Measure B TPA Funds. The parties also agree that the amount resulting from any Measure B Adjustment applied to the Claims-Based Funding may be allocated, in whole or in part, to increase the maximum obligation for (1) Lump-Sum Funding for Continued Access to Emergency Care for Medi-Cal Beneficiaries and/or (2) funding for Base Hospital Services for Continued Access to Emergency Care for Medi-Cal Beneficiaries, as set forth below, rather than to the Claims-Based Funding maximum obligation.

2. All funds collected, including audit claim penalties, shall be deposited to the County contract trauma hospitals Special Revenue Funds and utilized to make payments

to all County contract trauma service hospitals at the rates set forth in subparagraph I.C.1.d. of Exhibit B.

3. All County contract trauma hospitals shall be paid on a first come, first validated, basis until all funds are disbursed. All funds, including interest, shall be disbursed within forty-five (45) days of receipt of validated claims received by County for Contractor services performed hereunder during the term of this Agreement, all pursuant to the rate schedule identified in subparagraph I.C.1.d. of Exhibit B.

4. "Claims" for purposes of the above means validated claims at the rate defined herein. In no event, however, shall the total disbursement under this Paragraph to Contractor on a claim exceed Contractor's aggregate charges for the services provided (based upon Contractor's customary rates in effect on the dates of service).

5. Maximum amounts payable hereunder to each Contractor shall not be modified if, and upon, designation of any other trauma center not a Contractor hereunder.

E. BILLING AND PAYMENT - PHYSICIAN SERVICES: A copy of the revised Trauma Physician Services Program packet for County Fiscal Year 2008-09, Attachment "B-5 ", is attached and

incorporated herein by reference. The packet for future Fiscal Years shall be provided to Contractor as soon as available thereafter. To permit its physicians to bill County for the professional component of un-reimbursed trauma services furnished to Contractor's trauma patients during the term of this Agreement, Contractor shall furnish members of its physician staff providing such services with a copy of said packet.

Upon request, Director shall provide Contractor with reports showing total aggregate payments to trauma physicians reimbursed by County for the professional component of un-reimbursed trauma services provided to Contractor during the term of this Agreement.

F. RECOVERY OF PAYMENT: County shall recover monies paid to Contractor hereunder for any of the reasons which follow:

1. Contractor fails to furnish patient specific data and reports required by this Agreement or by the State, or by both. County shall recover all funds paid to Contractor for that patient.

2. Funds are used for patients deemed ineligible under this Agreement. County shall recover all amounts paid to Contractor for such patients.

3. Contractor has failed to submit to any known third-party payer(s) for the patient, an accurate, complete, and timely billing, and for that reason has been denied payment by such payer(s). County shall recover all amounts paid to Contractor for that patient.

4. Contractor had knowledge of a third party tortfeasor and failed to file a lien against such third party. County shall recover all amounts paid to Contractor for such patients, except as set forth in Paragraph I.C.1.h. of Exhibit B.

5. Any funds recovered by the County pursuant to Paragraph I.F. shall be deposited into the Special Revenue Funds.

II. LUMP SUM FUNDING FOR CONTINUED ACCESS TO EMERGENCY CARE FOR MEDI-CAL BENEFICIARIES

The parties acknowledge that a State Plan Amendment effective July 1, 2003, was approved by the United States Department of Health and Human Services, Center for Medicare and Medicaid Services (SPA). The SPA enables Los Angeles County to receive enhanced Federal Medi-Cal matching funds upon payment by the County of an intergovernmental transfer of funds (IGT) pursuant to Section 14087.3 of the Welfare and

Institutions Code. Pursuant to the SPA and a related interagency agreement between the County and the California Department of Health Services (CDHS), the IGT and Federal matching funds are distributed among the County-designated trauma hospitals to ensure continued access by Medi-Cal beneficiaries to trauma and emergency room care in the County.

Except for UCLA Medical Center, it is the intent of the County, and the County shall recommend to the State, that the funding to each trauma hospital be based on data regarding each hospital's actual trauma center losses, in accordance with the terms and conditions set forth in a separate agreement between the trauma hospital and the State, or its intermediary.

Due to its status as a public institution, UCLA Medical Center shall not receive Federal matching funds, and the County shall instead provide directly to UCLA Medical Center any funding allocation as described herein (with payments made at or about the same time that the other trauma hospitals receive the IGT and Federal matching funds):

A. For Fiscal Year 2008-09, the total County maximum obligation shall be $16.3 million, funded by Measure B funds. Except as set forth in this Exhibit, the following funding allocation shall be the basis for the

County's recommendation to the State for allocation of the IGT and Federal matching Medi-Cal funds:

Childrens Hospital	$ 314,298
All other trauma hospitals	$ 15,985,072

The parties acknowledge that the above amounts are funded by Measure B TPA Funds as described above, and that this aggregate amount for FY 2008-09 may vary based on (1) a percentage change, if any, in the total revenue generated for FY 2008-09 as compared to FY 2006-07 (the base year); and/or (2) an adjustment by the cumulative increase, if any, to the medical component of the Western Urban Consumer Price Index from July 1, 2003, as established by the United States Bureau of Labor Statistics if set by the Board of Supervisors, exclusively (Measure B Adjustment). As a result, the total maximum allocation may exceed the aggregate of $16.3 million, taking into account a Measure B Adjustment to the Measure B TPA Funds. The parties also agree that the amount resulting from any Measure B Adjustment applied to the Lump Sum Funding for Continued Access to Emergency Care for Medi-Cal Beneficiaries may be allocated, in whole or in part, to

increase the maximum obligation for the (1) Claims-Based Funding and/or (2) funding for Base Hospital Services for Continued Access to Emergency Care for Medi-Cal Beneficiaries, as set forth below rather than to the Lump Sum Funding for Continued Access to Emergency Care for Medi-Cal Beneficiaries maximum obligation.

Except for the funding allocation to UCLA Medical Center, the total of the funding allocations above shall comprise the IGT for FY 2008-09, which will enable the County-designated trauma hospitals to receive Federal matching funds in approximately the same amount, dollar for dollar. The County shall recommend to the State that the IGT and Federal matching funds be divided among all Contractor trauma hospitals according to trauma center losses as described above.

B. For Fiscal Year 2009-10, the total County maximum obligation shall be $16.1 million, funded by Measure B funds. Except as set forth in this Exhibit, the following funding allocation shall be the basis for the

County's recommendation to the State for allocation of the IGT and Federal matching funds:

Childrens Hospital	$ 340,122
All other trauma hospitals	$ 15,759,878

The parties acknowledge that the above amounts are funded by Measure B TPA Funds as described above, and that this aggregate amount for FY 2009-10 may increase based on (1) a percentage change, if any, in the total revenue generated for FY 2009-10 as compared to FY 2008-09 (the base year); and/or (2) an adjustment by the cumulative increase, if any, to the medical component of the Western Urban Consumer Price Index from July 1, 2003, as established by the United States Bureau of Labor Statistics if set by the Board of Supervisors, exclusively (Measure B Adjustment). As a result, the total maximum allocation may exceed the aggregate of $16.1 million, taking into account a Measure B Adjustment to the Measure B TPA Funds. The parties also agree that the amount resulting from any Measure B Adjustment applied to the Lump Sum Funding for Continued Access to Emergency Care for Medi-Cal Beneficiaries may be applied, in whole or in part, to

increase the maximum obligation for the (1) Claims-Based funding and/or (2) funding for Base Hospital Services for Continued Access to Emergency Care for Medi-Cal Beneficiaries, as set forth below, rather than to the Lump Sum Funding for Continued Access to Emergency Care for Medi-Cal Beneficiaries maximum obligation.

Except for the funding allocation to UCLA Medical Center, the total of the funding allocations above shall comprise the IGT for FY 2009-10, which will enable the County-designated trauma hospitals to receive Federal matching funds in approximately the same amount, dollar for dollar. The County shall recommend to the State that the IGT and Federal matching funds be divided among all Contractor trauma hospitals according to trauma center losses as described above.

III. FUNDING FOR BASE HOSPITAL SERVICES FOR CONTINUED ACCESS TO EMERGENCY CARE FOR MEDI-CAL BENEFICIARIES:

To account for the special costs incurred for those Contractors providing base hospital services (Childrens Hospital is not providing base hospital services), and to

ensure continued access by Medi-Cal beneficiaries to emergency rooms and emergency room care in the County by maintaining efficient prehospital transport of all patients to the most appropriate emergency room, the County has allocated funding for each such hospital.

It is the intent of the County to obtain Federal matching funding for each County-designated trauma center providing base hospital services, except for UCLA Medical Center, through the SPA as described above.

Due to its status as a public institution, UCLA Medical Center shall not receive Federal matching funds, and the County shall instead provide directly to UCLA Medical Center any funding allocation as described herein (with payments made at or about the same time that the other trauma hospitals receive the IGT and Federal matching funds) :

A. For Fiscal Year 2008-09, the total County maximum obligation shall be approximately $2.8 million (approximately $2.3 million for the IGT and $500,000 for UCLA Medical Center). Except as set forth in this Exhibit, the County shall determine the funding allocation of the IGT and Federal matching funds, as well as the direct payment to UCLA Medical Center, by

taking into account call volume for the prior calendar year of service, including Standing Field Treatment Protocols (SFTPs) requiring medical direction (joint runs) and excluding information only calls for all trauma hospitals providing base hospital services, as follows:

CALL VOLUME	MAXIMUM AMOUNT
Up to 1,500 calls/month	$ 500,178
1,501 to 3,000 calls/month	$ 609,498
Over 3,000 calls/month	$ 718,822

Except as set forth in this Exhibit, the County shall recommend to the State that the IGT and the Federal matching funding be divided as follows, with payment made on or about January of the applicable fiscal year.

CONTRACTOR	MAXIMUM AMOUNT
California Hospital Medical Center	$ 500,178
Cedars-Sinai Medical Center	$ 500,178
Providence Holy Cross Medical Center	$ 500,178
Huntington Memorial Medical Center	$ 500,178
Henry Mayo Newhall Memorial	$ 500,178
Long Beach Memorial Medical Center	$ 500,178

Northridge Hospital Medical Center	$	500,178
St. Francis Medical Center	$	500,178
St. Mary Medical Center	$	500,178

The County shall provide the following directly to UCLA Medical Center:

CONTRACTOR	MAXIMUM AMOUNT	
UCLA Medical Center	$	500,178

The parties acknowledge that this funding is comprised in part by revenue generated by Measure B Trauma Property Assessment (TPA) Funds as allocated by the County Board of Supervisors. The parties further acknowledge that the Measure B TPA funds may vary based on (1) a percentage change, if any, in the total revenue generated for FY 2008-09 as compared to FY 2006-07 (the base year); and/or (2) an adjustment by the cumulative increase, if any, to the medical component of the Western Urban Consumer Price Index from July 1, 2003, as established by the United States Bureau of Labor Statistics if set by the Board of Supervisors, exclusively (Measure B Adjustment). As a result, the total maximum allocation may exceed the aggregate of $2.8 million, taking into account a

Measure B Adjustment to the Measure B TPA Funds. The parties also agree that the amount resulting from any Measure B Adjustment applied to the funding for Base Hospital Services for Continued Access to Emergency Care for Medi-Cal Beneficiaries may be applied, in whole or in part, to increase the maximum obligation for (1) Claims-Based Funding and/or (2) Lump-Sum Funding for Continued Access to Emergency Care for Medi-Cal Beneficiaries, rather than to the funding for Base Hospital Services for Continued Access to Emergency Care for Medi-Cal Beneficiaries maximum obligation.

B. For Fiscal Year 2009-10, the total County maximum obligation shall be approximately $3.0 million (approximately $2.4 million for the IGT and $600,000 for UCLA Medical Center). Except as set forth in this Exhibit, the County shall determine the funding allocation of the IGT and Federal matching funds, as well as the direct payment to UCLA Medical Center, by taking into account call volume for the prior calendar year of service, including Standing Field Treatment Protocols (SFTPs requiring medical direction (joint

runs) and excluding information only calls for all trauma hospitals providing base hospital services, as follows:

CALL VOLUME	MAXIMUM AMOUNT
Up to 1,500 calls/month	$ 540,192
1,501 to 3,000 calls/month	$ 658,257
Over 3,000 calls/month	$ 776,328

Except for UCLA Medical Center, the parties acknowledge that the funding allocations to be determined according to each trauma hospital's call volume shall be comprised of 50% of IGT and 50% of Federal matching funds. If it is determined that the call volume for any or all of the trauma hospitals has increased such that the maximum amount to be paid exceeds the maximum county obligation as set forth above, the Department shall seek approval from the Board of Supervisors for additional funding as needed.

The parties acknowledge that this funding is comprised in part by revenue generated by Measure B Trauma Property Assessment (TPA) Funds as allocated by the County Board of Supervisors. The parties further acknowledge that the Measure B TPA Funds may vary based on (1) a percentage change, if any, in the total

revenue generated for FY 2009-10 as compared to FY 2008-09 (the base year); and/or (2) an adjustment by the cumulative increase, if any, to the medical component of the Western Urban Consumer Price Index from July 1, 2003, as established by the United States Bureau of Labor Statistics if set by the Board of Supervisors, exclusively (Measure B Adjustment). As a result, the total maximum allocation may exceed the aggregate of $3.0 million, taking into account a Measure B Adjustment to the Measure B TPA Funds. The parties also agree that the amount resulting from any Measure B Adjustment applied to the funding for Base Hospital Services for Continued Access to Emergency Care for Medi-Cal Beneficiaries may be applied, in whole or in part, to increase the maximum obligation for (1) Claims-Based Funding and/or (2) Lump-Sum Funding for Continued Access to Emergency Care for Medi-Cal Beneficiaries, rather than to the funding for Base Hospital Services for Continued Access to Emergency Care for Medi-Cal Beneficiaries maximum obligation.

IV. FUNDING FOR PEDIATRIC TRAUMA CENTERS:

The parties acknowledge that Chapter 841 of the Statutes of 2006, hereinafter referred to as "SB 1773", authorized the County Board of Supervisors, until January 1, 2009, unless a later enacted statute, that is chaptered before January 1, 2009, deletes or extends that date, to elect to levy an additional penalty in the amount of $2 for every $10, upon fines, penalties, and forfeitures collected for specific criminal offenses. SB 1773 further authorized the County Board of Supervisors to utilize fifteen percent (15%) of the funds collected pursuant to these provisions to provide funding for Pediatric Trauma Centers (PTCs) throughout the County, both publicly and privately owned and operated. Funds spent for these purposes shall be known as Richie's Fund, and are based on projected collections through December 2008.

In keeping with the intent of Richie's Fund, the following PTCs will receive from the County an estimated One Million Two Hundred Thousand Dollars ($1,200,000) one-allocation to be disbursed evenly amongst: 1) Harbor/UCLA Medical Center; 2) LAC+USC Medical Center; 3) Cedars-Sinai Medical Center; 4) Childrens Hospital Los

Angeles; 5) Long Beach Memorial Hospital; and (6) The Regents of The University of California, a California Corporation, on behalf of The University of California Los Angeles to augment the services provided to pediatric trauma patients, as detailed in Exhibit B.1, Pediatric Trauma Center Service Augmentation - SB 1773 Funding Requirements. An estimated Two Million Dollars ($2,000,000) one-time allocation would be disbursed to Northridge Hospital Medical Center, for opening and maintaining a PTC, as detailed in Exhibit B.2, Pediatric Trauma Center Service Augmentation - SB 1773 Funding Requirements.

TRAUMA CENTER SERVICE AGREEMENT

PEDIATRIC TRAUMA CENTER SERVICE AUGMENTATION

EXHIBIT B.1
SENATE BILL 1773 FUNDING REQUIREMENTS

On September 30, 2006, the Governor approved Senate Bill 1773 ("SB 1773"), which authorized the County Board of Supervisors, until January 1, 2009, unless a later enacted statute, that is chaptered before January 1, 2009, deletes or extends that date, to elect to levy an additional penalty in the amount of $2 for every $10, upon fines, penalties, and forfeitures collected for specific criminal offenses.

SB 1773 further authorized the County Board of Supervisors to utilize fifteen percent (15%) of the funds collected pursuant to these provisions to provide funding for Pediatric Trauma Centers (PTCs) throughout the County, both publicly and privately owned and operated. Funds spent for these purposes shall be known as Richie's Fund.

In keeping with the intent of Richie's Fund, the following PTCs will receive from the County, based on projected collections through December 2008, an estimated One Million Two Hundred Thousand Dollars ($1,200,000) one-time allocation to be disbursed evenly amongst: 1) Harbor/UCLA Medical Center; 2) LAC+USC Medical Center; 3) Cedars-Sinai Medical Center; 4) Childrens Hospital Los Angeles; 5) Long Beach Memorial Hospital;

and 6) The Regents of The University of California, a California Corporation, on behalf of The University of California Los Angeles.

Within three (3) months of receipt of these funds, the PTCs shall submit documentation for review and approval by the Department of Health Services' Emergency Medical Services (EMS) Agency to substantiate appropriate use for expenditures to augment pediatric trauma services in accordance with the Legislation's requirements.

TRAUMA CENTER SERVICE AGREEMENT

PEDIATRIC TRAUMA CENTER SERVICE AUGMENTATION

EXHIBIT B.2
SENATE BILL 1773 FUNDING REQUIREMENTS

On September 30, 2006, the Governor approved Senate Bill 1773 ("SB 1773"), which authorized the County Board of Supervisors, until January 1, 2009, unless a later enacted statute, that is chaptered before January 1, 2009, deletes or extends that date, to elect to levy an additional penalty in the amount of $2 for every $10, upon fines, penalties, and forfeitures collected for specific criminal offenses.

SB 1773 further authorized the County Board of Supervisors to utilize fifteen percent (15%) of the funds collected pursuant to these provisions to provide funding for pediatric trauma centers throughout the County, both publicly and privately owned and operated. Funds spent for these purposes shall be known as Richie's Fund.

In keeping with the intent of Richie's Fund, Northridge Hospital Medical Center (NRH) will receive from the County an estimated Two Million Dollars ($2,000,000) one-time allocation, for opening and maintaining a Pediatric Trauma Center (PTC), upon approval.

The County of Los Angeles' Emergency Medical Services (EMS) Agency will conduct an evaluation, which shall include:

1) submittal to, and approval by, the EMS Agency, of a detailed plan for designation and maintaining services as a PTC including approximate dates for the California State Department of Health Services (CCS) survey, 2) the ACS survey (late summer or early fall of 2008), 3) completion of the contractual requirement with The Regents of The University of California, a California Corporation, on behalf of The University of California Los Angeles to provide pediatric trauma surgeon coverage, 4) proof of the ability to comply and maintain services as specified in the Trauma Center Service Agreement, Exhibit A.III Level II Pediatric Trauma Center Requirements, attached hereto and incorporated herein by reference, and 5) submittal to, and approval by, the EMS Agency, of the Application to Provide Pediatric Level II Trauma Services.

Actual fund distribution will be made in installments and defined following approval of the detailed plan for designation and maintaining services as a PTC by NRH, and are based on projected collections through December 2008. County will make an initial payment of Five Hundred Thousand Dollars ($500,000) after approval of the plan; a second payment of One Million Dollars ($1,000,000) upon provisional or final approval by CCS; and a final payment of Five Hundred Thousand Dollars ($500,000) upon completion of the PTC designation process. Should NRH fail

to complete the PTC designation process by January 2010, and the EMS Agency concludes that PTC designation is not achievable; the remaining funds balance will be withheld by County and distributed in accordance with the Legislation's requirements. Further, NRH agrees to utilize all equipment and other products purchased using funds from SB 1773 Pediatric Trauma Allocation (Richie's Fund) to provide expanded pediatric care at NRH.

ATTACHMENT B-1

TRAUMA CENTER SERVICE AGREEMENT

TRAUMA SERVICE COUNTY ELIGIBILITY PROTOCOL

I. PURPOSE: The Trauma Service County Eligibility (TSCE) Protocol is to be used by the County of Los Angeles (County) and by County Contract Trauma Service Hospitals (Contractor) in connection with the Trauma Service Hospital Agreement between the County and Contractor for the purposes of adjusting hospital and other health care charges to Trauma Service Patients for Authorized Services according to the financial conditions of the patient and the patient's responsible relatives.

TSCE shall not in any way diminish or defeat the County's right, under California Government Code Sections 23004.1 and 23004.2 to recover from third-party tort-feasors the reasonable cost of health care services provided to the patients involved.

II. DEFINITIONS:

A. "County Hospital(s)" means any hospital or other health care facility which is owned and operated by the County of Los Angeles.

B. "General Relief recipient(s)" means any person who has been determined eligible for the County's General Relief program as administered by the County Department of Public Social Services (DPSS).

C. "Inpatient service(s)" means any preventive, diagnostic, or

treatment service(s) provided by Contractor to a patient who is a registered inpatient therein.

D. "Inpatient stay of admission " means an uninterrupted term of inpatient services and shall constitute an occurrence of inpatient services.

E. "Emergency Department visit" means any health care services, other than inpatient services, provided in the emergency department by Contractor.

F. "Responsible relative(s)" means the patient's spouse, or parent(s), or legal guardian(s) if the patient is a minor child, or other legal representatives if known.

G. "Special medical payment program(s)" means any program such as Medi-Cal, Medicare, CHAMPUS (Civilian Health and Medical Program of the Uniformed Services), California Children Services, and Victims of Crime, which is governed by particular statue, ordinance, or regulation.

H. "Third-party coverage" means any health care benefits payable on behalf of the patient from other than the financial resources of the patient and the patient's responsible relatives, if any. Generally, third-party coverage includes special medical payment programs, prepaid health plans, and private health insurance.

I. "Trauma Hospital Authorized Service(s)" means any emergency

department visits and inpatient services: (1) which have been specifically authorized by the County pursuant to a Trauma Service Hospital Agreement between the County and Contractor, and (2) for which such Contractor may receive reimbursement from the County under such Agreement.

J. "Trauma Patient" means any patient who receives Trauma Hospital Authorized Service.

K. "Trauma Service Hospital(s)" means any hospital or other health facility which is not a County Hospital and which has formally executed a Trauma Service Hospital Agreement with the County under which such hospital or other health care facility may receive reimbursement from the County for Trauma Hospital Authorized Services provided to trauma patients.

III. SERVICES COVERED: TSCE shall cover any occurrence of Trauma Hospital Authorized Service (i.e., an inpatient stay of admission or an emergency department visit) at any Trauma Service Hospital except for any such occurrence of service for which there is third-party coverage that will fully pay for the particular occurrence of service.

IV. ELIGIBILITY: In order to be eligible for TSCE for inpatient services or for emergency department visits, the patient and the patient's responsible relatives, if any, must cooperate with the

County and Contractor in terms of financial data acquisition and otherwise in accordance with TSCE, including, but not necessarily limited to, the following requirements:

A. provide the names and addresses of the patient and the patient's responsible relatives.

B. provide acceptable address verification.

C. complete and sign, under penalty of perjury, the TSCE Agreement, which shall be substantially similar to Attachment B-1, attached hereto and incorporated herein by reference, setting forth, among other things, the income and family size of the patient and the patient's responsible relatives, and the patient's third party coverage, including, but not limited to, prepaid health plan status (member or not). A separate TSCE Agreement shall be completed and signed for each inpatient stay of admission and for each emergency department visit.

D. complete and sign authorization(s) as requested by the County and the Contractor to allow the County and the Contractor to verify any information disclosed by the patient and the patient's responsible relatives on or in connection with the TSCE Agreement.

E. provide the County or the Contractor with any documentation requested by the County or the Contractor for any

information disclosed by the patient and the patient's responsible relatives on or in connection with the TSCE Agreement.

V. ELIGIBILITY DETERMINATIONS WHEN PATIENT UNABLE TO COOPERATE: The parties recognize that there may be situations when the patient and/or patient's responsible relatives, if any, are unable to cooperate with the County and the Contractor in terms of providing the financial information necessary to make a TSCE determination. Examples of these situations include, but are not necessarily limited to, situations where the patient has expired, or is comatose or otherwise mentally incompetent.

Under these circumstances, the Contractor may certify, under penalty of perjury, that it has endeavored to:

A. obtain the names and addresses of the patient and the patient's responsible relatives;

B. obtain acceptable address verification; and

C. obtain all of the information needed to complete the TSCE Agreement, including information regarding the income and family size of the patient and the patient's responsible relatives, and the patient's third-party coverage.

This certification by the Contractor which shall be substantially similar to Attachment U-2, attached hereto and incorporated by reference, shall be accepted by the County

in lieu of a TSCE Agreement completed by the patient or patient's responsible relatives.

VI. FREQUENCY OF TSCE DETERMINATIONS: TSCE determination, as to the patient's eligibility for TSCE, shall be subject to the TSCE Agreement (Attachment B-1) and shall establish eligibility for all inpatient services received at a Trauma Service Hospital during an inpatient stay of admission or for health care services received at the said hospital during an emergency department visit.

VII. TSCE ELIGIBILITY COMPUTATION: The patient's TSCE eligibility shall be established by comparing the gross monthly and annual income of the patient and patient's responsible relatives, if any, and the patient's family size to 200 per cent of the Poverty Income Guidelines as published annually in the Federal Register. If the gross monthly and annual income of the patient and the patient's responsible relatives is less than or equal to 200 per cent of the Poverty Guidelines for the patient's family size, then the patient shall be eligible for TSCE and shall not be liable for the inpatient services received during the particular inpatient stay of admission or for health care services received during the particular emergency department visit.

Any patient who is a verified County General Relief recipient shall automatically by granted TSCE eligibility. Once

TSCE eligibility has been established for an occurrence of Trauma Hospital Authorized Service (i.e., an inpatient stay of admission or an emergency department visit), it shall not be re-determined retroactively for any reason except where:

A. The patient and/or the patient's responsible relatives have intentionally failed to fully disclose or have intentionally misrepresented their income, family size, third-party coverage, and/or other requested information, in which case the liability of the patient and the patient's responsible relatives shall, at the election of the Director, revert to the full charge for such occurrence of Trauma Hospital Authorized Service; or

B. Clerical error has occurred or the patient and/or the patient's responsible relatives have negligently failed to fully disclose or have negligently misrepresented their income, family size, third-party coverage, and/or other requested information, in which case the TSCE eligibility shall be re-determined.

C. The patient is determined by the Director not to be eligible as a Trauma Patient for such occurrence of Trauma Hospital Authorized Service, in which case: (1) the patient and the patient's responsible relatives shall not be eligible for TSCE for such occurrence of service, and (2) any funds

received by the particular Contractor from the County for such occurrence of service must be repaid to the County. When a patient and/or patient's responsible relatives, if any, previously unable to cooperate with the County and the Contractor in terms of providing the financial information necessary to make TSCE determination, agrees to cooperate, TSCE eligibility shall be re-determined.

TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE) AGREEMENT

ATTACHMENT U-1

Trauma Service Hospital/Physician _____ Medical Record Number _____ Date(s) of Service _____

NOTE: Patients unwilling or refusing to cooperate DO NOT qualify for the California Healthcare for Indigents Program.

PATIENT INFORMATION

Last _____ First _____ Middle _____

Street _____ City _____ State _____ Zip _____

Patient's Responsible Relative(s) _____ Name(s) _____ Address(es) _____

_____ - _____ - _____ ( ) _____ - _____ _____/_____/_____

Social Security Number Telephone Number Birthdate

Third party coverage (i.e., private insurance) which may partially or fully cover the cost of health services on the above date(s)?

YES ☐ NO ☐ (IF YES, PATIENT IS NOT ELIGIBLE)

TSCE COMPUTATION: (TAKEN FROM 2008 Federal Poverty Level 04/01/08):

CIRCLE ONE IN EACH COLUMN BELOW: Figure Family Size based on the number of persons in the patient's household. Figure the income of the patient and the patient's responsible relative(s) before taxes and deductions.

Family Size	Monthly Income	Yearly Income
1	$1,734	20,808
2	2,334	28,008
3	2,934	35,208
4	3,534	42,408
5	4,134	49,608
6	4,734	56,808
7	5,334	64,008
8	5,934	71,208
9	6,534	78,408
10	7,134	85,608

(For family units with more than 10 members, add $600 monthly and $7,200 yearly for each additional member.)

My/our Monthly Income and Yearly Income are less than or equal to the amount circled above.

TSCE CERTIFICATION:

I/we understand that in order to be eligible for TSCE for the health services received on the above date(s), my/our Monthly Income and Yearly Income must be less than or equal to the amounts corresponding to my/our Family Size. I/we will not be liable for these health services.

I/we understand and agree that this Agreement shall be governed by the terms and conditions set forth in the TSCE, which has been made available to me/us for review, and that I/we shall fully cooperate with the County and Trauma Service Hospital in accordance with the TSCE.

I/WE, PATIENT OR RESPONSIBLE RELATIVE(S), CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE(S) THAT THE INFORMATION I/WE HAVE GIVEN TO DETERMINE MY/OUR TRAUMA SERVICE COUNTY ELIGIBILITY AS CIRCLED ABOVE FOR HEALTH SERVICES ON THE ABOVE DATE(S) IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF. I/WE ALSO CERTIFY THAT I/WE HAVE DISCLOSED ALL MY/OUR THIRD PARTY COVERAGE WHICH MAY PAY FOR ANY OF THE COST OF HEALTH SERVICES RECEIVED. I/WE UNDERSTAND THAT IF I/WE HAVE A THIRD OR FIRST PARTY CLAIM OR LAWSUIT, LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES, SHALL HAVE THE RIGHT TO RECOVER ALL REASONABLE HOSPITAL AND PHYSICIAN CHARGES INCURRED DURING THE ABOVE REFERENCED DATE OF SERVICE AND OTHER MEDICAL SERVICES RELATED HERETO AS PERMITTED BY STATE LAW. THIS INCLUDES THE FULL BILLED CHARGES OF THE HOSPITAL.

_____ _____/_____/_____

Patient/Responsible Relative(s) Signature Date

_____ _____/_____/_____

TSCE Hospital Reviewer (Required to verify above information and signature.) Date

THIS FORM OR A U-2 MUST BE ON FILE IN THE PATIENT'S FINANCIAL CHART

ATTACHMENT U-I

TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE) AGREEMENT

Hospital de Servicios de Trauma/Medico _____ Numero de Paciente _____ Fecha(s) de Servicio

AVISO: Los pacientes que no estan dispuestos o se niegan a cooperar NO tienen derecho a participar en el Programa de Cuidado Medico para Indigentes de California.

INFORMACION DEL PACIENTE:

Apellido _____ Nombre _____ Segundo nombre _____

Calle _____ Ciudad _____ Estado _____ Codigo postal _____

Pariente responsable del Paciente _____ Nombre(s) _____ Direccion _____

_____-_____-_____ ( ) _____-_____ ____/____/_____
Numero del Seguro Social Numero de Telefono Fecha de Nacimiento

Tiene cobertura de terceros (Por Ejemplo: Seguro privado) que cubra parcialmente o totalmente los gastos de estos servicios medicos en la fecha arriba indicada?

SI ☐ NO ☐

CALCULO DEL TSCE (Obtenido del Nivel Federal de Pobreza para el año 2009 (04/01/09):

MARQUE CON UN CIRCULO UN ELEMENTO POR COLUMNA: Estime el tamano de la familia basado en el numero de personas en la casa del paciente. Estime el ingreso del paciente y los parientes responsables del paciente antes de impuestos y deducciones.

Tamano de la familia	Ingresos mensuales	Ingresos anuales
1	$1,734	20,808
2	2,334	28,008
3	2,934	35,208
4	3,534	42,408
5	4,134	49,608
6	4,734	56,808
7	5,334	64,008
8	5,934	71,208
9	6,534	78,408
10	7,134	85,608

(Para familias con mas de 10 miembros, anada $600 mensuales y $7,200 anuales por cada miembro adicional).

Mi/nuestro ingreso mensual y anual es menor que o igual a la cantidad marcada con un circulo arriba.

CERTIFICACION TSCE

Yo/Nosotros comprendo que para reunir los requisitos del TSCE para los servicios de salud recibidos en las fecha(s) mencionadas anteriormente, mi/nuestro ingreso mensual y anual debe ser menos que o igual a la cantidad correspondiente al numero de personas en mi/nuestra familia. Yo/Nosotros no tenemos responsables por estos servicios de salud.

Yo/Nosotros comprendo y estamos de acuerdo que este Acuerdo debe regirse bajo las condiciones expuestas en el TSCE, que estan a mi/nuestra disposicion para su revision y que cooperaremos totalmente con el Condado y el Hospital de Servicios de Trauma de acuerdo al TSCE.

CON LA FIRMA, YO/NOSOTROS, EL PACIENTE O PARIENTES DEL PACIENTE DAMOS FE BAJO PENA DE PERJURIO QUE LA INFORMACION QUE HEMOS PROPORCIONADO PARA DETERMINAR SI REUNO LOS REQUISITOS PARA LOS SERVICIOS DE TRAUMA DEL CONDADO COMO SE MENCIONO ANTERIORMENTE POR LOS SERVICIOS DE SALUD EN LAS FECHAS MENCIONADAS ANTERIORMENTE ES VERDADERO Y COMPLETO SEGUN MI LEAL SABER Y ENTENDIMIENTO. TAMBIEN DOY/DAMOS FE QUE HE REVELADO MI/NUESTRA COBERTURA DE TERCEROS PARA QUE PUEDAN PAGAR POR LOS GASTOS RECIBIDOS POR LOS SERVICIOS MEDICOS. YO/NOSOTROS ENTENDEMOS QUE SI YO/NOSOTROS TENEMOS UNA TERCERA O PRIMERA DEMANDA O PLEITO DE PARTIDO, LOS SERVICIOS MEDICOS DE EMERGENCIA DEL CONDADO DE LOS ANGELES, TENDRAN EL DERECHO DE RECUPERAR TODOS LOS CARGOS RAZONABLES DEL HOSPITAL Y DEL MEDICO INCURRIDAS DURANTE LA FECHA ARRIBA REFERIDA DE SERVICIO Y CUALQUIER OTROS SERVICIOS MEDICOS AQUI RELACIONADOS SEGUN LO PERMITIDO POR LA LEY ESTATAL. ESTO INCLUYE TODOS LOS CARGOS INCLUIDOS EN LA CUENTA COMPLETA DEL HOSPITAL.

_____ ____/____/_____
Firma del Paciente/Persona Responsable(s) Fecha

_____ ____/____/_____
El Encargado de revisar la forma TSCE del Hospital Fecha
(Necesario para verificar la information y firma precedentes)

ESTE DOCUMENTO DEBE GUARDARSE CON LOS DATOS ECONOMICOS DEL PACIENTE

HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE

Trauma Service Hospital/Physician _____ Medical Record Number _____ Date(s) of Service _____

NOTE: Patients unwilling or refusing to cooperate DO NOT qualify for the California Healthcare for Indigents Program.

PATIENT INFORMATION:

Last _____ First _____ Middle _____

Street _____ City _____ State _____ Zip _____

Patient's Responsible Relative(s) _____ Name(s) _____ Address(es) _____

_____ - _____ - _____ ( ) _____ - _____ _____/_____/_____
Social Security Number Telephone Number Birthdate

I/WE CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE THAT WE HAVE USED ALL REASONABLE MEANS TO DETERMINE THE PATIENT'S ELIGIBILITY IN ACCORDANCE WITH THE TSCE AGREEMENT. SPECIFICALLY, WE HAVE USED ALL REASONABLE MEANS TO:

1) Obtain the names and addresses of the patient and the patient's responsible relatives,

2) Obtain acceptable address verification, and

3) Obtain all information needed to complete the TSCE Agreement, including information regarding the income and family size of the patient and patient's responsible relatives, and the patient's third party coverage

The patient and/or patient's responsible relatives, if any, were UNABLE to cooperate fully because

_____

and TO THE BEST OF OUR KNOWLEDGE AND BELIEF, THE PATIENT OR PATIENT'S RESPONSIBLE RELATIVES ARE UNABLE TO PAY FOR THE COST OF HEALTH SERVICES PROVIDED AND THE PATIENT OR PATIENT'S RESPONSIBLE RELATIVES HAVE NO THIRD PARTY COVERAGE FOR THESE HEALTH SERVICES. THE INFORMATION SET FORTH ABOVE IS ALL OF THE INFORMATION WE WERE ABLE TO OBTAIN WITH RESPECT TO THIS PATIENT.

_____ _____/_____/_____
Hospital Reviewer Date

_____ _____/_____/_____
Hospital Supervisor Date

THIS FORM OR A TSCE MUST BE ON FILE IN THE PATIENT'S FINANCIAL CHART

NOTICE

MEDICAL CARE FOR THOSE WHO CANNOT AFFORD TO PAY

THIS HEALTH CARE FACILITY IS RECEIVING FUNDING AS A RESULT OF PROPOSITION 99 – THE TOBACCO TAX AND HEALTH PROTECTION ACT OF 1988. THESE FUNDS ARE TO BE USED FOR THE PROVISION OF SERVICES FREE OF CHARGE OR AT A REDUCED CHARGE TO PERSONS WHO CANNOT AFFORD TO PAY FOR MEDICAL CARE.

IF YOU ARE UNABLE TO PAY FOR ALL OR PART OF THE CARE YOU NEED, YOU MAY CONTACT THE ADMISSIONS OR BUSINESS OFFICE OF THIS FACILITY AND ASK ABOUT THE AVAILABILITY OF SUCH CARE. IF YOU WOULD LIKE FURTHER INFORMATION, YOU MAY CALL THE COUNTY OF LOS ANGELES, PRIVATE SECTOR COORDINATOR'S OFFICE AT (323) 890-7521.

NOTICIA

SERVICIO MEDICO PARA QUIENES NO PUEDEN AFRONTAR PAGARLO

ESTE HOSPITAL ESTA RECIBIENDO FONDOS COMO RESULTADO DE LA PROPOSICION 99 – IMPUESTO SOBRE EL TABACO Y ACTA DE PROTECCION DE SAULD DE 1988. ESTOS FONDOS SON PARA SER USADOS EN PROVEER SERVICIOS GRATIS O A COSTO REDUCIDO A PERSONAS QUE NO PUEDEN PAGAR POR SERVICIOS MEDICOS.

SI USED NO PUEDE PAGAR POR TODO O PARTE DEL CUIDADO QUE NECESITA, USTED TIENE QUE COMUNICARSE CON LA OFICINA DE ADMISIONES O NEGOCIOS DE ESTE HOSPITAL Y PREGUNTAR ACERCA DE ESTE PROGRAMA. SI DESEA MAS INFORMACION, PUEDE LLAMAR AL CONDADO DE LOS ANGELES, OFICINA DEL COORDINADOR DEL SECTOR PRIVADO, AL (323) 890-7521.

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

INSTRUCTIONS FOR
SUBMISSION OF CLAIMS AND DATA COLLECTION

• • • Revised for Fiscal Year 2008/09 • • •

GENERAL INFORMATION

Physicians must submit both a **HCFA-1500 Form** and a **CHIP Form** for each patient's care if they are claiming reimbursement under the County's private physician California Healthcare for Indigents Program (CHIP). Information from both the CHIP Form and the HCFA-1500 Form are used by the County to comply with State reporting mandates. **An original CHIP form must be completed for each patient. Xeroxed documents/information will be rejected.**

PATIENT INFORMATION: Physicians are required to make reasonable efforts to collect all data elements; however, physicians are only required to provide patient data for services provided in a hospital to the extent the information is available from the hospital. If, after reasonable efforts are made, some data elements cannot be obtained, indicate "N/A" (not available) in the space for the data element which was not obtainable. **Claims for services provided to patients as INPATIENT or OUTPATIENT/OFFICE VISIT shall not be accepted without completion of all data elements unless a reasonable justification is provided.**

MEDI-CAL ELIGIBILITY: Procedures continue to be in place to run all FY 2008/09 claims against the State's Medi-Cal Eligibility Tape. Claims which match both patient and month of service will not be paid by the CHIP program. The physician will be provided with the patient's Medi-Cal number so that the physician can bill Medi-Cal.

ALL CLAIMS should be submitted to American Insurance Administrators.

TRAUMA PHYSICIANS - SUBMIT CLAIMS:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
Attention: **TRAUMA CLAIMS**

ALL OTHER PHYSICIANS--SUBMIT CLAIMS TO:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
Attention: **PHYSICIAN INDIGENT PROGRAM CLAIMS**

Contact: AIA Physician Hotline - (800) 303-5242 Ext. 518

COMPLETION OF CHIP FORM

PATIENT INFORMATION (Items #1-10)

1 TPS #

Enter Trauma Patient Summary number if claim is for a contract trauma patient. If claim is for a non-trauma patient, leave box blank.

2. SOCIAL SECURITY #

Enter Patient's social security number Failure to provide the social security number must be justified in item # 26 (REASON) of the CHIP Form.

3. PATIENT'S NAME

Enter Patient's last name, first name, and middle initial. (1) If Patient is a minor, parent/guardian name must be provided.

4. PLACE OF BIRTH

Enter Patient's city, state, and country of birth.

5. MOTHER'S MAIDEN NAME

Enter Patient's mother's maiden name.

6. ETHNICITY

Check appropriate box to indicate Patient's racial/ethnic background;

(1) white
(2) black
(3) asian/pacific islander
(4) native american/eskimo/aleut
(5) hispanic
(6) filipino
(7) other (or none of the above)

7. EMPLOYMENT TYPE

Check appropriate box to indicate occupation of Patient or Patient's family's primary wage earner.

(0) unemployed
(1) farming/forestry/fishing
(2) laborers/helpers/craft/inspection/repair/production/transportation
(3) sales/service
(4) executive/administrative/managerial/professional/technical/related support
(5) other

*** Note: **Employment type must be consistent with required employment information provided on the HCFA-1500. Claims with inconsistent information will be rejected.**

8. MONTHLY INCOME

Enter total of Patient's or Patient's family's primary wage earner's wages and salaries (including commissions, tips, and cash bonuses), net income from business or farm, pensions, dividends, interest, rents, welfare, unemployment or workers' compensation, alimony, child support, and any money received from friends or relatives during the previous month by all related family members currently residing in the patient's household.

9. FAMILY SIZE

Enter the number of individuals related by birth, marriage, or adoption who usually share the same place of residence (including any active duty members of the military who are temporarily away from home). This number includes a head of household who is responsible for payment, and all of this person's dependents. The following family members should be included in the family size:

- parent(s)
- children under 21 years of age living in the home. A child under 21 years of age who is in the military would be counted only if he/she gave his/her entire salary to the parent(s) for support of the family.
- children under 21 years of age living out of the home but supported by the parent(s), e g., a child in college

***** Note: For a minor child, entering one (1) in family size will result in rejection.**

10. SOURCE OF INCOME

Check appropriate box to indicate the primary source (largest single source) of family income:

(0) none
(1) general relief
(2) wages
(3) self-employed
(4) disability
(5) retirement
(6) other, e.g., unemployment/VA benefits/interest/dividends/rent/child support/alimony, etc.

PATIENT INFORMATION VERIFICATION (Items #26-27)

26. REASON(S)

If Patient Information is not available for services provided to patients as INPATIENT or OUTPATIENT/OFFICE VISIT, submitting physician/agency is required to enter a reason(s) why information was not obtained and N/A was indicated. All reasonable efforts must be taken to obtain patient information from the hospital.

***** Note: N/A will only be accepted for patients seen through the emergency department. Patients admitted to the hospital (INPATIENT) and seen as a doctor's appointment (OUTPATIENT/OFFICE VISIT) shall not be accepted without completion of all data elements unless a reasonable justification is provided.**

27. SIGNATURE

If Patient Information is not available for services provided to patients as INPATIENT or OUTPATIENT/OFFICE VISIT, enter a signature of the physician/submitting agency attesting to the fact that every attempt to obtain information was made. If all data elements are complete, a signature is not required.

PHYSICIAN SERVICES (Items #20-25)

20. PHYSICIAN FUND

Check appropriate box to indicate type of claim being submitted:

(1) **CONTRACT TRAUMA** -trauma care provided at the following hospitals:

California Hospital Medical Center
Cedars-Sinai Medical Center
Childrens Hospital Los Angeles
Henry Mayo Newhall Memorial Hospital
Holy Cross Medical Center
Huntington Memorial Hospital
Memorial Hospital Medical Center of Long Beach
Northridge Hospital Medical Center
St. Francis Medical Center
St. Mary Medical Center
UCLA Medical Center
Other hospitals as approved by the Board of Supervisors and designated by the EMS Agency

(2) **NON-CONTRACT EMERGENCY** - all emergency services provided by a licensed Physician excluding specialty care provided by a designated contract trauma hospital as per (1) above.

(3) **PEDIATRICS** - pediatric services means all medical services rendered by any licensed Physician to persons from birth to 21 years of age, and shall include attendance at labor and delivery.

(4) **OBSTETRICS** - obstetric services means the diagnosis of pregnancy and all other medical services provided by a licensed Physician to a pregnant woman during her pregnancy from the time of conception until 90 days following the end of the month in which the pregnancy ends.

***** Note: If "Obstetrics" is checked, the Expected Date of Delivery (EDD) must be entered.**

21. SERVICE SETTING
Check one of the following.

(1) inpatient
(2) emergency department

(3) outpatient/office visit, CHECK ONE OF: (a) primary care (b) specialty care

***** Note: If (1) INPATIENT or (2) OUTPATIENT/OFFICE VISIT is checked, items #2-10 cannot Indicate "N/A" (not available) unless a reasonable justification is indicated in item #26 (REASON).**

22. PHYSICIAN'S NAME AND STATE LICENSE NUMBER

Enter Physician's name and State license number.

23. PAYEE NAME, ADDRESS AND TAX ID NUMBER

Enter payee name, address, and nine (9) digit federal tax ID number.

24. DATE BILLED COUNTY

Enter date Physician billed the County.

CHARGES

Enter total amount of Physician charges.

25. CONTACT PERSON/TELEPHONE NO.

Enter name and telephone number of individual authorized to answer questions regarding the claim.

COMPLETION OF HCFA-1500 FORM

The following HCFA-1500 items must be completed:

Patient's Name (last, first, middle initial)

Patient's Date of Birth and Sex

Patient's Address (city, state, zip)

Employment Information

***** Note: All employment information must be consistent with CHIP Form, item #7(EMPLOYMENT TYPE).**

Hospitalization Dates Related to Current Services (Admission and Discharge dates)

***** Note: Hospital admit and discharge dates that are equal (i.e., 07-01-06 to 07-01-06) in box 18 must have an explanation in box 19 (Reserved for Local Use)**

Diagnoses (primary and two others)

Date of Service

Procedures (descriptions)

Patient's Account No.

Name and Address of Facility Where Services Were Rendered

The HCFA-1500 section at the top of the form indicating *Medicare, Medicaid, Champus, Group Health Plan, Other,* will only be accepted when *Other* is checked or the section is left blank. If any other box is checked (*Medicare, Medicaid, Group Health Plan, etc.*), the claim will be rejected.

When completing Section Number 24 (A thru K) all lines are to be utilized before going on to another HCFA-1500 form.

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAM

PROGRAM ENROLLMENT PROVIDER FORM FISCAL YEAR 2008/09

Completion of Enrollment Form is required annually by each physician

Physician Name: _____
(Last Name) (First Name) (M.I.)

Address: _____ City: _____ Zip Code: _____

Telephone No.: (____) _____ Contact Person: _____

E-mail Address: _____

Primary Specialty: _____ State License Number: _____

U.P.I.N.: _____ Payee Tax I.D.#: _____

Payee Address: _____ City: _____ State: _____ Zip Code _____

Physician/Group name must match IRS Tax ID Number

IF PAYEE IS A PHYSICIAN GROUP, COMPLETE GROUP INFORMATION BELOW:

Group Name: _____

IF USING A BILLING COMPANY, COMPLETE BILLING COMPANY INFORMATION BELOW:

Company Name: _____ E Mail Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: ( ) _____ Contact Person: _____

LIST ALL HOSPITAL WHERE MEDICAL SERVICES ARE PROVIDED WITHIN LOS ANGELES COUNTY

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

If information on this form changes in any way, a new provider application must be submitted with the corrected information. This application must be completed by each physician providing services claimed under this program.

As a condition of claiming reimbursement under the Physician Services for Indigents program and/or the Trauma Physician Services Program, I certify that the above information is true, and complete to the best of my knowledge.

_____ _____
SIGNATURE OF PHYSICIAN DATE

IMPORTANT: For prompt processing, return this form as soon as possible to:

AMERICAN INSURANCE ADMINISTRATORS
P.O. BOX 2340
Bassett, CA 91746-0340

COUNTY OF LOS ANGELES ● DEPARTMENT OF HEALTH SERVICES

TRAUMA PHYSICIAN SERVICES PROGRAM

BILLING PROCEDURES

● ● ● Revised for Fiscal Year 2008/09 ● ● ●

I. INTRODUCTION

Pursuant to provisions of the State of California Welfare and Institutions Code, sections 16950 et seq., and Health and Safety Code ("HSC"), sections 1797.98a, et seq., a Physician Services Account has been established by the County of Los Angeles ("County") to pay for contracts with private physicians ("Physician") to provide reimbursement for certain professional services they have rendered to eligible indigent patients. County has determined that a portion of the Physician Services Account should be allocated to a special County sub-account which will serve as a source of reimbursement for otherwise uncompensated physician services rendered to trauma patients in hospitals designated by County contract as trauma hospitals.

This document defines the procedures which must be followed by a Physician in seeking reimbursement from this trauma services sub-account. Reimbursement is also limited to the policy parameters set forth in the "Department of Health Services' Physician Reimbursement Policies, Revised for Fiscal Year 2008/09", attached as Exhibit "A" and incorporated herein by reference. The County may revise such policies from time to time as deemed necessary or appropriate and if approved by the Board of Supervisors.

Submission of a claim for trauma services by a Physician under these procedures establishes (1) a contractual relationship between the County and the Physician covering the services provided and (2) signifies the Physician's acceptance of all terms and conditions herein.

This claiming process is only valid for trauma services rendered during the period July 1, 2008 through June 30, 2009.

In no event may this claiming process be used by a Physician if his/her services are included as part of the trauma hospital services claimed for reimbursement by the hospital under County's contract with the hospital.

This claiming process may not be used by a Physician for services for which a billing has previously been submitted or could be submitted to the County under any other County contract or claiming process.

This claiming process may not be used by a physician if he or she is an employee of a County trauma hospital.

II. PHYSICIAN ELIGIBILITY

A. The Physician must complete a current fiscal year Trauma Physician Services Program "Conditions of Participation Agreement" and "Program Enrollment Provider Form" and provide them to the County's Office of Emergency Medical Services ("EMS") Agency in care of the contracted Claims Adjudicator (see address on page 4). Physician claims will not be accepted if said Agreement and form are not on file with the EMS Agency. A copy of the "Conditions of Participation Agreement" and "Program Enrollment Provider Form" are attached hereto as Exhibit "B" and incorporated herein by reference.

B. Any Physician, including an emergency department Physician, who responds as part of an organized system of trauma care to eligible patients in a hospital designated by formal County contract as a "trauma hospital" may submit a claim hereunder. (Physician employees of a County trauma hospital are not, however, eligible for reimbursement under this claiming process.)

C. Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California.

III. PATIENT ELIGIBILITY/BILLING EFFORTS

Patients covered by this claiming process are only those for whom the trauma hospital is required to complete a trauma patient summary ("TPS") form, and who do not have health insurance coverage for emergency services and care, and who cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, including Medi-Cal, but with the exception of claims submitted for reimbursement through Section 1011 of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003.

During the time prior to submission of the bill to the County, the Physician must have made reasonable efforts to obtain reimbursement and not received payment for any portion of the amount billed. For purposes of this claim process, reimbursement for unpaid Physician billings shall be limited to the following:

(a) patients for whom a Physician has conducted reasonable inquiry to determine if there is a responsible private or public third-party source of payment; and

(b) patients for whom a Physician has billed all possible payment sources, but has not received reimbursement for any portion of the amount billed; and

(c) either of the following has occurred:

1. A period of not less than three (3) months has passed from the date the Physician billed the patient or responsible third party, during which time the Physician has made reasonable efforts to obtain reimbursement and has not received payment for any portion of the amount billed.

2. The Physician has received actual notification from the patient or responsible third party that no payment will be made for the services rendered.

Upon receipt of payment from the County under this claiming process, Physician must cease any current, and waive any future, collection efforts to obtain reimbursement from the patient or responsible third party. During the period after a claim has been submitted and prior to receipt of payment, the Physician can continue attempts to collect from a patient. However, once the Physician receives payment from the County, further collection efforts shall cease.

Examples of when these County collection efforts might occur would include, but not necessarily be limited to, situations where there are third-party tortfeasors responsible for a patient's medical expenses. If, after receiving payment from the County hereunder, Physician is reimbursed by a patient or a responsible third party, Physician shall immediately notify the County (see address below) in writing of the payment, and reimburse the County the amount received from the County.

MAKE REFUND CHECK PAYABLE TO:
County of Los Angeles/Department of Health Services

Refund checks should be accompanied by:
— a copy of the Remittance Advice, and
-- a specific explanation for the refund, e.g., received payment for services from Medi-Cal, etc.

SUBMIT NOTIFICATION AND/OR REFUND TO:
County of Los Angeles/Department of Health Services
Special Funds Unit
313 North Figueroa Street, Room 531
Los Angeles, CA 90012
ATTN: **PHYSICIAN INDIGENT PROGRAM**

IV. CONDITIONS OF REIMBURSEMENT

Payment is contingent upon adherence to State law and County requirements regarding eligible claims, and provision of data as specified in these Billing Procedures.

V. CLAIM PERIOD

Claims may only be submitted for eligible services provided on/or after July 1, 2008 and through June 30, 2009. All claims for services provided during the fiscal year 2008/09 (July 1 through June 30) must be received by County's Claim Adjudicator no later than October 31, 2009. Claims received after this fiscal year deadline has passed will not be paid. Unless sooner terminated, canceled, or amended, this claim process shall expire on October 31, 2009.

VI. REIMBURSEMENT

Reimbursement of a valid claim hereunder will be limited to a maximum of 50% of the Official County Fee Schedule (OCFS), not to exceed 100% of Physician charges. The OCFS, which establishes rates of reimbursement deemed appropriate by the County, utilizes the most current Physicians' Current Procedural Terminology (CPT-4) codes in conjunction with the Resource Based Relative Value Scale (RBRVS) unit values and a County determined weighted average conversion factor. The conversion factor for all medical procedures other than anesthesiology is $79.49 per relative unit value. The conversion factor for anesthesiology procedures is $48.77 per relative unit value.

VII. COMPLETION OF FORMS

A. Complete "Fiscal Year 2008/09 Conditions of Participation Agreement" for the current fiscal year Trauma Physician Services Program (sample attached). Submit one original signed Agreement to the contracted Claims Adjudicator

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340

B. Complete one HFCA-1500 Form per patient.

C. Complete one California Healthcare for Indigents Program ("CHIP") Form per patient (sample attached as Exhibit "D"). Physicians are required to provide patient data for services provided in a hospital to the extent the information is available from the hospital. Additional requirements for data submission have been established. Refer to the Instructions for Submission of Claims and Data Collection (attached as Exhibit "C").

VIII. ELECTRONIC BILLING

As an option, the County's Claims Adjudicator can receive claims electronically. The record layout necessary for electronic submission shall be obtained directly from the County Claims Adjudicator at (800) 303-5242.

IX. SUBMIT CLAIM(S) TO COUNTY'S CONTRACTED CLAIMS ADJUDICATOR

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91745-0340
ATTN. TRAUMA CLAIMS

X. CLAIM REJECTION AND APPEALS

A. Revised claims previously rejected for incomplete information must be received by the contracted Claims Adjudicator within 20 calendar days from the date of the rejection letter.

B. The Physician must submit an appeal of any denied claim within thirty (30) calendar days from the date of the denied Remittance Advice. A denied claim can be appealed once; however, after the appeal is dispositioned, a further appeal will not be considered. All appeals shall be prepared and sent in accordance with the directions set forth in Exhibit "A".

XI. INFORMATION CONTACTS

For Status of Claims, call:
AIA Physician Hotline - (800) 303-5242 Ext. 518

XII. COUNTY LIABILITY/PAYMENT/SUBROGATION

Payment of any claim under this claiming process is expressly contingent upon the availability of monies allocated therefor by the State and by the County of Los Angeles Board of Supervisors. To the extent such monies are available for expenditure, valid claims may be paid. Valid claims will be paid in the order of receipt; that is, if a complete and correct claim is received by County, it will have priority over claims subsequently received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under the PSIP. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under the Trauma Services for Indigents Program. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

XIII. GENERAL OBLIGATION OF PHYSICIANS SUBMITTING CLAIMS

In addition to any Physician duties specified previously herein, Physicians using this claiming process are obligated as follows:

A. Records/Audit Adjustment

1. Physician shall immediately prepare, and thereafter maintain, complete and accurate records sufficient to fully and accurately reflect the services provided, the costs thereof, all collection attempts from the patient and third-party payers, and revenue collected, if any, for which claim has been made under this claiming process.

2. All such records shall be retained by Physician at a location in Los Angeles County for a minimum of three (3) years following the last date of the Physician services to the patient.

3. Such records shall be made available during normal County working hours to representatives of the County and/or State, upon request, at all reasonable times during such three year period for the purposes of inspection, audit, and copying. Photocopying capability must be made available to County representatives during an on-site audit.

4. County may periodically conduct an audit of the Physician's records. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a single claim, a group of claims, or a

5 statistically random sample of claims from the adjudicated universe for a fiscal year. The scope of the audit shall include an examination of patient medical and financial records, patient/insurance billing records, and collections agency reports associated with the sampled claims.

Audited claims that do not comply with program requirements shall result in a refund to the County.

If an audit of Physician or hospital records conducted by County and/or State representatives relating to the services for which claim was made and paid hereunder finds that (1) the records are incomplete or do not support the medical necessity for all or a portion of the services provided, or (2) no records exist to evidence the provision of all or a portion of the claimed services, or (3) Physician failed either to report or remit payments received from patients or third parties as required herein, or (4) the patient was ineligible for services hereunder, or (5) Physician did not otherwise qualify for reimbursement hereunder, Physician shall, upon receipt of County audit refund therefor, remit forthwith to the County the

difference between the claim amount paid by the County and the amount of the adjusted billing as determined by the audit.

County also reserves the right to exclude Physician from reimbursement of future claims for any failure to satisfy conditions of this claiming process.

B. Indemnification/Insurance

By utilizing this claiming process, the Physician certifies that the services rendered by him/her, and for which claim is made, are covered under a program of professional liability insurance with a combined single-limit of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate.

By utilizing this claiming process, the Physician further certifies that his/her workers' compensation coverage is in an amount and form to meet all applicable requirements of the California Labor Code, and that it specifically covers all persons providing services on behalf of the Physician and all risks to such persons.

C. Non-discrimination

In utilizing this claiming process, the Physician signifies that he/she has not discriminated in the provision of services for which claim is made because of race, color, religion, national origin, ancestry, sex, age, physical or mental disability, or

medical condition and has complied in this respect with all applicable non-discrimination requirements of Federal and State law.

XIV. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ('HIPAA'). Contractor understands and agrees that, as a provider of medical treatment services, it is a 'covered entity' under HIPAA and, as such, has obligations with respect to the confidentiality, privacy, and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, and the use of appropriate consents and authorizations specified under HIPAA.

The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Contractor understands and agrees that it is separately and independently

responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Contractor's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

CONTRACTOR AND COUNTY UNDERSTAND AND AGREE THAT EACH ISINDEPENDENTLY RESPONSIBLE FOR HIPAA COMPLIANCE AND AGREE TO TAKE ALL NECESSARY AND REASONABLE ACTIONS TO COMPLY WITH THE REQUIREMENTS OF THE HIPAA LAW AND IMPLEMENTING REGULATIONS RELATED TO TRANSACTIONS AND CODE SET, PRIVACY, AND SECURITY. EACH PARTY FURTHER AGREES TO INDEMNIFY AND HOLD HARMLESS THE OTHER PARTY (INCLUDING THEIR OFFICERS, EMPLOYEES, AND AGENTS), FOR ITS FAILURE TO COMPLY WITH HIPAA.

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAMS

PHYSICIAN REIMBURSEMENT POLICIES

• • • Revised for Fiscal Year 2008/09 • • •

I. POLICY STATEMENT

THE PURPOSE OF THIS POLICY IS TO ENSURE THE COUNTY'S CONFORMANCE WITH STATUTORY AND REGULATORY REQUIREMENTS, AND TO ADDRESS PRIORITIES OF THE HEALTH CARE SYSTEM WHICH ARE CRITICAL TO PROVIDING FOR THE MEDICAL NEEDS OF THE INDIGENT POPULATION, WITHIN THE LEVEL OF AVAILABLE FUNDS.

II. GENERAL RULES

A. Official County Fee Schedule: The Official County Fee Schedule is used to determine reimbursement rates for eligible physician claims. The Official County Fee Schedule, which establishes rates of reimbursement deemed appropriate by the County utilizes the most current Physicians' Current Procedural Terminology ("CPT-4") codes which coincides with the current Resource Based Relative Values Scale ("RBRVS") unit values and a County-determined weighted average conversion factor. The conversion factor for all medical procedures except anesthesiology is $79.49 per relative unit value. The conversion factor for anesthesiology procedures is $48.77 per relative unit value. Reimbursement is also limited to the policy parameters contained herein.

B. Eligible Period: Reimbursement shall be for emergency medical services provided on the calendar day on which emergency services are first provided and on the immediately following two calendar days. EXCEPTION: Trauma physicians providing trauma services at County contract trauma hospitals may bill for trauma physician services provided beyond this period.

C. Nonemergent Pediatric and OB Services: Reimbursement may be provided for nonemergency, medically necessary services ONLY IF they are provided to a patient who is under 21 years of age (a pediatric patient) or to a pregnant woman from time of conception until ninety (90) calendar days following the end of the month in which the pregnancy ends (an obstetric patient).

D. Medi-Cal/Medicare Exclusions:

1. Procedures which are not covered in the Medi-Cal Program's Schedule of Maximum Allowances ("SMA") are excluded from reimbursement.

2. Procedures which are covered in Medi-Cal's SMA but require a Treatment Authorization Request ("TAR") are excluded from reimbursement; however, will be considered upon appeal and/or provision of applicable operative and/or pathology reports.

3. Claims determined to be Medi-Cal eligible will be denied.

E. Screening Exams: Payment will be made for emergency department medical screening examinations required by law to determine whether an emergency

condition exists.

F. Assistant Surgeons: Reimbursement for assistant surgeons will be at a rate of 16% of the primary surgeon's fee.

G. Pediatric Hospitalization Over Five Days: All claims for pediatric patients hospitalized in excess of five calendar days must be accompanied by a statement from the hospital indicating sources the hospital utilized for reimbursement.

H. Multiple Surgery Procedure Codes: Adjudication of claims involving multiple surgery procedure codes performed in an inpatient operating room requires submission of operative reports. No more than five (5) Procedure Codes shall be paid as follows: 100% for 1st Procedure and 50% for the 2nd through 5th Procedures.

I. Nurse Practitioner and Physician's Assistant Services: Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician's assistants in California.

III. INELIGIBLE CLAIMS

A. Office Visits: Procedures performed in a physician's office will be denied unless documentation is provided to show that an eligible service was provided to either a pediatric or an obstetric patient. If a claim is made for services provided to an obstetric patient, the expected date of delivery ("EDD") must be included on the CHIP Form

(Item #20). An obstetric claim submitted without the EDD will be rejected.

B Duplicate Procedures: Claims which include duplicate procedures provided to the same patient for the same episode of care are generally excluded from reimbursement. This does not apply for Evaluation & Management codes billed by separate physicians.

C. Unlisted Procedures: Procedures which are not listed in the Official County Fee Schedule are excluded from reimbursement.

D. Non-physician Procedures: Procedures commonly not performed by a physician will be denied (e.g., venipuncture). Claims will be reviewed and considered on appeal only.

E. Insurance Rejections: Claims for patients with potential insurance or other third-party payer coverage will be denied unless a notice of rejection from the insurance company or other third-party payer is provided to the County. The rejection notice should indicate either (1) the patient is not a covered beneficiary or (2) the term of coverage expired prior to the date of the claimed service. If insurance or other

third-party coverage has been denied for other reasons, e.g., the deductible has not been met, the type or scope of service has been classified as a nonemergency, or other similar issues denying insurance coverage, the claim will be denied. Where limited insurance policies have been exhausted by hospital billings, physician claims will be reviewed and considered on appeal.

IV. EXCLUSIONS

A. Radiology/Nuclear Medicine (Codes 70002 - 79499): Reimbursement for radiology codes will be limited to readings performed while the patient is in the emergency department or other eligible site. Additionally, payment will only be made for the first radiology claim received by the County per patient per episode of care. Subsequent radiology claims for the same patient/episode will be denied.

B. EKG (Code 93010): Reimbursement for EKG codes will only be made for the first EKG claim received by the County per patient per episode of care. Subsequent EKG claims for the same patient/episode will be denied.

C. Pathology (Codes 80104 - 89999): Reimbursement for pathology codes will be limited to codes 86077, 86078, and 86079. Additionally, codes 88329, 88331, and 88332 will be reimbursed only if the pathologist is on site and pathology services are requested by the surgeon.

D. Surgery (Codes 10000 - 69979): There are no exclusions as long as the procedure is covered in Medi-Cal's SMA and does not require a TAR (see Medi-Cal Exclusions in section A. above).

E. Anesthesia: There are no exclusions as long as the procedure is covered in Medi-Cal's SMA and does not require a TAR (see Medi-Cal Exclusions in section A. above).

F. Modifiers: Reimbursement is excluded for all modifiers except radiology.

G. Prior Dx Codes: Reimbursement will no longer be made for wound checks and suture removal.

H. Critical Care (Codes 99291 and 99292) Reimbursement will not be made on critical care codes after the first 24 hours of service.

I. Newborn Care (Inpatient Code 99431 and Emergency Department Code 99283): Reimbursement will only be made once for the same recipient by any provider and only if accompanied by a Medi-Cal denial. V30 through V30.2 codes are reimbursable only if a copy of Medi-Cal denial is provided.

V. ADDITIONAL EXCLUSIONS

Upon approval of the Board of Supervisors, the County may revise the Physician Reimbursement Polices from time to time as necessary or appropriate.

VI. APPEALS

Appeals for claims rejected or denied may be submitted to the Physician Reimbursement Advisory Committee ("PRAC"), a committee of physicians selected by Hospital Council of Southern California and by the Los Angeles County Medical Association. Appeals shall include the CHIP Form, HCFA-1500, operative reports, if applicable, and supporting documents as needed. Appeals shall be mailed to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
ATTN: APPEALS UNIT

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS INDIGENT SERVICES PROGRAMS

FISCAL YEAR 2008/09
CONDITIONS OF PARTICIPATION AGREEMENT

SUBMIT TO: AMERICAN INSURANCE ADMINISTRATORS (AIA)
P.O. BOX 2340
BASSETT, CALIFORNIA 91746-0340

The undersigned physician (hereinafter "Physician") certifies that claims submitted hereunder are for services provided by him/her to patients who do not have health insurance coverage for medical services and care, and who cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government. Programs covered by this single agreement include:

Physician Services for Indigents Program – Emergency services (at hospitals defined in the Billing Procedures) for up to 72 hours (except for eligible trauma patients under other programs below).
Trauma Services for Indigents Program – Trauma services provided in an acute setting for full length of stay at a Los Angeles County designated trauma center.
Impacted Hospital Program – Emergency services and/or inpatient services provided for up to six inpatient days at a Los Angeles County designated Impacted Hospitals (associated with closure of MLK-Harbor Hospital).
Physicians Services for Indigents Program-MetroCare – Inpatient services for patients transferred from a County-operated or Impacted Hospitals (see above) to St. Vincent Medical Center.

Physician acknowledges receipt of a copy of the applicable Billing Procedures for each program (hereinafter "Billing Procedures"), promulgated by the County of Los Angeles, Department of Health Services, for fiscal year 2007-08, the terms and conditions of which are incorporated herein by reference.

Physician agrees that all obligations and conditions stated in the Billing Procedures will be observed by him/her, including, but not limited to, the proper refunding of monies to the County when patient or third-party payments are made after reimbursement under the claiming process has been received, the cessation of current, and waiver of future, collection efforts upon receipt of payment; and the preparation, maintenance, and retention of service and finance records, including their availability for audit. Physician affirms that for all claims submitted, reasonable efforts to identify third-party payers have been made, no third-party payers have been discovered, and no payment has been received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under any of these programs. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under any of these programs. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

Physician expressly acknowledges and accepts that any County liability for claims submitted hereunder is at all times subject to conditions defined in the Billing Procedures, including, but not limited to, (1) availability of monies, (2) priority of claim receipt, and (3) audit and adjustments. In accordance with instructions in the Billing Procedures, Physician agrees to submit required documents for claims, and provide other patient data as may be required by the County.

Physician certifies that information on claims submitted by him/her is true, accurate, and complete to the best of his/her knowledge.

TYPED/PRINTED NAME OF PHYSICIAN	TAX ID NUMBER
PRIMARY SPECIALTY OF PHYSICIAN	SIGNATURE OF PHYSICIAN
STATE LICENSE NUMBER	DATE

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAM

PROGRAM ENROLLMENT PROVIDER FORM FISCAL YEAR 2008/09

Completion of Enrollment Form is required annually by each physician

Physician Name: _____
(Last Name) (First Name) (M.I.)

Address: _____ City: _____ Zip Code: _____

Telephone No : (____) _____ Contact Person: _____

E-mail Address: _____

Primary Specialty: _____ State License Number: _____

U.P.I.N.: _____ Payee Tax I.D.#: _____

Payee Address: _____ City: _____ State: _____ Zip Code: _____

Physician/Group name must match IRS Tax ID Number

IF PAYEE IS A PHYSICIAN GROUP, COMPLETE GROUP INFORMATION BELOW:

Group Name: _____

IF USING A BILLING COMPANY, COMPLETE BILLING COMPANY INFORMATION BELOW:

Company Name: _____ E Mail Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: ( ) _____ Contact Person: _____

LIST ALL HOSPITAL WHERE MEDICAL SERVICES ARE PROVIDED WITHIN LOS ANGELES COUNTY

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

If information on this form changes in any way, a new provider application must be submitted with the corrected information. This application must be completed by each physician providing services claimed under this program.

As a condition of claiming reimbursement under the Physician Services for Indigents program and/or the Trauma Physician Services Program, I certify that the above information is true, and complete to the best of my knowledge.

_____ _____
SIGNATURE OF PHYSICIAN DATE

IMPORTANT: For prompt processing, return this form as soon as possible to:

AMERICAN INSURANCE ADMINISTRATORS
P.O. BOX 2340
Bassett, CA 91746-0340

ATTACHMENT B-6

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES AGENCY

TRAUMA CENTER PAYMENT REFUND FORM

FACILITY: _____

PATIENT NAME: _____

DATE OF SERVICE: _____ TPS#: _____

AMOUNT OF EMS PAYMENT: $_____

AMOUNT OF FACILITY REFUND: $_____

REASON FOR REFUND	DATE COVERAGE IDENTIFIED
☐ DUPLICATE (County Payment)	____/____/____
☐ INSURANCE (Health Plan/HMO)	____/____/____
☐ MEDI-CAL	____/____/____
☐ MEDICARE	____/____/____
☐ PATIENT	____/____/____
☐ THIRD PARTY TORTFEASORS	____/____/____
☐ OTHER _____ (Specify)	____/____/____

SUBMITTED BY: _____ DATE: ____/____/____

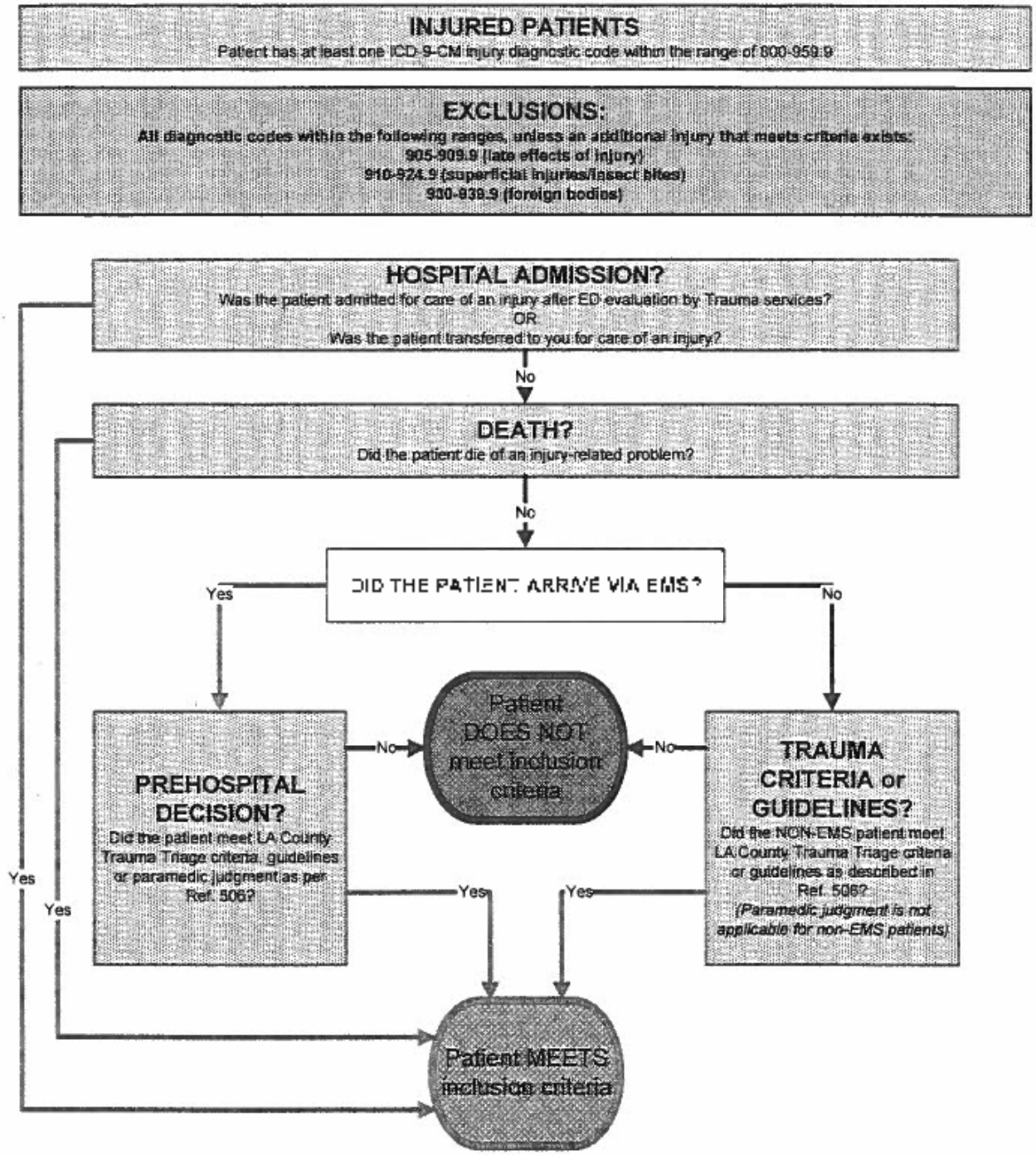
(THIS FORM MUST BE ATTACHED TO EACH REFUND CHECK)
Mail to: SPECIAL REVENUE FUNDS SECTION
313 N. Figueroa St., Room 531
Los Angeles, CA 90012

ATTN: Section Head

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT C

PATIENT INCLUSION IN THE TRAUMA DATA SYSTEM



CASES ENTERED INTO THE REGISTRY THAT DO NOT MEET "EXHIBIT C" CRITERIA MUST BE IDENTIFIED AS "DHS•NO", AND HAVE THE TPS RATIONALE OF "DHS•NO" INDICATED.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT D

TRAUMA CENTER DATA COLLECTION SYSTEM

1. SPECIFIC RESPONSIBILITIES OF COUNTY'S DEPARTMENT OF HEALTH SERVICES (COUNTY'S LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY) INCLUDE THE FOLLOWING:

   A. The local EMS agency shall develop and implement a standardized data collection instrument and implement a data management system for trauma care.

      (1) The system shall include the collection of both prehospital and hospital patient care data, as recommended by the Trauma Hospital Advisory Committee (THAC) to the local EMS agency.

      (2) Trauma data shall be integrated into the local EMS agency data management system.

      (3) County commits to pursue the participation, in the local EMS agency data collection system efforts, of all hospitals receiving trauma patients in accordance with local EMS agencies policies and procedures which are based on Title 22.

      (4) County shall generate and distribute periodic reports to all designated Trauma Centers participating in the trauma system on a quarterly basis, to include but not limited to:

         (a) system volume report on the total number of

patients by trauma center; and

(b) system volume report on the number of pediatric patients versus the number of adult patients by trauma center; and

(c) system volume report on the number of blunt injuries versus the number of penetrating injuries by trauma center; and

(d) system volume report on the mechanism of injury by trauma center.

(5) County shall generate and distribute for the purposes of benchmarking to Contractor quarterly reports on system aggregate data on the following:

(a) Intensive Care Unit (ICU) Length of Stay (LOS); and

(b) Payer Source distribution; and

(c) Injury Severity Score (ISS) distribution with the patient's outcome, lived versus died.

(6) County agrees to honor special request for reports by Contractor to compare hospital specific data elements to the system aggregate data elements within a reasonable agreed upon time period.

B. The Department agrees to provide the following to the Contractor:

(1) A current Trauma Center Trauma and Emergency Medicine Information System (TEMIS) software training/procedure manual.

(2) Annually a minimum of sixteen (16) hours TEMIS basic software training and twenty-four (24) hours of intermediate/advanced training will be offered, for all necessary persons identified by Contractor, to enable Contractor personnel to perform data entry, database maintenance, and basic and advanced report generation functions.

(a) Contractor's need for basic training of new employees will be met without regard to the minimum number of participants within two (2) weeks of Contractor's request.

(b) Intermediate/advanced training classes to be scheduled monthly, with a specific agenda for standardized education, with a minimum number of two (2) participants, in no less than four (4) hour increments.

(c) Additional training hours will be made available as needed.

(3) A nonexclusive, nontransferable license to Contractor to use current software and

documentation and any software updates, or until Agreement is terminated as set forth herein. Such license also includes the right of Contractor to copy TEMIS software and documentation for back-up or archive purposes, but such license further gives Contractors no right to sell, lease, sublease, donate, assign, distribute, or otherwise transfer any right in TEMIS software or documentation to any other person or entity.

(4) Installation and maintenance of personal computer (PC) peripherals and software meeting specifications shown in Attachment "D-1", TEMIS Hospital Hardware and Software Specifications, attached hereto and incorporated herein by reference, for the purpose of Trauma Center data entry and/or data manipulation. The Department will maintain said equipment in fully functioning order until Agreement is terminated or County replaces the equipment. In the event that Agreement is terminated for any reason, the Department shall promptly remove all TEMIS hardware and software and Contractor shall return to County all TEMIS documentation [and all copies

thereof made by Contractor hereunder; provided by County to Contractor.

(5) Unlimited technical support for the TEMIS system provided during normal business hours.

C. County does not warrant that operation of the hardware or software will be uninterrupted or error-free. In the event of a failure, breakdown of the equipment, or errors in software the Department, on behalf of County, shall use reasonable efforts to promptly rectify the software, repair the failure, or replace the defective component. Whenever possible, the Department shall correct a problem in twenty-four (24) hours or less. County shall have no such obligation if the problem(s) is (are) a direct or indirect result of hardware and/or software modifications, or both, made without written approval from Director. County's inability to resolve above issues will result in temporary suspension of Contractor's data obligations.

The foregoing including responsibilities for resolving hardware and software problems are the only warranties of any kind, either expressed or implied, that are made by County, and County disclaims all other warranties including, but not limited to, the implied

warranties of fitness for a particular purpose. In no event shall County be liable for any direct, indirect, incidental, or consequential damages of any nature whatsoever (including, without limitation, damages for loss of business profits, business interruption, loss of information and the like), arising out of the use or inability to use the software or hardware, even if County has been advised of the possibility of such damages.

County does not assume and shall have no liability under this Agreement for failure to repair or replace defective equipment, software, or the corresponding data due directly or indirectly to causes beyond the control of, and without the fault or negligence of County, including, but not limited to, acts of God, acts of public enemy, acts of the United States, any state, or other political subdivision, fires, floods, epidemics, quarantine, restrictions, strikes, freight embargoes, or similar or other conditions beyond the control of County.

2. SPECIFIC RESPONSIBILITIES OF CONTRACTOR INCLUDE THE FOLLOWING:

A. Contractor's data collection requirements for patient

inclusion in the trauma database are defined and set forth in Exhibit "C", attached hereto and incorporated herein by reference.

Contractor shall enter into the TEMIS database within fifteen (15) days of hospital admission, the data elements found in the Initial Patient Information Section (to include patient name, admit date, mode of entry, and sequence number) of the Trauma Patient Summary - Page 1 (TPS1). The remainder of TPS1 shall be entered into the TEMIS database within thirty (30) days of hospital admission. Data elements found in the Trauma Patient Summary - Page 2 (TPS2) shall be entered into the TEMIS database within sixty (60) days of hospital discharge.

B. Contractor acknowledges receipt of the County Department of Health Services Trauma Patient Summary Form, Attachment "D-2", attached hereto and incorporated herein by reference. Contractor agrees to provide all mandatory data elements from Attachment "D-2" in reporting trauma patient information to the Department, to assist the Department in its data collection effort. In the event that Director determines that the Department's Trauma Patient Summary

Form should be modified or that additional data must be collected by Contractor based on recommendations from the Trauma Hospital Advisory Committee (THAC), said request for additional data must first be referred to the EMSC Data Advisory Committee by Director for review and advice. The Department shall estimate the cost impact on Trauma Centers of the request for the modification and shall advise the EMSC. If the request for additional data results in increased costs to Contractor, Contractor may terminate this Agreement upon giving at least sixty (60) days prior written notice to County.

C. Contractor shall utilize TEMIS application programs and County-owned equipment, or provide their own equipment in accordance with the specifications shown in Attachment "D-1", TEMIS Hospital Hardware and Software Specifications, attached hereto and incorporated herein by reference, in a reasonably secure area of the hospital provided by the Contractor. Contractor shall in no way modify the structure or function of the County-owned hardware or software without prior written approval of Director. The hardware and software configuration provided shall be used exclusively for

the purposes intended herein. Use of County-owned equipment for any other purpose or for running any other programs or software shall be done only with the express written consent of Director. Contractors shall at all times provide County representative(s) designated by Director with reasonable access to Contractor premises to allow for installation, maintenance, or removal of County-owned property.

D. Contractor shall provide DSL or T1 internet connection for the submission of Contractor's TEMIS data to County.

E. Should County remove all or any portion of TEMIS software required to submit Contractor's data to County via County defined media, or fail to correct any software errors that prevent Contractor from being able to perform data entry, Contractor's obligation to submit data electronically shall cease, until County has reinstalled the necessary software or corrected the software error.

F. If it is reasonably determined by Director that any Contractor repair or replacement of County-owned equipment, or repair or recovery of software or data, to the extent deemed feasible by Director, was

necessary due to theft or due to Contractor's negligence, Contractor shall reimburse County for the repair, replacement, or recovery cost at a maximum labor rate of Fifty Dollars ($50) per hour, plus the actual cost of parts and materials.

G. Contractor shall provide all supplies necessary for the ongoing use of the County-owned equipment (e.g. printer cartridges, printer paper, floppy diskettes, etc.).

H. Contractor shall seek telephone assistance from Director, whenever TEMIS operation failure occurs, to obtain County TEMIS maintenance services as described herein.

I. Contractor shall assign qualified back-up personnel to operate TEMIS, as reasonably appropriate for Contractor to meet Contractor's data collection responsibilities described herein. Furthermore, Contractor shall permit adequate time for complete training of such personnel during equipment installation.

J. All software application modules, all modifications, enhancements, and revisions thereof and thereto, and all materials, documents, software programs and documentation, written training documentation and aids, and other items provided by County or its agents, are

"proprietary" or "confidential". Contractor shall use reasonable means to insure that these confidential products are safeguarded and held in confidence. Such means shall include, but not be limited to: requiring each Contractor employee or agent given access thereto to enter into a written agreement in the same form identified as Attachment "D-3", Hospital Employee Acknowledgement and Confidentiality Agreement Regarding Trauma Center Data Collection Obligations, attached hereto and incorporated herein by reference; disclosing confidential County products only to employees with a need to know of such confidential County products in order for Contractor to exercise its rights and perform its obligation as a Trauma Center; and refraining from reproducing, adapting, modifying, disassembling, decompiling, reverse engineering, distributing, or disclosing any confidential County products except as expressly permitted hereunder. Copies of software, application modules, and data may be made for the sole purpose of backup only.

K. Contractor shall indemnify, hold harmless, and defend County from and against any and all liability, damages, costs, and expenses, including, but not limited to,

defense costs and attorneys' fees, for or by reason of any actual or alleged infringement of any United States patent, copyright, or any actual or alleged trade secret disclosure, arising from or related to the misuse of the software license.

L. Contractor shall safeguard and protect the County-owned equipment to ensure full operation. No other application software programs shall be operated on County-owned equipment supplied to Contractor, unless specifically approved in writing by Director.

3. RELEASE AND/OR SALE OF TEMIS DATA:

A. The parties acknowledge that the data collection effort was undertaken for the purpose of improving the Los Angeles Trauma System and that the County and participating hospitals have expended significant amounts of time, effort and money to develop data collection systems and data. Accordingly, it is hereby acknowledged and agreed that County will not release or sell any identifiable data to any entity for publication or for any other use whatsoever without first receiving written permission from Contractor, if it is identified, except as otherwise provided by law.

B. Only non-hospital identifiable information resulting

from the TEMIS may be sold by County without permission of the hospitals.

C. Seventy-five percent (75%) of the proceeds of the sale of any TEMIS Trauma Center information shall be distributed to the participating hospitals in equal amounts. Said distribution shall be effected by reducing the annual fee by an amount equal to Contractor's share of the sale of proceeds from the previous year.

ATTACHMENT D-1

TRAUMA CENTER SERVICE AGREEMENT

TRAUMA and EMERGENCY MEDICINE INFORMATION SYSTEM (TEMIS)
HOSPITAL HARDWARE AND SOFTWARE

Description	Total Quantity
Hewlett-Packard MXL50	1
10/100 Ethernet	1
NEC DVD R/W ND-3500AG	1
Maxtor 6E040L0 30GB	1
512MB RAM	1
Phillips 190S 19" LCD Monitor	1
96MB Video	1
Keyboard	1
Mouse	1
HP LaserJet 2100	1
Windows XP Professional OS	1
Microsoft Office XP Professional	1
PC Anywhere 10.5	1
Symantec Antivirus Corporate v8.1	1
LA Trauma v4.1	1

ATTACHMENT D-2

TRAUMA PATIENT SUMMARY FORM (TPS) – PAGE 1

GENERAL INFO

LAST NAME ____ FIRST NAME ____ INIT. ____ ARRIVAL DATE / /

SEX M F AGE RACE/ETHN CITY: ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other
☐ Filipino ☐ Pacific Islander (oth)/Hawaiian ☐ Native American ☐ Unknown SSN #

☐ D.O.S. ENTRY MODE EMS: ☐ Ground ☐ Air LVS Form avail? ☐ Y ☐ N MR #

DOB / / NON EMS: ☐ Vehicle / Walk-in ☐ Police ☐ Other OTH #

ESTIMATE TRANSFERRED ☐ ED to ED ☐ Direct Admit FROV ___

PREHOSPITAL / WALK-INS

INJURY DATE / / INJURY DESCRIPTION ☐ Blunt ☐ Penetrating PRIMARY E-CODE:

INJURY TIME MECHANISM OF INJURY OTHER E/V-CODES:

PROVIDER PROTECTIVE DEVICES ☐ None Airbag deployed? ☐ N ☐ Y (front ☐ Side ☐ Other (portion, knee, etc.)

RAP SQUAD ☐ Helmet ☐ Protective clothing ☐ Non-clothing gear ☐ Eye protector ☐ Personal Protection Device ☐ Other ☐ Shoulder belt ☐ Lap belt ☐ Infant seat ☐ Child car seat ☐ Booster seat LOCATION E-CODE:

DISPATCH DATE / / INJ. ZIP CODE:

DISPATCH TIME ☐ UNK (must complete Address fields)

AT ON SCENE 1st FIELD GCS: EYE___ MOTOR___ VERBAL TOTAL FIELD INTUB? WORK RELATED? N Y

TRANSPORT ARR 1st FIELD VS: BP ___ HR___ RR___ O2 SAT ___% Y N OCCUPATION:

TRANSPORT LEFT INDUSTRY:

EMERGENCY DEPARTMENT

ARRIVAL TIME 1st ED VS: ME___ GCS ___V___V TOTAL ____ ED NOTIFIED? N Y

EXIT ED DATE TEMP:____ F C ☐ Sealed ☐ Eye obstruction ☐ Intubated MET CRITERIA? N Y

EXIT ED TIME BP / HR RR ASSIST? N O2 Sat ___% on O2? N ☐ GSW trunk ☐ Blunt Mod/v

ACTIVATION? Y N TPS RATIONALE: ☐ Admission ☐ Transferred to TRAUMA service ☐ PH ☐ PN ☐ Low BP

TYPE: ☐ Died ☐ Prehosp dispositive ☐ NON-EMS Criteria/Guidelines ☐ Other ☐ SCI ☐ PSI ☐ BH,GCS<15

LEVEL ADMITTING MD: ADMITTING SERVICE ☐ Flail Chest ☐ Fall >15'

MD SERVICE	MD CODE	RESPONSE	START	ARRIVAL
EMERGENCY PHYS			Y N	
TRAUMA SURGEON			Y N	
TRAUMA RESIDENT			Y N	
NEUROSURGEON			Y N	
ORTHOPEDIST			Y N	
ANESTHESIOLOGIST			Y N	
			Y N	
			Y N	

☐ Diffuse Abd Tenderness ☐ Neuro Comp ☐ PT Arrest

GUIDELINES MET:
☐ Pedestrian/Bike vs auto ☐ Ejected ☐ Extricated ☐ Med Hx ☐ Very old/young ☐ Survivor Fatal Accident ☐ Prehosp JUDGMENT only

ED FLUID TOTALS:
IV FLUIDS ____ ml
BLOOD PROD. ____ ml
AUTOTRANS. ____ ml

NEXT PHASE AFTER ED:
☐ <24hr Obs ☐ OR ☐ ICU ☐ Ward ☐ Telemetry/Step. ☐ Peds Ward ☐ Peds ICU ☐ Posthospital (complete TPS 2 only)

DEATH IN ED:
☐ DOA (minimum/no resusc.) ☐ Died (<15min ED resusc.) ☐ Died in ED (other)

HOSPITAL BLOOD TOTALS
(INCLUDE OR TOTALS)
BLOOD PROD. ____ ml
AUTOTRANS. ____ ml
TOTAL PROD. ____ ml

DRUGS OF ABUSE:
☐ Amphetamine ☐ Cocaine ☐ Barbiturates ☐ Opiates ☐ PCP ☐ Cannabinoids ☐ Other

RADIOLOGY / LAB

BODY REGION	X-RAYS: DONE	DATE	TIME	ANY ABN	CT: DONE	DATE	TIME	ANY ABN	LABS: TIME	GRP/PANEL	Result/Tested?
HEAD		/		N A		/		N A		HGB / CT	Norm Abn
NECK		/		N A		/		N A		TOX (BLOOD)	NT P NP
CHEST		/		N A		/		N A		TOX (URINE)	NT P NP
ABD		/		N A		/		N A		ETOH	NT P NP
PELVIS		/		N A		/		N A			
FAST		/		N A		/					

Comments / Results:

PROCEDURES

ENTER ALL THAT APPLY DURING HOSPITAL STAY

PHASE BEGUN	START DATE	START TIME	END TIME	PROCEDURE	PHASE BEGUN	START DATE	START TIME	END TIME	PROCEDURE
	/	:		☐ ETT ☐ NAS		/	:		☐ CENTRAL LINE
	/	:		☐ [illegible]		/	:		☐ ICP
	/	:		☐ [illegible]		/	:		
	/	:		☐ THORACOTOMY		/	:		
	/	:		☐ [illegible]		/	:		☐ VENTILATOR

END DATE: / /

TOTAL VENTILATOR DAYS: (MUST INCLUDE ALL EPISODES)

ATTACHMENT D-2

TRAUMA PATIENT SUMMARY FORM (TPS) – PAGE 2

NAME | ARRIVAL DATE: / / | MR# | SEQ# | OTH#

OPERATIONS / PROCEDURES

DATE	SLT TIME	END TIME	OPERATION	PROC ICD-9	SURG TYPE	MD CODE
/	:	:				
/	:	:				
/	:	:				
/	:	:				
/	:	:				
/	:	:				
/	:	:				
/	:	:				
/	:	:				
/	:	:				
/	:	:				
/	:	:				

ICU

ARRIVAL	EXIT
/	/
/	/
/	/
/	/

CONSULTS

DATE	SERVICE	MD CODE
/		
/		
/		
/		

PHASE AFTER OR:
1ST VISIT
2ND VISIT
3RD VISIT
4TH VISIT
5TH VISIT

POSTHOSPITAL

D/C DATE / /
D/C TIME : :
PRIOR PHASE

TRANSFER'D / D/C TO ☐ Home w/o services ☐ Home w/Home Health ☐ Morgue ☐ Acute Care Facility ☐ SNF ☐ Subacute Care ☐ Rehab ☐ Hospice ☐ AMA/Eloped/LWBS ☐ Jail ☐ Other:

RATIONALE ☐ Health Plan ☐ Financial ☐ Patient pref ☐ Specific Pmt Care ☐ Rehab ☐ Extended Care ☐ In Custody ☐ Other

FACILITY:

D/C CAPACITY ☐ Pre-Injury Capacity (D/C'd from ED with minimum or no injuries) ☐ Temporary Handicap (Admitted for injuries) ☐ Permanent Handicap, >1yr limitations (excludes splenectomy)

☐ LVLD ☐ DIED: ORGAN DONOR? Y N AUTOPSY PERFORMED? Y N CORONER # ☐ MA

DISCHARGE DIAGNOSIS	CD 9	AIS	MET SPC	DISCHARGE DIAGNOSIS	CD 9	AIS	SD SI

RAND-CALCULATED ISS	1) HEAD/NECK	2) FACE	3) CHEST	4) ABDOMEN/PELVIS	5) EXTREMITIES	6) EXTERNAL	TOTAL

NTDS CO-MORBID CONDITIONS ☐ No NTDS co-morbidities ☐ Alcoholism ☐ Angina within 30 days ☐ Ascites within 30 days ☐ Bleeding disorder ☐ Chemo within 30 days ☐ CHF ☐ Congenital Anomalies ☐ Current smoker ☐ CVA/Residual Neuro Deficit ☐ Diabetes ☐ Dialysis (needs/is on) ☐ Disseminated Cancer ☐ DNR status ☐ Esophageal varices ☐ Functional Dependent Hlth Statu ☐ HTN req'g meds ☐ Impaired sensorium ☐ MI within 6 months ☐ Obesity ☐ Prematurity ☐ Respiratory Disease ☐ Steroid use ☐ Revascularization/Amputation for PVD ☐ Other:

NTDS COMPLICATIONS ☐ No NTDS comp. ☐ Abd Compart Synd ☐ AMI ☐ Abd fascia left open ☐ Acute renal failure ☐ ARDS ☐ Anastomotic leak ☐ Base Deficit ☐ Bleeding ☐ Coagulopathy ☐ Coma ☐ CPR ☐ CVA ☐ Decub ulcer ☐ Drug/ETOH withdrawal ☐ DVT/thrombophleb. ☐ Extremity Compartment Syndrome ☐ Graft/prosthesis/flap failure ☐ ICP elevation ☐ Jaundice/hepatic failure ☐ Panc fistula ☐ PE ☐ Pneumonia ☐ Surg site infection (superficial) ☐ Surg site infection (deep) ☐ Surg site infection (organ/space) ☐ Sepsis ☐ Unanticipated intubation ☐ Unplanned readmit ☐ Wound disruption ☐ Wound infection ☐ Other:

FINANCES

Pvt/Commercial Insurance:
☐ Blue Cross/Blue Shield
☐ HMO ☐ Medi-Cal HMO
☐ Auto Insurance
☐ Worker's Comp.
☐ Organ Donor Subsidy
☐ Other private carrier:

Government:
☐ CCS (California Children's Services)
☐ CHIP eligible
☐ CHP (Comm. Hlth Plan)/Healthy Fam.
☐ Custody Funds
☐ Military Insurance
☐ VOC (Victims of Crime)

Self:
☐ Cash
☐ ATP w/liability
☐ Pre-pay

Not billed:
☐ Charity

Medicaid:
☐ Medi-Cal
☐ Medi-Cal pending
☐ Medicare

TOTAL CHARGES:
$

ATTACHMENT D-3

TRAUMA CENTER SERVICE AGREEMENT

HOSPITAL EMPLOYEE
ACKNOWLEDGMENT AND CONFIDENTIALITY AGREEMENT
REGARDING BASE/TRAUMA HOSPITAL DATA COLLECTION OBLIGATION

HOSPITAL: _____

I hereby agree that I will not divulge to any unauthorized person any data or information obtained while performing work associated with my employer's base/trauma hospital data obligations. I agree to forward all requests of the release of any data or information received by me to my employer's TEMIS supervisor.

I agree to keep all hospital, patient, and/or agency identifiable TEMIS data confidential and (unless authorized by the patient or the appropriate agency/hospital CEO) to protect these confidential materials against disclosure to other than my employer or County authorized employees who have a need to know the information.

I agree that all TEMIS software application modules, and all modifications, enhancements, and revisions thereof and thereto, and all materials, documents, software programs and documentation, written training documentation, aids, and other items provided to hospital by County for the purposes of the Trauma and Emergency Medicine Information System (TEMIS) data collection shall be considered confidential. As such, I will refrain from reproducing, distributing, or disclosing any such confidential County products except as necessary to perform the Hospital's base/trauma hospital data collection obligation.

I agree to report to my immediate supervisor any and all violations of this agreement by myself and/or by any other person of which I become aware. I agree to return all confidential materials to my immediate supervisor upon completion of my employer's data collection obligation or termination of my employment with my employer, whichever occurs first.

I acknowledge that violation of this agreement may subject me to civil and/or criminal action and that the County of Los Angeles may seek all possible legal redress.

NAME: _____ DATE: _____
(Signature)

POSITION: _____

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT K

EMERGENCY MEDICAL SERVICES COMMISSION (EMSC)
DATA ADVISORY COMMITTEE MEMBERSHIP & BY-LAWS

This committee is responsible for all matters regarding quality of prehospital data, report generation, prehospital research, and policy development impacting the Trauma & Emergency Medicine Information System (TEMIS).

- Committee to be Chaired by an EMSC Commissioner.
- Two or more EMSC Commissioners appointed to the Committee.
- A base hospital administrator or assistant administrator, or a non administrator duly authorized to represent a base hospital administrator/assistant administrator, selection facilitated by Healthcare Association of Southern California.
- A trauma center administrator or assistant administrator, or a non administrator duly authorized to represent a trauma center administrator/assistant administrator, selection facilitated by Healthcare Association of Southern California.
- A 9-1-1 receiving hospital (non-base/non-trauma) representative, selection facilitated by Healthcare Association of Southern California.
- A public sector paramedic provider representative selected by the Provider Agency Advisory Committee.
- A public sector paramedic provider representative from the Los Angeles County Fire Department.
- A public sector paramedic provider representative from the Los Angeles City Fire Department.
- A private sector paramedic provider representative, selection facilitated by the Ambulance Advisory Board.

- A prehospital care coordinator selected by the Base Hospital Advisory Committee.
- A trauma program manager and one physician selected by the Trauma Hospital Advisory Committee.
- A base hospital medical director selected by the Medical Council.
- A trauma center program director, selection facilitated by the Trauma Committee of the Southern California Chapter of the American College of Surgeons.
- A fire chief, selection facilitated by the Los Angeles County Chapter of the California Fire Chief's Association.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT F

PARAMEDIC BASE HOSPITAL REQUIREMENTS

This Agreement is authorized by the authorized by the Health and Safety Code Sections 1797.58 and 1798.100 and Title 22 California Code of Regulations, Section 100168. Pursuant to the authority granted under the Emergency Medical Services and Prehospital Emergency Medical Care Personnel Act ("Act") (Health and Safety Code, Sections 1797, et seq.), County maintains an Advanced Life Support ("ALS") system providing services utilizing Emergency Medical Technicians-Paramedics (hereafter "paramedics") for the delivery of emergency medical care to the sick and injured at the scene of an emergency, during transport to a general acute care hospital, during interfacility transfer, while in the emergency department of a general hospital, until care responsibility is assumed by the regular staff of that hospital, and during training within the facilities of a participating general acute care hospital.

1. BASIS AND PURPOSE: The basis of this Agreement is the desire and intention of the parties to cooperate in the operation of each party's component of the paramedic delivery system, consistent with each party's other health services

activities and fiscal requirements and the duties and responsibilities of the County. Its purposes are to establish, in a manner reflective of that cooperative basis, the specific duties and responsibilities of the parties with respect to the matters addressed herein and to provide mechanisms and procedures for the following:

A. resolution of disputes; and

B. communications regarding the operation of the system, and;

C. consideration of future development of the system in response to change in circumstances; and

D. interaction with other system participants; and

E. quality improvement.

2. SPECIFIC RESPONSIBILITIES OF COUNTY'S DEPARTMENT OF HEALTH SERVICES (COUNTY'S LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY): County has designated its Department of Health Services as the local Emergency Medical Services Agency (hereafter "Department", "local EMS Agency", "Agency" or "DHS").

A. The local EMS Agency approves and designates selected paramedic base hospital(s) as the Agency deems necessary to provide immediate medical direction and supervision of paramedics within Los Angeles County in accordance with policies and procedures established by

the Agency and State EMS Authority.

B. Policies and Procedures: County shall:

(1) Coordinate the countywide aspects of the ALS system and maintain and operate County components of the PCS.

(2) Establish policies and procedures consistent with State and County laws, regulations, and standards to assure medical control of ALS personnel.

(3) Review and revise policies every three years or as needed.

(4) Distribute to Contractor within sixty (60) calendar days of the execution of this Agreement a complete manual containing all protocols and policies which Agency currently considers to be applicable to participants in the ALS system.

(5) Establish policies and procedures that ensure a mechanism exists for replacing medical supplies and equipment used by advanced life support personnel during treatment of patients. Such policies and procedures shall not require Contractor to provide or replace such medical supplies and equipment.

(6) Establish policies and procedures that ensure a

mechanism exists for replacing controlled drugs and narcotics used by advanced life support personnel during treatment of patients. Such policies and procedures shall not require Contractor to provide or replace such medical supplies and equipment.

C. Interim System Re-Configuration: DHS may, on an interim basis, restructure the prehospital care system as it deems necessary, including reassignment of ALS Units to or from Contractor as the primary directing base hospital, in those instances when a designated base hospital gives notice that it is withdrawing from the system or when a designated base hospital is suspended or terminated from the prehospital care system. In the event that an interim restructuring occurs, Contractor, if affected by the restructuring, shall be given the immediate opportunity to provide written and oral statements to Director regarding the restructuring to the local EMS Agency and shall be provided with the "due process" procedures specified in Paragraph 16, Due Process, of Exhibit E. Nothing herein, however, is intended to prevent implementation by Director on an emergency basis of such changes as

he/she may find measurably necessary to preserve the integrity of the prehospital care system and to protect the health and safety of County residents.

D. System configuration: Director shall notify Contractor of proposals for substantial operational or structural changes in the components of the ALS system or in the overall operation or configuration of such system. This shall include, but not be limited to, increasing or decreasing the number of base hospitals in the event that a restructuring of the prehospital care system is deemed necessary. In the event the number of base hospitals is increased or decreased, written notice shall be given to Contractor at least thirty (30) calendar days prior to the effective date of any resulting substantial operational or structural changes to the local EMS Agency. If the need for Contractor to serve as a base hospital can no longer be substantiated, or if Contractor is adversely affected by the addition of a new base hospital, Contractor, upon request, shall be provided with "due process" as specified in Paragraph 16, Due Process, of Exhibit I.

E. Data Management: DHS, after consultation with and

advice from the Emergency Medical Services Commission ("EMSC") Data Advisory Committee, as defined by the EMS Commission bylaws, if duly constituted, shall continue maintenance of a comprehensive base hospital data collection system. The EMS base hospital data collection system includes:

(1) A base hospital data collection procedure manual.

(2) A minimum of sixteen (16) hours Trauma and Emergency Medicine Information System ("TEMIS") basic software training up to twenty-four (24) hours of intermediate/advanced training for all necessary persons identified by Contractor, to enable Contractor personnel to perform data entry, database maintenance, and basic report generation functions.

(3) A nonexclusive, nontransferable license to Contractor to use TEMIS software and documentation and any software updates for as long as County maintains its software license contract with Lancet Technology, Inc., or until Agreement is terminated as set forth herein. Such license also includes the right of Contractor to copy TEMIS software, data, and

documentation for back-up or archive purposes, but such license further gives Contractor no right to sell, lease, sublease, donate, assign, distribute, or otherwise transfer any right in TEMIS software, data, or documentation to any other person or entity.

(4) DHS will maintain said equipment in fully functioning order until Agreement is terminated or County replaces the equipment. In the event that Agreement is terminated for any reason, DHS shall promptly remove all TEMIS hardware and software and Contractor shall return to County all TEMIS data and documentation (and all copies thereof made by Contractor hereunder) provided by County to Contractor.

(5) DHS, on behalf of County, in the event of a failure, breakdown of the equipment, or errors in software, shall use reasonable efforts to promptly rectify the software, repair the failure, or replace the defective component. Whenever possible, DHS shall correct a problem in twenty-four (24) hours or less (excluding Saturday, Sunday, and Holidays). County shall

have no such obligation if the problem(s) is (are) a direct or indirect result of hardware or software modifications, or both, made without the prior written approval from Director.

(6) The foregoing are the only warranties of any kind, either expressed or implied, that are made by County, and County disclaims all other warranties including, but not limited to, the implied warranties of fitness for a particular purpose. In no event shall County be liable for any direct, indirect, incidental, or consequential damages of any nature whatsoever (including, without limitation, damages for loss of business profits, business interruption, loss of information, and the like), arising out of the use or inability to use the software or hardware, even if County has been advised of the possibility of such damages.

(7) County does not warrant that operation of the hardware or software will be uninterrupted or error-free or that all errors will be corrected.

(8) County does not assume and shall have no liability under this Agreement for failure to

ATTACHMENT F-7

TRAUMA CENTER SERVICE AGREEMENT

COMMUNICATIONS EQUIPMENT MAINTENANCE STANDARDS

I. Radio station room, antenna structure and control lines
   A. Radio Station Room
      1. Radio equipment shelter (with sufficient space to install three (3) radio stations). (Not required if the Hospital has suitable existing facility to house radio station equipment on roof or top floor of Hospital's tallest building.
      2. 1 each Power Distribution Panel (wired to hospital's emergency A.C. power as well as commercial power)
      3. 5 each A.C. Power Outlets near radio stations and connected to Item No. 2 above
      4. 1 lot - Hardware Kit, Antenna Mounting
   B. Antenna Structure
      1. 1 each Tower, antenna, up to 60 ft. or other structure suitable for antenna mounting (installed near radio station room)
   C. Radio Control Lines
      At least four (4) sets of 4 wire circuits (one set per transceiver and one spare set must be installed by hospital from terminal block(s) in the radio station room termination points close to the control consoles.
   D. Control Consoles and Paramedic Telephones
      1. Location in the Emergency Department
      2. Console Equipment
         a. 1 each - Hospital Coordination Console (HCC) per Specification No. 1928, or other suitable tone/remote control console with DTMF decoder
         b. 2 each - Medical Communications Console per Revised. Specification No. 1927

Above item can be a single equipment instead of two, if provision is made for control of both MED 1-8 transceivers from the single console. Provision must also be made for connection of both paramedic emergency telephones to the single console. The Console must provide means to log all traffic via radio channels and telephone calls to the console. The recording medium must be of archival quality. It is recommended that, unless space considerations for the consoles are the Hospital's primary concern, two MCTC's be installed.

II. Power Outlets
At least 8 A.C. power outlets shall be provided. Outlets must be connected to Hospital's emergency power system as well as commercial power.

III. Paramedic Emergency Telephones
Two telephones with telephone lines shall be dedicated for paramedic/hospital communications.

IV. Maintenance and Trouble Call Reporting
A. Purpose: To provide preventive and ongoing maintenance and/or repair for PCS Equipment.
B. Responsibilities of Hospital:
1. Provide the local EMS Agency with evidence of 24 hours per day, 7 days per week maintenance and repair service for radio and system equipment.
2. Report problems to the Internal Services Department.
3. Perform or cause to be performed the following preventive maintenance:
a. Quarterly: Systems check to include:
(1) console functions and operation;
(2) transmit and receive test of all frequencies.
(3) Clean and service base hospital console tape deck.
(4) Confirm operational performance of all EKG related equipment.
b. Annually:
(1) FCC frequency and deviation test for all radios;
(2) Visual inspection of the antenna structures;
(3) Solicit report from assigned field provider units about any chronic communication problems to include but not be limited to field equipment, dead space, radio failure and co-channel interference, and submit a written report to the local EMS Agency about such problems.

TRAUMA CENTER SERVICE AGREEMENT

Amendment No. 22

THIS AMENDMENT is made and entered into this 10th day of June, 2020.

By and between	**COUNTY OF LOS ANGELES** (hereafter "County")
And	**HUNTINGTON MEMORIAL HOSPITAL** (hereafter "Contractor")
	Business Address:
	100 W. California Blvd. Pasadena, CA 91105

WHEREAS, reference is made to that certain document entitled "Trauma Center Service Agreement," dated July 01, 2008, and further identified as Agreement No. H-703481, and any amendments thereto (all hereafter referred to as "Agreement") and,

WHEREAS, it is the intent of the parties hereto to amend Agreement to extend its term, to modify certain of its payment provisions, and to provide for the other changes set forth herein; and

WHEREAS, Agreement provides that changes in accordance to Additional Provisions, Paragraph 24, Merger Provision may be made in the form of an Amendment which is formally approved and executed by the parties; and

WHEREAS, Contractor warrants that it possesses the competence, expertise and personnel necessary to provide services consistent with the requirements of this Agreement and consistent with the professional standard of care for these services.

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

1. This Amendment shall be effective upon execution with payment provisions applied for services provided during the period of July 1, 2019 through June 30, 2020.

2. Agreement Paragraph 1, Term, Subparagraph A, is deleted in its entirety and replaced as follows:

> "A. The term of this Agreement shall commence and be effective July 1, 2008, and shall remain in full force and effect through to and including June 30, 2021. In any event, County may terminate this Agreement in accordance with the Termination Paragraphs of the Additional Provisions hereunder."

3. Agreement Exhibit B-5, Provisions for Reimbursement, is deleted in its entirety and replaced by Exhibit B-6 attached hereto and incorporated herein by reference. All reference in Agreement to Exhibit B-5 shall be deemed to be references to Exhibit B-6.

4. The Parties acknowledge and agree that none of the financial provisions in the Agreement apply to services provided on or after July 1, 2020.

5. Except for the changes set forth hereinabove, Agreement shall not be changed in any respect by this Amendment.

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be executed by the County's Director of Health Services or authorized designee, and Contractor has caused this Amendment to be executed in its behalf by its duly authorized officer, on the day, month, and year written above.

COUNTY OF LOS ANGELES

By: _____ for
Christina R. Ghaly, M.D.
Director of Health Services

HUNTINGTON MEMORIAL HOSPITAL

REDACTED

By: _____
Signature 06-10-2020

Lori J. Morgan, MD, MBA

REDACTED

Title

APPROVED AS TO FORM:

MARY C. WICKHAM
County Counsel

By _____
Brian Chu, Principal Deputy County Counsel

TRAUMA CENTER SERVICE AGREEMENT

PROVISIONS FOR REIMBURSEMENT

TABLE OF CONTENTS

SECTION		PAGE
I.	OVERVIEW	1
II.	ELIGIBLE PATIENT-BASED FUNDING	3
	A. BUDGET ALLOCATION	3
	B. GENERAL CONDITIONS	7
	C. PATIENT ELIGIBILITY	9
	D. CLAIMS SUBMISSION	12
	E. AUDITING OF RECORDS	17
III.	FUNDING FOR PEDIATRIC TRAUMA CENTERS	18
IV.	DESIGNATION SUPPORT FUNDING	20
	A. BASE HOSPITAL SERVICES AND INFRASTRUCTURE	20
V.	ADD-ON PAYMENTS	21
VI.	MEASURE B ADVISORY BOARD FUNDING	22
VII.	PAYMENT LIMIT	25
VIII	POTENTIAL IGT FOR FEDERAL MATCHING FUNDS	25
IX.	TOTAL MAXIMUM PAYMENTS	26
X.	EFFECTIVE DATES	28

TRAUMA CENTER SERVICE AGREEMENT

PROVISIONS FOR REIMBURSEMENT

I. OVERVIEW

This Exhibit addresses funding for the fiscal year ending June 30, 2020 (the "Contract Period") for the Los Angeles County trauma hospitals ("Non-County Trauma Hospitals"). Non-County Trauma Hospitals are hospitals that are not owned and operated by County of Los Angeles the "County"). The County's funding to Non-County Trauma Hospitals for this Contract Period assures the continuance of emergency care access for Medi-Cal beneficiaries and stabilizes the provision of trauma care services in Los Angeles County.

The funding identified in this Agreement for Non-County Trauma Hospitals, totaling $97,070,086, covers the following four components:

1. Patient/Hospital-Based Payments

This component includes uninsured trauma claims and pediatric trauma services as described in Sections II and III.

2. Designation Support Payments

This component includes payments for Non-County Trauma Hospitals that serve as base stations, and funding for trauma hospitals' infrastructure as described in Section IV.A.

3. Add-On Payments

This component includes payments for the following: a) trauma patient volume; b) patient acuity; c) the volume of underinsured patients (i.e., Medi-Cal and In-Custody patients); and d) a parity adjustment to mitigate the negative financial impact among various hospitals.

4. Measure B Advisory Board Funding

This component includes one-time payments for FY 2019-20 as recommended by the Measure B Advisory Board (MBAB) that was established at the direction of the County Board of Supervisors to distribute prior year unspent and unallocated Measure B funds.

The County intends to use the following fund sources for this Agreement: Measure B, Maddy, and Richie. In addition, the County will utilize the Measure B funds, to the extent possible, to make the inter-governmental transfer (IGT) of funds to the California Department of Health Care Services (CDHCS) to draw down the Federal matching dollars for enhanced

Medi-Cal payments to eligible private trauma hospitals, pursuant to pp. 51a-51c of Attachment 4.19B of the Medi-Cal State Plan (the "Trauma SPA").

The parties entering to this Agreement acknowledge that the Trauma SPA effective July 1, 2003, was approved by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. The Trauma SPA enables private trauma hospitals in Los Angeles County to receive additional Medi-Cal payments, under Section 14087.3 of the Welfare and Institutions Code. Pursuant to the Trauma SPA and a related interagency agreement between the County and the CDHCS, these additional Medi-Cal payments are distributed among the County-designated private trauma hospitals, in a lump-sum amount to ensure continued access by Medi-Cal beneficiaries to trauma and emergency room care in the County.

II. ELIGIBLE PATIENT-BASED FUNDING

A. BUDGET ALLOCATION

1. Patient-Based Allocation Amounts

This Section II is applicable to the Non-County Trauma Hospitals with the exception of Children's Hospital Los Angeles. For the Contract Period, the County has established

a budget allocation (the "Budget Allocation") for each such Non-County Trauma Hospital providing medical care to Eligible Patients (as defined below) during the Contract Period. The budget allocations are as follows:

Antelope Valley Hospital	$ 286,782
California Hospital Medical Center	$1,833,629
Cedars-Sinai Medical Center	$ 465,846
Henry Mayo Newhall Memorial Med. Ctr.	$ 476,495
Huntington Memorial Hospital	$ 196,837
Long Beach Memorial Medical Center	$ 408,102
Northridge Hospital Medical Center	$1,311,954
Pomona Valley Hospital Medical Center	$ 320,267
Providence Holy Cross Medical Center	$1,663,785
Ronald Reagan UCLA Medical Center	$ 242,855
St. Francis Medical Center	$1,031,094
St. Mary Medical Center	$ 91,621
Total Patient Based Funding	**$8,329,267**

The above amounts for each hospital were determined based on each Non-County Trauma Hospital's share of the total value of the Fiscal Year (FY) 2018-19 indigent claims submitted by all the Non-County Trauma Hospitals to the County, net of any FY 2017-18 disallowed claims, multiplied

by the total funding allocated for this category (which include Measure B, Maddy and Federal matching funds). The value of the indigent claims was computed by applying the emergency department (ED) visit or per diem rates described in the paragraph below. The final value of all the claims was adjusted upwards by an escalation factor of 66.05%, in order to fully distribute the entire funding available for this category. Payments to Non-County Trauma Hospitals listed in this section will be made directly by the County (inclusive of the Maddy Fund as defined below), and/or by CDHCS as enhanced Medi-Cal payments to eligible private hospitals as set forth in this Exhibit.

$ 6,425	per emergency department visit and assessment. (No such fee will be paid if the patient is admitted to the hospital as an inpatient from the emergency department.)
$12,471	for the first inpatient day; and
$ 5,417	for the second inpatient day; and
$ 4,283	for the third inpatient day; and
$ 4,283	for the fourth inpatient day; and
$ 3,023	for each day thereafter.

Accordingly, the Patient-Based Allocations will be taken into account in the amounts that the County recommends be

paid by CDHS as enhanced Medi-Cal payments taking into account direct payments the County has made or will make to the hospitals for such allocations.

2. Maddy Fund

Certain funding known as "Maddy Emergency Medical Services Fund" (Maddy Fund) is available for hospital care rendered to Eligible Patients (as defined in II.B below) by the Non-County Trauma Hospitals. As described in II.D of this Exhibit, Contractor is required to submit a claim (an "Eligible Claim") to the County for the hospital care rendered to Eligible Patients within the Contract Period. Based on claims for patient visits and days from July 1, 2018 to June 30, 2019, County will determine the Maddy Fund payment amount for ED visits and inpatient stays up to three (3) days, using the rates below plus an escalation adjustment factor of 66.05%, due to each hospital for this Contract Period. The amount of Maddy Fund payments is included in determining the total funding for the Patient/Hospital-Based Allocation amount.

$ 6,425 per emergency department visit and assessment. (No such fee will be paid if the patient is admitted to the hospital as an inpatient from the emergency department.)

$12,471 for the first inpatient day; and

$ 5,417 for the second inpatient day; and

$ 4,283 for the third inpatient day; and

$ 4,283 for the fourth inpatient day; and

$ 3,023 for each day thereafter.

B. GENERAL CONDITIONS

Contractor shall provide Trauma Services, as defined below to Eligible Patients. For purposes of this Exhibit, an "Eligible Patient" is a patient receiving Trauma Services from Contractor meeting the following two criteria: (1) the Contractor believes that the patient is unable to pay for the Trauma Services so provided; and (2) the patient has no third-party coverage, in part or in whole for the Trauma Services provided by Contractor. For purposes of this Exhibit, "third party coverage" or "third party payers" includes, but is not limited to commercial insurance or any program funded in whole or in part by the federal government. "Trauma Services" refers to all hospital services furnished by the Contractor to a patient who presents to the Contractor, or is classified subsequently during the patient's stay as a Trauma Patient from the time the patient presents at or is admitted to the Contractor's hospital until the patient is discharged. The term "Trauma Patient" for purposes of this Contract is defined in Exhibit C.

A claim (a "Patient-Based Claim") shall not be submitted to the County hereunder for an Eligible Patient if: (a) the patient has the ability to pay for the service, but refuses or fails to pay for same; or (b) Contractor has failed to submit to any known third-party payer(s) for the patient, an accurate, complete, and timely billing, and for that reason has been denied payment by such payer(s); or (c) for any Trauma Services which is covered in, or the subject of reimbursement in, any other contract between Contractor and County. Subject to the County's review and verification, Contractor will determine and document persons who are Eligible Patients as described in Section II.C below.

County claim is accepted from Non-County Trauma Hospitals for patient care provided to Trauma Patients who do not have the ability to pay for the services, under the following conditions: a) Contractor has made a reasonable, good faith effort to determine if there is a responsible private or public third-party source of payment, in accordance with Section II.C below; and b) Contractor either determines that there is no source of payment; or there is a potential source of payment but the Contractor is unable to obtain payment after making reasonable efforts to pursue

such revenue.

During the term of this Agreement, as required by Section 16818 of the Welfare and Institutions Code (W&IC), Contractor shall continue to provide, at the time treatment is sought by a patient at its facility, individual notice of the availability of reduced cost hospital care. Additionally, Contractor shall post, in conspicuous places in its emergency department and patient waiting rooms, notices of the procedures for applying for reduced cost hospital care. The approved "Notice" language is reflected in English in Attachment "B-2" and in Spanish in Attachment "B-3".

C. PATIENT ELIGIBILITY

For a patient to be an Eligible Patient, Contractor must document that it has made reasonable efforts to secure payment from the patient by billing (at least monthly) for a period of no less than two (2) months after the date of discharge, with a minimum of three (3) billings. Financial notes must clearly indicate that the patient was billed at least three (3) times. Contractor must document that the person cannot afford to pay for the services provided by the Contractor. This documentation must show that the patient's annual income places the patient at or below 200% of the current year

Federal Poverty Level. Contractor must also document that payment for the services will not be covered by third-party coverage, including any program funded in whole or in part by the federal government; and that Contractor has not received payment for any portion of the amount billed.

Contractor will determine and document the patients who are eligible for trauma care coverage hereunder in accordance with the procedures set forth in Attachment "B-1", Trauma Service County Eligibility ("TSCE") Protocol, attached hereto and incorporated herein by reference.

Contractor shall utilize Attachment "B-1.1", Trauma Service County Eligibility ("TSCE") Agreement form as the sole means for determining whether the patient is at or below the 200% of the current year Federal Poverty Level and therefore meets patient's eligibility criteria for trauma care claiming during the term of this Agreement. The TSCE Agreement form must be completed and signed by the patient or the patient's responsible relative(s) at the time it is determined there is not a responsible private or public third-party source of payment and that the patient meets the eligibility requirements. The completed form must be signed and dated by the hospital representative who obtained the

information, verifying that the information was obtained from the patient or the patient's responsible relative(s). If a TSCE Agreement form cannot be secured because the patient or the patient's responsible relative(s) is (are) unable to cooperate in providing the necessary financial information, then Attachment "B-1.1", *Hospital Certification of Inability to Cooperate* form must be completed. If the Inability to Cooperate form is used it should be completed at the initial interaction with the patient or the patient's responsible relative(s). A hospital representative will complete the form, sign and date it and a second hospital representative will verify the information by also signing and dating the form. The original (or electronic scan) of either the *TSCE* or *Inability to Cooperate* form must be maintained by Contractor as part of its financial records. Contractor shall submit a copy of the applicable form to the County Emergency Medical Services (EMS) Agency when submitting a claim to be included in the patient-based claims total as stated in Attachment "B-4", *Instructions for Submission of Claims and Data Collection.*

Documentation to establish that Contractor has complied with the aforementioned patient eligibility requirements must be maintained by Contractor and made available upon request,

pursuant to Paragraph 5, of the Additional Provisions Exhibit of this Agreement, to authorized County or State representatives for inspection, audit, and photocopying.

D. CLAIMS SUBMISSION:

Contractor shall submit all Patient-based Claims to the County for Trauma Services to Eligible Patients, for the Contract Period. These claims, subject to the following conditions and subsequent agreements of the parties, will be used to determine the amount of the Budget Allocation for Contractor for the contract period(s) following the Contract Period.

a) A valid claim shall include a completed Trauma Patient Summary ("TPS") form, found in Attachment "D-2", of Agreement, for each Eligible Patient receiving Trauma Services.

b) In addition to the TPS form, Contractor shall submit the required claim form, (UB04) as well as all required reports as set forth in Attachment "B-4", *Instructions for Submission of Claims and Data Collection*, attached hereto and incorporated herein by reference, to County's Emergency Medical Services Agency, 10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, California 90670, for Trauma Services provided

to Eligible Patients under the terms of this Agreement. This information shall be used in determining the next (and possibly subsequent) year's Budget Allocation.

c) Claims submitted to the County shall be limited to the hospital component of Trauma Services provided to Eligible Patients during the term of this Agreement. Inclusion of the claims in the determination of a Contractor's Budget Allocation or funding under this Agreement shall be limited to the claims for which all required data has been included in the Trauma and Emergency Medicine Information System (TEMIS) and which has been submitted as required by reporting procedures reflected in Attachment "B-4".

d) Claims shall be submitted to County's EMS Agency on an on-going basis once all eligibility requirements have been met and the Contractor has determined that no other source of funding is likely to be available. All Contractor claims for services provided during a County Fiscal Year (FY) (July 1 – June 30) must be received by County no later than the last working day of the first December following the close of the FY. Only claims for which the Contractor has ascertained that no payment will be received should be submitted.

e) To the extent permitted by law, upon submission of claim by Contractor to County for a trauma patient's care, and unless and until the claim is rejected by the County, Contractor assigns and subrogates to County any and all rights to collection as set forth herein, and Contractor shall cease all current and waive all future collection efforts, by itself and by its contractors/agents, to obtain any payment from the patient. At its sole discretion, County and/or County's Contractor may proceed independently against any parties responsible for payment for the Trauma Services to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement up to the full amount of usual and customary fees (including, for example, billed charges) for patient care and services regardless of any amount the Contractor has received under the TCSA, but only to the extent permitted by law. In the event Contractor is contacted by a third party's representative (e.g., insurance claim adjuster) or a patient's attorney regarding pending litigation concerning a claim that has been assigned to the County hereunder, Contractor shall indicate that the claim is assigned and subrogated to the County and refer such representative to the

designated County contact. Contractor shall reasonably cooperate with County in its collection efforts.

f) Contractor shall notify the County, and update the financial status of patient in TEMIS, if Contractor becomes aware of any third-party coverage such as Medi-Cal, Medicare, other government programs, or other health insurance for any claim that the Contractor submitted to be included for purposes of calculating the Budget Allocation. The County has all rights to work with the identified third-party payers to receive any payment due with respect to claims that Contractor has assigned to County, but only to the extent permitted by law.

g) Any and all payments received by Contractor from a Trauma Patient or from third-party payers, including a legal settlement, for a claim previously submitted to and not rejected by the County, must be immediately reported to the County and the payment amount shall be surrendered and remitted to the County since Contractor assigned and subrogated its rights to said claim. Contractor must remit to the County the payment it received within sixty (60) days of receipt of such payment, and must complete and submit a *TRAUMA CENTER PAYMENT SURRENDER FORM* (Attachment B-6) with each

surrendered payment.

h) For Trauma Patients admitted to Contractor's facility prior to or on the last day during the term of this Agreement, and remaining in the hospital after that date, reports and claim submission to County shall be made only after the patient has been discharged; the Contractor shall not submit partial or interim billings.

i) All reports and claims shall be completed in such detail and with such attachments as are in accordance with procedures prescribed in writing in Attachment "B-4". Contractor hereby acknowledges receipt of such forms, attachments, and procedures. Contractor and County agree that County may revise such forms, and such procedures and instructions without using a formal amendment to this Agreement. Such revised forms, procedures and instructions shall be effective at least fifteen (15) calendar days after written notice to Contractor. In the event Contractor submits a timely written objection, Contractor and County will promptly meet and confer in good faith in an effort to resolve their differences. In the event the parties are not able to resolve their differences, Contractor may send a written notice to County within (30) days of the meet and confer session terminating this Agreement. This

Agreement shall terminate fifteen (15) days after the date of the written notice, on such other days as the parties shall agree in writing.

E. AUDITING OF RECORDS

Contractor shall maintain and, upon request, make available to State or County representatives, records containing all of the financial information referenced in this Section, including records of patient and third-party payer payments, all in accordance with Paragraph 5 of the Additional Provisions Exhibit of this Agreement.

a) County may periodically conduct an audit of the Contractor's records pertaining to the Patient-Based Claims for Eligible Patients that are required under this Exhibit. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a statistically random sample of submitted claims for a fiscal year, provided the sampling methodology is statistically valid. The scope of the audit shall include an examination of patient medical and financial records, patient and/or insurance billing records, and collection agency reports associated with the sampled claims.

b) Audited claims that do not comply with requirements in this Agreement shall result in a reduction in the total value of Patient-Based Claims that will be used to determine each trauma hospital's Budget Allocation for the next fiscal year.

For example, if two Patient-Based Claims for the prior fiscal year with a total value of $12,850 were audited and determined not to be in compliance with the program requirements and the Contractor's total value of submitted claims for that prior fiscal year was $150,000, $12,850 would be subtracted from the total value, reducing it to $137,150 which would then be the amount used to determine the Contractor's Budget Allocation for the next fiscal year. The County will notify Contractor of any audit findings. Audit results may be appealed to the EMS Agency Director, or his/her designee.

III. FUNDING FOR PEDIATRIC TRAUMA CENTERS

The parties acknowledge that Chapter 841 of the Statutes of 2006, authorized the County Board of Supervisors (Board), until December 31, 2008, to elect to levy an additional penalty in the amount of two dollars ($2) for every ten dollars ($10), upon fines, penalties, and forfeitures

collected for specific criminal offenses. This authority was subsequently extended to December 31, 2013 by Chapter 288 of the Statutes of 2008. New legislation (SB 191) was chaptered October 5, 2013 and Section 76000.5 of the Government Code was amended extending these provisions through January 1, 2017. In 2016, legislation (SB 867) was again passed amending Section 76000.5 of the Government Code, extending these provisions through January 1, 2027.

The legislation further authorized the Board to utilize fifteen percent (15%) of the funds collected pursuant to the provisions of Health and Safety Code section 1797.98a, subdivision (e) (known as Richie's Fund) to provide funding to enhance pediatric trauma services by both publicly and privately owned and operated Pediatric Trauma Centers (PTCs) throughout the County.

The FY 2018-19 Richie Fund collections available for FY 2019-20 allocation to non-County PTCs and County PTCs are $950,644. This amount is allocated to PTCs for expansion of pediatric trauma care services as follows:

Cedars-Sinai Medical Center	$	87,661
Children's Hospital Los Angeles	$	87,661

Long Beach Memorial Medical Center	$ 87,661
Northridge Hospital Medical Center	$ 600,000
Ronald Reagan UCLA Medical Center	$ 87,661
Total	**$ 950,644**

IV. DESIGNATION SUPPORT FUNDING

The funding described in this Section IV is in addition to the funding described in Section II and III of this Exhibit.

A. BASE HOSPITAL SERVICES AND INFRASTRUCTURE

To account for the special costs incurred for those private trauma hospitals providing base and trauma hospital services and to ensure the continued access by Medi-Cal beneficiaries to emergency rooms and emergency room care in the County by maintaining efficient prehospital transport of all patients to the most appropriate emergency room, the County will recommend to the State that it make an aggregate supplemental payment in the amount of $700,000 for base station and $1,200,000 for infrastructure to each private Non-County Trauma Hospital pursuant to the Trauma SPA, with the exception of Children's Hospital Los Angeles. Children's Hospital

Los Angeles will receive a supplemental infrastructure payment in the amount of $1,200,000 but will not receive a supplemental base station payment because it does not provide base hospital services.

As public hospitals, Ronald Reagan UCLA Medical Center ("UCLA") and Antelope Valley Hospital ("Antelope") may not receive these supplemental Medi-Cal payments under the State Plan. Accordingly, the County will directly pay each of those hospitals the amount of $700,000 for base station support and $1,200,000 for infrastructure support at or about the same time as County makes its IGT payment to the State. In the event the County makes its IGT payment to the State in multiple installments, the County will make the base station and infrastructure supplemental payments to UCLA and Antelope in the same number of installments.

V. ADD-ONS PAYMENTS

The funding described in this Section V is in addition to the funding described in Sections II, III and IV of this Exhibit. The total payment amounts below were designed to reflect the following: a) trauma patient volume; b) trauma patient acuity; c) the levels of underinsured trauma patients treated; and d) a parity adjustment to mitigate the negative

financial impact among various hospitals.

Antelope Valley Hospital	$ 3,310,048
California Hospital Medical Center	$ 7,491,182
Cedars-Sinai Medical Center	$ 4,512,032
Children's Hospital Los Angeles	$ 1,790,265
Henry Mayo Newhall Mem. Med. Ctr.	$ 1,574,345
Huntington Memorial Hospital	$ 3,006,570
Long Beach Memorial Medical Center	$ 4,382,075
Northridge Hospital Medical Center	$ 2,736,169
Pomona Valley Hospital Medical Center	$ 4,417,447
Providence Holy Cross Medical Center	$ 1,763,818
Ronald Reagan UCLA Medical Center	$ 3,712,326
St. Francis Medical Center	$ 6,976,312
St. Mary Medical Center	$ 2,117,586
Total	**$50,790,175**

Except for UCLA and Antelope, it is the intent of the County to send an IGT to CDHCS so it can draw down federal matching dollars for enhanced Medi-Cal payments to the above hospitals in the amounts set forth above. The County will issue the above payments directly to UCLA and Antelope as grants to support their provision of trauma services.

VI. MEASURE B ADVISORY BOARD FUNDING

The Measure B Advisory Board (MBAB) recommended that the Board of Supervisor use unallocated and unspent Measure B funds from prior periods for the following one-time purposes in FY 2019-20: (i) to fund an IGT to CDHCS to draw down federal matching dollars to pay for the increased trauma program costs at the eleven (11) Non-County Trauma Hospitals that are classified as private hospitals; (ii) to issue a direct payment to two (2) public Non-County Trauma Hospitals that are ineligible for federal matching dollars.

The payments to the thirteen (13) Trauma Hospitals are as follows:

1. Trauma Program Services:

Antelope Valley Hospital	$ 727,449
California Hospital Medical Center	$ 1,485,487
Cedars-Sinai Medical Center	$ 910,216
Children's Hospital Los Angeles	$ 395,731
Henry Mayo Newhall Mem. Med. Ctr.	$ 522,853
Huntington Memorial Hospital	$ 675,383
Long Beach Memorial Medical Center	$ 885,376
Northridge Hospital Medical Center	$ 787,173
Pomona Valley Hospital Medical Center	$ 878,433

Providence Holy Cross Medical Center	$ 1,102,072
Ronald Reagan UCLA Medical Center	$ 774,873
St. Francis Medical Center	$ 1,311,143
St. Mary Medical Center	$ 543,811
Total	**$11,000,000**

2. Community Hospital Services:

Northridge Hospital Medical Center	$ 2,000,000

VII. PAYMENT LIMIT

Contractor acknowledges that the amounts payable under the Trauma SPA are limited to the uncompensated costs of providing outpatient hospital services of all eligible private trauma hospitals in Los Angeles County and are also limited by the State's upper payment limit, as established in 42 C.F.R. Section 447.321. To the extent that either or both limits preclude the State from paying all the aggregate amounts set forth below, the amount to be recommended by the County for each private trauma hospital shall be reduced by the same percentage as the percentage of total allowable supplemental payments under the Trauma SPA is to total recommended supplemental Medi-Cal payments under the Trauma SPA to all private trauma hospitals.

VIII. POTENTIAL IGT FOR FEDERAL MATCHING FUNDS

As discussed in Section IV, the County intends that the Designation Support payments, Add-On Payments, and a portion of the Patient-Based and MBAB payments to the private Non-County Trauma Hospitals be made as additional Medi-Cal payments in accordance with the Trauma SPA. Unless CDHCS rejects this payment approach, the County will transfer the non-federal share of such funds to CDHCS in one or more IGTs. The amount of the additional Medi-Cal payments to the private Non-County Trauma Hospitals will be included in the amounts set forth in Sections II.A.1, IV, V and VI.1 and VI.2 above.

The parties acknowledge and agree that some or all of the IGT which the County intends to make to effectuate the provisions of this Agreement may not be capable of drawing down federal matching funds under the Trauma SPA. To the extent that is true, the parties agree that the County shall have no obligation to make an IGT of such amounts and shall instead provide such IGT funds directly to the private Non-County Trauma Hospitals in proportion to the payments that would have been made to each hospital relating to such IGT funds if the funds had been accepted as a permissible IGT for which federal matching funds would be available under the Trauma SPA. To the extent that Non-County Trauma Hospitals receive the full amounts set forth in Section IX , County has

no obligation to make further direct payments, even if not all of the funds set aside for use as an IGT are ultimately used for that purpose.

The total amount of the IGT that the County intends to make shall be $39.99 million.

IX. TOTAL MAXIMUM PAYMENTS

The total maximum payments that each Non-County Trauma Hospital may receive, either directly from the County, or from the State of California as additional Medi-Cal payments under the Trauma SPA (which includes the amounts of IGTs made by the County and federal matching funds), and subject to the limitations and conditions as described in this Agreement, shall be as follows:

Antelope Valley Hospital	$ 6,224,279
California Hospital Medical Center	$ 12,710,298
Cedars-Sinai Medical Center	$ 7,875,755
Children's Hospital Los Angeles	$ 3,473,657
Henry Mayo Newhall Memorial Med. Ctr.	$ 4,473,693
Huntington Memorial Medical Center	$ 5,778,790
Long Beach Memorial Medical Center	$ 7,663,214
Northridge Hospital Medical Center	$ 9,335,296
Pomona Valley Hospital Medical Center	$ 7,516,147
Providence Holy Cross Medical Center	$ 9,429,675

Ronald Reagan UCLA Medical Center	$ 6,717,715
St. Francis Medical Center	$ 11,218,549
St. Mary Medical Center	$ 4,653,018
Total	**$ 97,070,086**

Each non-County Trauma Hospital will be paid the above amounts through a combination of direct payments by the County or additional Medi-Cal payments under the Trauma SPA, except for UCLA and Antelope which shall receive only funds from the County. Payments may be reduced to the extent that the amounts anticipated to be paid as Medi-Cal funds through the Trauma SPA cannot be paid in that manner, in which case the County will make direct payments of the non-federal share of such payments, up to, but not exceeding the amount of the IGT set forth above, less the amount used to fund the Medi-Cal payments which were actually made.

X. EFFECTIVE DATES

The provisions of this Exhibit shall only apply to trauma services provided on or after July 1, 2019 and before July 1, 2020.

Exhibit 23-B

Master Agreement for Specialty Care Center Designations



MASTER AGREEMENT

BY AND BETWEEN

COUNTY OF LOS ANGELES

AND

PASADENA HOSPITAL ASSOCIATION, LTD. DBA HUNTINGTON HOSPITAL

FOR

SPECIALTY CARE CENTER DESIGNATIONS

TABLE OF CONTENTS

PARAGRAPH	TITLE	PAGE
RECITALS		**1**
1.0	**APPLICABLE DOCUMENTS**	**2**
2.0	**DEFINITIONS**	**3**
3.0	**SPECIALTY CARE CENTER DESIGNATIONS**	**4**
4.0	**TERM OF AGREEMENT**	**5**
5.0	**AGREEMENT SUM, BILLING AND PAYMENT**	**5**
6.0	**ADMINISTRATION OF AGREEMENT- COUNTY**	**6**
6.1	COUNTY'S PROJECT DIRECTOR	6
6.2	COUNTY'S PROJECT MANAGER	6
6.3	COUNTY'S PROJECT MONITOR	6
7.0	**ADMINISTRATION OF AGREEMENT – CONTRACTOR**	**7**
7.1	CONTRACTOR'S PROJECT MANAGER	7
7.2	CONTRACTOR'S AUTHORIZED OFFICIAL	7
7.3	APPROVAL OF CONTRACTOR'S STAFF (INTENTIONALLY OMITTED)	7
7.4	CONTRACTOR'S STAFF IDENTIFICATION (INTENTIONALLY OMITTED)	7
7.5	BACKGROUND AND SECURITY INVESTIGATIONS (INTENTIONALLY OMITTED)	7
7.6	CONFIDENTIALITY	7
7.7	STAFF PERFORMANCE UNDER THE INFLUENCE	8
8.0	**STANDARD TERMS AND CONDITIONS**	**8**
8.1	AMENDMENTS	8
8.2	ASSIGNMENT AND DELEGATION/MERGERS OR ACQUISITIONS	9
8.3	AUTHORIZATION WARRANTY	10
8.4	BUDGET REDUCTIONS(INTENTIONALLY OMITTED)	10
8.5	CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION – LOWER TIER COVERED TRANSACTIONS (2 C.F.R. PART 373) (INTENTIONALLY OMITTED)	10
8.6	INTENTIONALLY OMITTED	10
8.7	COMPLIANCE WITH APPLICABLE LAWS, RULES & REGULATIONS	10
8.8	COMPLIANCE WITH CIVIL RIGHTS LAWS – ANTI DISCRIMINATION	

TABLE OF CONTENTS

PARAGRAPH	TITLE	PAGE
	AND AFFIRMATIVE ACTION LAWS	11
8.9	COMPLIANCE WITH THE COUNTY'S JURY SERVICE PROGRAM (INTENTIONALLY OMITTED)	13
8.10	CONFLICT OF INTEREST (INTENTIONALLY OMITTED)	13
8.11	CONSIDERATION OF HIRING COUNTY EMPLOYEES TARGETED FOR LAYOFF/OR RE-EMPLOYMENT LIST (INTENTIONALLY OMITTED)	13
8.12	CONSIDERATION OF HIRING GAIN/GROW PARTICIPANTS (INTENTIONALLY OMITTED)	13
8.13	CONTRACTOR RESPONSIBILITY AND DEBARMENT	13
8.14	CONTRACTOR'S ACKNOWLEDGEMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW	16
8.15	CONTRACTOR'S EXCLUSION FROM PARTICIPATING IN A FEDERALLY FUNDED PROGRAM	16
8.16	CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM	17
8.17	CONTRACTOR'S WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM (INTENTIONALLY OMITTED)	17
8.18	COUNTY'S QUALITY ASSURANCE PLAN	17
8.19	DAMAGE TO COUNTY FACILITIES, BUILDINGS OR GROUNDS (INTENTIONALLY OMITTED)	18
8.20	EMPLOYMENT ELIGIBILITY VERIFICATION	18
8.21	FACSIMILE REPRESENTATIONS	18
8.22	FAIR LABOR STANDARDS	18
8.23	FEDERAL ACCESS TO RECORDS (INTENTIONALLY OMITTED)	19
8.24	FORCE MAJEURE	19
8.25	GOVERNING LAW, JURISDICTION, AND VENUE	19
8.26	HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) (INTENTIONALLY OMITTED)	20
8.27	INDEPENDENT CONTRACTOR STATUS (INTENTIONALLY OMITTED)	20
8.28	INDEMNIFICATION	20
8.29	GENERAL PROVISIONS FOR ALL INSURANCE COVERAGE	20

TABLE OF CONTENTS

PARAGRAPH	TITLE	PAGE
8.30	INSURANCE COVERAGE	24
8.31	NOTICE OF DISPUTES (INTENTIONALLY OMITTED)	25
8.32	LIQUIDATED DAMAGES (INTENTIONALLY OMITTED)	25
8.33	MOST FAVORED PUBLIC ENTITY (INTENTIONALLY OMITTED)	25
8.34	NONDISCRIMINATION AND AFFIRMATIVE ACTION (INTENTIONALLY OMITTED)	25
8.35	NON-EXCLUSIVITY (INTENTIONALLY OMITTED)	26
8.36	NOTICE OF DELAYS (INTENTIONALLY OMITTED)	26
8.37	NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT	26
8.38	NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY LAW	26
8.39	NOTICES	26
8.40	PROHIBITION AGAINST INDUCEMENT OR PERSUASION (INTENTIONALLY OMITTED)	26
8.41	PUBLIC RECORDS ACT (INTENTIONALLY OMITTED)	26
8.42	PUBLICITY	26
8.43	RECORD RETENTION AND INSPECTION/AUDIT SETTLEMENT (INTENTIONALLY OMITTED)	27
8.44	RECYCLED BOND PAPER (INTENTIONALLY OMITTED)	27
8.45	RESTRICTIONS ON LOBBYING (INTENTIONALLY OMITTED)	27
8.46	SUBCONTRACTING	27
8.47	SURVIVAL	27
8.48	TERMINATION FOR BREACH OF WARRANTY TO MAINTAINCOMPLIANCE WITH COUNTY'S CHILD SUPPORTCOMPLIANCE PROGRAM	28
8.49	TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM (INTENTIONALLY OMITTED)	28
8.50	TERMINATION FOR CONVENIENCE	28
8.51	TERMINATION FOR DEFAULT	29
8.52	TERMINATION FOR IMPROPER CONSIDERATION	31
8.53	TERMINATION FOR INSOLVENCY	31

TABLE OF CONTENTS

PARAGRAPH	TITLE	PAGE
8.54	TERMINATION FOR NON-ADHERENCE OF COUNTY LOBBYIST ORDINANCE	32
8.55	TERMINATION FOR NON-APPROPRIATION OF FUNDS (INTENTIONALLY OMITTED)	32
8.56	TIME OFF FOR VOTING	32
8.57	UNLAWFUL SOLICITATION	32
8.58	VALIDITY	33
8.59	WAIVER	33
8.60	WARRANTY AGAINST CONTINGENT FEES	33
8.61	COMPLIANCE WITH COUNTY'S ZERO TOLERANCE POLICY ON HUMAN TRAFFIKING	33
8.62	COMPLIANCE WITH FAIR CHANCE EMPLOYMENT PRACTICES	34
8.63	COMPLIANCE WITH THE COUNTY POLICY OF EQUITY	34
9.0	**UNIQUE TERMS AND CONDITIONS**	**34**
9.1	DUE PROCESS	34
9.2	RESPONSIBILITY FOR INDIGENT PATIENTS	37
9.3	STATUS OF CONTRACTOR	37
SIGNATURES		38

STANDARD EXHIBITS

A SPECIALTY CARE CENTER DESIGNAITONS EXHIBIT

B (INTENTIONALLY OMITTED)

C (INTENTIONALLY OMITTED)

D CONTRACTOR'S EEO CERTIFICATION

E COUNTY'S ADMINISTRATION

F CONTRACTOR'S ADMINISTRATION

G FORM(S) REQUIRED AT THE TIME OF AGREEMENT EXECUTION

H JURY SERVICE ORDINANCE (INTENTIONALLY OMITTED)

I SAFELY SURRENDERED BABY LAW

MASTER AGREEMENT BETWEEN
COUNTY OF LOS ANGELES
AND
PASADENA HOSPITAL ASSOCIATION, LTD. DBA
HUNTINGTON HOSPITAL
FOR
SPECIALTY CARE CENTER DESIGNATION

This Master Agreement and Exhibits made and entered into this ___ day of _____, 20__ by and between the County of Los Angeles, hereinafter referred to as Pasadena Hospital Association, LTD DBA Huntington Hospital, hereinafter referred to as Contractor. The Contractor is located at 100 West California Boulevard, Pasadena, CA 91105-3097.

RECITALS

WHEREAS, the County may contract with private healthcare facilities or hospitals for specialty care center designations when certain requirements are met; and

WHEREAS, Contractor is a private or a public healthcare facility or hospitals specializing in providing certain specialty healthcare services; and

WHEREAS, County has designated its Department of Health Services as the local Emergency Medical Services Agency (hereafter " EMS Agency"); and

WHEREAS, pursuant to the authority granted under the Emergency Medical Services System and Prehospital Emergency Medical Care Personnel Act ("Act") (Health and Safety [H&S] Code, Sections 1797, et seq.), the EMS Agency serves as the lead agency for coordinating an Emergency Medical System for the County consisting of both private and public healthcare facilities and hospitals possessing Specialty Care Center Designations; and

WHEREAS, pursuant to the Act, the County may award Specialty Care Center Designations to qualified private and public healthcare facilities and hospitals when certain requirements are met; and

WHEREAS, Contractor is an acute care hospital or a healthcare facility, licensed to operate in the State of California; and

WHEREAS, the Act and related implementing regulations require the commitment of Contractor's administration, emergency department, and medical staff to meet requirements for program participation as specified by law and by EMS Agency policies and procedures; and

WHEREAS, the parties wish to cooperate with each other, other healthcare facilities, and provider agencies in the joint development and operation of the EMS system in Los Angeles County in order to efficiently and appropriately meet the needs of Los Angeles County residents for high quality EMS services; and

WHEREAS, the parties desire to carry out their respective obligations under this Agreement in an efficient cost-effective manner; and

WHEREAS, Contractor agrees to share in a portion of costs required to implement and maintain a countywide computerized data collection, monitoring, evaluation, and information management system (costs specified per designation program); and

WHEREAS, Contractor agrees to share in a portion of costs associated with managing and administering these Specialty Care Center Designation Programs (costs specified per designation program); and

WHEREAS, in exchange, County agrees to provide countywide standardized reports and to make available countywide statistical data; and

WHEREAS, this Master Agreement is authorized by H&S Code Sections 1797.67, 1797.78, 1797.204, 1797.252; and

WHEREAS, this Master Agreement is therefore authorized under California Government Code Section 3100 which authorizes the Board of Supervisors to contract for medical services; and

WHEREAS, the Board of Supervisors has authorized the Director of the Department of Health Services or designee to execute and administer this Master Agreement; and

WHEREAS, Contractor warrants that it possesses the competence, expertise and personnel necessary to provide services consistent with the requirements of this Master Agreement and with the professional standard of care for these services.

NOW THEREFORE, in consideration of the mutual covenants contained herein, and for good and valuable consideration, the parties agree to the following:

1.0 APPLICABLE DOCUMENTS

Exhibits A, D, E, F, G, are attached to and form a part of this Agreement. In the event of any conflict or inconsistency in the definition or interpretation

of any word, responsibility, schedule, or the contents or description of any task, deliverable, goods, service, or other work, or otherwise between the Master Agreement and the Exhibits, or between Exhibits, such conflict or inconsistency shall be resolved by giving precedence first to the Master Agreement and then to the Exhibits according to the following priority.

Standard Exhibits:

1.1 EXHIBIT A - Specialty Care Center Designation Agreements

1.2 EXHIBIT B - (INTENTIONALLY OMITTED

1.3 EXHIBIT C - Contractor's Proposed Schedule (INTENTIONALLY OMITTED)

1.4 EXHIBIT D - Contractor's EEO Certification

1.5 EXHIBIT E - County's Administration

1.6 EXHIBIT F - Contractor's Administration

1.7 EXHIBIT G - Forms Required at the Time of Agreement Execution

1.8 EXHIBIT H - Jury Service Ordinance (INTENTIONALLY OMITTED)

1.9 EXHIBIT I - Safely Surrendered Baby Law

This Master Agreement and the Exhibits hereto constitute the complete and exclusive statement of understanding between the parties, and supersedes all previous Agreements, written and oral, and all communications between the parties relating to the subject matter of this Master Agreement. No change to this Master Agreement shall be valid unless prepared pursuant to sub-paragraph 8.1 - Amendments and signed by both parties.

2.0 DEFINITIONS

2.1 **Contractor:** The sole proprietor, partnership, corporation, or public hospital or healthcare center that has entered into this Master Agreement with the County to obtain a Specialty Care Center Designation and comply with the respective designation's requirements, standards, protocols, perform or execute any performance requirements, and/or other tasks specified in the respective Specialty Care Center Designation in Exhibit A.

2.3 **Contractor's Project Manager:** The individual designated by Contractor, a healthcare facility or hospital, to administer the Master Agreement operations after the Master Agreement award.

2.4 **Day(s):** Calendar day(s) unless otherwise specified.

2.5 **DHS:** Los Angeles County Department of Health Services

2.6 **Director:** Los Angeles County Director of Health Services (acting, interim or permanent) or authorized designee.

2.7 **County's Project Director:** Person designated by County with authority for County on contractual or administrative matters relating to this Master Agreement that cannot be resolved by the County's Project Manager.

2.8 **County's Project Manager:** Person designated by County's Project Director to manage the operations under this Master Agreement.

2.9 **County's Project Monitor:** Person with responsibility to oversee the day to day activities of this Master Agreement. Responsibility for inspections of any and all tasks, deliverables, goods, services and other work provided by the healthcare facility or hospital.

2.10 **Fiscal Year:** The twelve (12) month period beginning July 1st and ending the following June 30th.

2.11 **Master Agreement:** This Agreement, including all Exhibits and Amendments thereto, as may be made from time to time, executed between County and Contractor, a healthcare facility or hospital. It sets forth the terms and conditions for the issuance and performance of the Specialty Care Center Designation in Exhibit A.

3.0 SPECIALTY CARE CENTER DESIGNATIONS

3.1 Pursuant to the provisions of this Master Agreement, Contractor shall fully comply with all requirements, standards, and policies and shall perform, complete and deliver on time, all tasks, deliverables, and other specific items as set forth in herein and as set forth in any Specialty Care Center Designation Agreements in Exhibit A Contractor is subsequently awarded pursuant to this Master Agreement.

3.2 If Contractor provides any tasks, deliverables, goods, services, or other work, other than as specified in this Master Agreement, the same shall be deemed to be a gratuitous effort on the part of the Contractor, and Contractor shall have no claim whatsoever against the County under this Master Agreement.

4.0 TERM OF AGREEMENT

4.1 The term of this Master Agreement shall be five (5) years or less commencing after execution by the Director as authorized by the County's Board of Supervisors, and shall terminate on June 30, 2024 unless sooner terminated or extended, in whole or in part, as provided in this Agreement (hereinafter "Initial Term"). The County shall have the sole option to extend this Master Agreement term for up to five (5) additional one-year extension options, through June 30, 2029 (hereafter "Optional Term") for a maximum total Agreement term of ten (10) years. Each such option and extension shall renew automatically, unless sooner terminated or extended, in whole or in part, as provided in the Master Agreement, Sub-paragraph 4.4.

4.3 The County maintains databases that track/monitor Contractor's performance history and compliance with Health and Safety Code, Division 2.5., Information entered into such databases may be used for a variety of purposes, including determining whether the County will exercise an agreement term extension option.

4.4 Notwithstanding any other provision of this Master Agreement, Director may suspend this Master Agreement immediately upon giving written notice to Contractor if Contractor's license to operate as a general acute care hospital or its permit to operate basic or comprehensive emergency service is revoked or suspended. Any such action by the EMS Agency shall be subject to the review procedures for suspensions established in Paragraph 9.1, Due Process, herein below. If such a suspension order has been issued and remains in effect for a period of at least sixty (60) calendar days, Director may terminate this Master Agreement upon giving at least thirty (30) calendar days prior written notice thereof to Contractor.

5.0 AGREEMENT SUM, BILLING AND PAYMENT

5.1 To provide ongoing financial support to County for data collection, monitoring, and evaluation of the respective Specialty Care Center Designation Agreement of this Master Agreement. Contractor shall not be entitled to payment or reimbursement for any tasks or services performed, nor for any incidental or administrative expenses whatsoever incurred in or incidental to performance hereunder, except as specified herein. Assumption or takeover of any of Contractor's duties, responsibilities, or obligations, or performance of same by any entity other than Contractor, whether through assignment, subcontract, delegation, merger, buyout, or any other mechanism, with or without consideration for any reason

whatsoever, shall occur only with the County's express prior written approval.

6.0 ADMINISTRATION OF AGREEMENT – COUNTY

COUNTY ADMINISTRATION

The Director shall have the authority to administer this Master Agreement on behalf of the County. The Director retains professional and administrative responsibility for the services rendered under this Master Agreement. A listing of all County Administration referenced in the following Sub-paragraphs are designated in Exhibit E - County's Administration. The County shall notify Contractor in writing of any change in the names or addresses shown.

6.1 County's Project Director

Responsibilities of the County's Project Director include:

ensuring that the objectives of this Master Agreement are met; and

providing direction to Contractor in the areas relating to County policy, information requirements, and procedural requirements.

6.2 County's Project Manager

6.2.1 The responsibilities of the County's Project Manager include:

meeting with Contractor's Project Manager on a regular basis; and

inspecting any and all tasks, deliverables, goods, services, or other work provided by or on behalf of Contractor.

6.2.1 The County's Project Manager is not authorized to make any changes in any of the terms and conditions of this Master Agreement and is not authorized to further obligate County in any respect whatsoever.

6.3 County's Project Monitor

The County's Project Monitor is responsible for overseeing the day-to-day administration of this Master Agreement. The Project Monitor reports to the County's Project Manager.

7.0 ADMINISTRATION OF AGREEMENT – CONTRACTOR

7.1 Contractor's Project Manager

7.1.1 Contractor's Project Manager is designated in Exhibit F – Contractor's Administration. Contractor shall notify the County in writing of any change in the name or address of Contractor's Project Manager within five (5) business days of such change.

7.1.2 Contractor's Project Manager shall be responsible for Contractor's day-to-day activities as related to this Master Agreement and shall coordinate with County's Project Manager and County's Agreement Project Monitor on a regular basis.

7.2 Contractor's Authorized Official (s)

7.2.1 Contractor's Authorized Official(s) are designated in Exhibit F. Contractor shall promptly notify the County in writing of any change in the name(s) or address(es) of Contractor's Authorized Official(s) within five (5) business days of such change.

7.2.2 Contractor represents and warrants that all requirements of Contractor have been fulfilled to provide actual authority to such officials to execute documents under this Master Agreement on behalf of Contractor.

7.3 Approval of Contractor's Staff (INTENTIONALLY OMITTED)

7.4 Contractor's Staff Identification (INTENTIONALLY OMITTED)

7.5 Background and Security Investigations (INTENTIONALLY OMITTED)

7.6 Confidentiality

7.6.1 Contractor shall maintain the confidentiality of all records and information, including, but not limited to, billings, the County records, and patient records, in accordance with all applicable Federal, State and local laws, rules, regulations, ordinances, directives, guidelines, policies and procedures relating to confidentiality, including, without limitation, County policies, of which Contractor has been provided concerning information technology security and the protection of confidential records and information.

7.6.2 Contractor shall indemnify, defend, and hold harmless County, its Special Districts, elected and appointed officers, employees, and agents, from and against any and all claims,

demands, damages, defense costs and legal fines asserted by third parties from any material breach by Contractor, its officers, employees, agents, or subcontractors, to comply with this Sub-paragraph 7.6, as determined by County in its sole judgment. Any legal defense pursuant to Contractor's indemnification obligations under this Sub-paragraph 7.6 shall be conducted by Contractor and performed by counsel selected by Contractor and approved by County. Notwithstanding the preceding sentence, the County shall have the right to participate in any such defense at its sole cost and expense, except that in the event Contractor fails to provide the County with a full and adequate defense, as determined by County in its sole judgment, the County shall be entitled to retain its own counsel, including, without limitation, County Counsel, and reimbursement from Contractor for all costs and expenses incurred by County in doing so. Contractor shall not have the right to enter into any settlement, agree to any injunction, or make any admission, in each case, on behalf of the County without the County's prior written approval.

7.6.3 Contractor shall inform all of its officers, employees, agents and subcontractors providing services hereunder of the confidentiality provisions of this Master Agreement.

7.6.4 Contractor shall sign and adhere to the provisions of Exhibit G1 - Contractor Acknowledgement and Confidentiality Agreement.

7.7 Staff Performance under the Influence

Contractor shall not knowingly permit any employee to perform services under this Master Agreement while under the influence of any alcoholic beverage, medication, narcotic, or other substance which might impair their physical or mental performance.

8.0 STANDARD TERMS AND CONDITIONS

8.1 AMENDMENTS

8.1.1 For any change which affects the scope of work, term, Master Agreement Sum, payments, or any term or condition included under this Master Agreement, an Amendment shall be prepared, mutually agreed to in writing, and then executed by Contractor and by the Board of Supervisors or its authorized designee.

8.1.2 The County's Board of Supervisors or Chief Executive Officer or designee may require the addition and/or change of certain terms and conditions in the Master Agreement during the

term of this Master Agreement. The County reserves the right to add and/or change such provisions as required by the County's Board of Supervisors or Chief Executive Officer or designee. To implement such changes, an Amendment to the Master Agreement shall be prepared and executed by Contractor and by Director or his/her designee. Any such amendment will be effective only if accepted by the Contractor by signing such amendment. County or Contractor may terminate this agreement for convenience at any time as pursuant to Sub-paragraph 8.50.

8.1.3 The Director or his/her designee, may at his/her sole discretion, authorize extensions of time as defined in Paragraph 4.0 - Term of Agreement. Contractor agrees that such extensions of time shall not change any other term or condition of this Master Agreement during the period of such extensions. To implement an extension of time, an Amendment to the Master Agreement shall be prepared by the County, mutually agreed to in writing, and then executed by Contractor and by the Director or his/her designee.

8.1.4 The Director or his/her designee may require, at his/her sole discretion, the addition and/or change of certain terms and conditions in the Master Agreement to conform to changes in federal or state law or regulation, during the term of this Master Agreement. The County reserves the unilateral right to add and/or change such provisions as required by law or regulation, without the need for Contractor's written consent, to preserve this Master Agreement's conformity and compliance to federal and state law or regulation. To implement such changes, an Amendment to the Master Agreement shall be prepared by the County and then executed by Contractor and by the Director or his/her designee.

8.2 ASSIGNMENT AND DELEGATION/MERGERS OR ACQUISITIONS

8.2.1 Contractor shall notify the County of any pending acquisitions/mergers of its company unless otherwise legally prohibited from doing so. If Contractor is restricted from legally notifying the County of pending acquisitions/mergers, then it should notify the County of the actual acquisitions/mergers as soon as the law allows.

8.2.2 Contractor's assignment of its rights or delegation of its duties under this Master Agreement, or both, whether in whole or in part, is not allowed.

8.2.3 The surviving entity of an acquisition or merger, if not Contractor, will be required to enter into a new Master

Agreement, if it is qualified, to obtain any Specialty Care Center Designation(s) that Contractor was granted under this Master Agreement.

8.3 AUTHORIZATION WARRANTY

Contractor represents and warrants that the person executing this Master Agreement for Contractor is an authorized agent who has actual authority to bind Contractor to each and every term, condition, and obligation of this Master Agreement and that all requirements of Contractor have been fulfilled to provide such actual authority.

8.4 BUDGET REDUCTIONS (INTENTIONALLY OMITTED)

8.5 CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION – LOWER TIER COVERED TRANSACTIONS (2 C.F.R. PART 376)(INTENTIONALLY OMITTED)

8.6 COMPLAINTS (INTENTIONALLY OMITTED)

8.7 COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

8.7.1 In the performance of this Master Agreement, Contractor shall comply with all applicable Federal, State and local laws, regulations, ordinances and the standards of a Centers for Medicare and Medicaid Services (CMS) approved accrediting body (e.g. The Joint Commission), by which Contractor is accredited as well as the standards set forth in California Code of Regulations, Title 22, Division 5. All provisions required thereby to be included in this Master Agreement are incorporated herein by reference.

8.7.2 Contractor and County shall indemnify, defend, and hold harmless each party, its officers, employees, and agents, from and against any and all claims, demands, damages, defense costs and legal fines, arising from any material breach, connected with, or related to any failure by Contractor, its officers, employees, agents, or subcontractors, to comply with any such laws, rules, regulations, ordinances or standards. Any legal defense pursuant to Contractor's indemnification obligations under this Sub-paragraph 8.7 shall be conducted by Contractor and performed by counsel selected by Contractor and approved by the County. Notwithstanding the preceding sentence, County shall have the right to participate in any such defense at its sole cost and expense, except that in the event Contractor fails to provide County with a full and adequate defense as determined by the County in its sole judgement, the County shall be entitled to retain its own counsel, including, without limitation, County Counsel, and

reimbursement from Contractor for all such costs and expenses incurred by County in doing so. Contractor shall not have the right to enter into any settlement, agree to any injunction or other equitable relief, or make any admission, in each case, on behalf of County without County's prior written approval.

8.8 COMPLIANCE WITH CIVIL RIGHTS LAWS – ANTI-DISCRIMIATION AND AFFIRMATIVE ACTION

8.8.1 Contractor hereby assures that it will comply with Subchapter VI of the Civil Rights Act of 1964, 42 USC Sections 2000(e)(1) through 2000(e)(17), the Fair Employment & Housing Act, Government Code Sections 12920-12922; and Affirmative Action in County Agreements, Chapter 4.32 of the Los Angeles County Code, to the end that no person shall, on the grounds of race, creed, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Master Agreement or under any project, program, or activity supported by this Master Agreement.

8.8.2 Contractor certifies and agrees that all persons employed by it, its affiliates, subsidiaries, or holding companies are and shall be treated equally without regard to or because of race, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation, in compliance with all applicable Federal and State anti-discrimination laws and regulations.

8.8.3 Contractor shall take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to race, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation, in compliance with all applicable Federal and State anti-discrimination laws and regulations. Such action shall include, but is not limited to: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.

8.8.4 Contractor certifies and agrees that it will deal with its subcontractors, bidders, or vendors without regard to or

because of race, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation.

8.8.5 Contractor certifies and agrees that it, its affiliates, subsidiaries, or holding companies shall comply with all applicable Federal and State laws and regulations to the end that no person shall, on the grounds of race, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Master Agreement or under any project, program, or activity supported by this Master Agreement.

8.8.6 Contractor shall allow County representatives access to Contractor's employment records during regular business hours to verify compliance with the provisions of this Sub-paragraph 8.8 when so requested by the County.

8.8.7 If the County finds that any provisions of this Sub-paragraph 8.8 have been violated, such violation shall constitute a material breach of this Master Agreement upon which the County may terminate or suspend this Master Agreement. While the County reserves the right to determine independently that the anti-discrimination provisions of this Master Agreement have been violated, in addition, a determination by the California Fair Employment Practices Commission or the Federal Equal Employment Opportunity Commission that Contractor has violated Federal or State anti-discrimination laws or regulations shall constitute a finding by the County that Contractor has violated the anti-discrimination provisions of this Master Agreement.

8.8.8 The parties agree that in the event Contractor violates any of the anti-discrimination provisions of this Master Agreement, the County shall, at its sole option after considering any written evidence in mitigation or explanation of the violation presented by Contractor, be entitled to the sum of Five Hundred Dollars ($500) for each such violation or a maximum of One Thousand Five Hundred ($1,500) for any continuing course of violations, pursuant to California Civil Code Section 1671 as liquidated damages in lieu of terminating or suspending this Master Agreement.

8.8.9 **Anti-discrimination in Services:**

Contractor shall not discriminate in the provision of services hereunder because of race, color, religious creed, national origin, ethnic group identification, ancestry, age, sex, sexual orientation, medical condition, marital status, political affiliation, or physical or mental disability in accordance with requirements of Federal and State laws. For the purpose of this Sub-paragraph, discrimination in the provision of services may include, but is not limited to, the following: Denying any person any service or benefit or the availability of a facility; providing any service or benefit to a person which is not equivalent or is provided in a non-equivalent manner or at a non-equivalent time, from that provided to others; subjecting any person to segregation or separate treatment in any manner related to the receipt of any service; restricting any person in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit; and treating any person differently from others in determining admission, enrollment quota, eligibility, membership, or any other requirements or conditions which persons must meet in order to be provided any service or benefit. Contractor shall take affirmative action to ensure that intended beneficiaries of this Master Agreement are provided services without regard to race, color, religious creed, national origin, ethnic group identification, ancestry, sex, sexual orientation, age, medical condition, marital status, political affiliation, physical or mental disability.

8.8.10 Contractor shall certify to, and comply with, the provisions of Exhibit D - Contractor's EEO Certification.

8.9 COMPLIANCE WITH THE COUNTY'S JURY SERVICE ROGRAM

(INTENTIONALLY OMITTED)

8.10 CONFLICT OF INTEREST(INTENTIONALLY OMITTED)

8.11 CONSIDERATION OF HIRING COUNTY EMPLOYEES TARGETED FOR LAYOFF/OR RE-EMPLOYMENT LIST (INTENTIONALLY OMITTED)

8.12 CONSIDERATION OF HIRING GAIN/GROW PARTICIPANTS (INTENTIONALLY OMITTED)

8.13 CONTRACTOR RESPONSIBILITY AND DEBARMENT

8.13.1 **Responsible Contractor**

A responsible Contractor is a Contractor who has demonstrated the attribute of trustworthiness, as well as quality, fitness, capacity and experience to satisfactorily

perform the agreement. It is the County's policy to conduct business only with responsible Contractors.

8.13.2 **Chapter 2.202 of the County Code**

Contractor is hereby notified that, in accordance with Chapter 2.202 of the County Code, if the County acquires information concerning the performance of Contractor on this or other contracts which indicates that Contractor is not responsible, the County may, in addition to other remedies provided in the Master Agreement, debar Contractor from bidding or proposing on, or being awarded, and/or performing work on County contracts for a specified period of time, which generally will not exceed five (5) years but may exceed five (5) years or be permanent if warranted by the circumstances, and terminate any or all existing Contracts Contractor may have with the County.

8.13.3 **Non-responsible Contractor**

The County may debar a Contractor if the Board of Supervisors finds, in its discretion, that Contractor has done any of the following: (1) violated a term of an agreement with the County or a nonprofit corporation created by the County, (2) committed an act or omission which negatively reflects on Contractor's quality, fitness or capacity to perform an agreement with the County, any other public entity, or a nonprofit corporation created by the County, or engaged in a pattern or practice which negatively reflects on same, (3) committed an act or offense which indicates a lack of business integrity or business honesty, or (4) made or submitted a false claim against the County or any other public entity.

8.13.4 **Contractor Hearing Board**

1. If there is evidence that Contractor may be subject to debarment, the Department will notify Contractor in writing of the evidence which is the basis for the proposed debarment and will advise Contractor of the scheduled date for a debarment hearing before Contractor Hearing Board.

2. Contractor Hearing Board will conduct a hearing where evidence on the proposed debarment is presented. Contractor and/or Contractor's representative shall be given an opportunity to submit evidence at that hearing. After the hearing, Contractor Hearing Board shall prepare a tentative proposed decision, which shall contain a recommendation regarding whether

Contractor should be debarred, and, if so, the appropriate length of time of the debarment. Contractor and the Department shall be provided an opportunity to object to the tentative proposed decision prior to its presentation to the Board of Supervisors.

3. After consideration of any objections, or if no objections are submitted, a record of the hearing, the proposed decision, and any other recommendation of Contractor Hearing Board shall be presented to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of Contractor Hearing Board.

4. If a Contractor has been debarred for a period longer than five (5) years, that Contractor may after the debarment has been in effect for at least five (5) years, submit a written request for review of the debarment determination to reduce the period of debarment or terminate the debarment. The County may, in its discretion, reduce the period of debarment or terminate the debarment if it finds that Contractor has adequately demonstrated one or more of the following: (1) elimination of the grounds for which the debarment was imposed; (2) a bona fide change in ownership or management; (3) material evidence discovered after debarment was imposed; or (4) any other reason that is in the best interests of the County.

5. Contractor Hearing Board will consider a request for review of a debarment determination only where (1) Contractor has been debarred for a period longer than five (5) years; (2) the debarment has been in effect for at least five (5) years; and (3) the request is in writing, states one or more of the grounds for reduction of the debarment period or termination of the debarment, and includes supporting documentation. Upon receiving an appropriate request, Contractor Hearing Board will provide notice of the hearing on the request. At the hearing, Contractor Hearing Board shall conduct a hearing where evidence on the proposed reduction of debarment period or termination of debarment is presented. This hearing shall be conducted and the request for review decided by Contractor Hearing Board pursuant to the same procedures as for a debarment hearing.

6. Contractor Hearing Board's proposed decision shall contain a recommendation on the request to reduce

the period of debarment or terminate the debarment. Contractor Hearing Board shall present its proposed decision and recommendation to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of Contractor Hearing Board.

8.13.5 **Subcontractors of Contractor**

These terms shall also apply to Subcontractors of County Contractors.

8.14 CONTRACTOR'S ACKNOWLEDGEMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW

Contractor acknowledges that the County places a high priority on the implementation of the Safely Surrendered Baby Law. Contractor understands that it is the County's policy to encourage all County Contractors to voluntarily post the County's "Safely Surrendered Baby Law" poster in a prominent position at Contractor's place of business. Contractor will also encourage its Subcontractors, if any, to post this poster in a prominent position in the Subcontractor's place of business. Contractor, and its subcontractors, can access posters and other campaign material at www.babysafela.org.

8.15 CONTRACTOR'S EXCLUSION FROM PARTICIPATING IN A FEDERALLY FUNDED PROGRAM

8.15.1 Contractor hereby warrants that neither it nor any of its Subcontractors' owners, officers, partners, directors, other principals, employees or independent contractors is restricted or excluded from providing services under any health care program funded by the Federal government, directly or indirectly, in whole or in part, (which includes Medicare, Medi-Cal and Healthy Families) and that Contractor will notify Director within ten (10) calendar days in writing of Contractor's knowledge of such restriction or exclusion of: (1) any event that would require Contractor or any of the aforementioned parties' mandatory exclusion from participation in a Federally funded health care program; and (2) any exclusionary or suspension action taken by any agency of the Federal or State governments against any of the aforementioned parties' barring these parties from participating in a Federally funded health care program, whether such bar is direct or indirect, or whether such bar is in whole or in part.

8.15.2 Contractor shall indemnify and hold the County harmless against any and all loss or damage the County may suffer

arising from any exclusion or suspension of Contractor or its Subcontractors' owners, officers, partners, directors, other principals, employees or independent contractors from such participation in a Federally funded health care program.

8.15.3 Failure by Contractor to meet the requirements of this Sub-paragraph shall constitute a material breach of contract upon which the County may immediately terminate or suspend this Master Agreement.

8.16 CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM

8.16.1 Contractor acknowledges that the County has established a goal of ensuring that all individuals who benefit financially from the County through agreement are in compliance with their court-ordered child, family and spousal support obligations in order to mitigate the economic burden otherwise imposed upon the County and its taxpayers.

8.16.2 As required by the County's Child Support Compliance Program (County Code Chapter 2.200) and without limiting Contractor's duty under this Master Agreement to comply with all applicable provisions of law, Contractor warrants that it is now in compliance and shall during the term of this Master Agreement maintain in compliance with employment and wage reporting requirements as required by the Federal Social Security Act (42 USC Section 653a) and California Unemployment Insurance Code Section 1088.5, and shall implement all lawfully served Wage and Earnings Withholding Orders or Child Support Services Department Notices of Wage and Earnings Assignment for Child, Family or Spousal Support, pursuant to Code of Civil Procedure Section 706.031 and Family Code Section 5246(b).

8.17 CONTRACTOR'S WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM(INTENTIONALLY OMITTED)

8.18 COUNTY'S QUALITY ASSURANCE PLAN

The County or its agent will monitor Contractor's performance under this Master Agreement on not less than a three year basis. Such evaluation will include assessing Contractor's compliance with all Master Agreement terms and conditions and performance standards. Contractor deficiencies which the County determines are significant or continuing and that may place performance of the Master Agreement in jeopardy if not corrected will be reported to the Board and listed in the appropriate contractor performance database. The report to the

Board will include improvement/corrective action measures taken by the County and Contractor. If improvement does not occur consistent with the corrective action measures, the County may terminate this Master Agreement or impose other penalties as specified in this Master Agreement.

8.19 DAMAGE TO COUNTY FACILITIES, BUILDINGS OR GROUNDS (INTENTIONALLY OMITTED)

8.20 EMPLOYMENT ELIGIBILITY VERIFICATION

8.20.1 Contractor warrants that it fully complies with all Federal and State statutes and regulations regarding the employment of aliens and others and that all its employees performing work under this Master Agreement meet the citizenship or alien status requirements set forth in Federal and State statutes and regulations. Contractor shall obtain, from all employees performing work hereunder, all verification and other documentation of employment eligibility status required by Federal and State statutes and regulations including, but not limited to, the Immigration Reform and Control Act of 1986, (P.L. 99-603), or as they currently exist and as they may be hereafter amended. Contractor shall retain all such documentation for all covered employees for the period prescribed by law.

8.20.2 Contractor shall indemnify, defend, and hold harmless, the County, its agents, officers, and employees from employer sanctions and any other liability which may be assessed against Contractor or the County or both in connection with any alleged violation of any Federal or State statutes or regulations pertaining to the eligibility for employment of any persons performing work under this Master Agreement.

8.21 FACSIMILE REPRESENTATIONS

The County and Contractor hereby agree to regard facsimile representations of original signatures of authorized officers of each party, when appearing in appropriate places on the Amendments prepared pursuant to sub-paragraph 8.1, and received via a facsimile communicative, as legally sufficient evidence that such original signatures have been affixed to Amendments to this Master Agreement, such that the parties need not follow up facsimile transmissions of such documents with subsequent (non-facsimile) transmission of “original” versions of such documents.

8.22 FAIR LABOR STANDARDS

Contractor shall comply with all applicable provisions of the Federal Fair Labor Standards Act and shall indemnify, defend, and hold

harmless the County and its agents, officers, and employees from any and all liability, including, but not limited to, wages, overtime pay, liquidated damages, penalties, court costs, and attorneys' fees arising under any wage and hour law, including, but not limited to, the Federal Fair Labor Standards Act, for work performed by Contractor's employees for which the County may be found jointly or solely liable.

8.23 FEDERAL ACCESS TO RECORDS (INTENTIONALLY OMITTED)

8.24 FORCE MAJEURE

8.24.1 Neither party shall be liable for such party's failure to perform its obligations under and in accordance with this Master Agreement, if such failure arises out of fires, floods, epidemics, quarantine restrictions, other natural occurrences, strikes, lockouts (other than a lockout by such party or any of such party's subcontractors), freight embargoes, or other similar events to those described above, but in every such case the failure to perform must be totally beyond the control and without any fault or negligence of such party (such events are referred to in this Sub-paragraph as "force majeure events").

8.24.2 Notwithstanding the foregoing, a default by a subcontractor of Contractor shall not constitute a force majeure event, unless such default arises out of causes beyond the control of both Contractor and such subcontractor, and without any fault or negligence of either of them. In such case, Contractor shall not be liable for failure to perform, unless the goods or services to be furnished by the subcontractor were obtainable from other sources in sufficient time to permit Contractor to meet the required performance schedule. As used in this Sub-paragraph, the term "subcontractor" and "subcontractors" mean subcontractors at any tier.

8.24.3 In the event Contractor's failure to perform arises out of a force majeure event, Contractor agrees to use commercially reasonable best efforts to obtain goods or services from other sources, if applicable, and to otherwise mitigate the damages and reduce the delay caused by such force majeure event.

8.25 GOVERNING LAW, JURISDICTION, AND VENUE

This Master Agreement shall be governed by, and construed in accordance with, the laws of the State of California. Contractor agrees and consents to the exclusive jurisdiction of the courts of the State of California for all purposes regarding this Master Agreement and further agrees and consents that venue of any action brought

hereunder shall be exclusively in the County of Los Angeles.

8.26 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) (INTENTIONALLY OMITTED)

8.27 INDEPENDENT CONTRACTOR STATUS (INTENTIONALLY OMITTED)

8.28 INDEMNIFICATION

Contractor shall indemnify, defend and hold harmless the County, its Special Districts, elected and appointed officers, employees, and agents and volunteers ("County Indemnitees") from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, and expenses (including attorney and expert witness fees), arising out of the performance of this Master Agreement, but only in proportion to and to the extent such demands, claims, actions, fees, costs, and expenses are causes by or result from the negligent or intentional acts and/or omissions of Contractor, its officers, employees, or agents.

The County shall indemnify, defend and hold harmless Contractor, and its agents and employees from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, and expenses (including attorney and expert witness fees), arising from or connected with the County's acts and/or omissions arising out of the performance of this Master Agreement, but only in proportion to and to the extent such demands, claims, actions, fees, costs, and expenses are causes by or result from the negligent or intentional out of the performance of this Agreement, but only in proportion to and to the extent such demands, claims, actions, fees, costs, and expenses are caused by or result from the negligent or intentional acts or omissions of County, its officers, employees, or agents.

8.29 GENERAL PROVISIONS FOR ALL INSURANCE COVERAGE

Without limiting the Contractor's indemnification of County, and in the performance of this Master Agreement and until all of its obligations pursuant to this Master Agreement have been met, the Contractor shall and will be required provide and maintain at its own expense insurance coverage satisfying the requirements specified in Subparagraphs 8.29 and 8.30 of this Master Agreement. These minimum insurance coverage terms, types and limits (the "Required Insurance") also are in addition to and separate from any other Contractual obligation imposed upon the Contractor pursuant to this Master Agreement and Specialty Care Center Designation Agreement. The County in no way warrants that the Required Insurance is sufficient to protect the Contractor for liabilities which may arise from or relate to this Master Agreement.

8.29.1 **Evidence of Coverage and Notice to County**

Certificate(s) of insurance coverage (Certificate) or other evidence of coverage satisfactory to County, and a copy of an Additional Insured endorsement confirming County and its Agents (defined below) has been given Insured status under the Contractor's General Liability policy, shall be delivered to County at the e-mail address shown below and provided prior to commencing services under this Agreement.

Renewal Certificates shall be provided to County prior to the Contractor's policy expiration dates. The County reserves the right to obtain complete, certified copies of any required Contractor and/or Sub-Contractor insurance policies at any time.

Certificates shall identify all Required Insurance coverage types and limits specified herein, reference this Agreement by name or number, and be signed by an authorized representative of the insurer(s). The Insured party named on the Certificate shall match the name of the Contractor identified as the contracting party in this Agreement. Certificates shall provide the full name of each insurer providing coverage, its NAIC (National Association of Insurance Commissioners) identification number if applicable, , the amounts of any policy deductibles or self-insured retentions exceeding fifty thousand ($50,000.00) dollars, and list any County required endorsement forms.

Neither the County's failure to obtain, nor the County's receipt of, or failure to object to a non-complying insurance certificate or endorsement, or any other insurance documentation or information provided by the Contractor, its insurance broker(s) and/or insurer(s), shall be construed as a waiver of any of the Required Insurance provisions.

Certificates and copies of any required endorsements shall be e-mailed to:

emsinsurance@dhs.lacounty.gov

The Contractor also shall promptly report to County any injury or property damage accident or incident, including any injury to a Contractor employee occurring on County property, and any loss, disappearance, destruction, misuse, or theft of County property, monies or securities entrusted to the Contractor. The Contractor also shall promptly notify

County of any third party claim or suit filed against the Contractor or any of its Sub-Contractors which arises from or relates to this Agreement, and could result in the filing of a claim or lawsuit against the Contractor and/or County.

8.29.2 **Additional Insured Status and Scope of Coverage**

Unless insured under a program of self-insurance, the County of Los Angeles, its Special Districts, Elected Officials, Officers, Agents, Employees and Volunteers (collectively County and its Agents) shall be provided additional insured status under the Contractor's General Liability policy with respect to liability arising out of the Contractor's ongoing and completed operations performed on behalf of the County. The County and its Agents additional insured status shall apply with respect to liability and defense of suits arising out of the Contractor's acts or omissions, whether such liability is alleged to be attributable to the Contractor or to the County. The full policy limits and scope of protection also shall apply to the County and its Agents as an additional insured, even if they exceed the County's minimum Required Insurance specifications herein. Use of an automatic additional insured endorsement form is acceptable provided it satisfies the Required Insurance provisions herein.

8.29.3 **Cancellation of or Changes in Insurance**

The Contractor shall provide County with, or the Contractor's insurance policies shall contain a provision that County shall receive, written notice of cancellation or any change in Required Insurance, including insurer, limits of coverage, term of coverage or policy period. The written notice shall be provided to County at least ten (10) days in advance of cancellation for non-payment of premium and thirty (30) days in advance for any other cancellation or policy change. Failure to provide written notice of cancellation or any change in Required Insurance may constitute a material breach of the Agreement, in the sole discretion of the County, upon which the County may suspend or terminate this Agreement.

8.29.4 **Failure to Maintain Insurance**

The Contractor's failure to maintain or to provide acceptable evidence that it maintains the Required Insurance shall constitute a material breach of the Agreement, upon which County immediately may withhold payments due to the Contractor, and/or suspend or terminate this Agreement. The County, at its sole discretion, may obtain damages from

the Contractor resulting from said breach. Alternatively, the County may purchase the Required Insurance, and without further notice to the Contractor, pursue the Contractor reimbursement.

8.29.5 **Insurer Financial Ratings**

Coverage shall be placed with insurers acceptable to the County with A.M. Best ratings of not less than A:VII unless otherwise approved by County.

8.29.6 **Contractor's Insurance Shall Be Primary**

The Contractor's insurance policies, with respect to any claims related to this Agreement, shall be primary with respect to all other sources of coverage available to the Contractor. Any County maintained insurance or self-insurance coverage shall be in excess of and not contribute to any Contractor coverage.

8.29.7 **Waivers of Subrogation**

To the fullest extent permitted by law, the Contractor hereby waives its rights and its insurer(s)' rights of recovery against the County under all the Required Insurance for any loss arising from or relating to this Agreement. The Contractor shall require its insurers to execute any waiver of subrogation endorsements which may be necessary to effect such waiver.

8.29.8 **Sub-Contractor Insurance Coverage Requirements**

Intentionally Omitted

8.29.9 **Deductibles and Self-Insured Retentions (SIRs)**

The Contractor's policies shall not obligate the County to pay any portion of any Contractor deductible or SIR. County retains the right to require the Contractor to reduce or eliminate policy deductibles and SIRs as respects the County, or to provide a bond guaranteeing the Contractor's payment of all deductibles and SIRs, including all related claims investigation, administration and defense expenses. Such bond shall be executed by a corporate surety licensed to transact business in the State of California.

8.29.10 **Claims Made Coverage**

If any part of the Required Insurance is written on a claims made basis, any policy retroactive date shall precede the effective date of this Agreement. The Contractor understands and agrees it shall maintain such coverage for

a period of not less than three (3) years following Agreement expiration, termination or cancellation.

8.29.11 **Application of Excess Liability Coverage**

The Contractors may use a combination of primary, and excess insurance policies which provide coverage as broad as ("follow form" over) the underlying primary policies, to satisfy the Required Insurance provisions.

8.29.12 **Separation of Insureds**

All liability policies shall provide cross-liability coverage as would be afforded by the standard ISO (Insurance Services Office, Inc.) separation of insureds provision with no insured versus insured exclusions or limitations.

8.29.13 **Alternative Risk Financing Programs**

The County reserves the right to review, and then approve, the Contractor use of self-insurance, risk retention groups, risk purchasing groups, pooling arrangements and captive insurance to satisfy the Required Insurance provisions. The County and its Agents shall be designated as an Additional Covered Party under any approved program.

8.29.14 **County Review and Approval of Insurance Requirements**

The County reserves the right to review and adjust the Required Insurance provisions, conditioned upon County's determination of changes in risk exposures.

8.30 INSURANCE COVERAGE

8.30.1 **Commercial General Liability** insurance (providing scope of coverage equivalent to ISO policy form CG 00 01), naming County and its Agents as an additional insured, with limits of not less than:

General Aggregate:	$2 million
Products/Completed Operations Aggregate:	$1 million
Personal and Advertising Injury:	$1 million
Each Occurrence:	$1 million

8.30.2 **Automobile Liability** insurance (providing scope of coverage equivalent to ISO policy form CA 00 01) with limits of not less than $1 million for bodily injury and property damage, in combined or equivalent split limits, for each single accident. Insurance shall cover liability arising out of the Contractor's use of autos pursuant to this Agreement, including owned,

leased, hired, and/or non-owned autos, as each may be applicable.

8.30.3 **Workers Compensation and Employers' Liability** insurance or qualified self-insurance satisfying statutory requirements, which includes Employers' Liability coverage with limits of not less than $1 million per accident. If the Contractor will provide leased employees, or, is an employee leasing or temporary staffing firm or a professional employer organization (PEO), coverage also shall include an Alternate Employer Endorsement (providing scope of coverage equivalent to ISO policy form WC 00 03 01 A) naming the County as the Alternate Employer, and the endorsement form shall be modified to provide that the County will receive not less than thirty (30) days advance written notice of cancellation of this coverage provision. If applicable to the Contractor's operations, coverage also shall be arranged to satisfy the requirements of any federal workers or workmen's compensation law or any federal occupational disease law.

8.30.4 **Unique Insurance Coverage**

Sexual Misconduct Liability

INTENTIONALLY OMITTED

Professional Liability/Errors and Omissions

Insurance covering the Contractor's liability arising from or related to this Agreement, with limits of not less than $1 million per claim and $3 million aggregate. Further, Contractor understands and agrees it shall maintain such coverage for a period of not less than three (3) years following this Agreement's expiration, termination or cancellation.

Property Coverage

INTENTIONALLY OMITTED

Miscellaneous Coverage

INTENTIONALLY OMITTED

8.31 NOTICE OF DISPUTES (INTENTIONALLY OMITTED)

8.32 LIQUIDATED DAMAGES (INTENTIONALLY OMITTED)

8.33 MOST FAVORED PUBLIC ENTITY (INTENTIONALLY OMITTED)

8.34 NONDISCRIMINATION AND AFFIRMATIVE ACTION (INTENTIONALLY OMITTED)

8.35 NON EXCLUSIVITY (INTENTIONALLY OMITTED)

8.36 NOTICE OF DELAYS (INTENTIONALLY OMITTED)

8.37 NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT

Contractor shall notify its employees, and shall require each Subcontractor to notify its employees, that they may be eligible for the Federal Earned Income Credit under the federal income tax laws. Such notice shall be provided in accordance with the requirements set forth in Internal Revenue Service Notice No. 1015.

8.38 NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY LAW

Contractor shall notify and provide to its employees, and shall require each Subcontractor to notify and provide to its employees, a fact sheet regarding the Safely Surrendered Baby Law, its implementation in Los Angeles County, and where and how to safely surrender a baby. The fact sheet is set forth in Exhibit I of this Master Agreement and is also available on the Internet at www.babysafela.org for printing purposes.

8.39 NOTICES

All notices or demands required or permitted to be given or made under this Master Agreement shall be in writing and shall be hand delivered with signed receipt or mailed by first-class registered or certified mail, postage prepaid, addressed to the parties as identified in Exhibits E - County's Administration and F – Contractor's Administration. Addresses may be changed by either party giving ten (10) days' prior written notice thereof to the other party.

Notwithstanding the foregoing, in addition, and in lieu of written notification, the Director, or designee, shall have the authority to issue any notice to Contractor electronically via e-mail at the designated email address as identified in Exhibit F – Contractor's Administration. This includes all notices or demands required or permitted by the County under this Master Agreement.

8.40 PROHIBITION AGAINST INDUCEMENT OR PERSUASION (INTENTIONALLY OMITTED)

8.41 PUBLIC RECORDS ACT (INTENTIONALLY OMITTED)

8.42 PUBLICITY

8.42.1 Contractor shall not disclose any details in connection with this Master Agreement to any person or entity except as may be otherwise provided hereunder or required by law. However, in recognizing Contractor's need to identify

its services and related clients to sustain itself, the County shall not inhibit Contractor from publishing its role under this Master Agreement within the following conditions:

Contractor shall develop all publicity material in a professional manner; and

During the term of this Master Agreement, Contractor shall not, and shall not authorize another to, publish or disseminate any commercial advertisements, press releases, feature articles, or other materials using the name of the County without the prior written consent of the Director or his/her designee. The County shall not unreasonably withhold written consent.

8.42.2 Contractor may, without the prior written consent of County, indicate in its proposals and sales materials and signs that it has been awarded this Master Agreement with the County of Los Angeles, provided that the requirements of this Sub-paragraph 8.42 shall apply.

8.43 RECORD RETENTION AND INSPECTION/AUDIT SETTLEMENT (INTENTIONALLY OMITTED)

8.44 RECYCLED BOND PAPER (INTENTIONALLY OMITTED)

8.45 RESTRICTIONS ON LOBBYING (INTENTIONALLY OMITTED)

8.46 SUBCONTRACTING

8.46.1 The designation or participation award under this Master Agreement may not be subcontracted by Contractor.

8.47 SURVIVAL

In addition to any provisions of this Master Agreement which specifically state that they will survive the termination or expiration of this Master Agreement and any rights and obligations under this Master Agreement which by their nature should survive, the following Sub-paragraphs shall survive any termination or expiration of this Master Agreement:

Sub-paragraph 7.6 (Confidentiality)

Sub-paragraph 8.7 (Compliance with Applicable Laws, Rules and Regulations

Sub-paragraph 8.25 (Governing Law, Jurisdiction, and Venue)

Sub-paragraph 8.28 (Indemnification)

Sub-paragraph 8.29 (General Provisions for all Insurance Coverage)

Sub-paragraph 8.30 (Insurance Coverage)

Sub-paragraph 8.43 (Record Retention and Inspection/Audit Settlement)

Sub-paragraph 8.47 (Survival)

8.48 TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM

Failure of Contractor to maintain compliance with the requirements set forth in Sub-paragraph 8.16 – Contractor's Warranty of Adherence to County's Child Support Compliance Program, shall constitute default under this Master Agreement. Without limiting the rights and remedies available to the County under any other provision of this Master Agreement, failure of Contractor to cure such default within ninety (90) calendar days of written notice shall be grounds upon which the County may terminate this Master Agreement pursuant to Sub-paragraph 8.51 - Termination for Default and pursue debarment of Contractor, pursuant to County Code Chapter 2.202.

8.49 TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM (INTENTIONALLY OMITTED)

8.50 TERMINATION FOR CONVENIENCE

8.50.1 The County may terminate this Master Agreement, in whole or in part, from time to time or permanently, when such action is deemed by the County, in its sole discretion, to be in its best interest. Termination of the designation(s) hereunder shall be effected by notice of termination to Contractor specifying the extent to which the designation is terminated and the date upon which such termination becomes effective. The date upon which such termination becomes effective shall be no less than thirty (30) days after the notice is sent.

8.50.2 After receipt of a notice of termination and except as otherwise directed by the County, the Contractor shall:

Stop operating as the designation(s) under this Master Agreement on the date and to the extent specified in such notice; and

Transfer title and deliver to the County all completed work and work in process; and

Complete performance of such part of the work as shall not have been terminated by such notice.

8.50.3 All material including books, records, documents, or other evidence bearing on the costs and expenses of Contractor under this Master Agreement shall be maintained by Contractor in accordance with Sub-paragraph 8.42, Record Retention and Inspection/Audit Settlement.

8.50.4 Contractor may terminate this Master Agreement, in whole or in part. Termination of the designation(s) hereunder shall be effected by notice of termination to the County specifying the extent to which the designation(s) is terminated and the date upon which such termination becomes effective. The date upon which such termination becomes effective shall be no less than thirty (30) days after the notice is sent. Contractor shall be obligated to comply with Sub-paragraphs 8.50.2 and 8.50.3 herein.

8.51 TERMINATION FOR DEFAULT

8.51.1 The County may, by written notice to Contractor, terminate the whole or any part of this Master Agreement, if, in the judgment of the Director or his/her designee:

Contractor has materially breached this Master Agreement; or

Contractor fails to satisfactorily meet the requirements and/or standards required under this Master Agreement; or

Contractor fails to demonstrate a high probability of timely complying with the requirements and/or standards required under this Master Agreement, or fails to demonstrate convincing progress toward a cure within five (5) working days (or such longer period as the County may authorize in writing) after receipt of written notice from the County specifying such failure.

Contractor expressly repudiates this Master Agreement by an unequivocal refusal to perform

8.51.2 In the event the County intends to terminate this Master Agreement in accordance with Paragraph 8.51.1, it shall give thirty (30) days' notice to Contractor that it is in material breach and/or anticipatory breach of the Master Agreement. In the notice of intended termination, the Director or his/her designee shall set forth the facts underlying its claim that Contractor is in material breach and/or anticipatory breach. Remedy of the breach or convincing progress towards a cure within twenty (20) days (or such longer period as the County

may authorize in writing) of receipt of said notice shall revive the Master Agreement in effect for the remaining term.

8.51.3 In the event that the County terminates this Master Agreement in whole or in part as provided in Sub-paragraph 8.51.1, the County may procure, upon such terms and in such manner as the County may deem appropriate, goods and services similar to those so terminated. Contractor shall be liable to the County for any and all excess costs incurred by the County, as determined by the County, for such similar goods and services. Contractor shall continue the performance of this Master Agreement to the extent not terminated under the provisions of this sub-paragraph. The parties agree that this particular damage provision (i.e., that the costs incurred by the County) shall be limited to a time period of twelve (12) months or the remaining period this Master Agreement after breach or whichever time period is less.

8.51.4 Except with respect to defaults of any Subcontractor, Contractor shall not be liable for any such excess costs of the type identified in Sub-paragraph 8.51.3 if its failure to perform this Master Agreement arises out of causes beyond the control and without the fault or negligence of Contractor. Such causes may include, but are not limited to: acts of God or of the public enemy, acts of the County in either its sovereign or contractual capacity, acts of Federal or State governments in their sovereign capacities, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, and unusually severe weather; but in every case, the failure to perform must be beyond the control and without the fault or negligence of Contractor. If the failure to perform is caused by the default of a Subcontractor, and if such default arises out of causes beyond the control of both Contractor and Subcontractor, and without the fault or negligence of either of them, Contractor shall not be liable for any such excess costs for failure to perform, unless the goods or services to be furnished by the Subcontractor were obtainable from other sources in sufficient time to permit Contractor to meet the required performance schedule. As used in this Sub-paragraph, the term "Subcontractor(s)" means Subcontractor(s) at any tier.

8.51.5 If, after the County has given notice of termination under the provisions of this Sub-paragraph 8.51, it is determined by the County that Contractor was not in default under the provisions of this sub-paragraph 8.51, or that the default was excusable under the provisions of sub-paragraph 8.51.4, the

rights and obligations of the parties shall be the same as if the notice of termination had been issued pursuant to Sub-paragraph 8.50 - Termination for Convenience.

8.51.6 The rights and remedies of the County provided in this Sub-paragraph 8.51 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Master Agreement.

8.52 TERMINATION FOR IMPROPER CONSIDERATION

8.52.1 The County may, by written notice to Contractor, immediately terminate the right of Contractor to proceed under this Master Agreement if it is found that consideration, in any form, was offered or given by Contractor, either directly or through an intermediary, to any County officer, employee, or agent with the intent of securing this Master Agreement or securing favorable treatment with respect to the award, amendment, or extension of this Master Agreement or the making of any determinations with respect to Contractor's performance pursuant to this Master Agreement. In the event of such termination, the County shall be entitled to pursue the same remedies against Contractor as it could pursue in the event of default by Contractor.

8.52.2 Contractor shall immediately report any attempt by a County officer or employee to solicit such improper consideration. The report shall be made either to the County manager charged with the supervision of the employee or to the County Auditor-Controller's Employee Fraud Hotline at (800) 544-6861 or www.lacountyfraud.org.

8.52.3 Among other items, such improper consideration may take the form of cash, discounts, service, the provision of travel or entertainment, or tangible gifts.

8.53 TERMINATION FOR INSOLVENCY

8.53.1 The County may terminate this Master Agreement forthwith in the event of the occurrence of any of the following:

Insolvency of Contractor: Contractor shall be deemed to be insolvent if it has ceased to pay its debts for at least sixty (60) days in the ordinary course of business or cannot pay its debts as they become due, whether or not a petition has been filed under the Federal Bankruptcy Code and whether or not Contractor is insolvent within the meaning of the Federal Bankruptcy Code;

The filing of a voluntary or involuntary petition regarding Contractor under the Federal Bankruptcy Code;

The appointment of a Receiver or Trustee for Contractor; or

The execution by Contractor of a general assignment for the benefit of creditors.

8.53.2 The rights and remedies of the County provided in this Sub-paragraph 8.53 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Master Agreement.

8.54 TERMINATION FOR NON-ADHERENCE OF COUNTY LOBBYIST ORDINANCE

Contractor, and each County Lobbyist or County Lobbying firm as defined in County Code Section 2.160.010 retained by Contractor, shall fully comply with the County's Lobbyist Ordinance, County Code Chapter 2.160. Failure on the part of Contractor or any County Lobbyist or County Lobbying firm retained by Contractor to fully comply with the County's Lobbyist Ordinance shall constitute a material breach of this Master Agreement, upon which the County may in its sole discretion, immediately terminate or suspend this Master Agreement.

8.55 TERMINATION FOR NON-APPROPRIATION OF FUNDS (INTENTIONALLY OMITTED)

8.56 TIME OFF FOR VOTING

Contractor shall notify its employees, and shall require each Subcontractor to notify and provide to its employees, information regarding the time off for voting law (Elections Code Section 14000). Not less than 10 days before every statewide election, every Contractor and Subcontractors shall keep posted conspicuously at the place of work, if practicable, or elsewhere where it can be seen as employees come or go to their place of work, a notice setting forth the provisions of Section 14000.

8.57 UNLAWFUL SOLICITATION

Contractor shall inform all of its officers and employees performing services hereunder of the provisions of Article 9 of Chapter 4 of Division 3 (commencing with section 6150) of Business and Professions Code of the State of California (i.e. State Bar Act provisions regarding unlawful solicitation as a runner or capper for attorneys) and shall take positive and affirmative steps in its performance hereunder to ensure that there is no violation of said provisions by its officers and employees. Contractor agrees that if a patient requests assistance in obtaining the services of any attorney, it will refer the patient to the attorney referral service of all those bar associations within Los Angeles County that have such a service.

8.58 VALIDITY

If any provision of this Master Agreement or the application thereof to any person or circumstance is held invalid, the remainder of this Master Agreement and the application of such provision to other persons or circumstances shall not be affected thereby.

8.59 WAIVER

No waiver by the County of any breach of any provision of this Master Agreement shall constitute a waiver of any other breach or of such provision. Failure of the County to enforce at any time, or from time to time, any provision of this Master Agreement shall not be construed as a waiver thereof. The rights and remedies set forth in this Sub-paragraph 8.59 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Master Agreement.

8.60 WARRANTY AGAINST CONTINGENT FEES

8.60.1 Contractor warrants that no person or selling agency has been employed or retained to solicit or secure this Master Agreement upon any agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by Contractor for the purpose of securing business.

8.60.2 For breach of this warranty, the County shall have the right to terminate this Master Agreement and, at its sole discretion, deduct from the Master Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, brokerage, or contingent fee.

8.61 COMPLIANCE WITH COUNTY'S ZERO TOLERANCE POLICY ON HUMAN TRAFFICKING

8.61.1 Contractor acknowledges that the County has established a Zero Tolerance Policy on Human Trafficking prohibiting Contractors from engaging in human trafficking.

8.61.2 If a Contractor or member of Contractor's staff is convicted of a human trafficking offense, the County shall require that Contractor or member of Contractor's staff be removed immediately from performing services under this Master Agreement. The County will not be under any obligation to disclose confidential information regarding the offenses other than those required by law.

8.61.3 Disqualification of any member of Contractor's staff pursuant to this Sub-paragraph shall not relieve Contractor

of its obligation to complete all work in accordance with the terms and conditions of this Master Agreement.

8.62 COMPLIANCE WITH FAIR CHANCE EMPLOYMENT PRACTICES

To the extend applicable, Contractor shall comply with fair chance employment hiring practices set forth in California Government Code Section 12952, Employment Discrimination: Conviction History. Contractor's violation of this paragraph of the Master Agreement may constitute a material breach of the Master Agreement. In the event of such material breach, County may, in its sole discretion, terminate the Master Agreement.

8.63 COMPLIANCE WITH THE COUNTY POLICY OF EQUITY

Contractor acknowledges that the County takes its commitment to preserving the dignity and professionalism of the workplace very seriously, as set forth in the County Policy of Equity (CPOE) (https://ceop.lacounty.gov/). Contractor further acknowledges that the County strives to provide a workplace free from discrimination, harassment, retaliation and inappropriate conduct based on a protected characteristic, and which may violate the CPOE. Contractor, its employees and subcontractors acknowledge and certify receipt and understanding of the CPOE. Failure of Contractor, its employees or its subcontractors to uphold the County's expectations of a workplace free from harassment and discrimination, including inappropriate conduct based on a protected characteristic, may subject Contractor to termination of contractual agreements as well as civil liability.

9.0 UNIQUE TERMS AND CONDITIONS

9.1 DUE PROCESS

9.1.1 Notice of Proposed Adverse Action: In all cases in which the EMS Agency has the authority to, and pursuant to this authority, has taken any of the actions constituting grounds for hearing as set forth in Paragraph 9.1.2 herein below, Contractor shall promptly be given written notice of the specific charges and factual basis upon which the EMS Agency action is based. With the exception of summary suspensions, summary suspensions with intent to terminate Master Agreement, or interim system re-configuration, Contractor shall be afforded its due process right to a hearing before implementation of any of the actions which constitute grounds for a hearing. Contractor shall have thirty (30) calendar days following the receipt of such notice within

which to file with Director a written request for hearing before the Emergency Medical Services Commission (EMSC).

9.1.2 Grounds for Hearing: Any one or more of the following actions constitute grounds for a hearing:

REMEDIAL HEARING:

1) Summary Suspension
2) Summary Suspension with intent to terminate
3) Suspension
4) Suspension with intent to terminate
5) Termination for cause

OTHER:

6) Substantial operational changes in the ALS program (interim system re-configuration and system re-configuration).
7) Restructuring, including deletions, additions, or substitution of base hospitals in the system.
8) Agency requests to modify existing forms, logs, and documentation or Agency's request for additional data as specified in Appendix B, Paragraph 6.20.

9.1.3 Summary Suspension or Summary Suspension with Intent to Terminate: In the case of summary suspensions or summary suspensions with intent to terminate, Contractor, at its election, shall have the right to request Director in writing to reconsider the summary suspension action. Director shall act on this request for reconsideration within ten (10) calendar days after the receipt of the reconsideration request. Contractor shall be given an opportunity to meet with Director. The meeting shall not be a full hearing but is intended to identify the alleged basis for the summary action.

Within ten (10) calendar days following the meeting with Director, Director shall issue to Contractor a written recommendation regarding the summary suspension. This recommendation may be that the suspension be continued for a particular time or upon particular conditions, that the summary suspension be terminated, that Contractor's Master Agreement be terminated, that other conditions be imposed on Contractor, or such other action as may seem warranted. If Director recommends any action other than immediate return of Contractor to full base hospital status, Contractor may request a hearing on the summary

suspension before the EMSC, as provided in this Paragraph. Such request shall be in writing and addressed to Director. Any such request shall be delivered within five (5) calendar days of Director's delivery to Contractor of their written decisions.

9.1.4 Time and Place of Hearing: Director shall, within fifteen (15) calendar days of receipt of a Contractor request for hearing as set forth above, apply to the EMSC for such hearing. Director shall give notice to Contractor of the time, place, and date of the hearing in accordance with EMSC rules and procedures. The date of commencement of the hearing shall be not less than thirty (30) calendar days, nor more than ninety (90) calendar days from the receipt of the request for hearing, subject to the convenience and approval, however, of the EMSC. However, if the request is received from Contractor when under a summary suspension then in effect, Director shall attempt to arrange a hearing before the EMSC as soon as possible. In situations involving a summary suspension, Director shall use his/her best efforts to schedule a hearing within forty-five (45) calendar days of receipt of a request for hearing.

9.1.5 Notice of Charges: As part of, or together with the notice of hearing, Director shall state in writing, in concise language, the acts or omissions with which Contractor is charged or reasons for substantial operational change or restructuring. If either party, by written notice, requests a list of individuals who will appear on behalf of the other, then each party within ten (10) calendar days of such request shall furnish to the other a list, in writing, of the names and addresses of the individuals, so far as is then reasonably known, who will give testimony or evidence in support of that party at the hearing.

9.1.6 Hearing Procedure: At the hearing, subject to the rules of the EMSC, both sides shall have the following rights: to call and examine witnesses, to introduce exhibits, and to rebut any evidence. The EMSC may question witnesses.

9.1.7 Memorandum of Points and Authorities: Subject to the rules of EMSC, each party shall have the right to submit to the EMSC a memorandum of points and authorities.

9.1.8 Basis of Decision: Subject to the rules of the EMSC, the EMSC decision on a hearing under this Master Agreement shall be based upon the evidence produced at the hearing. The evidence may consist of the following:

1) Oral testimony of the parties' representatives;

2) Documentary evidence introduced at the hearing;

3) Briefs or memoranda of points and authorities presented in connection with the hearing;

4) Policies and procedures of the EMS Agency; and

5) All officially noticed matters.

9.1.9 Record of Hearing: The parties understand that the EMSC maintains a record of hearings by one or more of the following methods: a shorthand reporter, an audio or disc recording, or by its clerk's minutes of the proceedings. If a shorthand reporter is specifically requested in writing by Contractor or by Director, the costs of same shall be borne by such party. The parties understand that the EMSC may, but shall not be required to, order that oral evidence shall be taken only by oath or affirmation administered by any person designated by such body and entitled to notarize documents in the State of California.

9.1.10 Decision of the EMSC: The decision of the EMSC shall be effective and binding on the parties to the extent permitted and prescribed in County Code Section 3.20.070 B.

9.2 RESPONSIBILITY FOR INDIGENT PATIENTS

Nothing contained in this Master Agreement is intended nor shall it be construed to affect either party's existing rights, obligations, and responsibilities with respect to care required by or provided to indigent patients.

9.3 STATUS OF CONTRACTOR

The parties hereto agree that Contractor, its officers, agents, and employees, including its professional and non-professional personnel, shall act in an independent capacity and not as officers, agents, or employees of County and shall not have the benefit of County employees. Except as may otherwise expressly be provided hereunder, Contractor shall employ all personnel (excluding physicians), assure physicians availability, provide supplies, equipment, equipment space, furniture, insurance, utilities, and telephones necessary for performance of Contractor's responsibilities as set forth in this Master Agreement. This Paragraph shall not preclude or limit Contractor from seeking reimbursement, contributions, tuition, or other payment from public or private paramedic provider agencies for services provided by Contractor. However, this Paragraph shall not be interpreted to mean that any such reimbursement, contributions, or payment is required or mandated.

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Master Agreement to be executed by the County's Director of Health Services and Contractor has caused this Master Agreement to be executed in its behalf by its duly authorized officer, the day, month and year first above written.

COUNTY OF LOS ANGELES

BY _____ for
Christina R. Ghaly, M.D.
Director of Health Services

CONTRACTOR

PASADENA HOSPITAL ASSOCIATION, LTD. DBA
HUNTINGTON HOSPITAL

By [redacted]
Signature

Lori J. Morgan, MD, MBA
Printed Name

President and CEO
Title

APROVED AS TO FORM:
MARY C. WICKMAN
County Counsel

By _____
Brian Chu, Principal Deputy County Counsel

EXHIBIT A

Specialty Care Center Designation Exhibits

EXHIBIT A-1

INTENTIONALLY OMITTED

EXHIBIT A-2

SPECIALTY CARE CENTER DESIGNATION EXHIBIT

FOR

HOSPITAL PREPAREDNESS PROGRAM PARTICIPANT

JANUARY 1 – DECEMBER 31, 2020

SECTION **TITLE** **PAGE**

1.0 PURPOSE 1

2.0 SCOPE OF AGREEMENT 1

3.0 GENERAL REQUIREMENTS 1

4.0 TERM OF SPECIALTY CARE CENTER DESIGNATION 1

5.0 ANNUAL FEES 2

6.0 ADDITION AND/OR DELETION OF FACILITIES, SPECIFIC TASKS AND/OR WORK HOURS 2

7.0 QUALITY CONTROL 2

8.0 QUALITY ASSURANCE PLAN 2

9.0 DEFINITIONS 3

10.0 RESPONSIBILITIES 4

COUNTY 4

10.1 Agreement Compliance 4
10.2 Funding… 4
10.3 Staff Designation 5

CONTRACTOR 5

10.4 Agreement Compliance 5
10.5 Project Manager… 6
10.6 Business Continuity 6
10.7 Exercise and Drills… 7
10.8 Training… 7
10.9 Situational Awareness… 8
10.10 Decontamination Team… 9
10.11 Health Care Coalition Program Coordination… 9
10.12 Equipment/Supplies/Pharmaceuticals… 12
10.13 Access to Equipment and Supplies… 13
10.14 Mutual Assistance… 13
10.15 Additional Funding… 13
10.16 Program Monitoring 13

11.0 HOURS/DAY OF WORK 14

12.0 WORK SCHEDULES 14

13.0 UNSCHEDULED WORK 14

14.0 PROCEDURE FOR NON-COMPLIANCE AND PENALTIES 14

LISTING OF ATTACHMENTS

ATTACHMENT	ATTACHMENT NAME
1	PARTICIPATING HOSPITALS AND FUNDING
2	CONTRACT DISCREPANCY REPORT
3	PROCEDURES FOR NON-COMPLIANCE

SPECIALTY CARE CENTER DESIGNATION EXHIBIT
FOR
HOSPITAL PREPAREDNESS PROGRAM PARTICIPANT

1.0 PURPOSE

The Hospital Preparedness Program (HPP) prepares the health care system, both private and public, to save lives through the development of a regional health care coalition (HCC). The HCC is comprised of health care and response organizations that collaborate to prepare for and respond to medical surge events. The HCC incentivizes diverse and often competitive health care organizations to work together.

2.0 SCOPE OF AGREEMENT

Each contractor participating in the HPP will participate with Los Angeles County's (County) and other healthcare partners to support the development and sustainment of healthcare preparedness capabilities in the County's Health Care Coalition (HCC), in order to respond to and rapidly recover from public health threats and other emergencies.

3.0 GENERAL REQUIREMENTS

3.1 Contractor must be licensed by the California Department of Public Health as a general acute care hospital.

3.2 Contractor must be accredited by the Joint Commission or other accrediting body deemed acceptable by the Centers for Medicare and Medicaid Services (CMS).

3.3 Contractor must subscribe and have access to ReddiNet®

3.4 Contractor administration, and medical staff shall meet the requirements under applicable State regulations and the Emergency Medical Services' (EMS) Agency's policies and procedures for the provision of services under this Master Agreement.

4.0 TERM OF SPECIALTY CARE CENTER DESIGNATION

4.1 The term of this Designation shall be one (1) year commencing January 1, 2020 after execution by the Director as authorized by the County's Board of Supervisors, and shall terminate on December 31, 2020, unless sooner terminated or extended, in whole or in part, as provided in the Master Agreement, Sub-paragraph 8.1, Amendments.

4.2 Each year the County shall have the sole option to extend this Designation, based on available HPP federal grant funding, for another one year performance period with specific funding levels and Contractor requirements to cover the period of January 1 through December 31 of that year. This Designation may be extended for a maximum total Agreement term of ten (10) years. Such option and extension shall renew automatically, with notification to the Contractor of any changes to the annual requirements, unless sooner terminated or extended, in whole or in part, as provided in the Master Agreement, Sub-paragraph 4.4.

5.0 ANNUAL FEES

Intentionally Omitted

6.0 ADDITION AND/OR DELETION OF FACILITIES, SPECIFIC TASKS AND/OR WORK HOURS

6.1 All changes must be made in accordance with sub-paragraph 8.1 Amendments of the Master Agreement.

7.0 QUALITY CONTROL

7.1 The Contractor shall establish and utilize a comprehensive Quality Control Plan to assure the County that the funding that is provided is utilized in the manner intended and as described in Sub-paragraph 10.4, Responsibilities Contractor herein below, and that there is a method of monitoring to ensure that Agreement requirements are being met.

7.2 The Contractor shall establish a method of monitoring to ensure that Master Agreement and Exhibit A - HPP requirements are being met.

7.3 A record of all inspections conducted by Contractor, any corrective action taken, the time a problem was first identified, a clear description of the problem, and the time elapsed between identification and completed corrective action, shall be provided to the County upon request.

8.0 QUALITY ASSURANCE PLAN

8.1 The County will evaluate the Contractor's performance under this Exhibit A - HPP using the quality assurance procedures as defined in Master Agreement, Paragraph 8.0, Standard Terms and Conditions, Sub-paragraph 8.18, County's Quality Assurance Plan of the Agreement.

8.2 **Contract Discrepancy Report (Attachment 2)**

8.2.1 Verbal notification of a Master Agreement and Exhibit A - HPP discrepancy will be made to the County Agreement Project Monitor as soon as possible

whenever a Master Agreement and/or Exhibit A - HPP discrepancy is identified. The problem shall be resolved within a time period mutually agreed upon by the County and Contractor.

8.2.2 The County Agreement Project Monitor will determine whether a formal Contract Discrepancy Report shall be issued. Upon receipt of this document, Contractor is required to respond in writing to the County Agreement Project Monitor within thirty (30) workdays, acknowledging the reported discrepancies or presenting contrary evidence. A plan for correction of all deficiencies identified in the Contract Discrepancy Report shall be submitted to the County Agreement Project Monitor within thirty (30) workdays

8.3 **County Observations**

8.3.1 In addition to departmental contracting staff, other County personnel may observe performance, activities, and review documents relevant to the Master Agreement and this Exhibit A - HPP at any time during normal business hours. However, these personnel may not unreasonably interfere with Contractor's performance.

9.0 DEFINITIONS

9.1 **No Emergency Department (No ED) Participant -** A licensed, general acute care hospital that does not have a permit for basic or comprehensive emergency medicine services pursuant to the provisions of California Code of Regulations Title 22, Division 5 and is not approved by the Los Angeles County EMS Agency (LAEMSA) to receive patients with emergency medical conditions from the 9-1-1 system.

9.2 **Emergency Department (ED) Participant -** A licensed, general acute care hospital with a permit for basic or comprehensive emergency medicine services pursuant to the provisions of California Code of Regulations Title 22, Division 5, and approved by the LAEMSA to receive patients with emergency medical conditions from the 9-1-1 system.

9.3 **Trauma Center (TC) Participant –** A TC is a licensed acute care hospital designated as a "Trauma Center" by the LAEMSA. A TC has the personnel, services, and equipment necessary to care for acutely injured patients, or trauma patients. These are also designated Burn Resource Centers per current policy.

9.4 **Disaster Resource Center (DRC) Participant -** A DRC is one of a limited number of hospitals designated by the LAEMSA that is responsible for developing plans, relationships and procedures to enhance hospital surge capacity in a geographical area for responding to a terrorist/disaster event.

9.5 **Trauma Disaster Resource Center (TDRC) Participant -** A DRC that is also a TC.

9.6 **Pediatric Disaster Resource Center (PDRC) Participant -** A PDRC is a licensed acute care hospital that exclusively provides pediatric services and is responsible for developing plans, relationships and procedures to enhance pediatric surge capacity in the County for responding to a terrorist/disaster event.

9.7 **Health Care Coalition (HCC) -** A HCC is a group of individual healthcare and response organizations (e.g., hospitals, emergency medical services, emergency management organizations, and public health agencies) in a defined geographic location that play a critical role in developing healthcare system preparedness and response capabilities.

9.8 **CHEMPACK Storage Site (CSS) -** A site designated by the LAEMSA to store a cache of antidotes specific to nerve agent release. The CHEMPACK program is a component of the Strategic National Stockpile (SNS).

10.0 RESPONSIBILITIES

The County's and Contractor's responsibilities are as follows:

COUNTY

10.1 Agreement Compliance

The County will administer the Master Agreement according to Master Agreement, Paragraph 6.0, Administration of Agreement - County. Specific duties will include:

10.1.1 Monitoring Contractor's performance in the daily operation of the Master Agreement and Exhibit A - HPP. Inspections by EMS Agency staff shall be conducted during County's normal business hours and only after Director has given Contractor at least three (3) working days' prior written notice thereof. In computing the three (3) working days, a Saturday, Sunday, or legal holiday shall not be included. Entry and exit conferences shall be held with Contractor's Program Manager or his or her designee.

10.1.2 Providing direction to Contractor in areas relating to policy, information and procedural requirements.

10.1.3 Preparing Amendments in accordance with the Master Agreement, Paragraph 8.0, Standard Terms and Conditions, Sub-paragraph 8.1 Amendments.

10.1.4 Conducting HPP Review: At minimum, administrative audits shall be conducted annually and site visits every three (3) years to ensure

compliance with Federal and EMS Agency policies and regulations. Contractor shall be given no less than thirty (30) calendar days' notice in advance of said review. Contractor and its staff shall fully cooperate with County representatives. In the conduct of such audit and review, Contractor shall allow such representatives access to all reports, plans, inventory, maintenance records, and other reports pertaining to this Master Agreement, and shall allow photocopies to be made of these documents, utilizing Contractor's photocopier.

10.1.5 An exit conference shall be held following the performance of such an on-site compliance review by Director or his or her designee and results of the compliance review shall be discussed with Contractor's Administrator or his or her authorized designee prior to the generation of any final written report or action by Director or other EMS Agency representatives based on such review. The exit conference shall be held on site prior to the departure of the reviewers and Contractor shall be provided with an oral list of preliminary findings at the exit conference. A written report of the program review shall be prepared and provided to Contractor.

10.2 Funding

10.2.1 The County will provide to the Contractor funding as described in Sub-paragraphs 10.6 through 10.15, Contractor Responsibilities herein below.

10.2.2 The County will provide access to and use of a mass notification system free of charge.

10.3 Staff Designation

10.3.1 Director shall designate staff within the EMS Agency to review, monitor, communicate and coordinate matters related to HPP deliverables.

CONTRACTOR

10.4 Agreement Compliance

10.4.1 Should the EMS Agency, as determined by Contractor, fail to comply with any provision set forth hereunder as an EMS Agency responsibility or obligation, Contractor may do any or all of the following in addition to other rights which Contractor may have hereunder or at law:

10.4.1.1 Send Director a written statement itemizing the areas of concern and request or specify a plan for remedial action.

10.4.1.2 Send Director a written itemized listing of the area(s) of concern and notification of intent to terminate Master Agreement.

10.4.2 Institute the review procedures outlined in Paragraph 9.1, Due Process of the Master Agreement.

10.5 Project Manager

10.5.1 Contractor shall provide a Project Manager and designate an alternate.

10.5.2 Project Manager, typically the emergency manager for the hospital, shall act as a central point of contact between the HPP Awardee (LAEMSA) and the sub-awardee (Contractor) with the County.

10.5.3 Project Manager/alternate shall have full authority to act for Contractor on all matters relating to the requirements of the Master Agreement and the requirements as a HPP participant under this Exhibit A - HPP. Project Manager/alternate shall be able to effectively communicate, in English, both orally and in writing.

10.5.4 Project manager/alternate shall designate a Terrorism Liaison Officer (TLO) for the facility

10.5.5 Project Manager/alternate shall attend the annual HPP Orientation conducted by the Awardee.

10.5.6 Project Manager/alternate shall complete and submit an After-Action Report(s) within sixty (60) days to the EMS Agency, if any aspect of the emergency management plans is implemented through real events. This includes internal disaster diversion requests in excess of four (4) hours.

10.5.7 Project Manager/alternate shall notify the EMS Agency of personnel changes identified in this Exhibit within thirty (30) days of appointment using the approved "Notification of Personnel Change" form provided by the EMS Agency.

10.5.8 Project Manager/alternate shall complete all official requests or surveys as requested by the EMS Agency by the established due date, providing the data/information required by the HPP and other HCC requirements. Those requests may be in the form of letters, emails, or polls through a third-party vendor (e.g., Survey Monkey®).

10.6 Business Continuity

10.6.1 All participants will receive Five Thousand Dollars ($5,000) to address health care continuity and recovery through participation in Health Care

Coalition (HCC) sponsored business continuity plan (BCP) exercise(s) and/or workshop(s).

10.7 Exercise and Drills

10.7.1 All participants receive Six Thousand Dollars ($6,000) to participate in exercises and drills in conjunction with County and community partners to ensure hospital preparedness.

10.7.1.1 Participate in the annual Medical and Health Exercise, if conducted during the term of the Master Agreement by attending the participant seminar, the exercise evaluation conference and submitting an After-Action Report/Improvement Plan to the EMS Agency within sixty (60) days of the exercise's completion

10.7.1.2 Participate in the HCC Surge Exercise.

10.8 Training

10.8.1 All participants receive Six Thousand Dollars ($6,000) to provide opportunities for staff to attend trainings/conferences related to disaster preparedness, response and recovery.

10.8.2 The following conditions are necessary to verify training expenses:

10.8.2.1 Certificate of attendance or sign-in roster which must contain the following information:

10.8.2.1.1 Clear legible name and signature of instructor
10.8.2.1.2 Hours of attendance
10.8.2.1.3 Name of course and brief description

10.8.2.2 Copies of receipts related to training:

10.8.2.2.1 Ground transportation fees
10.8.2.2.2 Airfare
10.8.2.2.3 Conference fees
10.8.2.2.4 Meals (except tips and alcohol)
10.8.2.2.5 Lodging

10.8.2.3 Hourly rate (average salary), if using funds for staff time.

10.9 Situational Awareness

10.9.1 All participants receive Two Thousand and Forty Dollars ($2,040) to maintain:

10.9.1.1 ReddiNet® satellite communication capability and two satellite phones (one in Emergency Department and one in Hospital Command Center), or

10.9.1.2 **No ED** will maintain mobile satellite radio/phone subscription for the satellite device provided by **EMS** Agency.

10.9.2 All participants receive Six Hundred and Sixty Dollars ($660) to maintain system participation in the Family Reunification Module provided through ReddiNet®

10.9.3 All participants receive Six Thousand Dollars ($6,000) to participate in the following activities to enhance HCC situational awareness and refine reporting processes. Contractors shall respond at least seventy five percent (75%) of the time. These activities include:

10.9.3.1 Report bed availability via ReddiNet® within sixty (60) minutes when requested by the EMS Agency

10.9.3.2 Respond to all assessment polls or service level polls sent out via ReddiNet® by the EMS Agency within the time frame requested on the poll.

10.9.3.3 For all participants, **except No ED**:

10.9.3.3.1 For Multi Casualty Incident (MCI) polls, provide the number and types of patients your facility can receive. Additionally, ensure that any patient from an actual MCI who is transported to your facility is entered in the victim list of ReddiNet®'s MCI Module. Ensure all required data fields are completed.

10.9.3.3.2 Provide daily hospital emergency department volume based data through the ReddiNet® as part of the County's syndromic bio-surveillance program.

10.10 Decontamination Team

10.10.1 All participants, **except No ED**, will receive Six Thousand Dollars ($6,000) to maintain decontamination capability that provides coverage twenty-four (24) hours a day, three hundred and sixty-five (365) days a year. Decontamination program should be capable of decontaminating at least fifty (50) ambulatory patients an hour for at least two (2) hours.

10.10.1.1 Provide a minimum of four (4) to a maximum of six (6) team members from the hospital's decontamination team who will "suit up" and participate in the assigned DRC Regional Decontamination training and wet decontamination exercise.

10.10.1.2 Provide at least one (1) decontamination team member to be a controller or evaluator at another DRC Regional decontamination training/exercise.

10.10.1.3 Maintain monthly equipment inspection log for the Powered Air Purifying Respirators (PAPRs) using the PAPR Monthly Equipment Checklist" form provided by the EMS Agency and make inspection logs available for review as set forth in section 10.16.

10.10.1.4 Store, secure and maintain all equipment and supplies that have been provided and/or funded under the HPP and other disaster related grants, such as the Homeland Security Grant Program. Continue to inventory all equipment, supplies and pharmaceuticals annually or more frequently per federal, state or local regulations/policies. Notify the EMS Agency immediately if any equipment or pharmaceuticals are lost or stolen. Notify the EMS Agency prior to dispositioning of any grant funded equipment, supplies and/or pharmaceuticals. This includes, but is not limited to, decontamination and infection control personal protective equipment, communication equipment and surge supplies.

10.11 Health Care Coalition Program Coordination

10.11.1 **No ED, ED and TC Participants** - Receive **Six Thousand Dollars** ($6,000) to appoint an Emergency Management Officer (EMO) who will support the HCC by actively participating in Coalition activities that promotes a coordinated response to disasters.

10.11.1.1 Attend DRC umbrella regional meetings for the geographical area, evidenced by at least eighty percent (80%) attendance to these meetings and contributing to County-wide response plan activities, such as, participating in the Regional Hazard Vulnerability Analysis.

10.11.1.2 Participate in their local Regional Hazard Vulnerability Analysis (HVA).

10.11.1.3 Participate in at least one (1) exercise/drill as part of these meetings, such as a Table Top Exercise prior to the Statewide Medical and Health Exercise.

10.11.2 **TC Participant** - Receive Eighty-Five Thousand Dollars ($85,000) to appoint a Trauma/Burn Surge Coordinator who will actively participate in County-wide trauma and burn surge response planning and attend 100% of the Trauma/Burn Surge Coordinator meetings hosted by the EMS Agency.

10.11.3 **DRC Participant** - Receive One Hundred Sixty Thousand Dollars ($160,000) to maintain a full-time DRC Coordinator who will support the HCC by actively participating in Coalition activities which includes:

10.11.3.1 Coordinate, conduct and attend the DRC umbrella regional meetings for the geographical area, evidenced by hosting a minimum of five (5) meetings annually without any meetings being conducted in consecutive months. Submit meeting agendas, minutes and sign-in rosters within thirty (30 days) of each meeting. At least two (2) of these meetings should involve participating healthcare sectors within the DRC's geographic area, such as, community health centers, long-term care facilities, ambulatory surgery centers, dialysis, home health and EMS provider agencies.

10.11.3.1.1 Conduct a Regional HVA at one of the annual meetings. Submit the completed Regional HVA to the EMS Agency by June 30, 2020.

10.11.3.1.2 Conduct at least one (1) exercise/drill (e.g. Table Top Exercise) at one of these meetings prior to the Statewide Medical and Health Exercise.

10.11.3.2 Participate in County-wide response planning and attend 100% of the DRC Coordinator meetings hosted by the EMS Agency.

10.11.3.3 Coordinate and conduct an annual DRC Regional decontamination training/exercise that will prepare the participating teams to handle converging ambulatory patients who require decontamination.

10.11.3.4 Nine Thousand Dollars ($9,000) of the funding allocated (5%) should be used for additional administrative planning costs associated with the ongoing management of the DRC activities in the assigned geographical region, such as, parking for umbrella meetings and miscellaneous supplies.

10.11.3.5 Designate a person within the DRC Region who is knowledgeable in the HPP and Emergency Management who can instruct/assist with at least two (2) of the HCC Hospital Disaster Management Training classes annually.

10.11.3.6 If also a **TDRC**, receive Thirty-Six Thousand Dollars ($36,000) to maintain a Trauma/Burn Surge Coordinator who will support the HCC by actively participating in Coalition activities. Participate in County-wide trauma and burn surge response planning and attend 100% of the Trauma Surge Coordinator meetings hosted by the EMS Agency.

10.11.4 **PDRC Participant (Children's Hospital Los Angeles)** - Receive One Hundred Sixty Thousand Dollars ($160,000) to maintain a full-time DRC Coordinator who will support the HCC by actively participating in Coalition activities which includes:

10.11.4.1 Participate in all nine (9) DRC umbrella regional meetings at least once in the first six (6) months of this agreement period. At these meetings, a representative from Children's Hospital of Los Angeles (CHLA) will provide subject matter expertise on pediatric preparedness, response and recovery. Additionally, CHLA will provide updates on pediatric disaster projects, programs and activities pertinent to the Los Angeles County HCC. CHLA will also provide this information at the annual HPP orientation meeting held during the second half of the year.

10.11.4.1.1 Participate in their local Regional HVA.

10.11.4.1.2 Participate in at least one (1) exercise/drill (e.g., Table Top Exercise) prior to the Statewide Medical and Health Exercise.

10.11.4.2 Participate in County-wide response planning and attend 100% of the DRC Coordinator meetings hosted by the EMS Agency.

10.11.4.3 Nine Thousand Dollars ($9,000) of the funding allocated (5%) should be used for additional administrative planning costs associated with the ongoing management of the DRC activities in the assigned geographical region, such as, parking for umbrella meetings and miscellaneous supplies.

10.11.4.4 Identify a person who is knowledgeable in the HPP, Emergency Management and is a Pediatric Subject Matter Expert will instruct/assist with the four (4) HCC Hospital Disaster Management Training classes annually.

10.11.4.5 Receive Thirty-Six Thousand Dollars ($36,000) to maintain a Trauma/Burn Surge Coordinator who will support the HCC by actively participating in Coalition activities. Participate in County-wide trauma and burns surge response plans and attend 100% of the Trauma Surge Coordinator meetings hosted by the EMS Agency.

10.12 **Equipment/Supplies/Pharmaceuticals**

10.12.1 Each **DRC, PDRC and TDRC** will receive Twenty-Four Thousand Dollars ($24,000) to maintain in a state of readiness, purchase new, and replace outdated: DRC equipment, medical surgical supply caches, local pharmaceutical caches, and other support equipment. Notify the EMS Agency if the DRC equipment, supplies and/or pharmaceutical caches fall below minimum levels per current policy.

10.12.2 Each **TC, TDRC and PDRC** will receive Nine Thousand Dollars ($9,000) to maintain in a state of readiness, purchase new, and replace outdated Trauma/Burn Surge equipment, supplies and pharmaceuticals in accordance with the minimum levels per current policy. Notify the EMS Agency if the Trauma/Burn Surge equipment, supplies and/or pharmaceuticals fall below minimum levels.

10.12.3 Each **DRC, TDRC and PDRC** will receive Six Thousand Dollars ($6,000) for a one-time replacement/upgrade of VORTRAN® Automatic Resuscitator Devices.

10.12.4 Each hospital participant that is also a designated **CSS** will receive One Thousand Dollars ($1,000) to secure CHEMPACK cache in a climate controlled environment and ensure all CHEMPACK location requirements are met per current policy.

10.13 Access to Equipment and Supplies

10.13.1 Contractor shall allow County immediate access to the equipment, supplies and pharmaceuticals obtained under the HPP and other supporting grant programs.

10.14 Mutual Assistance

10.14.1 Private hospitals and other healthcare organizations will be called upon to provide essential services to assist the County in addressing the medical needs of the community during a disaster event. This mutual assistance may include expanding services at their own facility and sharing resources during disaster events to meet the community's need. Hospitals participating in the HPP shall assist other healthcare entities whenever possible without compromising their own capabilities. Medical Mutual Assistance shall be requested and coordinated by the EMS Agency, and the Medical and Health Operational Area Coordinator for the County. When a state of emergency is proclaimed by the Governor, an eligible Private Nonprofit organization that provides essential community services may receive state assistance for eligible activities that result in extraordinary costs.

10.15 Additional Funding

10.15.1 Participating contractors may receive additional funding, to be used for special projects which meet Capability requirements under the applicable HPP Application and Federal program guidance. The amount of funding each eligible contractor receives will be determined based on the amount budgeted for the project and the number of eligible contractors participating in the special project. The County shall issue to the Contractor work orders, as necessary, and shall specify all Contractor receivables (including amount of additional funding) and deliverables. Additionally, funding from other Federal grants such as the Public Health Emergency Preparedness Program, Ebola Preparedness and Response Activities and the Homeland Security Grant Program may be provided to participating contractors for projects, which assist the healthcare community in meeting Capability requirements of the HPP. This funding may be on a reimbursement basis and the amount of funding will be specified prior to commencement of the project(s) and/or purchase(s).

10.16 **Program Monitoring**

10.16.1 Contractor extends to Director, or his or her designee the right to review and monitor Contractor's programs and procedures with respect to the Master Agreement and this Exhibit A - HPP.

10.16.2 Contractor shall submit requested contract monitoring documents to the EMS Agency within sixty (60) days of the request.

10.16.3 Contractor and its staff shall fully cooperate with County representatives in the conduct of scheduled program audits, conferences, and reviews to verify compliance with the requirements of the Master Agreement and this Exhibit A - HPP. Contractor shall allow such representatives access to all reports, plans, inventory, maintenance records, and other reports pertaining to the Master Agreement and this Exhibit A - HPP, and shall allow photocopies to be made of these documents, utilizing Contractor's photocopier.

11.0 HOURS/DAY OF WORK

Intentionally Omitted

12.0 WORK SCHEDULES

Intentionally Omitted

13.0 UNSCHEDULED WORK

Intentionally Omitted

14.0 PROCEDURE FOR NON-COMPLIANCE AND PENALTIES

Contractor's failure to meet exhibit requirements shall be addressed by the County in accordance with Attachment 3, Procedures for Non-Compliance.

HPP PARTICIPATING HOSPITALS AND FUNDING Agreement Period January 1 through December 31, 2020 FFY 2018 (1901-01)	DUNS	Level of Participation	Total Funding
Glendora Community Hospital	62-201-2334	Closing 9/19	$0
Kaiser Foundation Hospital - Los Angeles	05-305-2619	DRC Participant	$222,700
PIH Health Hospital - Whittier	06-233-6912	DRC Participant	$222,700
Providence Saint Joseph Medical Center	10-794-8341	DRC Participant	$222,700
Adventist Health-Glendale	07-623-2735	ED Participant	$37,700
Adventist Health-White Memorial	05-388-6851	ED Participant	$37,700
Alhambra Hospital Medical Center	07-601-2203	ED Participant	$37,700
Beverly Hospital	07-415-0459	ED Participant	$37,700
Catalina Island Medical Center	60-224-3024	ED Participant	$38,700
Cedars-Sinai Marina Del Rey Hospital	81-440-3579	ED Participant	$37,700
Centinela Hospital Medical Center	78-076-3722	ED Participant	$37,700
Coast Plaza Medical Center	07-191-7033	ED Participant	$37,700
College Medical Center	07-917-2148	ED Participant	$37,700
Community Hospital of Huntington Park	06-730-9303	ED Participant	$37,700
Dignity Health - Glendale Memorial Hospital and Health Center	06-380-2136	ED Participant	$37,700
East Los Angeles Doctors Hospital	80-975-7542	ED Participant	$37,700
Emanate Health Foothill Presbyterian Hospital	07-620-3421	ED Participant	$37,700
Emanate Health Inter-Community Hospital	04-647-1330	ED Participant	$37,700
Emanate Health Queen of the Valley Hospital	04-647-1330	ED Participant	$38,700
Encino Hospital Medical Center	83-227-6245	ED Participant	$37,700
Garfield Medical Center	01-552-0844	ED Participant	$37,700
Good Samaritan Hospital	06-238-9657	ED Participant	$37,700
Greater El Monte Community Hospital	96-215-1804	ED Participant	$37,700
Hollywood Presbyterian Medical Center	07-412-6881	ED Participant	$37,700
Kaiser Foundation Hospital - Baldwin Park	03-797-7668	ED Participant	$37,700
Kaiser Foundation Hospital - Downey	05-305-2619	ED Participant	$37,700
Kaiser Foundation Hospital - Panorama City	05-305-2619	ED Participant	$37,700
Kaiser Foundation Hospital - South Bay	05-305-2619	ED Participant	$37,700
Kaiser Foundation Hospital - West Los Angeles	05-305-2619	ED Participant	$37,700
Kaiser Foundation Hospital - Woodland Hills	05-305-2619	ED Participant	$37,700
LAC Olive View-UCLA Medical Center	11-042-1133	ED Participant	$37,700
Lakewood Regional Medical Center	62-606-2601	ED Participant	$37,700
Martin Luther King Jr. Community Hospital	07-866-0249	ED Participant	$37,700
Memorial Hospital of Gardena	04-909-1140	ED Participant	$37,700
Methodist Hospital of Southern California	06-669-4803	ED Participant	$37,700
Mission Community Hospital	07-531-4872	ED Participant	$37,700
Monterey Park Hospital	07-530-0913	ED Participant	$37,700
Norwalk Community Hospital	83-967-4975	ED Participant	$37,700
Olympia Medical Center	06-224-7442	ED Participant	$37,700
Pacifica Hospital of the Valley	19-046-1293	ED Participant	$37,700
Palmdale Regional Medical Center	09-372-5133	ED Participant	$52,700
PIH Health Hospital - Downey	04-743-7306	ED Participant	$37,700
Providence Little Company of Mary Medical Center San Pedro	10-271-9296	ED Participant	$37,700
Providence Little Company of Mary Medical Center Torrance	87-823-8876	ED Participant	$37,700
Providence St. Johns Health Center	07-294-5850	ED Participant	$37,700
Providence Tarzana Medical Center	82-886-4467	ED Participant	$37,700
Saint Vincent Medical Center	07-230-1195	ED Participant	$37,700
San Dimas Community Hospital	07-622-7701	ED Participant	$37,700
San Gabriel Valley Medical Center	96-719-0815	ED Participant	$37,700

Santa Monica - UCLA Medical Center	93-983-8090	ED Participant	$37,700
Sherman Oaks Hospital	79-077-1070	ED Participant	$37,700
Southern California Hospital at Culver City	06-380-6194	ED Participant	$37,700
Torrance Memorial Medical Center	07-227-4426	ED Participant	$37,700
USC Verdugo Hills Hospital	07-531-3031	ED Participant	$37,700
Valley Presbyterian Hospital	07-294-0307	ED Participant	$37,700
West Hills Hospital and Medical Center	19-430-3816	ED Participant	$37,700
Whittier Hospital Medical Center	03-453-0316	ED Participant	$37,700
Barlow Respiratory Hospital	06-779-1913	No ED Participant	$31,700
City of Hope National Medical Center	80-763-5962	No ED Participant	$31,700
Kindred Hospital San Gabriel		No ED Participant	$31,700
Kindred Hospital South Bay		No ED Participant	$31,700
LA Downtown Medical Center (FKA Silver Lake)	83-057-3312	No ED Participant	$31,700
LAC/Rancho Los Amigos National Rehabilitation Center	02-753-4119	No ED Participant	$31,700
Los Angeles Community Hospital	04-915-8079	No ED Participant	$31,700
Miller Children's & Women's Hospital	06-324-0614	No ED Participant	$31,700
Southern California Hospital at Hollywood	07-292-7264	No ED Participant	$31,700
Children's Hospital Los Angeles	05-227-7936	PDRC	$267,700
Cedars Sinai Medical Center	07-530-7785	TDRC	$267,700
Dignity Health - California Hospital Medical Center	14-524-3171	TDRC	$267,700
Dignity Health - St. Mary Medical Center	12-022-9166	TDRC	$267,700
Henry Mayo Newhall Memorial Hospital	08-540-5439	TDRC	$267,700
LAC Harbor-UCLA Medical Center	05-992-8962	TDRC	$267,700
LAC+USC Medical Center	05-545-4695	TDRC	$267,700
Long Beach Memorial Medical Center	13-346-2556	TDRC	$267,700
Pomona Valley Hospital Medical Center	07-724-6197	TDRC	$267,700
Ronald Reagan - UCLA Medical Center	95-413-1416	TDRC	$267,700
Antelope Valley Hospital	04-034-9462	Trauma Participant	$132,700
Dignity Health - Northridge Hospital Medical Center	13-160-6022	Trauma Participant	$131,700
Huntington Memorial Hospital	06-668-3962	Trauma Participant	$131,700
Providence Holy Cross Medical Center	01-469-5515	Trauma Participant	$131,700
Saint Francis Medical Center	07-796-8014	Trauma Participant	$131,700

Community Clinic Association of Los Angeles County $360,000

ATTACHMENT 2

CONTRACT DISCREPANCY REPORT

TO:

FROM:

DATES: **Prepared:** _____

Returned by Contractor: _____

Action Completed: _____

DISCREPANCY PROBLEMS: _____

_____

_____

_____ _____

Signature of County Representative Date

CONTRACTOR RESPONSE (Cause and Corrective Action): _____

_____

_____

_____ _____

Signature of Contractor Representative Date

COUNTY EVALUATION OF CONTRACTOR RESPONSE: _____

_____

_____

_____ _____

Signature of Contractor Representative Date

COUNTY ACTIONS: _____

_____

_____

CONTRACTOR NOTIFIED OF ACTION:

County Representative's Signature and Date _____

Contractor Representative's Signature and Date _____

NON-COMPLIANCE PROCEDURES

Procedure Step #	Contractor	County
1		Contractor is notified of non-compliance with agreement. Letter addressed to Chief Executive Officer (CEO) and the project manager.
2	Contractor acknowledges receipt of non-compliance letter and submits improvement action plan (IAP) within 30 days of postmark that addresses the identified findings relative to areas of non-compliance.	Reviews IAP and determines if IAP addresses all non-compliance items. Within 15 days of receipt of IAP, County will do one of the following: a) If IAP is satisfactory, a compliance letter is sent to the CEO and project manager identifying that the Contractor has met the requirements in the agreement and is now compliant with no further action needed. b) If IAP is not satisfactory, an email is sent to the project manager addressing any remaining findings not adequately addressed in the IAP.
3	**If addressed in the IAP**	Within 15 days of receipt the County will review the additional information provided and will do one of the following: a) If all information has been received to provide an adequate IAP, a compliance letter is sent to the CEO identifying that Contractor has met the requirements in the agreement and is now compliant with no further action needed. b) If IAP is not satisfactory another follow-up email is sent to the project manager addressing any remaining findings not adequately addressed in the IAP.
4	If additional action was identified by the County, the project manager will provide the necessary information within 7 days of notification of findings that still were not adequately addressed in the revised IAP.	Within 15 days of receipt the County will review the additional information provide and will do one of the following: a) If all information has been received to provide an adequate IAP, a compliance letter is sent to the CEO identifying that the Contractor has met the requirements in the agreement and is now compliant with no further action needed. b) If IAP still does not satisfactorily address all findings of non-compliance, a second letter will be sent to the CEO and the project manager identifying that the Contractor is still not compliant with agreement requirements and future funding may be impacted[1]. Continue corresponding per above until IAP is complete
5	Contractor will provide necessary updates on IAP	If County determines while monitoring the IAP that the IAP is not being adhered to an email will be sent to the project manager to get an update on the status
6	Contractor will ensure IAP is being followed	County continues to ensure compliance and that IAP is being followed.

[1]Contractor could be placed on reimbursement status until compliant with all requirements of the agreement. Other causes for placing a Contractor on reimbursement status could be subsequent years with audit findings showing a pattern of non-compliance with the requirements of the agreement.

INTENTIONALLY OMITTED

INTENTIONALLY OMITTED

CONTRACTOR'S EEO CERTIFICATION

Pasadena Hospital Association, Ltd.
Contractor Name

100 W. California Blvd., Pasadena, CA 91105
Address

95-1644036
Internal Revenue Service Employer Identification Number

GENERAL CERTIFICATION

In accordance with Section 4.32.010 of the Code of the County of Los Angeles, the contractor, supplier, or vendor certifies and agrees that all persons employed by such firm, its affiliates, subsidiaries, or holding companies are and will be treated equally by the firm without regard to or because of race, religion, ancestry, national origin, or sex and in compliance with all anti-discrimination laws of the United States of America and the State of California.

CONTRACTOR'S SPECIFIC CERTIFICATIONS

1.	The Contractor has a written policy statement prohibiting discrimination in all phases of employment.	Yes ☑	No ☐
2.	The Contractor periodically conducts a self analysis or utilization analysis of its work force.	Yes ☑	No ☐
3.	The Contractor has a system for determining if its employment practices are discriminatory against protected groups.	Yes ☑	No ☐
4.	Where problem areas are identified in employment practices, the Contractor has a system for taking reasonable corrective action, to include establishment of goals or timetables.	Yes ☑	No ☐

Steven L. Mohr, SVP and Chief Financial Officer
Authorized Official's Printed Name and Title

REDACTED
Authorized Official's Signature

01-06-2020
Date

EXHIBIT E

COUNTY'S ADMINISTRATION

MASTER AGREEMENT NO. _____

FACILITY MASTER AGREEMENT PROJECT DIRECTOR (MAPD):

Name: _____
Title: _____
Address: _____
_____
Telephone: _____
Facsimile: _____
E-Mail Address: _____

FACILITY PROJECT DIRECTOR:

Name: _____
Title: _____
Address: _____
_____
Telephone: _____
Facsimile: _____
E-Mail Address: _____

FACILITY PROJECT MANAGER:

Name: _____
Title: _____
Address: _____
_____
Telephone: _____
Facsimile: _____
E-Mail Address: _____

EXHIBIT F

CONTRACTOR'S ADMINISTRATION

Pasadena Hospital Association, Ltd.
CONTRACTOR'S NAME

MASTER AGREEMENT NO. H-708207

CONTRACTOR'S PROJECT DIRECTOR:

Name: Jenny Van Styke
Title: Prehospital Care Coordinator
Address: 100 W. California Blvd.
Pasadena, CA 91105
Telephone: 626-397-8482
Facsimile: 626-397-2981
E-Mail Address: jenny.vanstyke@huntingtonhospital.com

CONTRACTOR'S AUTHORIZED OFFICIAL(S)

Name: Karen Knudsen
Title: Emergency Dept. Manager
Address: 100 W. California Blvd.
Pasadena, CA 91105
Telephone: 626-397-3872
Facsimile: 626-397-9281
E-Mail Address: Karen.Knudsen@huntingtonhospital.com

Name: Alison Birnie
Title: Clinical Director, ED/Trauma/CCU/Dou/OMC
Address: 100 W. California Blvd.
Pasadena, CA 91105
Telephone: 626-397-5105
Facsimile: 626-397-9281
E-Mail Address: alison.birnie@huntingtonhospital.com

Notices to Contractor shall be sent to the following address:

Name: Lori J. Morgan, MD, MBA
Title: President and CEO
Address: 100 W. California Blvd.
Pasadena, CA 91105
Telephone: 626-397-5555
Facsimile: 626-397-2995
E-Mail Address: Lori.morgan@huntingtonhospital.com

FORMS REQUIRED AT THE TIME OF MASTER AGREEMENT EXECUTION

G1 CONTRACTOR ACKNOWLEDGEMENT AND CONFIDENTIALITY AGREEMENT

EXHIBIT G1

(Note: This certification is to be executed and returned to County with Contractor's Master Agreement.)

Contractor Name _____

County Master Agreement No. _____

GENERAL INFORMATION:

The Contractor referenced above has entered into a Master Agreement with the County of Los Angeles to provide certain services to the County. The County requires the Corporation to sign this Contractor Acknowledgement and Confidentiality Agreement.

CONTRACTOR ACKNOWLEDGEMENT:

Contractor understands and agrees that the Contractor employees, consultants, Outsourced Vendors and independent contractors (Contractor's Staff) that will provide services in the above referenced agreement are Contractor's sole responsibility. Contractor understands and agrees that Contractor's Staff must rely exclusively upon Contractor for payment of salary and any and all other benefits payable by virtue of Contractor's Staff's performance of work under the above-referenced Master Agreement.

Contractor understands and agrees that Contractor's Staff are not employees of the County of Los Angeles for any purpose whatsoever and that Contractor's Staff do not have and will not acquire any rights or benefits of any kind from the County of Los Angeles by virtue of performance of work under the above-referenced Master Agreement. Contractor understands and agrees that Contractor's Staff will not acquire any rights or benefits from the County of Los Angeles pursuant to any agreement between any person or entity and the County of Los Angeles.

CONFIDENTIALITY AGREEMENT:

Contractor and Contractor's Staff may be involved with work pertaining to services provided by the County of Los Angeles and, if so, Contractor and Contractor's Staff may have access to confidential data and information pertaining to persons and/or entities receiving services from the County. In addition, Contractor and Contractor's Staff may also have access to proprietary information supplied by other vendors doing business with the County of Los Angeles. The County has a legal obligation to protect all such confidential data and information in its possession, especially data and information concerning health, criminal, and welfare recipient records. Contractor and Contractor's Staff understand that if they are involved in County work, the County must ensure that Contractor and Contractor's Staff, will protect the confidentiality of such data and information. Consequently, Contractor must sign this Confidentiality Agreement as a condition of work to be provided by Contractor's Staff for the County.

Contractor and Contractor's Staff hereby agrees that they will not divulge to any unauthorized person any data or information obtained while performing work pursuant to the above-referenced Master Agreement between Contractor and the County of Los Angeles. Contractor and Contractor's Staff agree to forward all requests for the release of any data or information received to County's Project Manager.

Contractor and Contractor's Staff agree to keep confidential all health, criminal, and welfare recipient records and all data and information pertaining to persons and/or entities receiving services from the County, design concepts, algorithms, programs, formats, documentation, Contractor proprietary information and all other original materials produced, created, or provided to Contractor and Contractor's Staff under the above-referenced Master Agreement. Contractor and Contractor's Staff agree to protect these confidential materials against disclosure to other than Contractor or County employees who have a need to know the information. Contractor and Contractor's Staff agree that if proprietary information supplied by other County vendors is provided during this employment, Contractor and Contractor's Staff shall keep such information confidential.

Contractor and Contractor's Staff agree to report any and all violations of this agreement by Contractor and Contractor's Staff and/or by any other person of whom Contractor and Contractor's Staff become aware.

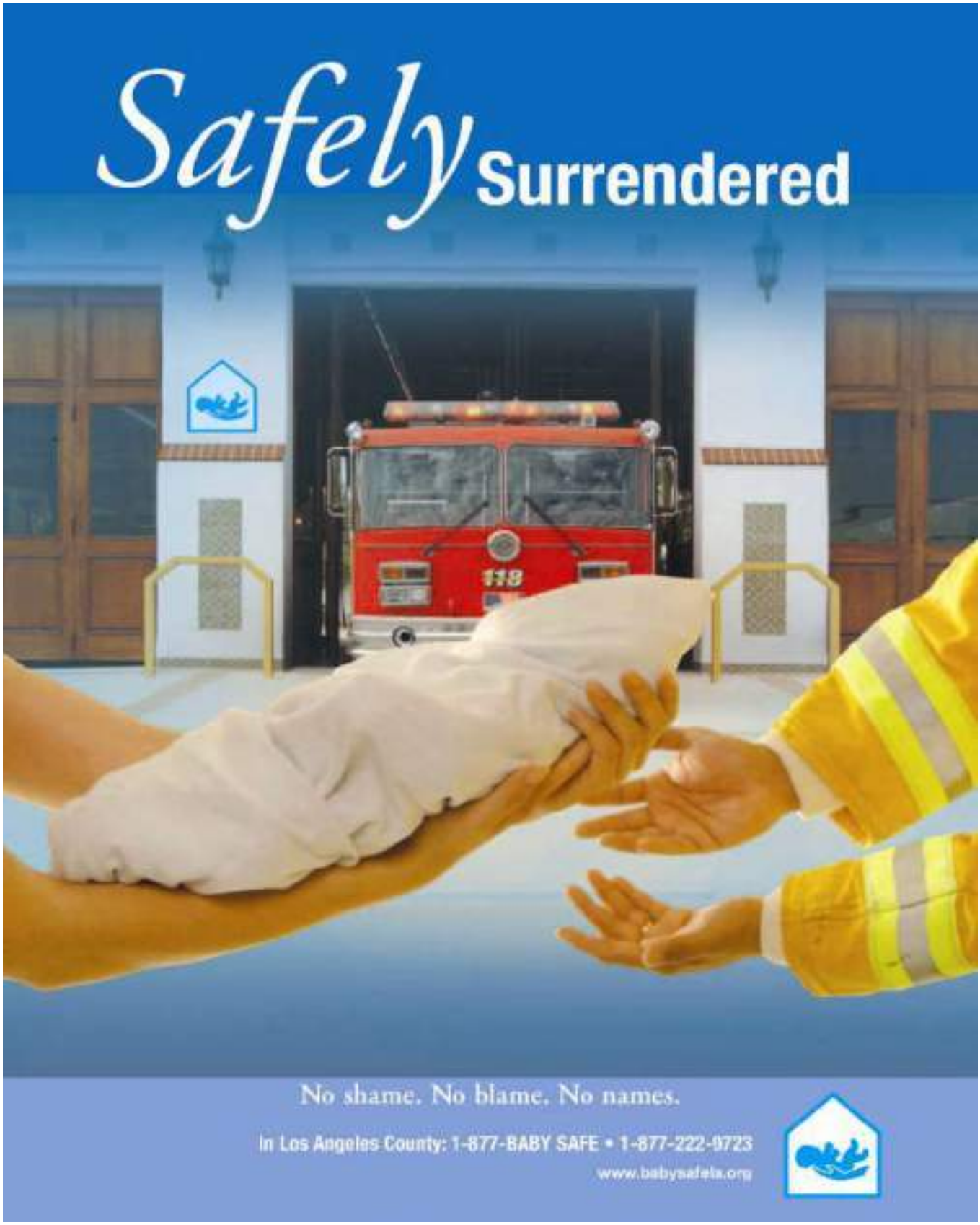
Contractor and Contractor's Staff acknowledge that violation of this agreement may subject Contractor and Contractor's Staff to civil and/or criminal action and that the County of Los Angeles may seek all possible legal redress.

SIGNATURE: REDACTED DATE: 01 / 06 / 2020

PRINTED NAME: Kory J. Meagan, MD, MBA

POSITION: President and CEO

INTENTIONALLY OMITTED


Safely Surrendered
No shame. No blame. No names.
In Los Angeles County: 1-877-BABY SAFE • 1-877-222-9723
www.babysafela.org

Safely Surrendered Baby Law

In Los Angeles County: 1 877 BABY SAFE 1 877 222 9723
www.babysafela.org

What is the Safely Surrendered Baby Law?

California's Safely Surrendered Baby Law allows parents or other persons, with lawful custody, which means anyone to whom the parent has given permission to confidentially surrender a baby. As long as the baby is three days (72 hours) of age or younger and has not been abused or neglected, the baby may be surrendered without fear of arrest or prosecution.

How does it work?

A distressed parent who is unable or unwilling to care for a baby can legally, confidentially, and safely surrender a baby within three days (72 hours) of birth. The baby must be handed to an employee at a hospital or fire station in Los Angeles County. As long as the baby shows no sign of abuse or neglect, no name or other information is required. In case the parent changes his or her mind at a later date and wants the baby back, staff will use bracelets to help reconnect them to each other. One bracelet will be placed on the baby, and a matching bracelet will be given to the parent or other surrendering adult.

What if a parent wants the baby back?

Parents who change their minds can begin the process of reclaiming their baby within 14 days. These parents should call the Los Angeles County Department of Children and Family Services at **1-800-540-4000**.

Can only a parent bring in the baby?

No. While in most cases a parent will bring in the baby, the Law allows other people to bring in the baby if they have lawful custody.

Does the parent or surrendering adult have to call before bringing in the baby?

No. A parent or surrendering adult can bring in a baby anytime, 24 hours a day, 7 days a week, as long as the parent or surrendering adult surrenders the baby to someone who works at the hospital or fire station.

Does the parent or surrendering adult have to tell anything to the people taking the baby?

No. However, hospital or fire station personnel will ask the surrendering party to fill out a questionnaire designed to gather important medical history information, which is very useful in caring for the baby. The questionnaire includes a stamped return envelope and can be sent in at a later time.

What happens to the baby?

The baby will be examined and given medical treatment. Upon release from the hospital, social workers immediately place the baby in a safe and loving home and begin the adoption process.

What happens to the parent or surrendering adult?

Once the parent or surrendering adult surrenders the baby to hospital or fire station personnel, they may leave at any time.

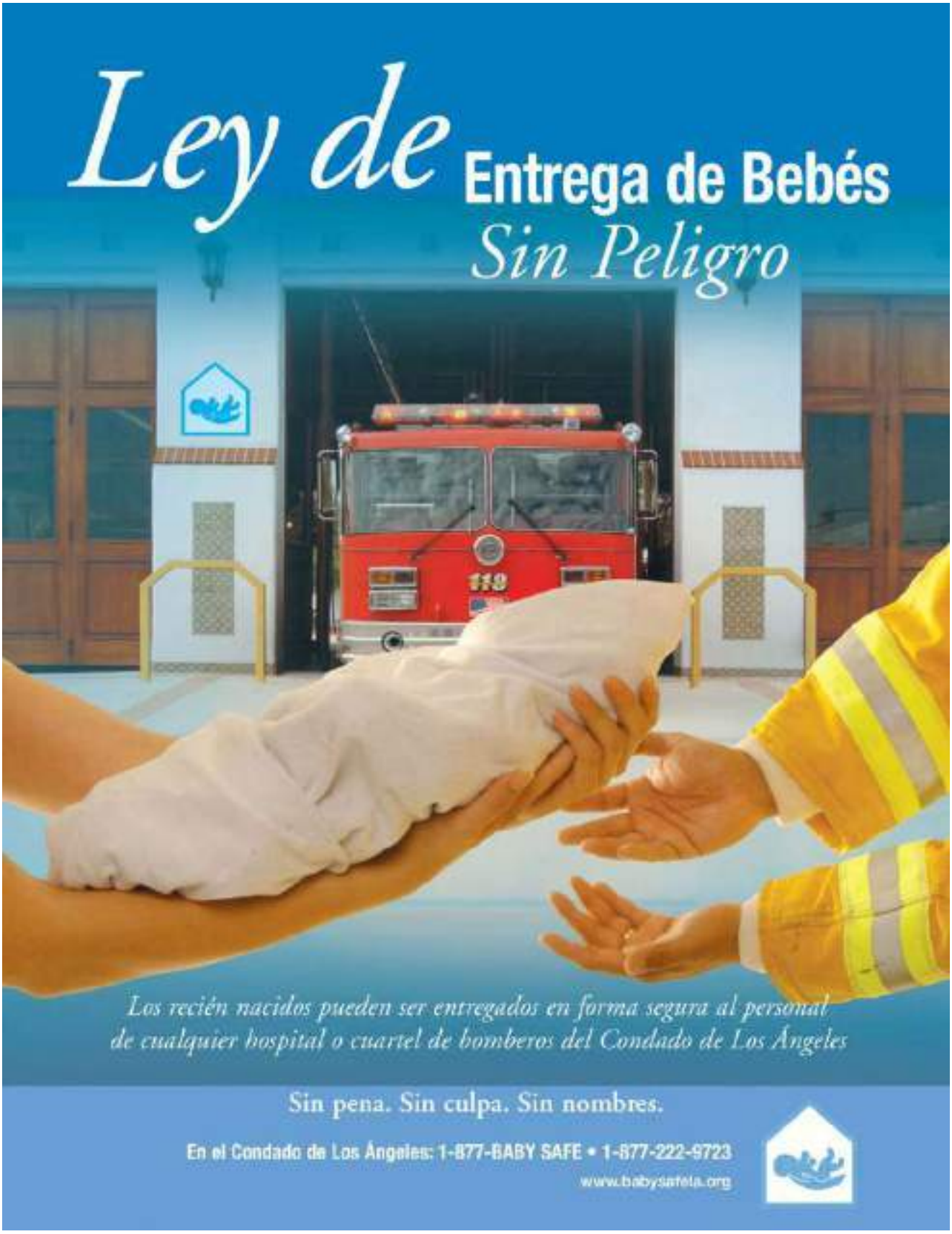
Why is California doing this?

The purpose of the **Safely Surrendered Baby Law** is to protect babies from being abandoned, hurt or killed by their parents. You may have heard tragic stories of babies left in dumpsters or public bathrooms. Their parents may have been under severe emotional distress. The mothers may have hidden their pregnancies, fearful of what would happen if their families found out. Because they were afraid and had no one or nowhere to turn for help, they abandoned their babies. Abandoning a baby is illegal and places the baby in extreme danger. Too often, it results in the baby's death. The **Safely Surrendered Baby Law** prevents this tragedy from ever happening again in California.

A baby's story



Early in the morning on April 9, 2005, a healthy baby boy was safely surrendered to nurses at Harbor-UCLA Medical Center. The woman who brought the baby to the hospital identified herself as the baby's aunt and stated the baby's mother had asked her to bring the baby to the hospital on her behalf. The aunt was given a bracelet with a number matching the anklet placed on the baby; this would provide some identification in the event the mother changed her mind about surrendering the baby and wished to reclaim the baby in the 14-day period allowed by the Law. The aunt was also provided with a medical questionnaire and told she would have the mother complete and mail back in the stamped return envelope provided. The baby was examined by medical staff and pronounced healthy and full-term. He was placed with a loving family that had been approved to adopt him by the Department of Children and Family Services.


Ley de Entrega de Bebés Sin Peligro
Los recién nacidos pueden ser entregados en forma segura al personal de cualquier hospital o cuartel de bomberos del Condado de Los Ángeles
Sin pena. Sin culpa. Sin nombres.
En el Condado de Los Angeles: 1-877-BABY SAFE • 1-877-222-9723
www.babysafela.org

Ley de Entrega de Bebés *Sin Peligro*

En el Condado de Los Ángeles: 1-877-BABY SAFE • 1-877-222-9723
www.babysafela.org

¿Qué es la Ley de Entrega de Bebés sin Peligro?

La Ley de Entrega de Bebés sin Peligro de California permite la entrega confidencial de un recién nacido por parte de sus padres u otras personas con custodia legal, es decir cualquier persona a quien los padres le hayan dado permiso. Siempre que el bebé tenga tres días (72 horas) de vida o menos, y no haya sufrido abuso ni negligencia, pueden entregar al recién nacido sin temor de ser arrestados o procesados.

Cada recién nacido se merece la oportunidad de tener una vida saludable. Si alguien que usted conoce está pensando en abandonar a un recién nacido, infórmele que tiene otras opciones. Hasta tres días (72 horas) después del nacimiento, se puede entregar un recién nacido al personal de cualquier hospital o cuartel de bomberos del condado de Los Angeles.

¿Cómo funciona?

El padre/madre con dificultades que no puede o no quiere cuidar de su recién nacido puede entregarlo en forma legal, confidencial y segura dentro de los tres días (72 horas) del nacimiento. El bebé debe ser entregado a un empleado de cualquier hospital o cuartel de bomberos del Condado de Los Ángeles. Siempre que el bebé no presente signos de abuso o negligencia, no será necesario suministrar nombres ni información alguna. Si el padre/madre cambia de opinión posteriormente y desea recuperar a su bebé, los trabajadores utilizarán brazaletes para poder vincularlos. El bebé llevará un brazalete y el padre/madre o el adulto que lo entregue recibirá un brazalete igual.

¿Qué pasa si el padre/madre desea recuperar a su bebé?

Los padres que cambien de opinión pueden comenzar el proceso de reclamar a su recién nacido dentro de los 14 días. Estos padres deberán llamar al Departamento de Servicios para Niños y Familias (Department of Children and Family Services) del Condado de Los Ángeles al 1-800-540-4000.

¿Sólo los padres podrán llevar al recién nacido?

No. Si bien en la mayoría de los casos son los padres los que llevan al bebé, la ley permite que otras personas lo hagan *si tienen custodia legal.*

¿Los padres o el adulto que entrega al bebé deben llamar antes de llevar al bebé?

No. El padre/madre o adulto puede llevar al bebé en cualquier momento, las 24 horas del día, los 7 días de la semana, siempre y cuando entreguen a su bebé a un empleado del hospital o cuartel de bomberos.

¿Es necesario que el padre/madre o adulto diga algo a las personas que reciben al bebé?

No. Sin embargo, el personal del hospital o cuartel de bomberos le pedirá a la persona que entregue al bebé que llene un cuestionario con la finalidad de recabar antecedentes médicos importantes, que resultan de gran utilidad para cuidar bien del bebé. El cuestionario incluye un sobre con el sello postal pagado para enviarlo en otro momento.

¿Qué pasará con el bebé?

El bebé será examinado y le brindarán atención médica. Cuando le den el alta del hospital, los trabajadores sociales inmediatamente ubicarán al bebé en un hogar seguro donde estará bien atendido, y se comenzará el proceso de adopción.

¿Qué pasará con el padre/madre o adulto que entregue al bebé?

Una vez que los padres o adulto hayan entregado al bebé al personal del hospital o cuartel de bomberos, pueden irse en cualquier momento.

¿Por qué se está haciendo esto en California? ?

La finalidad de la **Ley de Entrega de Bebés sin Peligro** es proteger a los bebés para que no sean abandonados, lastimados o muertos por sus padres. Usted probablemente haya escuchado historias trágicas sobre bebés abandonados en basureros o en baños públicos. Los padres de esos bebés probablemente hayan estado pasando por dificultades emocionales graves. Las madres pueden haber ocultado su embarazo, por temor a lo que pasaría si sus familias se enteraran. Abandonaron a sus bebés porque tenían miedo y no tenían nadie a quien pedir ayuda. El abandono de un recién nacido es ilegal y pone al bebé en una situación de peligro extremo. Muy a menudo el abandono provoca la muerte del bebé. La **Ley de Entrega de Bebés sin Peligro** impide que vuelva a suceder esta tragedia en California.

Historia de un bebé



A la mañana temprano del día 9 de abril de 2005, se entregó un recién nacido saludable a las enfermeras del Harbor-UCLA Medical Center. La mujer que llevó el recién nacido al hospital se dio a conocer como la tía del bebé, y dijo que la madre le había pedido que llevara al bebé al hospital en su nombre. Le entregaron a la tía un brazalete con un número que coincidía con la pulsera del bebé; esto serviría como identificación en caso de que la madre cambiara de opinión con respecto a la entrega del bebé y decidiera recuperarlo dentro del período de 14 días que permite esta ley. También le dieron a la tía un cuestionario médico, y ella dijo que la madre lo llenaría y lo enviaría de vuelta dentro del sobre con franqueo pagado que le habían dado. El personal médico examinó al bebé y se determinó que estaba saludable y a término. El bebé fue ubicado con una buena familia que ya había sido aprobada para adoptarlo por el Departamento de Servicios para Niños y Familias.

Exhibit 23-C

Mental Health Services Agreement No. MH060087 for Psychiatric Inpatient Hospital Services

LR

CONTRACTOR'S COPY

MENTAL HEALTH SERVICES AGREEMENT
CONTRACT ALLOWABLE RATE – FEE-FOR-SERVICE
MEDI-CAL ACUTE PSYCHIATRIC INPATIENT HOSPITAL SERVICES

CONTRACTOR

Pasadena Hospital Association LTD.

MH060067
Agreement Number

dba Huntington Memorial Hospital

MH060051
Reference Number

Business Address:

100 West California Blvd.

Pasadena, CA 91105

Contract Headquarters' Supervisorial District(s) 5

Mental Health Service Area: 3

----------Below This Line For Official CDAD Use Only----------

DISTRIBUTION
(Please type in the applicable name for each)

Medical Director: Roderick Shaner, M.D.

Lead Manager: Pansy Washington, District Chief

K: S X or U

TABLE OF CONTENTS

PARAGRAPH		PAGE
	RECITALS	1
1.	TERM	4
2.	TERMINATION WITHOUT CAUSE	5
3.	IMMEDIATE TERMINATION BY COUNTY	5
4.	CONTRACTOR ALERT REPORTING DATABASE (CARD)	6
5.	ADMINISTRATION	6
6.	DESCRIPTION OF SERVICES	6
7.	FINANCIAL PROVISIONS	8
8.	COUNTY'S OBLIGATION FOR CURRENT AND FUTURE FISCAL YEARS	12
9.	STAFFING	12
10.	STAFF TRAINING AND SUPERVISION	12
11.	PROGRAM SUPERVISION, MONITORING AND REVIEW	13
12.	PERFORMANCE STANDARDS AND OUTCOMES MEASURES	13
13.	COUNTY'S QUALITY MANAGEMENT PROGRAM	13
14.	RECORDS AND AUDITS	14
15.	REPORTS	16
16.	CONFIDENTIALITY	17
17.	BENEFICIARIES RIGHTS	18
18.	REPORTING OF BENEFICIARY ABUSE AND RELATED PERSONNEL REQUIREMENTS	18
19.	NONDISCRIMINATION IN SERVICES	19
20.	NONDISCRIMINATION IN EMPLOYMENT	20
21.	FAIR LABOR STANDARDS	21
22.	INDEMNIFICATION AND INSURANCE	21
23.	WARRANTY AGAINST CONTINGENT FEES	25
24.	CONFLICT OF INTEREST	25
25.	UNLAWFUL SOLICITATION	25
26.	INDEPENDENT STATUS OF CONTRACTOR	25
27.	CONSIDERATION OF HIRING COUNTY EMPLOYEES TARGETED FOR LAYOFF OR FORMER COUNTY EMPLOYEES ON A REEMPLOYMENT LIST	26
28.	CONSIDERATION OF HIRING GREATER AVENUES FOR INDEPENDENCE (GAIN) PARTICIPANTS OR GENERAL RELIEF OPPORTUNITIES FOR WORK (GROW) PARTICIPANTS FOR EMPLOYMENT	26
29.	DELEGATION AND ASSIGNMENT	26
30.	SUBCONTRACTING	27
31.	GOVERNING LAW, JURISDICTION AND VENUE	29
32.	COMPLIANCE WITH APPLICABLE LAW	30
33.	THIRD PARTY BENEFICIARIES	30
34.	LICENSES, PERMITS, REGISTRATIONS, ACCREDITATIONS, AND CERTIFICATIONS	30
35.	CHILD SUPPORT COMPLIANCE PROGRAMS	30
36.	TERMINATION FOR INSOLVENCY	31
37.	TERMINATION FOR DEFAULT	31
38.	TERMINATION FOR IMPROPER CONSIDERATION	32
39.	SEVERABILITY	32
40.	CAPTIONS AND PARAGRAPH HEADINGS	32
41.	ALTERATION OF TERMS	32
42.	ENTIRE AGREEMENT	33
43.	WAIVER	33
44.	BENEFICIARY ELIGIBILITY	33
45.	EMPLOYMENT ELIGIBILITY VERIFICATION	33
46	PUBLIC ANNOUNCEMENTS AND LITERATURE	34

PARAGRAPH		PAGE
47.	AUTHORIZATION WARRANTY	34
48.	RESTRICTIONS ON LOBBYING	34
49.	CERTIFICATION OF DRUG-FREE WORK PLACE	34
50.	COUNTY LOBBYISTS	34
51.	MAINTENANCE STANDARDS FOR SERVICE DELIVERY SITES	34
52.	NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT	34
53.	USE OF RECYCLED-CONTENT PAPER PRODUCTS	35
54.	CONTRACTOR RESPONSIBILITY AND DEBARMENT	35
55.	CONTRACTOR'S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM	36
56.	HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT	37
57.	TECHNOLOGY REQUIREMENTS	39
58.	COMPLIANCE WITH JURY SERVICE PROGRAM	39
59.	NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY LAW	40
60.	CONTRACTOR'S ACKNOWLEDGEMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW	41
61.	CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION – LOWER TIER COVERED TRANSACTIONS	41
62.	CONTRACTOR CHARITABLE ACTIVITIES COMPLIANCE	41
63.	LOCAL SMALL BUSINESS ENTERPRISE PREFERENCE PROGRAM	41
64.	FORCE MAJEURE	42
65.	CONTRACTOR'S WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION	42
66.	TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM	43
67.	PUBLIC RECORDS ACT	43
68.	SECURITY AND BACKGROUND INVESTIGATION	43
69.	AIR OR WATER POLLUTION REQUIREMENTS	44
70.	TIME OFF FOR VOTING	44
71.	NOTICES	44

ATTACHMENTS

ATTACHMENT I	DEFINITIONS
ATTACHMENT II	FFS SERVICE EXHIBIT A
ATTACHMENT III	ATTESTATION REGARDING FEDERALLY FUNDED PROGRAM
ATTACHMENT IV	SAFELY SURRENDERED BABY LAW FACT SHEET (In English and Spanish)
ATTACHMENT V	CHARITABLE CONTRIBUTIONS CERTIFICATION
ATTACHMENT VI	ATTESTATION REGARDING STAFFING RATIO
ATTACHMENT VII	CROSSWALK FACT SHEET
ATTACHMENT VIII	ACKNOWLEDGEMENT AND CONFIDENTIALITY AGREEMENTS
ATTACHMENT IX	CONTRACTOR'S EEO CERTIFICATION
ATTACHMENT X	ELECTRONIC TRADING PARTNER AGREEMENT
ATTACHMENT XI	PDP SERVICE EXHIBIT B

MENTAL HEALTH SERVICES AGREEMENT
CONTRACT ALLOWABLE RATE - FEE FOR SERVICE
MEDI-CAL ACUTE PSYCHIATRIC INPATIENT HOSPITAL SERVICES

THIS AGREEMENT is made and entered into this 1st day of July, 2015, by and between the County of Los Angeles (hereafter "County"), and

Pasadena Hospital Association LTD.
dba Huntington Memorial Hospital
(hereafter "Contractor")

Business Address:
100 West California Blvd.
Pasadena, CA 91105

WHEREAS, County desires to provide to those persons in Los Angeles County who qualify therefore certain mental health services contemplated and authorized by the California Welfare and Institutions Code Section 14712 et seq., Joint Commission on Accreditation of Health Care Organizations (JCAHCO) accreditation standards or by an approved equivalent agency; and

WHEREAS, Contractor is equipped, staffed, and prepared to provide these services as described in this Agreement; and

WHEREAS, pursuant to California Welfare and Institutions Code Section 14712 et seq., County is authorized to contract with various providers of Psychiatric Inpatient Hospital Services for Medi-Cal beneficiaries that seek reimbursement for such services under the Medi-Cal Local Mental Health Plan (LMHP) program; and

WHEREAS, Contractor recognizes that this Agreement is formed under California Welfare and Institutions Code Section 14712 et seq., and State of California regulations adopted pursuant thereto which authorize County to contract for the provision of Psychiatric Inpatient Hospital Services to Medi-Cal beneficiaries eligible for such services under the Medi-Cal Fee-For-Service program in accordance with the terms and conditions negotiated by County; and

WHEREAS, these services shall be provided by Contractor in accordance with all applicable federal, State and Local Mental Health Plan (LMHP) laws, ordinances, rules, regulations, manuals, guidelines, and directives, which may include, but are not necessarily limited to, the following: California Welfare and Institutions Code Section 14712 et seq., including, but not limited to, Sections 14713, 14714, 14718 and 14721; Medi-Cal Act, California Welfare and Institutions Code Section 14000 et seq.; California Welfare and Institutions Code Sections 14680, 14681, 14683, and 14684; California Government Code Sections 26227 and 53703; Title XIX of the Social Security Act, 42 United States Code Section 1396 et seq.; California Penal Code Section 11164 et seq.; California Code of Regulations Title 9, Chapter 11 and Title 22; Medi-Cal Fee-For-Service Inpatient Hospital Provider Manual-Third Edition; State's Medicaid Plan; Agreement between Los Angeles County Department of Mental Health and State of California Department of Health Care Services for the provision of Specialty Mental Health Services ; and policies and procedures issued by the

LMHP; and

WHEREAS, this Agreement is authorized by California Welfare and Institutions Code Section 14712 et seq., California Government Code Sections 29004, 26227 and 53703, and otherwise.

PREAMBLE

For over a decade, the County has collaborated with its community partners to enhance the capacity of the health and human services system to improve the lives of children and families. These efforts require, as a fundamental expectation, that the County's contracting partners share the County and community's commitment to provide health and human services that support achievement of the County's vision, goals, values, and adopted outcomes. Key to these efforts is the integration of service delivery systems and the adoption of the Customer Service and Satisfaction Standards.

The County of Los Angeles' Vision is to improve the quality of life in the County by providing responsive, efficient, and high quality public services that promote the self-sufficiency, well-being and prosperity of individuals, families, business and communities. This philosophy of teamwork and collaboration is anchored in the shared values of:

- Responsiveness
- Professionalism
- Accountability
- Compassion
- Integrity
- Commitment
- A Can – Do Attitude
- Respect for Diversity

These shared values are encompassed in the County Mission to enrich lives through effective caring service and the County Strategic Plan's eight goals: 1) Service Excellence; 2) Workforce Excellence; 3) Organizational Effectiveness; 4) Fiscal Responsibility; 5) Children's and Families' Well-Being; 6) Community Services; 7) Health and Mental Health and 8) Public Safety. Improving the well-being of children and families requires coordination, collaboration, and integration of services across functional and jurisdictional boundaries, by and between County departments/agencies, and community and contracting partners.

The basic conditions that represent the well-being we seek for all children and families in Los Angeles County are delineated in the following five outcomes, adopted by the Board of Supervisors in January 1993.

- Good Health;
- Economic Well-Being;
- Safety and Survival;
- Emotional and Social Well Being; and
- Education and Workforce Readiness.

Recognizing no single strategy – in isolation – can achieve the County's outcomes of well-being for children and families, consensus has emerged among County and community leaders that making substantial improvements in integrating the County's health and human services system is necessary to significantly move toward achieving these outcomes. The County has also established the following values and goals for guiding this effort to integrate the health and human services delivery system:

- ✓ Families are treated with respect in every encounter they have with the health, educational, and social service systems.
- ✓ Families can easily access a broad range of services to address their needs, build on their

strengths, and achieve their goals.

- ✓ There is no "wrong door": wherever a family enters the system is the right place.
- ✓ Families receive services tailored to their unique situations and needs.
- ✓ Service providers and advocates involve families in the process of determining service plans, and proactively provide families with coordinated and comprehensive information, services and resources.
- ✓ The County service system is flexible, able to respond to service demands for both the Countywide population and specific population groups.
- ✓ The County service system acts to strengthen communities, recognizing that just as individuals live in families, families live in communities.
- ✓ In supporting families and communities, County agencies work seamlessly with public and private service providers, community-based organizations, and other community partners.
- ✓ County agencies and their partners work together seamlessly to demonstrate substantial progress towards making the system more strength-based, family-focused, culturally competent, accessible, user-friendly, responsive, cohesive, efficient, professional, and accountable.
- ✓ County agencies and their partners focus on administrative and operational enhancements to optimize the sharing of information, resources, and best practices while also protecting the privacy rights of families.
- ✓ County agencies and their partners pursue multi-disciplinary service delivery, a single service plan, staff development opportunities, infrastructure enhancements, customer service and satisfaction evaluation, and revenue maximization.
- ✓ County agencies and their partners create incentives to reinforce the direction toward service integration and seamless service delivery system.
- ✓ The County human service system embraces a commitment to the disciplined pursuit of results accountability across systems. Specifically, any strategy designed to improve the County human services system for children and families should ultimately be judged by whether it helps achieve the County's five outcomes for children and families; good health, safety and survival, economic well-being, social and emotional well-being, and education and workforce readiness.

The County, its clients, contracting partners, and the community will continue to work together to develop practical ways to make County services more accessible, customer friendly, better integrated, and outcome-focused. Several departments have identified shared themes in their strategic plans for achieving these goals including: making an effort to become more consumer/client-focused; valuing community partnerships and collaborations; emphasizing values and integrity; and using a strengths-based and multi-disciplinary team approach. County departments are also working to provide the Board of Supervisors and the community with a better understanding of how resources are being utilized, how well services are being provided, and what are the results of the services: is anyone better off?

The County of Los Angeles health and human service departments and their partners are working together to achieve the following ***Customer Service And Satisfaction Standards*** in support of improving

outcomes for children and families.

Personal Service Delivery

The service delivery team -- staff and volunteers -- will treat customers and each other with courtesy, dignity, and respect.

- Introduce themselves by name
- Listen carefully and patiently to customers
- Be responsive to cultural and linguistic needs
- Explain procedures clearly
- Build on the strengths of families and communities

Service Access

Service providers will work proactively to facilitate customer access to services.

- Provide services as promptly as possible
- Provide clear directions and service information
- Outreach to the community and promote available services
- Involve families in service plan development
- Follow-up to ensure appropriate delivery of services

Service Environment

Service providers will deliver services in a clean, safe, and welcoming environment, which supports the effective delivery of services.

- Ensure a safe environment
- Ensure a professional atmosphere
- Display vision, mission, and values statements
- Provide a clean and comfortable waiting area
- Ensure privacy
- Post compliant and appeals procedures

The basis for all County health and human services contracts is the provision of the highest level of quality services that support improved outcomes for children and families. The County and its contracting partners must work together and share a commitment to achieve a common vision, goals, outcomes, and standards for providing services.

NOW, THEREFORE, Contractor and County agree as follows:

1. TERM:

A. Initial Period: The Initial Period of this Agreement shall commence on July 1, 2015 and shall continue in full force and effect through June 30, 2016.

B. Automatic Renewal Period(s): After the Initial Period, this Agreement shall be automatically renewed without further action by the parties hereto unless either party desires to terminate this Agreement at the end of the Initial Period or First Automatic Renewal Period and gives written notice to the other party not less than thirty (30) days prior to the end of the initial period or at the end of the First Automatic Renewal Period, as applicable.

(1) First Automatic Renewal Period: If this Agreement is automatically renewed, the First Automatic Renewal Period shall commence on July 1, 2016 and shall continue in full force and effect through June 30, 2017.

(2) Second Automatic Renewal Period: If this Agreement is automatically renewed, the Second Automatic Renewal Period shall commence on July 1, 2017 and shall continue in full force and effect through June 30, 2018.

(3) Third Automatic Renewal Period: If this Agreement is automatically renewed, the Third Automatic Renewal Period shall commence on July 1, 2018 and shall continue in full force and effect through June 30, 2019.

(4) Fourth Automatic Renewal Period: If this Agreement is automatically renewed, the Fourth Automatic Renewal Period shall commence on July 1, 2019 and shall continue in full force and effect through June 30, 2020.

2. TERMINATION WITHOUT CAUSE: This Agreement may be terminated by either party at any time without cause by giving at least 30 calendar days prior written notice to the other party.

3. IMMEDIATE TERMINATION BY COUNTY:

A. In addition to any other provisions for termination provided in this Agreement, this Agreement may be terminated by County immediately if County determines that:

(1) Any federal, State, and/or County funds are not available for this Agreement or any portion thereof; or

(2) Contractor has failed to initiate delivery of services within 30 days of the commencement date of this Agreement; or

(3) Contractor has failed to comply with any of the provisions of Paragraphs 19. (NONDISCRIMINATION IN SERVICES), 20. (NONDISCRIMINATION IN EMPLOYMENT), 22. (INDEMNIFICATION AND INSURANCE), 23. (WARRANTY AGAINST CONTINGENT FEES), 24. (CONFLICT OF INTEREST), 29. (DELEGATION AND ASSIGNMENT), 30. (SUBCONTRACTING), 35. (CHILD SUPPORT COMPLIANCE PROGRAM), and/or 49. (CERTIFICATION OF DRUG-FREE WORK PLACE) and/or; 55. (CONTRATOR'S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM); or

(4) In accordance with Paragraph 36. (TERMINATION FOR INSOLVENCY), 37. (TERMINATION FOR DEFAULT), 38. (TERMINATION FOR IMPROPER CONSIDERATION), 50. (COUNTY LOBBYISTS), and/or 55. (TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM).

B. This Agreement shall terminate as of June 30 of the last Fiscal Year for which funds for this Agreement were appropriated by County as provided in Paragraph 8 (COUNTY'S OBLIGATION FOR CURRENT AND FUTURE FISCAL YEARS).

C. In the event that this Agreement is terminated, then:

(1) Upon issuance of any notice of termination, Contractor shall make immediate and appropriate plans to transfer or refer all beneficiaries receiving services under this Agreement to other agencies for continuing services in accordance with the beneficiaries needs. Such plans shall be subject to prior written approval of Director or the Director's designee, except that in specific cases, as determined by Contractor, where an immediate beneficiary transfer or referral is indicated. Contractor may make an

immediate transfer or referral. If Contractor terminates this Agreement, all costs related to all such transferees or referrals as well as all costs related to all continuing services shall not be a charge to this Agreement nor reimbursable in any way under this Agreement.

(2) Any termination of this Agreement by County shall be approved by County's Board of Supervisors.

D. Six Months Notification of Agreement Expiration: Contractor shall notify County when this Agreement is within six (6) months of expiration. Contractor shall send such notice to those persons and addresses which are set forth in Paragraph 70 (NOTICES).

4. CONTRACTOR ALERT REPORTING DATABASE (CARD): The County maintains databases that track/monitor contractor performance history. Information entered into such databases may be used for a variety of purposes, including determining whether the County will exercise an Agreement term extension option.

5. ADMINISTRATION. Director or the director's designee shall have the authority to administer this Agreement on behalf of County. All references to the actions or decisions to be made by the County in this Agreement shall be made by the Director or the Director's designee or the Director's designee unless otherwise expressly provided.

A. The Director may designate one or more person(s) to act as his/her designee for the purposes of administering this Agreement.

B. Contractor shall designate in writing a Single Point of Contact who shall function as liaison with County regarding Contractor's performance hereunder.

C. Contractor shall not maintain, utilize, or otherwise arrange for mobile 5150 assessment personnel or processes outside the confines of the Contractor's facility without the written consent of the Director, or the Director's designee.

6. DESCRIPTION OF SERVICES:

A. General:

(1) Contractor shall provide Acute Psychiatric Inpatient Hospital Services to any Beneficiary in need of such services as authorized by this Agreement and shall assume total liability and responsibility for the provision of all Acute Psychiatric Inpatient Hospital Services rendered to any such Beneficiary, either directly or through subcontractors as permitted under this Agreement.

Contractor shall provide Psychiatric Inpatient Hospital Services in the form as described in Service Exhibit A (FEE-FOR-SERVICE MEDI-CAL ACUTE PSYCHIATRIC INPATIENT HOSPITAL SERVICES), the Program Description of the Contracts Allowable Rate Fee-For-Service Medi-Cal Acute Psychiatric Inpatient Hospital Services Contract Package for this Agreement as approved in writing by Director or the Director's designee, including any addenda thereto as approved in writing by Director or the Director's designee, and otherwise in this Agreement.

Contractor shall accept as payment in full for these Acute Psychiatric Inpatient Hospital Services the payment from Fiscal Intermediary as provided in Paragraph 7 (FINANCIAL PROVISIONS).

(2) Contractor shall, at its own expense, provide and maintain all facilities and

professional, allied and supportive paramedical personnel necessary and appropriate to provide all Acute Psychiatric Inpatient Hospital Services.

(3) Contractor shall, at its own expense, provide and maintain all organizational and administrative capabilities to carry out all of its obligations and responsibilities under this Agreement and all applicable statutes and regulations pertaining to Medi-Cal providers.

(4) Contractor shall, at its own expense, inform DMH of all Medi-Cal beneficiary admissions and discharges within 24 hours; and shall actively participate in DMH programs to increase hospital admissions from Psychiatric Emergency Services (PES), Urgent Care Centers (UCC), the Mental Evaluation Team/System wide Mental Assessment Response Team (Met/Smart) and the Psychiatric Mobile Response Teams (PMRT).

B. Licensure And Certification As Conditions Precedent To Contractor's Eligibility For Reimbursement:

(1) Contractor hereby represents and warrants that it is currently, and for the term of this Agreement shall remain, licensed as a general acute care hospital or acute psychiatric hospital in accordance with California Health and Safety Code Section 1250 et seq. and CCR Title 9 Chapter 11 Subchapter 1810.217, 1810.219.

(2) Contractor hereby represents and warrants that it is currently, and for the term of this Agreement shall remain, certified as a Medi-Cal provider under Title XIX.

(3) Contractor agrees that compliance with its obligations to remain licensed as a general acute care hospital or acute psychiatric hospital as provided in this Subparagraph B and certified as a Medi-Cal provider under Title XIX as provided in this Subparagraph B, shall be express conditions precedent to Contractor's eligibility for reimbursement under this Agreement.

C. Utilization Controls As Conditions Precedent To Contractors Eligibility For Reimbursement: As express conditions precedent to Contractor's eligibility for reimbursement under this Agreement, Contractor shall adhere to all utilization controls and for services in accordance with the CCR, Title 9, Chapter 11, Section 1820.210 through 1820.225 and CFR 42, Chapter IV, Subchapter C, Part 456, Subpart D Section 456.150 through 456.245, LMHP and this Agreement.

D. Quality Of Care As Condition Precedent To Contractor's Eligibility For Reimbursement: As an express condition precedent to Contractors eligibility for reimbursement under this Agreement, Contractor shall:

(1) Assure that any and all Beneficiaries receive care as required by the CCR, Title 9, Chapter 11, Section 1820.210 through 1820.225 and CFR 42, Chapter IV, Subchapter C, Part 456, Subpart D Section 456.150 through 456.245, LMHP, and this Agreement.

(2) Take such action as required by Contractor's medical staff bylaws against any medical staff members who violate those bylaws.

(3) Provide Acute Psychiatric Inpatient Hospital Services to Beneficiaries in the same manner and at the same level as Contractor provides to all other patients/clients to whom Contractor renders similar services.

(4) Not discriminate against any Beneficiary in any manner whatsoever, including, but not limited to, admission practices, placement in special or separate wings or rooms, and provision of special or seperate meals.

E. Assumption Of Financial Risk By Contractor. Notwithstanding any other provision of this Agreement, Contractor shall bear the total financia risk for the cost of all Acute Psychiatric Inpatient Hospital Services rendered to each Beneficiary covered by this Agreement. As used in this Subparagraph E, the term "risk" means that Contractor shall accept as payment in full for any and all Acute Psychiatric Inpatient Hospital Services the payments made by Fisca Intermediary pursuan: to this Agreement. Such acceptance shall be made regardless of whether the cost of such services and relatec administrative expenses shall have exceeded reimbursement under this Agreement. The term "risk" also includes, but is not limited to, the cost for all Acute Psychiatric Inpatient Hospital Services for all illness or injury which may result from or is contributed to by any catastrophe or disaster which occurs subsequent to the effective date of this Agreement, including, but not limited to, acts of God, war or the public enemy.

F. Service Location(s): Contractor shall provide all Acute Psychiatric Inpatient Hospital Services under this Agreement only at the following Contractor facility(ies): 760 South Pasadena Avenue, Pasadena, CA 91105

Contractor shall obtain the prior written consent of Director at least seventy days before terminating services at any such location(s) and/or before commencing such services at any other location(s).

7. FINANCIAL PROVISIONS:

A. Contract Allowable Rates (CAR): This is a CAR agreement. Fiscal Intermediary shall reimburse Contractor during the term of this Agreement for Acute Psychiatric Inpatient Hospital Services provided to Beneficiaries in accordance with WIC Section 14712 et seq., CCR, Title 9, Chapter 11, Section 1820.210 through 1820.225, and this Agreement. Reimbursement for Acute Psychiatric Inpatient Hospital Services shall be at the applicable CAR for Acute Psychiatric Inpatient Hospital Services and Administrative Day Services as mutually agreed upon between Contractor and County and shown in this Subparagraph A less any available third party coverage and/or Medi-Cal Share Of Cost as determined pursuant to Subparagraph B (Billing Procedures As Conditions Precedent To Contractor's Eligibility For Reimbursement).

Acute Psychiatric Inpatient Hospital Services shall be provided in either a licensed acute psychiatric hospital or a distinct acute psychiatric part of a licensed general acute care hospital. Acute Psychiatric Inpatient Hospital Services provided in an acute psychiatric hospital which is larger than sixteen beds shall be reimbursed only for Beneficiaries age under 21 years of age or the beneficiary is 65 years of age or older or the beneficiary was receiving such services prior to his/her twenty-first birthday and the services are rendered without interruption until no longer required or his/her twenty-second birthday, whichever is earlier. During the term of this Agreement, the CAR for Acute Psychiatric Inpatient Hospital Services shall be:

(1) SIX HUNDRED DOLLARS ($600) per day of service for each Medi-Cal Beneficiary during the Period of this Agreement as described in Paragraph 1 (TERM).

The CAR shall cover all services, including, but not limited to, medical ancillaries provided by Contractor to deliver a day of service of Acute Psychiatric Inpatient Hospital Services. Notwithstanding the foregoing, the

CAR shall not include the cost of physician services and psychologist services rendered to Beneficiaries, nor shall it include the cost of transportation services incurred in providing Acute Psychiatric Inpatient Hospital Services. The cost of physician services, psychologist services, and transportation services shall not be reimbursed by the CAR.

During the term of this Agreement, the Contract Allowable Rate for Administrative Day Services shall be at the reimbursement rate determined by the California Department of Healthcare Services (DHCS).

The CAR shall cover all services, including, but not limited to, medical ancillaries provided by Contractor to deliver a day of service of Administrative Day Services. Notwithstanding the foregoing, the CAR shall not include the cost of physician services and psychologist services rendered to Beneficiaries, nor shall it include the cost of transportation services incurred in providing Administrative Day Services. The cost of physician services, psychologist services, and transportation services shall not be reimbursed by the CAR.

Each Fiscal Year or portion thereof of the term of this Agreement, reimbursement for Acute Psychiatric Inpatient Hospital Services shall be made on the basis of: (1) the current FFP match funds which are paid by Fiscal Intermediary to Contractor pursuant to this Agreement; and (2) current match from funds which are allocated by State for County specifically for Acute Psychiatric Inpatient Hospital Services, which are paid by Fiscal Intermediary to Contractor pursuant to this Agreement, and which qualify as eligible FFP matching funds.

Notwithstanding any other provision of this Agreement, Contractor shall be entitled to reimbursement from Fiscal Intermediary for Acute Psychiatric Inpatient Hospital Services only: (1) if there is a Treatment Authorization Request for the particular Acute Psychiatric Inpatient Hospital Services or Administrative Day Services which has been submitted by Contractor to County as required by this Agreement and approved by County; (2) if the particular Acute Psychiatric Inpatient Hospital Services or Administrative Day Services provided pursuant to the County-approved Treatment Authorization Request are consistent with the County-approved Treatment Authorization Request and are appropriate for clinical reimbursement as determined by Director or the Director's designee; (3) to the extent that funds allocated by State for County specifically for Acute Psychiatric Inpatient Hospital Services are available as eligible FFP matching funds; and (4) for all Los Angeles County Regional Center beneficiaries, except Harbor Regional Center, the County acting as the Local Mental Health Plan, shall only be responsible for authorizing a maximum reimbursement for four (4) administrative days.

B. <u>Billing Procedures As Conditions Precedent To Contractor's Eligibility For Reimbursement</u>: As an express condition precedent to Contractor's eligibility for reimbursement under this Agreement, Contractor shall determine:

(1) Whether the Acute Psychiatric Inpatient Hospital Services for which claim is made are covered, in whole or in part, under any other State or Federal medical care program or under any other contractual or legal entitlement, including, but not limited to, any private group indemnification or insurance program or workers' compensation, and (2) whether the Beneficiaries for whom claim is made are responsible for any/all Medi-Cal Share Of Cost for the particular Acute Psychiatric Inpatient Hospital Services.

Notwithstanding any other provision of this Agreement, to the extent that any such third party coverage and/or Medi-Cal Share of Cost is available, Contractor's reimbursement shall be reduced.

(2) As a further express condition precedent to Contractor's eligibility for reimbursement under this Agreement, Contractor shall submit claims on the prescribed form and with the appropriate allowable psychiatric accommodation codes to Fiscal Intermediary for reimbursement for all Acute Psychiatric Inpatient Hospital Services rendered to Beneficiaries, under this Agreement, in accordance with all applicable requirements.

(3) Contractor shall claim a day of service of Acute Psychiatric Inpatient Hospital Services or Administrative Day Services for each Beneficiary who occupies an inpatient psychiatric bed at 12:00 midnight in Contractor's facility(ies), based on the particular services provided at that time. Contractor shall claim a day of service for the Beneficiary for the day of admission and not the day of discharge; however, a day of service may be claimed if the Beneficiary is admitted and discharged during the same day, provided that such admission and discharge is not within twenty-four hours of a prior discharge.

C. Government Funding Restrictions: This Agreement shall be subject to any restrictions, limitations, or conditions imposed by State, including, but not limited to, those contained in State's Budget Act, which may in any way affect the provisions or funding of this Agreement. This Agreement shall also be subject to any additional restrictions, limitations, or conditions imposed by the federal government which may in any way affect the provisions or funding of this Agreement.

D. Recovery Of Overpayments: When an audit or review performed by County, State and/or Federal governments or by any other authorized agency discloses that Contractor has been overpaid under this Agreement, and then the overpayment shall be due by Contractor to County.

For Federal audit exceptions, Federal audit appeal processes shall be followed. County recovery of Federal overpayment shall be made in accordance with all applicable Federal laws, regulations, manuals, guidelines, and directives.

For State, County and other authorized agency audit and/or review exceptions, County shall recover the payment from Contractor within sixty days of the date of the applicable audit report or other determination of overpayment, provided that if State recovers the overpayment from County before the end of such sixty days, then County shall immediately recover the overpayment from Contractor. Within ten days after written notification by County to Contractor of any overpayment due by Contractor to County, Contractor shall notify County as to which of the following two payment options Contractor requests be used as the method by which the overpayment shall be recovered by County. Any overpayment shall be: (1) paid in one cash payment by Contractor to County or (2) paid by cash payment(s) by Contractor to County over a period not to exceed such sixty days. If Contractor does not so notify County within such ten days or if Contractor fails to make payment of any overpayment to County as required, then the total amount of the overpayment, as determined by Director or the Director's designee, shall be immediately due and payable. For Certain Beneficiary Claims from the State, the Contractor shall reimburse Medi-Cal Beneficiaries for the full amount out of pocket payment received by the Contractor. The Contractor shall respond to the County's request within 30 days of the letter which includes information on the amount and date paid to the Medi-Cal

Beneficiary.

E. Contractor Appeal Procedures: Contractor may appeal the processing or payment of any of its claims for Acute Psychiatric Inpatient Hospital Services or the denial of any request for reimbursement of Acute Psychiatric Inpatient Hospital Services in accordance with the Medi-Cal Acute Psychiatric Inpatient Hospital Services LACDMH Medical Fee-For-Service Inpatient Hospital Provider Manual and CCR Title 9, Chapter 11, Section 1850.305 through 1850.325.

F. County Audit Settlements: If, at any time during the term of this Agreement or at any time after the expiration or termination of this Agreement, authorized representatives of County conduct an audit or review regarding the Acute Psychiatric Inpatient Hospital Services provided hereunder and if such audit or review finds that the dollar liability of County and/or federal governments for such services is less than the payments made by Fiscal Intermediary to Contractor, then the difference shall be due by Contractor to County. Within thirty days after written notification by County to Contractor of any such difference due by Contractor to County, Contractor shall pay County by one cash payment.

G. Interest Charges on Delinquent Payments: If Contractor, without good cause as determined in the sole judgment of Director, fails to pay County any amount due to County under this Agreement within sixty days after the due date, as determined by Director, then Director, in Director's sole discretion and after written notice to Contractor, may assess interest charges at a rate equal to County's Pool Rate, as determined by County's Auditor-Controller, per day on the delinquent amount due commencing on the sixty-first day after the due date. The interest charges shall be paid by Contractor to County by cash payment upon demand.

I. No payment for Services Provided following Expiration/Termination of Agreement: Contractor shall have no claim against County for payment of any money or reimbursement, of any kind whatsoever, for any service provided by Contractor after the expiration or other termination of this Agreement. Should Contractor receive any such payment, it shall immediately notify County and shall immediately repay all such funds to County. Payment by County for services rendered after expiration/termination of this Agreement shall not constitute a waiver of County's right to recover such payment from Contractor. This provision shall survive the expiration or other termination of this Agreement.

J. Limitation of County's Obligation Due to Non-Appropriation of Funds. Notwithstanding any other provision of this Agreement, County shall not be obligated for Contractor's performance hereunder or by any provision of this Agreement during this or any of County's future fiscal years unless and until County's Board of Supervisors appropriates funds for this Agreement in County's Budget for each such fiscal year. Should County, during this or any subsequent fiscal year impose budgetary restrictions which appropriate less than the amount provided for in Subparagraph A (Contract Allowable Rates (CAR)) and Subparagraph C (Government Funding Restrictions) of this Agreement, County shall reduce services under this Agreement consistent with such imposed budgetary reductions. In the event funds are not appropriated for this Agreement, this Agreement shall terminate as of June 30 of the last fiscal year for which funds were appropriated. County shall notify Contractor of any such changes in allocation of funds at the earliest possible date.

K. Suspension of Payments: Payments to Contractor under this Agreement shall be suspended if Director, for good cause, determines that Contractor is in default under any of the provisions of this Agreement. Except in cases of alleged fraud or similar intentional wrongdoing, at least 30 calendar days' notice of such suspension shall be provided to Contractor, including a statement of the reason(s) for such suspension. Thereafter, contractor may, within 15 calendar days, request reconsideration of the Director's decision. Payments shall not be withheld pending the results of the reconsideration process.

8. COUNTY'S OBLIGATION FOR CURRENT AND FUTURE FISCAL YEARS: Notwithstanding any other provision of this Agreement, this Agreement shall not be effective and binding upon the parties unless and until County's Board of Supervisors appropriates funds for purposes hereof in County's Budget for County's current Fiscal Year. Further, County shall not be obligated for Contractor's performance hereunder or by any provision of this Agreement during any of County's future Fiscal Years unless and until County's Board of Supervisors appropriates funds for purposes hereof in County's Budget for each such future Fiscal Year. In the event that funds are not appropriated for this Agreement, then this Agreement shall terminate as of June 30 of the last Fiscal Year for which funds were appropriated.

9. STAFFING: Contractor shall operate throughout the term of this Agreement with staff, including, but not limited to, professional staff, as indicated in Contractor's contract package for this Agreement, as approved in writing by Director or the Director's designee, including any addenda thereto as approved in writing by Director or the Director's designee and as required by WIC and CCR. Such staff shall be qualified and shall possess all appropriate licenses in accordance with WIC Sections 14718 and all other applicable requirements of the California Business and Professions Code, WIC, CCR and State Policy Letters and function within the scope of practice as dictated by licensing boards/bodies. Contractor shall have available and shall provide upon request to authorized representatives of County, a list of all persons by name, title, professional degree, and experience, who are providing any services under this agreement. Contractor shall provide a copy of the hospital By-laws which specifically allows psychologists to admit, transfer, and discharge patients and other procedures related to the care of mentally ill patients. Additionally, the contractor shall include in its By-law provisions of telepsychiatry services if utilized. Additionally, the contractor shall provide the County a list of attending physicians and licensed psychologists with attending privileges whenever there is a change.

10. STAFF TRAINING AND SUPERVISION: Contractor shall institute and maintain an in-service training program of treatment review and case conferences in which all its professional, para-professional, intern, student and clinical volunteer personnel shall participate. Contractor shall institute and maintain appropriate supervision of all persons providing services under this Agreement with particular emphasis on the supervision of para-professionals, interns, students, and clinical volunteers. Contractor shall be responsible for the provision of mandatory training for all staff at the time of initial employment and on an ongoing basis as required by Federal and State law, including but not limited to HIPAA and Sexual Harassment. Contractor shall be responsible for the training of all appropriate staff on State and County policies and procedures as well as on any other matters that County may reasonably require.

Contractor shall document and make available upon request by the Federal, State and/or County the type

and number of hours of training provided to Contractor's officers, employees and agents,.

11. PROGRAM SUPERVISION, MONITORING AND REVIEW: Director or the Director's designee shall have the right to monitor and specify the kind, quality, appropriateness, timeliness, amount of services, and the criteria for determining the persons to be served. To assure compliance with this Agreement and for any other reasonable purpose relating to performance of this Agreement, and subject to the provisions of State and Federal law, Authorized County, State and/or Federal representatives shall have the right to enter Contractor's premises (including all other places where duties under this Agreement are being performed, with or without notice, to inspect , monitor and/or audit Contractor's facilities, programs and procedures, or to otherwise evaluate the work performed or being performed; review and copy any records and supporting documentation pertaining to the performance of this Agreement; and elicit information regarding the performance of this Agreement or any related work. The representatives and designees of such agencies may examine, audit and copy such records at the site at which they are located. Contractor shall provide access to facilities and shall cooperate and assist County, State, and/or Federal representatives and designees in the performance of their duties. Unless otherwise agreed upon in writing, Contractor must provide specified data upon request by County, State, and/or Federal representative and designees within ten (10) State working days for monitoring purposes.

12. PERFORMANCE STANDARDS AND OUTCOME MEASURES: The Contractor shall comply with all applicable Federal, State, and County policies and procedures relating to performance standards and outcome measures including but not limited to those performance standards and outcome measures required by specific Federal or State funding, which has policies or procedures for performance standards and/or outcome measures included as part of the Contractor's contract and shall apply for all County policies, procedures, or departmental bulletins approved by the Director or the Director's designee for performance standards and/or outcome measures. County will notify Contractor whenever County policies or procedures are to apply to this contract provision at least, where feasible, 30 days prior to implementation. These Federal, State or County performance standards and/or outcome measures will be used as part of the determination of the effectiveness of the services delivered by Contractor. Provider Manual, Provider Alerts, and policies are an extension of the Contract Agreement and the Contractor must abide by the conditions set forth in the contract, Provider Manual, Provider Alerts, and policies.

13. QUALITY MANAGEMENT PROGRAM:

A. Contractor shall establish and maintain a Quality Management Program. Contractor's written Quality Management Program shall describe its quality assurance, quality improvement and utilization review structure, process, decisions, actions and monitoring, in accordance with the Department's Quality Improvement Program Policy No. 105.1 and CFR 42, Chapter IV, Subchapter C, Part 456, Subpart D Section 456.150 through 456.245 , to ensure that the quality and appropriateness of care delivered to clients of the mental health system meets or exceeds the established County, State, and federal service standards and complies with the standards set by the State Department of Mental Health through the Medi-Cal Performance Contract.

B. The Contractor's Quality Management Program shall be consistent with Department's Quality Improvement Program Policy No. 105.1 including the Department's Quality Improvement Work Plan and participation in Service Area Quality Assurance and Quality Improvement Committee meetings as outlined in Policy No. 105.1.

C. The Contractor's Quality Management Program shall be consistent with the Department's Cultural Competency Plan.

D. The Contractor's shall cooperate with County Quality Improvement activities to improve the quality of care and services and patient's experience. Cooperation includes collection and evaluation of the data and participation in the organization's Quality Improvement programs in accordance with National Committee of Quality Assurance (NCQA) Element A, Factor 1

E. The Contractor's level of performance under this Agreement shall be evaluated by the County no less than biannually. Failure to meet performance standards may place Contractor's Agreement in jeopardy; performance deficits that are not remedied will be reported to the Board of Supervisors. The report shall include improvement/corrective action measures taken by the County and Contractor. If improvement does not occur consistent with the corrective action measures, County may terminate this Agreement or invoke other remedies as specified in this Agreement.

14. RECORDS AND AUDITS:

A. Records:

(1) General:

(a) Contractor shall maintain books, records, documents and other evidence as well as accounting procedures and practices sufficient to reflect properly all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Agreement.

(b) Contractor shall maintain all the information described in Subparagraph (a) in accordance with the Federal Health Care Financing Administration's Health Insurance Manual Volume 15 (HIM 15) and generally accepted accounting principles.

(c) Contractor shall maintain medical records required by CCR, Title 22, Sections 70747 through 70751, and other records relating to a Beneficiary's eligibility for services, the services rendered, the Beneficiary to whom the services were rendered, the date(s) of service, the medical necessity of the services, and the quality of the care provided. Records shall be maintained in accordance with CCR, Title 22, Section 51476.

(d) In addition to the requirements in this Paragraph 14, Contractor shall comply with any additional record requirements described in the Service Exhibit(s) and shall adequately document the delivery of all services described in this Agreement.

(2) Beneficiary Records: Contractor shall maintain treatment and other records of all services in accordance with all applicable County, State and Federal requirements on each individual Beneficiary which shall include, but not be limited to, Beneficiary identification number, Beneficiary face sheet, all data elements required by the County's claims processing information system, consent for treatment form, initial evaluation form, treatment plan, progress notes and discharge summary.

All such records shall be maintained by Contractor for a minimum period of seven years following discharge of the Beneficiary or termination of services (except that the records of unemancipated minors shall be kept at least one year after such minor has reached the age of eighteen years and in any case not less than seven years), or until any litigation, claim, negotiation, County, State and/or Federal audit, and/or other action involving the records, is fully resolved, whichever is later. During such retention period, all such records shall be made available during County's normal business hours to authorized representatives of County, State, and/or Federal governments for purposes of inspection, program review, and/or audit. In the event any records are located outside Los Angeles County, Contractor shall pay County for all travel, per diem, and other costs incurred by County for any inspection or audit at such other location.

(3) Financial Records: Contractor shall prepare and maintain, on a current basis, accurate and complete financial records of its activities and operations relating to this Agreement in accordance with generally accepted accounting principles and all guidelines, standards, and procedures which may be provided by County to Contractor. Minimum standards for accounting principles are set forth in County's Auditor-Controller's Contract Accounting and Administration Handbook which shall be furnished to Contractor by County upon request.

The entries in all finance records must be readily traceable to applicable source documentation (e.g. remittance invoices, vendor invoices, employee timecards signed by employee and countersigned by supervisor in ink, subsidiary ledgers and journals, appointment logs, patient ledger cards, etc.). Any apportionment of costs shall be made in accordance with the requirements of the Federal Health Care Financing Administration's Health Insurance Manual Volume 15 (HIM 15) and other guidelines, standards, and procedures which may be provided by County to Contractor.

All such records shall be maintained by Contractor for a minimum period of seven years following the expiration or termination of the Agreement, or until any litigation, claim, negotiation, County, State and/or Federal audit, and/or other action involving the records, is fully resolved, whichever is later. During such retention period, all such records shall be made available during County's normal business hours to authorized representatives of County, State, and/or Federal governments for purposes of inspection, program review, and/or audit. In the event any records are located outside Los Angeles County, Contractor shall pay County for all travel, per diem, and other costs incurred by County for any inspection or audit at such other location.

(4) Preservation of Records: If, following termination of this Agreement, Contractor's facility(ies) is (are) closed or if majority ownership of Contractor changes, then within seventy-two hours thereafter, Director of DHCS and County or the Director's designee shall be notified thereof by Contractor in writing of all arrangements made by Contractor for preservation of all the Beneficiary, financial, and other records referred to in this Paragraph 14.

B. Audits:

(1) Contractor shall provide County, State and/or Federal governments, and their authorized representatives, access to and the right to examine, audit, excerpt, copy, or transcribe, any pertinent transaction, activity, time cards, or any other records or information relating to this Agreement.

(2) County, State and/or Federal governments may, in their sole discretion, perform periodic fiscal and/or program review(s) of Contractor's records that relate to this Agreement. If County determines that the results of any such reviews indicate the need for corrective action, Contractor shall within 30 days after receiving the findings of the fiscal and/or program review either (a) submit a plan of action to DMH, or (b) request a review by the Director or the Director's designee. If Contractor requests a review by the Director or the Director's designee within the 30 days, and if a corrective plan of action is then required, Contractor shall have 30 days to submit its corrective plan of action.

(3) County, State and/or Federal governments may conduct onsite reviews and audits during normal working hours with at least 72-hour notice, except that unannounced onsite reviews and requests for information may be made in those exceptional situations where arrangement of an appointment is not possible or is inappropriate to the nature of the intended visit.

(4) Audit Reports: In the event that any audit of any or all aspects of this Agreement is conducted of Contractor by any Federal or State auditor, or by any auditor or accountant employed by Contractor or otherwise, then Contractor shall file a copy of such audit report(s) with DMH's Contracts Development and Administration Division within 30 days of Contractor's receipt thereof, unless otherwise provided by applicable Federal or State law or under this Agreement. Contractor shall promptly notify County of any request for access to information related to this Agreement by any other governmental agency.

(5) California Department of Health Care Services Access to Records: Contractor agrees that for a period of seven years or until final audit is completed, whichever occurs later, following the furnishing of services under this Agreement, Contractor shall maintain and make available to the California Department of Health Care Services, the Secretary of the United States Department of Health and Human Services or the Controller General of the United States, and any other authorized Federal and State agencies, or to any of their duly authorized representatives, the contracts, books, documents and records of Contractor which are necessary to verify the nature and extent of the cost of services hereunder.

(6) Federal Access To Records: If, and to the extent that, Section 1861(v)(1)(I) of the Social Security Act (42 United States Code Section 1395x(v)(1)(I)) is applicable, Contractor agrees that for a period of seven years following the furnishing of services under this Agreement, Contractor shall maintain and make available, to the Secretary of the United States Department of Health and Human Services or the Controller General of the United States, or to any of their duly authorized representatives, the contracts, books, documents and records of Contractor which are necessary to verify the nature and extent of the cost of services hereunder.

15. REPORTS:

A. General: Contract shall make reports as required by Director or the Director's designee or by State regarding Contractor's activities and operations as they relate to Contractor's performance of this Agreement. In no event may County require such reports unless it has provided Contractor with at least 30 days' prior written notification. County shall provide Contractor with a written explanation of the procedures for reporting the required information.

B. County's Claims Processing Information System:

(1) Contractor shall participate in the County's Processing Information System as required by Director or the Director's designee. Contractor shall report to County, all program, beneficiary, staff, and other data and information about Contractor's services, within the specified time periods as required by County Chief Information Office's Training Manuals, Bulletins, Reference Guide, Medi-Cal Fee-For-Service Inpatient Hospital Provider Manual Provider, Alerts and Updates, and any other County requirements, in no event, no later than 40 calendar days after the close of each Fiscal Year in which the services were provided.

(2) Notwithstanding any other provision of this Agreement, only those days of service of Acute Psychiatric Inpatient Hospital Services and Administrative Day Services, as set forth on County-approved Treatment Authorization Requests and properly entered into the County's Claims Processing Information System, shall be counted as reimbursable services. Contractor shall ensure that all data reported in the County's Claims Processing Information System is accurate and complete. Contractor has responsibility to review all provider reports and to report any discrepancies to County's Claims Processing Information System representatives. Admission data must be entered by Contractor into the County's Claims Processing Information System within 24 hours of the time of admission.

(3) After the close of the monthly County's Claims Processing Information System reporting period, no data and information relating to services for that month may be added without the written approval of Director or the Director's designee.

(4) There may be good reasons that prevent Contractor from entering into the County's Claims Processing Information System all data and information documenting days of service of Acute Psychiatric Inpatient Hospital Services and Administrative Day Services before the close of a particular month. If, after the close of the monthly County's Claims Processing Information System reporting period, Contractor desires to enter any data and information documenting services for a particular month, then Contractor shall submit a request in writing setting forth the good cause reasons which prevented Contractor from timely entering such particular data and information into County's Claims Processing and Information System. Director or the Director's designee may, at their sole discretion, approve in writing Contractor's request to enter the data and information into the County's Claims Processing Information System. Notwithstanding any other provision of this Agreement, the only services which shall be considered legitimate and reimbursable shall be those services as entered by Contractor into the County's Claims Processing Information System.

(5) Contractor shall train its staff in the operation, procedures, policies, and all related use of County's Claim Processing Information System as required by County. County shall train Contractor's designated trainer in the operation, procedures, policies, and all related use of the County's Claims Processing Information System.

16. CONFIDENTIALITY: Contractor shall maintain the confidentiality of all records and information, including, but not limited to, claims, County records, patient/client records and information, and County claims processing information system records, in accordance with WIC Sections 5328 through 5330, inclusive, and all other applicable County, State, and Federal laws, ordinances, rules, regulations, manuals, guidelines, and

directives, relating to confidentiality and privacy. Contractor shall require all its officers, employees, and agents providing services hereunder to acknowledge, in writing, understanding of, and agreement to fully comply with, all such confidentiality and privacy provisions. Contractor shall indemnify and hold harmless County, its officers, employees, and agents, from and against any and all loss, damage, liability, and expense arising from any disclosure of such records and information by Contractor, its officers, employees, or agents.

Contractor shall sign and adhere to the provisions of the "Contractor Acknowledgement and Confidentiality Agreement", Attachment X -1.

17. BENEFICIARIES RIGHTS: Contractor shall comply with all applicable beneficiaries rights provisions, including, but not limited to, WIC Section 5325 et seq., CCR Title 9, Section 850 et seq., and CCR Title 22, including, but not limited to, Section 70707. Contractor shall also comply with all beneficiaries' policies provided by County. Contractor shall post in a conspicuous place a written policy on beneficiary's rights in accordance with WIC Section 5325, CCR Title 22, Section 70707, and CCR, Title 9, Chapter 11, Section 1810.360(d). Contractor shall freely communicate with the Beneficiaries about their treatment, regardless of benefit coverage limitations in accordance with NCQA requirement, Element B.

DHCS, County Patients' Rights Advocates and/or other DMH staff designated by Director or the Director's designee, and any other authorized agencies shall be given access by Contractor to beneficiary's records, and Contractor's personnel in order to investigate any complaints by beneficiaries and/or to monitor Contractor's compliance with all applicable statutes, regulations, manuals and policies.

18. REPORTING OF BENEFICIARY ABUSE AND RELATED PERSONNEL REQUIREMENTS:

A. Elders And Dependent Adults Abuse: Contractor, and all persons employed shall comply with WIC Section 15630 et seq. and shall report all known or suspected instances of physical abuse of elders and dependent adults under the care of Contractor either to an appropriate County adult protective services agency or to a local law enforcement agency, as mandated by these WIC Sections 15630, and permitted by 15631 and 15632. Contractor and all persons employed shall make the report on such abuse, and shall submit all required information, in accordance with WIC Sections 15630, 15633 and 15633.5.

B. Minor Children Abuse: Contractor and all persons employed or subcontracted by Contractor, shall comply with California Penal Code (hereafter "PC") Section 11164 et seq. and shall report all known or suspected instances of child abuse to an appropriate child protective agency, as mandated by California Penal Code 11164, 11165.9 and 11166. Contractor and all persons employed or subcontracted by Contractor, shall make the report on such abuse, and shall submit all required information, in accordance with PC Sections 11166 and 11167.

C. Contractor Staff:

(1) Contractor shall assure that any person who enters into employment as a care custodian of elders, dependent adults or minor children, or who enters into employment as a health or other practitioner, prior to commencing employment, and as a prerequisite to that employment, shall sign a statement on a form provided by Contractor in accordance with the above code sections to the effect that such person has knowledge of, and will comply with, these code sections.

(2) Contractor shall assure that clerical and other non-treatment staff who are not

legally required to directly report suspected cases of abuse, consult with mandated reporters upon suspecting any abuse.

(3) For the safety and welfare of elders, dependent adults, and minor children, Contractor, shall, to the maximum extent permitted by law, ascertain arrest and conviction records for all current and prospective employees and shall not employ or continue to employ any person convicted of any crime involving any harm or inappropriate behavior to elders, dependent adults, or minor children.

(4) Contractor shall not employ or continue to employ, or shall take other appropriate action to fully protect all persons receiving services under this Agreement concerning, any person whom Contractor knows, or reasonably suspects, has committed any acts which are inimical to the health, morals, welfare, or safety of elders, dependent adults or minor children, or which otherwise make it inappropriate for such person to be employed by Contractor.

19. NONDISCRIMINATION IN SERVICES:

A. Contractor shall not discriminate in the provision of services hereunder because of race, religion, national origin, ancestry, gender, age, marital status, sexual orientation and/or physical or mental handicap, or medical conditions, (except to the extent clinically appropriate), in accordance with requirements of Federal and State law. For the purpose of this Paragraph 19, discrimination in the provision of services may include, but is not limited to, the following: denying any person any service or benefit or the availability of a facility; providing any service or benefit to any person which is different, or is provided in a different manner or at a different time, from that provided to others; subjecting any person to segregation or separate treatment in any matter related to the receipt of any service; restricting any person in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit; and treating any person differently from others in determining admission, enrollment, eligibility, membership, or any other requirement or condition which persons must meet in order to be provided any service or benefit. Contractor shall take affirmative action to ensure that that those Beneficiaries who qualify for services under this Agreement are provided services without regard to ability to pay or source of payment, race, religion, national origin, ancestry, gender, age, marital status, sexual orientation and/or physical or mental handicap or medical condition.

B. Contractor shall establish and maintain written complaint procedures under which any person applying for or receiving any services under this Agreement may seek resolution from Contractor of a complaint with respect to any alleged discrimination in rendering services by Contractor's personnel. Such procedures shall also include a provision whereby any such person, who is dissatisfied with Contractor's resolution of the matter, shall be referred by Contractor to Director or the Director's designee for the purpose of presenting his complaint of the alleged discrimination. Such complaint procedures shall also indicate that if such person is not satisfied with County's resolution or decision with respect to the complaint of alleged discrimination, such person may appeal the matter to the State if appropriate.

C. Contractor shall not employ discriminatory practices in the admission of any person, assignment or accommodations, or otherwise. Any time any person applies for services under this Agreement, such person shall be advised by Contractor of the complaint procedures described in the

above paragraph. A copy of such complaint procedures shall be posted by Contractor in each of Contractor's facilities where services are provided under this Agreement in a conspicuous place, available to the public.

20. NONDISCRIMINATION IN EMPLOYMENT:

A. Contractor certifies and agrees that all persons employed by it, its affiliates, subsidiaries, or holding companies are and will be treated equally by it without regard to, or because of, race, color, religion, national origin, ancestry, gender, age, marital status, condition of physical disability (including HIV and AIDS) or mental disability, medical condition (e.g. cancer), denial of family care leave, or political affiliation, and in compliance with all applicable Federal and State anti-discrimination laws and regulations. The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations, are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Contractor shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

B. Contractor shall take affirmative steps to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to race, color, religion, national origin, ancestry, gender, age, marital status, sexual orientation, condition of physical disability (including HIV and AIDS), or mental disability, medical condition (e.g. cancer), denial of family care leave, or political affiliation. Such treatment shall include, but is not limited to, the following actions: employment, promotion, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, selection for training, including apprenticeship and granting or denying family care leave. Contractor shall not discriminate against or harass, nor shall it permit harassment of, its employees during employment based upon race, color, religion, national origin, ancestry, gender, age, marital status, sexual orientation, condition of physical disability (including HIV and AIDS) or mental disability, medical condition (e.g. cancer), denial of family care leave, or political affiliation in compliance with all applicable federal and State anti-discrimination laws and regulations. Contractor shall ensure that the evaluation and treatment of its employees and applicants for employment are free from such discrimination and harassment, and will comply with the provisions of the Fair Employment and Housing Act (Government Code Section 12990 et seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285.0 et seq.).

C. Contractor shall deal with its bidders, or vendors without regard to or because of race, color, religion, ancestry, national origin, gender, age, marital status, sexual orientation, condition of physical disability (including HIV and AIDS) or mental disability, medical condition (e.g. cancer) denial of family care leave, or political affiliation. Further, Contractor shall give written notice of its obligations under this Paragraph 20 to labor organizations with which it has a collective bargaining or other agreement.

D. Contractor shall allow County representatives access to its employment records during regular business hours to verify compliance with the provisions of this Paragraph 20 when so requested by Director or the Director's designee.

E. If County finds that any of the above provisions has been violated, the same shall constitute a material breach of this Agreement upon which County may immediately terminate or suspend this Agreement. The County reserves the right to determine independently that the anti-discrimination provisions of this Agreement have been violated. In addition, a determination by the California Fair Employment Practices Commission or the Federal Equal Employment Opportunity Commission that Contractor has violated State or federal anti-discrimination laws or regulations shall constitute a finding by County that Contractor has violated the anti-discrimination provisions of this Agreement.

F. In the event that Contractor violates any of the anti-discrimination provisions of this Paragraph 20, County shall be entitled, at its option, to the sum of FIVE HUNDRED DOLLARS ($500) pursuant to California Civil Code Section 1671 as liquidated damages in lieu of terminating or suspending this Agreement.

21. FAIR LABOR STANDARDS: Contractor shall comply with all applicable provisions of the Federal Fair Labor Standards Act, and shall indemnify, defend, and hold harmless County, its officers, employees, and agents, from any and all liability, including, but not limited to, wages, overtime pay, liquidated damages, penalties, court costs, and attorneys' fees arising under any wage and hour law, including, but not limited to, the Federal Fair Labor Standards Act, for services performed by Contractor's employees for which County may be found jointly or solely liable.

22. INDEMNIFICATION AND INSURANCE:

A. Indemnification: The Contractor shall indemnify, defend and hold harmless the County, its Special Districts, elected and appointed officers, employees, agents and volunteers ("County Indemnitees") from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, and expenses (including attorney and expert witness fees), arising from and/or relating to this Agreement, except for such loss or damage arising from the sole negligence or willful misconduct of the County Indemnitees.

B. General Provisions for all Insurance Coverage: Without limiting Contractor's indemnification of County, and in the performance of this Agreement and until all of its obligations pursuant to this Agreement have been met, Contractor shall provide and maintain at its own expense insurance coverage satisfying the requirements specified in Subparagraphs B and C of this Paragraph 22. These minimum insurance coverage terms, types and limits (the "Required Insurance") also are in addition to and separate from any other contractual obligation imposed upon Contractor pursuant to this Agreement. The County in no way warrants that the Required Insurance is sufficient to protect the Contractor for liabilities which may arise from or relate to this Agreement.

(1) Evidence of Coverage and Notice to County

(a) Certificate(s) of insurance coverage (Certificate) satisfactory to County, and a copy of an Additional Insured endorsement confirming County and its Agents (defined below) has been given Insured status under the Contractor's General Liability policy, shall be delivered to County at the address shown below and provided prior to commencing services under this Agreement.

(b) Renewal Certificates shall be provided to County not less than 10 days prior to Contractor's policy expiration dates. The County reserves the right to obtain complete, certified

copies of any required Contractor and/or Sub-Contractor insurance policies at any time.

(c) Certificates shall identify all Required Insurance coverage types and limits specified herein, reference this Agreement by name or number, and be signed by an authorized representative of the insurer(s). The Insured party named on the Certificate shall match the name of the Contractor identified as the contracting party in this Agreement. Certificates shall provide the full name of each insurer providing coverage, its NAIC (National Association of Insurance Commissioners) identification number, its financial rating, the amounts of any policy deductibles or self-insured retentions exceeding fifty thousand ($50,000.00) dollars, and list any County required endorsement forms.

(d) Neither the County's failure to obtain, nor the County's receipt of, or failure to object to a non-complying insurance certificate or endorsement, or any other insurance documentation or information provided by the Contractor, its insurance broker(s) and/or insurer(s), shall be construed as a waiver of any of the Required Insurance provisions.

Certificates and copies of any required endorsements shall be sent to:

Los Angeles County - Department of Mental Health
Contracts Development and Administration Division
550 South Vermont Avenue, 5th Floor
Los Angeles, CA 90020
Attention: Chief of Contracts

Contractor also shall promptly report to County any injury or property damage accident or incident, including any injury to Contractor employee occurring on County property, and any loss, disappearance, destruction, misuse, or theft of County property, monies or securities entrusted to Contractor. Contractor also shall promptly notify County of any third party claim or suit filed against Contractor or any of its Sub-Contractors which arises from or relates to this Agreement, and could result in the filing of a claim or lawsuit against Contractor and/or County.

(2) Additional Insured Status and Scope of Coverage

The County of Los Angeles, it's Special Districts, Elected Officials, Officers, Agents, Employees and Volunteers (collectively County and its Agents) shall be provided additional insured status under Contractor's General Liability policy with respect to liability arising out of Contractor's ongoing and completed operations performed on behalf of County. County and its Agents additional insured status shall apply with respect to liability and defense of suits arising out of the Contractor's acts or omissions, whether such liability is attributable to the Contractor or to the County. The full policy limits and scope of protection also shall apply to the County and its Agents as an additional insured, even if they exceed the County's minimum Required Insurance specifications herein. Use of an automatic additional insured endorsement form is acceptable providing it satisfies the Required Insurance provisions herein.

(3) Cancellation of or Changes in Insurance

Contractor shall provide County with, or Contractor's insurance policies shall contain a provision that County shall receive, written notice of cancellation or any change in Required Insurance, including insurer, limits of coverage, term of coverage or policy period. The written notice shall be provided to County at least ten (10)

days in advance of cancellation for non-payment of premium and thirty (30) days in advance for any other cancellation or policy change. Failure to provide written notice of cancellation or any change in Required Insurance may constitute a material breach of the Agreement, in the sole discretion of the County, upon which the County may suspend or terminate this Agreement.

(4) Failure to Maintain Insurance

Contractor's failure to maintain or to provide acceptable evidence that it maintains the Required Insurance shall constitute a material breach of the Agreement, upon which County immediately may withhold payments due to Contractor, and/or suspend or terminate the Agreement. County, at its sole discretion, may obtain damages from Contractor resulting from said breach. Alternatively, the County may purchase the Required Insurance, and without further notice to Contractor, deduct the premium cost from sums due to Contractor or pursue Contractor reimbursement.

(5) Insurer Financial Ratings

Coverage shall be placed with insurers acceptable to the County with A.M. Best rating of not less than A: VII unless otherwise approved by County.

(6) Contractor's Insurance Shall Be Primary

Contractor's insurance policies, with respect to any claims related to this Agreement, shall be primary with respect to all other sources of coverage available to Contractor. Any County maintained insurance or self-insurance coverage shall be in excess of and not contribute to any Contractor coverage.

(7) Waivers of Subrogation

To the fullest extent permitted by law, the Contractor hereby waives its rights and its insurer(s)' rights of recovery against County under all the Required Insurance for any loss arising from or relating to this Agreement. The Contractor shall require its insurers to execute any waiver of subrogation endorsements which may be necessary to effect such waiver.

(8) Deductibles and Self-Insured Retentions (SIRs)

Contractor's policies shall not obligate the County to pay any portion any Contractor deductible or SIR. The County retains the right to require Contractor to reduce or eliminate policy deductibles and SIR as respects the County, or to provide a bond guaranteeing Contractor's payment of all deductibles and SIRs, including all related claims investigation, administration and defense expenses. Such bond shall be executed by a corporate surety licensed to transact business in the State of California.

(9) Claims Made Coverage

If any part of the Required Insurance is written on a claim made basis, any policy retroactive date shall precede the effective date of this Agreement. Contractor understands and agrees it shall maintain such coverage for a period of not less than three (3) years following Agreement expiration, termination or cancellation.

(10) Application of Excess Liability Coverage

Contractors may use a combination of primary, and excess insurance policies which provide coverage as broad as ("follow form" over) the underlying primary policies, to satisfy the Required Insurance provisions.

(11) Separation of Insured

All liability policies shall provide cross-liability coverage as would be afforded by the standard ISO (Insurance Services Office, Inc.) separation of insured provision with no insured versus insured exclusions or limitations.

(12) Alternative Risk Financing Programs.

The County reserves the right to review, and then approve, Contractor use of self-insurance, risk retention groups, risk purchasing groups, pooling arrangements and captive insurance to satisfy the Required Insurance provisions. The County and its Agents shall be designated as an Additional Covered Party under an approved program.

(13) County Review and Approval of Insurance Requirements.

The County reserves the right to review and adjust the Required Insurance provisions, conditioned upon County's determination of changes in risk exposures.

C. Insurance Coverage:

(1) Commercial General Liability insurance (providing scope coverage equivalent to ISO policy form CG 00 01), naming County and its Agents as an additional insured, with limits of not less than:

General Aggregate:	$2 million
Products/Completed Operations Aggregate:	$1 million
Personal and Advertising Injury:	$1 million
Each Occurrence:	$1 million

(2) Automobile Liability insurance (providing scope of coverage equivalent to ISO policy form CA 00 01) with limits of not less than $1 million for bodily injury and property damage, in combined or equivalent split limits, for each single accident. Insurance shall cover liability arising out of Contractor's use of autos pursuant to this Agreement, including owned, leased, hired, and/or non-owned autos, as each may be applicable.

(3) Workers Compensation and Employers' Liability insurance or qualified self-insurance satisfying statutory requirements, which includes Employers' Liability coverage with limits of not less than $1 million per accident. If Contractor will provide leased employees, or, is an employee leasing or temporary staffing firm or a professional employer organization (PEO), coverage also shall include an Alternate Employer Endorsement (providing scope of coverage equivalent to ISO policy form WC 00 03 01 A) naming the County as the Alternate Employer, and the endorsement form shall be modified to provide that County will receive not less than thirty (30) days advance written notice of cancellation of this coverage provision. If applicable to Contractor's operations, coverage also shall be arranged to satisfy the requirements of any federal workers or workmen's compensation law or any federal occupational disease law.

(4) Sexual Misconduct Liability insurance covering actual or alleged claims for sexual misconduct and/or molestation with limits of not less than $2 million per claim and $2 million aggregate, and claims for negligent employment, investigation, supervision, training or retention of, or failure to report to proper authorities, a person(s) who committed any act of abuse, molestation, harassment, mistreatment or maltreatment of a sexual nature.

(5) Professional Liability/Errors and Omissions Insurance covering Contractor's liability arising from or related to this Agreement, with limits of not less than $1 million per claim and $3 million aggregate. Further, Contractor understands and agrees it shall maintain such coverage for a period of not less than three (3) years following this Agreement's expiration, termination or cancellation.

23. WARRANTY AGAINST CONTINGENT FEES: Contractor warrants that no person or selling agency has been employed or retained to solicit or secure this Agreement upon any agreement or understanding for any commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by Contractor for the purpose of securing business. For Contractor's breach or violation of this warranty, County may, in its sole discretion, deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, brokerage, or contingent fee.

24. CONFLICT OF INTEREST:

A. No County employee whose position in County enables such employee to influence the award or administration of this Agreement or any competing agreement, and no spouse or economic dependent of such employee, shall be employed in any capacity by Contractor or have any direct or indirect financial interest in this Agreement. No officer or employee of Contractor who may financially benefit from the provision of services hereunder shall in any way participate in County's approval, or ongoing evaluation, of such services, or in any way attempt to unlawfully influence County's approval or ongoing evaluation of such services.

B. Contractor shall comply with all conflict of interest laws, ordinances and regulations now in effect or enacted during the term of this Agreement. Contractor warrants that it is not now aware of any facts which create a conflict of interest. If Contractor hereafter becomes aware of any facts which might reasonably be expected to create a conflict of interest, it shall immediately make full written disclosure of such facts to County. Full written disclosure shall include, without limitation, identification of all persons implicated and complete description of all relevant circumstances.

25. UNLAWFUL SOLICITATION: Contractor shall require all of its employees to acknowledge, in writing, understanding of and agreement to comply with the provisions of Article 9 of Chapter 4 of Division 3 (commencing with Section 6150) of California Business and Professions Code (i.e., State Bar Act provisions regarding unlawful solicitation as a runner or capper for attorneys) and shall take positive and affirmative steps in its performance hereunder to insure that there is no violation of such provisions by its employees. Contractor shall utilize the attorney referral service of all those bar associations within the County of Los Angeles that have such a service.

26. INDEPENDENT STATUS OF CONTRACTOR:

A. This Agreement is by and between County and Contractor and is not intended, and shall not be construed, to create the relationship of agent, servant, employee, partnership, joint venture, or association, as between County and Contractor. The employees and agents of one party shall not be, or be construed to be, the employees or agents of the other party for any purpose whatsoever.

B. Contractor shall be solely liable and responsible for providing to, or on behalf of, all

persons performing work pursuant to this Agreement all compensation and benefits. County shall have no liability or responsibility for the payment of any salaries, wages, unemployment benefits, disability benefits, federal, State, or local taxes, or other compensation, benefits, or taxes for any personnel provided by or on behalf of Contractor.

C. Contractor understands and agrees that all persons performing services pursuant to this Agreement are, for purposes of workers' compensation liability, the sole employees of Contractor and not employees of County. Contractor shall be solely liable and responsible for furnishing any and all workers' compensation benefits to any person as a result of any injuries arising from or connected with any services performed by or on behalf of Contractor pursuant to this Agreement.

D. Contractor shall obtain and maintain on file an executed Contractor Employee Acknowledgment of Employer in the form as contained in Contractor's contract package for this Agreement, for each of its employees performing services under this Agreement. Such Acknowledgments shall be executed by each such employee on or immediately after the commencement date of this Agreement but in no event later than the date such employee first performs services under this Agreement.

27. CONSIDERATION OF HIRING COUNTY EMPLOYEES TARGETED FOR LAYOFF OR FORMER COUNTY EMPLOYEES ON A REEMPLOYMENT LIST: Should Contractor require additional or replacement personnel after the effective date of this Agreement to perform the services set forth herein, Contractor shall give first consideration for such employment openings to qualified permanent County employees who are targeted for layoff or qualified former County employees who are on a reemployment list during the term of this Agreement.

28. CONSIDERATION OF HIRING GREATER AVENUES FOR INDEPENDENCE (GAIN) PARTICIPANTS OR GENERAL RELIEF OPPORTUNITIES FOR WORK (GROW) PARTICIPANTS FOR EMPLOYMENT:

A. Should Contractor require additional or replacement personnel after the effective date of this Agreement, Contractor shall give consideration for any such employment openings to participants in the County's Department of Public Social Services' GAIN Program or GROW Program who meets Contractor's minimum qualifications for the open position. If contractor decides to pursue consideration of GAIN/GROW participants for hiring, County will refer GAIN/GROW participants, by job category, to Contractor. Contractors shall report all job openings with job requirements to: GAINGROW@dpss.lacounty.gov to obtain a list of qualified GAIN/GROW job candidates.

B. In the event that both laid-off County employees and GAIN/GROW participants are available for hiring, county employees shall be given first priority.

29. DELEGATION AND ASSIGNMENT:

A. Contractor shall not assign its rights or delegate its duties under this Agreement, or both, whether in whole or in part, without the prior written consent of County, in its discretion, and any attempted assignment or delegation without such consent shall be null and void. For purposes of this paragraph, County consent shall require a written amendment to this Agreement, which is formally approved and executed by the parties. Any payments by County to any approved delegate or assignee on any claim under

this Agreement shall be deductible, at County's sole discretion, against the claims which Contractor may have against County.

B. Shareholders, partners, members, or other equity holders of Contractor may transfer, sell, exchange, assign, or divest themselves of any interest they may have in Contractor. However, in the event any such sale, transfer, exchange, assignment, or divestment is effected in such a way as to give majority control of Contractor to any person(s), corporation, partnership, or legal entity other than the majority controlling interest therein at the time of execution of this Agreement, such disposition shall be deemed is an assignment requiring the prior written consent of County in accordance with applicable provisions of this Agreement.

C. Any assumption, assignment, delegation, or takeover of any of the Contractor's duties, responsibilities, obligations, or performance of same by any entity other than the Contractor, whether through assignment, subcontract, delegation, merger, buyout, or any other mechanism, with or without consideration for any reason whatsoever without County's express prior written approval, shall be a material breach of this Agreement which may result in the termination of this Agreement. In the event of such termination, County shall be entitled to pursue the same remedies against Contractor as it could pursue in the event of default by Contractor.

D. Shareholders, partners, members, or other equity holders of Contractor may transfer, sell, exchange, assign, or divest themselves of any interest they may have therein. However, in the event any such sale, transfer, exchange, assignment, or divestment is effected in such a way as to give majority control of Contractor to any person(s), corporation, partnership, or legal entity other than the majority controlling interest therein at the time of execution of the Agreement, such disposition is an assignment requiring the prior written consent of County in accordance with applicable provisions of this Agreement.

E. Any assumption, assignment, delegation, or takeover of any of the Contractor's duties, responsibilities, obligations, or performance of same by any entity other than the Contractor, whether through assignment, subcontract, delegation, merger, buyout, or any other mechanism, with or without consideration for any reason whatsoever without County's express prior written approval, shall be a material breach of the Agreement which may result in the termination of the Agreement. In the event of such termination, County shall be entitled to pursue the same remedies against Contractor as it could pursue in the event of default by Contractor.

30. SUBCONTRACTING:

A. No performance of this Agreement, or any portion thereof, shall be subcontracted by Contractor without the prior written consent of County as provided in this Paragraph. Any attempt by Contractor to subcontract any performance, obligation, or responsibility under this Agreement, without the prior written consent of County, shall be null and void and shall constitute a material breach of this Agreement. Notwithstanding any other provision of this Agreement, in event of any such breach by Contractor, this Agreement may be terminated forthwith by County. Notwithstanding any other provision of this Agreement, the parties do not in any way intend that any person or entity shall acquire any rights as a third party beneficiary of this Agreement.

B. If Contractor desires to subcontract any portion of its performance, obligations, or responsibilities under this Agreement, Contractor shall make a written request to County, for written approval to enter into the particular subcontract. Contractor's request to County shall include:

(1) The reasons for the particular subcontract.

(2) A detailed description of the services to be provided by the subcontract.

(3) Identification of the proposed subcontractor and an explanation of why and how the proposed subcontractor was selected, including the degree of competition involved.

(4) A description of the proposed subcontract amount and manner of compensation, together with Contractor's cost or price analysis thereof.

(5) A copy of the proposed subcontract which shall contain the following provision:

"This contract is a subcontract under the terms of the prime contract with the County of Los Angeles and shall be subject to all of the provisions of such prime contract."

(6) A copy of the proposed subcontract, if in excess of $10,000 and utilizes public funds, shall also contain the following provision:

"The contracting parties shall be subject to the examination and audit of the State Auditor, pursuant to the California Government Code, Section 8546.7 for a period of seven (7) years from the end of the Fiscal Year in which such services were provided or until final resolution of any audits, whichever occurs later." The Contractor will also be subject to the examination and audit of the State Auditor.

(7) Any other information and/or certifications requested by County.

C. County shall review Contractor's request to subcontract and shall determine, in its sole discretion, whether or not to consent to such request on a case-by-case basis.

D. Contractor shall indemnify and hold harmless County, its officers, employees, and agents, from and against any and all liability, damages, costs, and expenses, including, but not limited to, defense costs and legal fees, arising from or related to Contractor's use of any subcontractor, including any officers, employees, or agents of any subcontractor, in the same manner as required for Contractor, its officers, employees, and agents, under this Agreement.

E. Notwithstanding any County consent to any subcontracting, Contractor shall remain fully liable and responsible for any and all performance required of it under this Agreement, and no subcontract shall bind or purport to bind County. Further, County approval of any subcontract shall not be construed to limit in any way any Contractor's performance, obligations, or responsibilities, to County, nor shall such approval limit in any way any of County's rights or remedies contained in this Agreement. Additionally, County approval of any subcontract shall not be construed in any way to constitute the determination of the allowability or appropriateness of any cost or payment under this Agreement.

F. In the event that County consents to any subcontracting, such consents shall be subject to County's right to give prior and continuing approval of any and all subcontractor personnel providing services under such subcontract. Contractor shall assure that any subcontractor personnel not approved by County shall be immediately removed from the provision of any services under the particular subcontract or that other action is taken as requested by County. County shall not be liable or

responsible in any way to Contractor, to any subcontractor, or to any officers, employees, or agents of Contractor or any subcontractor, for any liability, damages, costs or expenses arising from or related to County's exercise of such right.

G. In the event that County consents to any subcontracting, such consent shall be subject to County's right to terminate, in whole or in part, any subcontract at any time upon written notice to Contractor when such action is deemed by County to be in its best interest. County shall not be liable or responsible in any way to Contractor, to any subcontractor, or to any officers, employees, or agents of Contractor or any subcontractor, for any liability, damages, costs, or expenses arising from or related to County's exercise of such right.

H. In the event that County consents to any subcontracting, each and all of the provisions of this Agreement and any amendment thereto shall extend to, be binding upon, and inure to the benefit of, the successors or administrators of the respective parties.

I. In the event that County consents to any subcontracting, such consent shall apply to each particular subcontract only and shall not be, or be construed to be, a waiver of this Paragraph 30 or a blanket consent to any further subcontracting.

J. In the event that County consents to any subcontracting, Contractor shall be solely liable and responsible for any and all payments and/or other compensation to all subcontractors and their officers, employees, and agents. County shall have no liability or responsibility whatsoever for any payment and/or other compensation for any subcontractors or their officers, employees, and agents.

K. Contractor shall deliver to the Chief of DMH's Contracts Development and Administration Division a fully executed copy of each subcontract entered into by Contractor pursuant to this Paragraph 30, on or immediately after the effective date of the subcontract but in no event later than the date any services are performed under the subcontract.

L. In the event that County consents to any subcontracting, Contractor shall obtain and maintain on file an executed Contractor Non-Employee Acknowledgement And Confidentiality Agreement, in the form as contained in Attachment X - 3 of this Agreement, for each of the subcontractor's employees performing services under the subcontract. Such Acknowledgments shall be obtained and maintained on file and made available upon request on or immediately after the commencement date of the particular subcontract but in no event later than the date such employee first performs any services under the subcontract.

M. County shall have no liability or responsibility whatsoever for any payment or other compensation for any subcontractor or its officers, employees, and agents.

N. Director or the Director's designee is hereby authorized to act for and on behalf of County pursuant to this Paragraph 30, including, but not limited to, consenting to any subcontracting.

31. GOVERNING LAW, JURISDICTION AND VENUE: This Agreement shall be governed by, and construed in accordance with, the laws of the State of California. Contractor agrees and consents to the exclusive jurisdiction of the courts of the State of California for all purposes regarding this Agreement and further agrees and consents that venue of any action brought hereunder shall be exclusively in the County of

Los Angeles, California. Further, this Agreement shall be governed by, and construed in accordance with, all laws, regulations, and contractual obligations of County under agreement with the State.

32. COMPLIANCE WITH APPLICABLE LAW:

A. Contractor shall comply with all Federal, including, but not limited to, Title XIX of the Social Security Act, State and local laws, ordinances, rules, regulations, manuals, guidelines, Americans with Disabilities Act (ADA) standards, and directives applicable to its performance hereunder. Further, all provisions required thereby to be included in this Agreement are hereby incorporated herein by reference.

B. Contractor shall be governed by and comply with all contractual obligations of the DHCS' Mental Health Plan Agreement with the County.

C. Contractor shall indemnify and hold harmless County from and against any and all liability, damages, costs or expenses, including, but not limited to, defense costs and attorneys' fees, arising from or related to any violation on the part of Contractor, its officers, employees, or agents, of any such federal State or local laws, ordinances, rules, regulations, manual, guidelines, ADA standards, or directives.

D. Contractor shall maintain in effect an active compliance program in accordance with the recommendations set forth by the Department of Health and Human Services, Office of the Inspector General, Publication of the OIG Compliance Program Guide for Hospitals (1998), and Center for Medi-Care/Medicaid Services (CMS) guidelines for hospitals.

E Duty to Notify: Contractor agrees to notify County of any and all legal complaints, citations, enforcement proceedings, administrative proceedings, judgments or litigation, known to Contractor, whether civil or criminal initiated against Contractor, its officers, employees, or agents which are likely to have a material effect on the organization's stewardship, financial position and/or ability to perform and deliver services under this contract.

33. THIRD PARTY BENEFICIARIES: Notwithstanding any other provision of this Agreement, the parties do not in any way intend that any person or entity shall acquire any rights as a third party beneficiary of this Agreement.

34. LICENSES, PERMITS, REGISTRATIONS, ACCREDITATIONS, AND CERTIFICATIONS: In addition to the requirements Subparagraph B (Licensure And Certification As Conditions Precedent To Contractor's Eligibility For Reimbursement) of Paragraph 5 (DESCRIPTION OF SERVICES), Contractor shall obtain and maintain in effect during the term of this Agreement, all licenses, permits, registrations, accreditations, and certifications as required by all Federal, State, and local laws, ordinances, rules, regulations, manuals, guidelines, and directives, which are applicable to Contractor's facility(ies) and services under this Agreement. Contractor shall further ensure that all of its officers, employees, and agents, who perform services hereunder, shall obtain and maintain in effect during the term of this Agreement all licenses, permits, registrations, accreditations, and certificates which are applicable to their performance hereunder. A copy of each such license, permit, registration, accreditation, and certificate as required by all applicable Federal, State, and local laws, ordinances, rules, regulations, manuals, guidelines and directives shall be provided, in duplicate, to DMH's Contracts Development and Administration Division.

35. CHILD SUPPORT COMPLIANCE PROGRAM:

A. Contractor's Warranty of Adherence to County's Child Support Compliance Program: Contractor acknowledges that County has established a goal of ensuring that all individuals who benefit financially from County through a contract are in compliance with their court-ordered child, family, and spousal support obligations in order to mitigate the economic burden otherwise imposed upon County and its taxpayers.

As required by County's Child Support Compliance Program (County Code Chapter 2.200) and without limiting Contractor's duty under this Agreement to comply with all applicable provisions of law, Contractor warrants that it is now in compliance and shall during the term of this Agreement maintain in compliance with employment and wage reporting requirements as required by the Federal Social Security Act (42 United States Code (USC) Section 653a) and California Unemployment Insurance Code Section 1088.5, and shall implement all lawfully served Wage and Earnings Withholdings Orders or Child Support Services Department Notices of Wage and Earnings Assignment for Child, Family, or Spousal Support, pursuant to Code of Civil Procedure Section 706.031 and Family Code Section 5246(b).

B. Termination for Breach of Warranty to Maintain Compliance with County's Child Support Compliance Program: Failure of Contractor to maintain compliance with the requirements set forth in Subparagraph A (Contractor's Warranty of Adherence to County's Child Support Compliance Program) shall constitute default under this Agreement. Without limiting the rights and remedies available to County under any other provision of this Agreement, failure of Contractor to cure such default within 90 calendar days of written notice shall be grounds upon which County may terminate this Agreement pursuant to Paragraph 37 (TERMINATION FOR DEFAULT) and pursue debarment of Contractor, pursuant to County Code Chapter 2.202.

36. TERMINATION FOR INSOLVENCY:

A. County may terminate this Agreement immediately in the event of the occurrence of any of the following:

(1) Insolvency of Contractor. Contractor shall be deemed to be insolvent if it has ceased to pay its debts for at least 60 days in the ordinary course of business or cannot pay its debts as they become due, whether or not a petition has been filed under the Federal Bankruptcy Code and whether or not Contractor is insolvent within the meaning of the Federal Bankruptcy Code.

(2) The filing of a voluntary or involuntary petition regarding Contractor under the Federal Bankruptcy Code.

(3) The appointment of a Receiver or Trustee for Contractor

(4) The execution by Contractor of a general assignment for the benefit of creditors.

B. The rights and remedies of County provided in this Paragraph 36 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

37. TERMINATION FOR DEFAULT:

A. County may, by written notice of default to Contractor, terminate this Agreement immediately in any one of the following circumstances:

(1) If, as determined in the sole judgment of County, Contractor fails to perform any

services within the times specified in this Agreement or any extension thereof as County may authorize in writing; or

(2) If, as determined in the sole judgment of County, Contractor fails to perform and/or comply with any of the other provisions of this Agreement or so fails to make progress as to endanger performance of this Agreement in accordance with its terms, and in either of these two circumstances, does not cure such failure within a period of five days (or such longer period as County may authorize in writing) after receipt of notice from County specifying such failure.

B. In the event that County terminates this Agreement as provided in Subparagraph A, County may procure, upon such terms and in such manner as County may deem appropriate, services similar to those so terminated, and Contractor shall be liable to County for any reasonable excess costs incurred by County, as determined by County, for such similar services.

C. The rights and remedies of County provided in this Paragraph 37 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

38. TERMINATION FOR IMPROPER CONSIDERATION: County may, by written notice to Contractor, immediately terminate the right of Contractor to proceed under this Agreement if it is found that consideration, in any form, was offered or given by Contractor, either directly or through an intermediary, to any County officer, employee or agent with the intent of securing the Agreement or securing favorable treatment with respect to the award, amendment or extension of the Agreement or the making of any determinations with respect to the Contractor's performance pursuant to the Agreement. In the event of such termination, County shall be entitled to pursue the same remedies against Contractor as it could pursue in the event of default by the Contractor.

Contractor shall immediately report any attempt by a County officer or employee to solicit such improper consideration. The report shall be made either to the County manager charged with the supervision of the employee or to the County Auditor-Controller's Employee Fraud Hotline at (800) 544-6861.

Among other items, such improper consideration may take the form of cash, discounts, and service, the provision of travel or entertainment, or tangible gifts.

39. SEVERABILITY: If any provision of this Agreement or the application thereof to any person or circumstance is held invalid, the remainder of this Agreement and the application of such provision to other persons or circumstances shall not be affected thereby.

40. CAPTIONS AND PARAGRAPH HEADINGS: Captions and paragraph headings used in this Agreement are for convenience only and are not a part of this Agreement and shall not be used in construing this Agreement.

41. ALTERATION OF TERMS: No addition to, or alteration of, the terms of the body of this Agreement or Statement of Work, Service Exhibit(s) hereto, whether by written or oral understanding of the parties, their officers, employees or agents, shall be valid and effective unless made in the form of a written amendment to this Agreement which is formally approved and executed by the parties in the same manner as this Agreement.

The County's Board of Supervisors or Chief Administrative Officer or designee may require the

addition and/or change of certain terms and conditions in the Agreement during the term of this Agreement. The County reserves the right to add and/or change such provisions as required by the County's Board of Supervisors or Chief Administrative Officer. To implement such orders, an Amendment to the Agreement shall be prepared and executed by the Contractor and by the Director of Mental Health.

42. ENTIRE AGREEMENT: The body of this Agreement; all attachments, Service Exhibit(s) A, contract package, Provider Manual, Provider Alerts, and other policies and procedures, attached hereto and incorporated herein by reference; for this Agreement, as approved in writing by Director or the Director's designee, including any addenda thereto as approved in writing by Director or the Director's designee, which are hereby incorporated herein by reference but not attached; shall constitute the complete and exclusive statement of understanding between the parties which supersedes all previous agreements, written or oral, and all other communications between the parties relating to the subject matter of this Agreement. In the event of any conflict or inconsistency in the definition or interpretation of any word, responsibility, or form, or the contents or description of any service or other work, or otherwise, between the body of this Agreement and the other referenced documents, or between such other documents, such conflict or inconsistency shall be resolved by giving precedence first to the body of this Agreement and its definitions and then to such other documents according to the following priority:

1. Service Exhibit(s) A and B
2. Attachments I, II, III, IV, V, VI, VII, VIII, IX, X and XI
3. Contract Package
4. Local Mental Health Plan (LMHP) Provider Manual and Provider Alerts
6. Other LMHP Policies and Procedures

43. WAIVER: No waiver by County of any breach of any provision of this Agreement shall constitute a waiver of any other breach of such provision. Failure of County to enforce at any time, or from time to time, any provision of this Agreement shall not be construed as a waiver thereof. The rights and remedies set forth in this Paragraph 43 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

44. BENEFICIARY ELIGIBILITY: This Agreement is not intended to change the determination of Medi-Cal eligibility for any Beneficiary in any way. However, in the event that the California Legislature or United States Congress enacts a statute which redefines Medi-Cal eligibility so as to affect the provision of Psychiatric Inpatient Hospital Services under this Agreement, then the new definition shall apply to the Agreement.

45. EMPLOYMENT ELIGIBILITY VERIFICATION: Contractor warrants that it fully complies with all Federal statutes and regulations regarding employment of aliens and others and that all its employees performing services hereunder meet the citizenship or alien status requirements set forth in federal statutes and regulations. Contractor shall obtain, from all covered employees performing services hereunder, all verification and other documentation of employment eligibility status required by Federal statutes and regulations as they currently exist and as they may be hereafter amended. Contractor shall retain all such documentation for the period prescribed by law. Contractor shall indemnify, defend, and hold harmless

County, its officers and employees from and against any employer sanctions and any other liability which may be assessed against Contractor or County in connection with any alleged violation of any federal statutes or regulations pertaining to the eligibility for employment of persons performing services under this Agreement.

46. PUBLIC ANNOUNCEMENTS AND LITERATURE: In public announcements and literature distributed by Contractor for the purpose of apprising patients/clients and the general public of the nature of its Psychiatric Inpatient Hospital Services, Contractor shall clearly indicate that the services which it provides under this Agreement are provided under authorization of the County of Los Angeles.

47. AUTHORIZATION WARRANTY: Contractor represents and warrants that the person executing this Agreement for Contractor is an authorized agent who has actual authority to bind Contractor to each and every term, condition, and obligation of this Agreement and that all requirements of Contractor have been fulfilled to provide such actual authority.

48. RESTRICTIONS ON LOBBYING: If any federal funds are to be used to pay for any of Contractor's services under this Agreement, Contractor shall fully comply with all certification and disclosure requirements prescribed by Section 319 of Public Law 101-121 (31 United States Code Section 1352) and any implementing regulations, and shall ensure that each of its subcontractors receiving funds under this Agreement also fully complies with all such certification and disclosure requirements.

49. CERTIFICATION OF DRUG-FREE WORK PLACE: Contractor certifies and agrees that Contractor and its employees shall comply with DMH's policy of maintaining a drug-free work place. Contractor and its employees shall not manufacture, distribute, dispense, possess, or use any controlled substances as defined in 21 United States Code Section 812, including, but not limited to, marijuana, heroin, cocaine, and amphetamines, at any of Contractor's facilities or work sites or County's facilities or work sites. If Contractor or any of its employees is convicted of or pleads nolo contendere to any criminal drug statute violation occurring at any such facility or work site, then Contractor, within five (5) days thereafter, shall notify Director in writing.

50. COUNTY LOBBYISTS: Contractor and each County lobbyist or County lobbying firm as defined in Los Angeles County Code Section 2.160.010, retained by Contractor, shall fully comply with the County Lobbyist Ordinance, Los Angeles County Code Chapter 2.160. Failure on the part of Contractor or any County lobbyist firm retained by Contractor to fully comply with the County Lobbyist Ordinance shall constitute a material breach of this Agreement upon which County may immediately terminate or suspend this Agreement.

51. MAINTENANCE STANDARDS FOR SERVICE DELIVERY SITES: Contractor shall assure that all locations where services are provided under this Agreement are operated at all times in accordance with all County community standards with regard to property maintenance and repair, graffiti abatement, refuse removal, fire safety, landscaping, and in full compliance with all applicable local laws, ordinances, and regulations relating to the property. County's periodic monitoring visits to Contractors' facility(ies) shall include a review of compliance with this Paragraph 51.

52. NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT: Contractor

shall notify its employees, that they may be eligible for the Federal Earned Income Credit under the Federal Income tax laws. Such notice shall be provided in accordance with the requirements set forth in Internal Revenue Service Notice 1015.

53. USE OF RECYCLED-CONTENT PAPER PRODUCTS: Consistent with the Board of Supervisors' policy to reduce the amount of solid waste deposited at the County landfills, the Contractor agrees to use recycled-content paper to the maximum extent possible on the Project.

54. CONTRACTOR RESPONSIBILITY AND DEBARMENT: The following requirements set forth in the County's Non-Responsibility and Debarment Ordinance (Title 2, Chapter 2.202 of the County Code) are effective for this Agreement, except to the extent applicable State and/or federal laws are inconsistent with the terms of the Ordinance.

A. A responsible Contractor is a Contractor who has demonstrated the attribute of trustworthiness, as well as quality, fitness, capacity and experience to satisfactorily perform the contract. It is the County's policy to conduct business only with responsible contractors.

B. The Contractor is hereby notified that, in accordance with Chapter 2.202 of the County Code, if the County acquires information concerning the performance of the Contractor on this or other Agreements which indicates that the Contractor is not responsible, the County may, in addition to other remedies provided in the Agreement, debar the Contractor from bidding or proposing on, or being awarded, and/or performing work on County Agreements for a specified period of time which generally will not exceed five years but may exceed five years or be permanent if warranted by the circumstances, and terminate any or all existing Agreements the Contractor may have with the County.

C. The County may debar a Contractor if the Board of Supervisors finds, in its discretion, that the Contractor has done any of the following: (1) violated a term of an Agreement with the County or a nonprofit corporation created by the County, (2) committed an act or omission which negatively reflects on the Contractor's quality, fitness or capacity to perform a contract with the County, any other public entity, or a nonprofit corporation created by the County, or engaged in a pattern or practice which negatively reflects on same, (3) committed an act or offense which indicates a lack of business integrity or business honesty, or (4) made or submitted a false claim against the County or any other public entity.

D. If there is evidence that the Contractor may be subject to debarment, the Department will notify the Contractor in writing of the evidence which is the basis for the proposed debarment and will advise the Contractor of the scheduled date for a debarment hearing before the Contractor Hearing Board.

E. The Contractor Hearing Board will conduct a hearing where evidence on the proposed debarment is presented. The Contractor and/or the Contractor's representative shall be given an opportunity to submit evidence at the hearing. After the hearing, the Contractor Hearing Board shall prepare a tentative proposed decision, which shall contain a recommendation regarding whether the Contractor should be debarred, and, if so, the appropriate length of time of the debarment. The Contractor and the Department shall be provided an opportunity to object to the tentative proposed decision prior to its presentation to the Board of Supervisors.

F. After consideration of any objections, or if no objections are submitted, a record of the

hearing, the proposed decision any other recommendation of the Contractor Hearing Board shall be presented to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny or adopt the proposed decision and recommendation of the Hearing Board.

G. If a Contractor has been debarred for a period longer than five (5) years, that Contractor may, after the debarment has been in effect for at least five (5) years, submit a written request for review of the debarment determination to reduce the period of debarment or terminate the debarment. The County may, in its discretion, reduce the period of debarment or terminate the debarment if it finds that the Contractor has adequately demonstrated one or more of the following: (1) elimination of the grounds for which the debarment was imposed; (2) a bona fide change in ownership or management; (3) material evidence discovered after debarment was imposed; (4) any other reason that is in the best interests of County.

H. The Contractor Hearing Board will consider a request for review of a debarment determination only where (1) the Contractor has been debarred for a period longer than five (5) years; (2) the debarment has been in effect for at least five (5) years; and (3) the request is in writing, states one or more of the grounds for reduction of the debarment period or termination of the debarment, and includes supporting documentation. Upon receiving an appropriate request, the Contractor Hearing Board will provide notice of the hearing on the request. At the hearing, the Contractor Hearing Board shall conduct a hearing where evidence on the proposed reduction of debarment period or termination of debarment is presented. This hearing shall be conducted and the request for review decided by the Contractor Hearing Board pursuant to the same procedures as for a debarment hearing.

I. The Contractor Hearing Board's proposed decision shall contain a recommendation on the request to reduce the period of debarment or terminate the debarment. The Contractor Hearing Board shall present its proposed decision and recommendation to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of the Contractor Hearing Board.

J. These terms shall also apply to subcontractors of County Contractors.

55. CONTRACTOR'S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM: Contractor hereby warrants that neither it nor any of its staff members is restricted, excluded or suspended from providing services under any health care program funded by the federal government, directly or indirectly, in whole or in part, and that Contractor will notify Director within 30 calendar days in writing of: (1) any event that would require Contractor or a staff member's mandatory exclusion or suspension from participation in a Federally funded health care program; and (2) any exclusionary or suspension action taken by any agency of the federal or State governments against Contractor or one or more staff members barring it or the staff members from participation in a Federally funded health care program, whether such bar is direct or indirect, or whether such bar is in whole or in part. This warranty and notice requirements apply equally to suspensions from the Medi-Cal program as well as any other Federally funded health care programs including but not limited to Medicare and.

There are a variety of different reasons why an individual or entity may be excluded from participating in a federally funded health care program. Sometimes, the exclusion is mandatory and in other cases the Office

of Inspector General (OIG), and State officials have the discretion not to exclude.

The mandatory bases for federal exclusion include: (1) felony convictions for program related crimes, including fraud or false claims, or for offenses related to the dispensing or use of controlled substances, or (2) convictions related to patient abuse.

Permissive exclusions may be based on: (1) conviction of a misdemeanor related to fraud or financial misconduct involving a government program; (2) obstructing an investigation; (3) failing to provide access to documents or premises as required by federal health care program officials; (4) conviction of a misdemeanor related to controlled substances; (5) failing to disclose information about the entity itself, its subcontractors or its significant business transactions; (6) loss of a State license to practice a health care profession; (7) default on a student loan given in connection with education in a health profession; (8) charging excessive amounts to a Federally funded health care program or furnishing services of poor quality or which are substantially in excess of the needs of the patients; (9) paying a kickback or submitting a false or fraudulent claim. Persons controlling or managing excluded entities who knew of the conduct leading to the exclusion can themselves be excluded, and entities which are owned and controlled by excluded individuals can also be excluded.

Mandatory exclusions under State law from Medi-Cal are similar but also include convictions of a misdemeanor for fraud or abuse involving the Medi-Cal program or a Medi-Cal beneficiary.

Contractor shall indemnify and hold County harmless against any and all loss or damage County may suffer arising from any federal or State exclusion or suspension of Contractor or its staff members from such participation in a federally funded health care program. Contractor shall provide the certification set forth in Attachment VI as part of its obligation under this Paragraph 55.

Failure by Contractor to meet the requirements of this Paragraph 55 shall constitute a material breach of Agreement upon which County may immediately terminate or suspend this Agreement.

56. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT:

A. The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996, its implementing regulations ("HIPAA") and subtitle D, Privacy, of the Health Information Technology for Economic and Clinical Health Act ("HITECH"). Contractor understands and agrees that it is a *'Covered Entity'* under HIPAA and, as such, has obligations with respect to the confidentiality, privacy, and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of staff and the establishment of proper procedures for the release of such information, including the use of appropriate consents and authorizations specified under HIPAA.

B. The parties acknowledge their separate and independent obligations with respect to HIPAA and HITECH, and that such obligations relate to *transactions and code sets, privacy, and security.* Contractor understands and agrees that it is separately and independently responsible for compliance with HIPAA and HITECH in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Contractor's obligations under HIPAA or HITECH, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing

regulations.

C. Contractor and County understand and agree that each is independently responsible for HIPAA and HITECH compliance and agree to take all necessary and reasonable actions to comply with the requirements of HIPAA law and implementing regulations related to Transactions and Code Sets, Privacy, and Security. Each party further agrees to indemnify and hold harmless the other party (including their officers, employees, and agents), for its failure to comply with HIPAA or HITECH.

D. Contractor and County understand and agree that HIPAA has imposed additional requirements in regards to changes in DMH's County's information system.

(1) County has a Guide to Procedure Codes available at http://ladmh.lacounty.gov/hipaa/index.html which includes a "crosswalk" of DMH activity codes to Current Procedural Terminology (CPT) and Health Care Procedure Coding System (HCPCS) codes.

(2) County has an electronic Data Interchange (EDI) Agreement forms available at http://ladmh.lacounty.gov/hipaa/ffs_EDI_Forms.htmand http://ladmh.lacounty.gov/hippa/ffs_IBHIS_EDI_Certification.htm which includes information about the applicable HIPAA transactions that can be processed in the County's Integrated System (IS) and the Integrated Behavioral Health Information System (IBHIS) respectively.

(3) Contractor acknowledges that County is transitioning from the IS to IBHIS in which clinical, demographic, administrative, financial, claims, outcomes, and other information will be exchanged between DMH and contract providers exclusively through the use of EDI transactions.

(4) As County defines standard formats for each EDI transaction and determines the method by which each transaction is to be exchanged between Contractor and County, County shall notify Contractor of the effective date(s) by which Contractor shall be required to implement each newly defined EDI transaction through County's release of revised Companion Guides no less than 180 days prior to the effective date(s) upon which each newly defined EDI transaction is required, unless earlier effective date(s) are imposed by law or regulation.

(5) Contractor acknowledges that County may modify EDI transactions as needed. County shall notify Contractor of the effective dates(s) by which Contractor shall be required to comply with each modified EDI transaction in accordance with County's revised EDI transaction requirements through County's release of revised Companion Guides no less than 90 days prior to the effective date(s) of each modified EDI transaction.

(6) Contractor agrees to comply with the exchange of all EDI transactions specified by

County and the method by which these transactions are to be exchanged between Contractor and County as of the effectives date(s) specified by County.

(7) County has Trading Partner Agent Authorization Agreements available at http://ladmh.lacounty.gov/hipaa/ffs_EDI_Forms.htmand http://ladmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_Certification.htmwhich includes the Contractor's authorization to its Agent(s) to submit HIPAA-compliant transactions on behalf of Contractor to the S and IBHIS respectively.

E. Contractor understands that County operates an informational website http://dmh.lacounty.gov/wps/portal/dmhrelated to the services under this Agreement and the parties' HIPAA obligations, and agrees to undertake reasonable efforts to utilize said website to obtain updates, other information, and forms to assist Contractor in its performance.

F. Contractor understands and agrees that if it uses the services of an Agent in any capacity in order to receive, transmit, store or otherwise process Data or Data Transmissions or perform related activities, the Contractor shall be fully liable to DMH or for any acts, failures or omissions of the Agent in providing said services as though they were the Contractor's own acts, failures, or omissions.

G. Contractor further understands and agrees that the terms and conditions of the current Trading Partner Agreement (TPA) available at http://ladmh.lacounty.gov/hipaa/ffs_EDI_Forms.htm and http://ladmh.lacounty.gov/hippa/ffs_IBHIS_EDI_Certification.htm shall apply to this Agreement and that said Terms and Conditions are incorporated by reference as though fully set forth herein.

57. TECHNOLOGY REQUIREMENTS:

A. Contractor shall acquire, manage, and maintain Contractor's own information technology and systems and/or services in order to meet all functional and EDI transaction requirements as specified by County.

B. Contractor shall ensure that all individuals using electronic methods to sign electronic health records in the performance of work specified under this Agreement complete an Electronic Signature Agreement annually.

(1) Contractor shall maintain a copy of each Electronic Signature Agreement and make them available for inspection by County upon request.

(2) Contractor shall submit to County a Legal Entity Electronic Signature Certification to certify compliance with this provision of this Agreement. Contractors who implement electronic methods to sign electronic health records subsequent to the execution of this Agreement shall submit to County a Legal Entity Electronic Signature Certification immediately upon implementation.

(3) County has a Legal Entity Electronic Signature Certification and a sample Electronic Signature Agreement available at: http://ladmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_Forms.htm

58. COMPLIANCE WITH JURY SERVICE PROGRAM:

A. Jury Service Program: This Agreement is subject to the provisions of the County's

ordinance entitled Contractor Employee Jury Service ("Jury Service Program") as codified in Sections 2.203.010 through 2.203.090 of the Los Angeles County Code.

B. Written Employee Jury Service Policy:

(1) Unless Contractor has demonstrated to the County's satisfaction either that Contractor is not a "Contractor" as defined under the Jury Service Program (Section 2.203.020 of the County Code) or that Contractor qualifies for an exception to the Jury Service Program (Section 2.203.070 of the County Code), Contractor shall have and adhere to a written policy that provides that its Employees shall receive from the Contractor, on an annual basis, no less than five (5)days of regular pay for actual jury service. The policy may provide that Employees deposit any fees received for such jury service with the Contractor or that the Contractor deduct from the Employee's regular pay the fees received for jury service.

(2) For purposes of this Section, "Contractor" means a person, partnership, corporation or other entity which has an Agreement with the County or a subcontract with a County Contractor and has received or will receive an aggregate sum of $50,000 or more in any 12-month period under one or more County Agreements or subcontracts. "Employee" means any California resident who is a full-time employee of Contractor. "Full-time" means 40 hours or more worked per week or a lesser number of hours if: 1) the lesser number is a recognized industry standard as determined by the County, or 2) Contractor has a long-standing practice that defines the lesser number of hours as full-time. Full-time employees providing short-term, temporary services of 90 days or less within a 12-month period are not considered full-time for purposes of the Jury Service Program. If Contractor uses any subcontractor to perform services for the County under the Agreement, the subcontractor shall also be subject to the provisions of this Section. The provisions of this Section shall be inserted into any such subcontract Agreement and a copy of the Jury Service Program shall be attached to the Agreement.

(3) If Contractor is not required to comply with the Jury Service Program when the Agreement commences, Contractor shall have a continuing obligation to review the applicability of its "exception status" from the Jury Service Program, and Contractor shall immediately notify County if Contractor at any time either comes within the Jury Service Program's definition of "Contractor" or if Contractor no longer qualifies for an exception to the Program. In either event, Contractor shall immediately implement a written policy consistent with the Jury Service Program. The County may also require, at any time during the Agreement and at its sole discretion, that Contractor demonstrate to the County's satisfaction that Contractor either continues to remain outside of the Jury Service Program's definition of "Contractor" and/or that Contractor continues to qualify for an exception to the Program.

(4) Contractor's violation of this section of the Agreement may constitute a material breach of the Agreement. In the event of such material breach, County may, in its sole discretion, terminate the Agreement and/or bar Contractor from the award of future County Agreements for a period of time consistent with the seriousness of the breach."

59. NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY LAW: The Contractor shall notify and provide to its employees, and shall require each subcontractor to notify and provide to its employees, a fact sheet regarding the Safely Surrendered Baby Law, its implementation in Los

Angeles County, and where and how to safely surrender a baby.

The fact sheet is set forth in Attachment IV of this Agreement and is also available on the Internet at www.babysafela.org for printing purposes.

60. CONTRACTOR'S ACKNOWLEDGEMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW: The Contractor acknowledges that the County places a high priority on the implementation of the Safely Surrendered Baby Law. The Contractor understands that it is the County's policy to encourage all County Contractors to voluntarily post the County's "Safely Surrendered Baby Law" poster in a prominent position at the Contractor's place of business. The Contractor will also encourage its subcontractors, if any, to post this poster in a prominent position in the subcontractor's place of business. The County's Department of Children and Family Services will supply the Contractor with the poster to be used.

61. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION – LOWER TIER COVERED TRANSACTIONS (45 C.F.R. PART 76): The Contractor hereby acknowledges that the County is prohibited from contracting with and making sub-awards to parties that are suspended, debarred, ineligible, or excluded or whose principals are suspended, debarred, ineligible, or excluded from securing Federally funded contracts. By executing this Agreement, Contractor certifies that neither it nor any of its owners, officers, partners, directors or other principals is currently suspended, debarred, ineligible, or excluded from securing federally funded contracts. Further by executing this Agreement, Contractor certifies that, to its knowledge, none of its subcontractors, at any tier, or any owner, officer, partner, director or other principal of any subcontractor is currently suspended, debarred, ineligible, or excluded from securing federally funded contracts. Contractor shall immediately notify County in writing, during the term of this Agreement, should it or any of its subcontractors or any principals of either be suspended, debarred, ineligible, or excluded from securing federally funded contracts. Failure of Contractor to comply with this provision shall constitute a material breach of this Agreement upon which the County may immediately terminate or suspend this Agreement.

62. CONTRACTOR'S CHARITABLE ACTIVITIES COMPLIANCE: The Supervision of Trustees and Fundraisers for Charitable Purposes Act regulates entities receiving or raising charitable contributions. The Nonprofit Integrity Act of 2004: (SB 1262, Chapter 919) increased Charitable Purposes Act requirements. By requiring Contractors to complete the certification in Attachment V, (CHARITABLE CONTRIBUTIONS CERTIFICATION) the County seeks to ensure that all County contractors which receive or raise charitable contributions comply with law in order to protect the County and its taxpayers. A Contractor which receives or raises charitable contributions without complying with its obligations under California law commits a material breach subjecting it to either agreement termination or debarment proceedings or both. (County Code Chapter 2.202)

63 LOCAL SMALL BUSINESS ENTERPRISE PREFERENCE PROGRAM: This Agreement is subject to all provisions of the County's ordinance entitled Local Business Enterprise Preference Program as codified in Chapter 2.204 of the Los Angeles County Code. Specifically, Contractor shall pay particular attention to the following provisions in Chapter 2.204:

Contractor shall not knowingly and with the intent to defraud, fraudulently obtain, retain, attempt to obtain or retain, or aid another in fraudulently obtaining or retaining or attempting to obtain or retain certification as a Local Small Business Enterprise.

Contractor shall not willfully and knowingly make a false statement with the intent to defraud, whether by affidavit, report, or other representation, to a County official or employee for the purpose of influencing the certification or denial of certification of any entity as a Local Small Business Enterprise.

If Contractor has obtained certification as a Local Small Business Enterprise by reason of having furnished incorrect information or by reason of having withheld information, and which knew, or should have known, the information furnished was incorrect or the information withheld was relevant to its request for certification, and which by reason of such certification has been awarded this agreement to which it would not otherwise have been entitled, then Contractor shall:

1. Pay to the County any difference between the Contract amount and what the County's costs would have been if the contract had been properly awarded;

2. Be assessed a penalty in an amount of not more than 10 percent (10%) of the amount of the contract, in addition to the amount described in subdivision (1); and

3. Be subject to the provisions of Chapter 2.202 of the Los Angeles County Code (Determinations of Contractor Non-responsibility and Contractor Debarment).

The above penalties shall also apply to any Contractor that has previously obtained proper certification, however, as a result of a change in their status would no longer be eligible for certification, and fails to notify the State and the Internal Services Department of this information prior to responding to a solicitation or accepting a contract agreement award.

64. FORCE MAJEURE:

A. Neither party shall be liable for such party's failure to perform its obligations under and in accordance with this Agreement, if such failure arises out of fires, floods, epidemics, quarantine restrictions, other natural occurrences, strikes, lockouts (other than a lockout by such party or any of such party's subcontractors), freight embargoes, or other similar events to those described above, but in every such case the failure to perform must be totally beyond the control and without any fault or negligence of such party (such events are referred to in this sub-paragraph as "force majeure events").

C. In the event Contractor's failure to perform arises out of force majeure event, Contractor agrees to use commercially reasonable best efforts to obtain goods or services from other sources, if applicable, and to otherwise mitigate the damages and reduce the delay caused by such force majeure event.

65. CONTRACTOR'S WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM: Contractor acknowledges that County has established a goal of ensuring that all individuals and businesses that benefit financially from County through agreement are current in paying their property tax obligations (secured and unsecured roll) in order to mitigate the economic burden otherwise imposed upon County and its taxpayers. Unless Contractor qualifies for an exemption or

exclusion, Contractor warrants and certifies that to the best of its knowledge it is now in compliance, and during the term of this agreement will maintain compliance, with Los Angeles County Code Chapter 2.206.

66. TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM: Failure of Contractor to maintain compliance with the requirements set forth in Paragraph 65 (CONTRACTOR'S WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM) shall constitute default under this agreement. Without limiting the rights and remedies available to County under any other provision of this agreement, failure of Contractor to cure such default within 10 days of notice shall be grounds upon which County may terminate this agreement and/or pursue debarment of Contractor, pursuant to County Code Chapter 2.206.

67. PUBLIC RECORDS ACT:

A. Any documents submitted by the Contractor; all information obtained in connection with the County's right to audit and inspect the Contractor's documents, books, and accounting records pursuant to Paragraph 14 - Record and Audits of this Agreement; as well as those documents which were required to be submitted in response to any solicitation conducted by the County for any services and/or programs for this Agreement, become the exclusive property of the County. All such documents become a matter of public record and shall be regarded as public records. Exceptions will be those elements in the California Government Code Section 6250 et seq. (Public Records Act) and which are marked "trade secret", "confidential", or "proprietary". The County shall not in any way be liable or responsible for the disclosure of any such records including, without limitation, those so marked, if disclosure is required by law, or by an order issued by a court of competent jurisdiction.

(1) County shall notify Contractor upon receipt of a request for such marked documents.

B. In the event the County is required to defend an action on a Public Records Act request, following notification to Contractor, for any of the aforementioned documents, information, books, records, and/or contents of a proposal marked "trade secret", "confidential", or "proprietary", the Contractor agrees to defend and indemnify the County from all costs and expenses, including reasonable attorney's fees, in action or liability arising under the Public Records Act.

68. SECURITY AND BACKGROUND INVESTIGATION:

A. All Contractor staff performing services under this Agreement who are in a designated sensitive position, as determined by County in County's sole discretion, shall undergo and pass a background investigation to the satisfaction of County as a condition of beginning and continuing to perform services under this Agreement. Such background investigation must be obtained through fingerprints submitted to the California Department of Justice to include State, local, and Federal-level review, which may include, but shall not be limited to, criminal conviction information. The fees associated with the background investigation shall be at the expense of the Contractor, regardless if the member of Contractor's staff passes or fails the background investigation.

B. If a member of Contractor's staff does not pass the background investigation, County may request that the member of Contractor's staff be immediately removed from performing services under the Agreement at any time during the term of the Agreement. County will not provide to Contractor or to Contractor's staff any information obtained through the County's background investigation.

C. County, in its sole discretion, may immediately deny or terminate facility access to any member of Contractor's staff that does not pass such investigation to the satisfaction of the County or whose background or conduct is incompatible with County facility access.

D. Disqualification of any member of Contractor's staff pursuant to this Paragraph 67 shall not relieve Contractor of its obligation to complete all work in accordance with the terms and conditions of this Agreement.

69. AIR OR WATER POLLUTION REQUIREMENTS: Unless specifically exempted under federal law, any federally funded Legal Entity Agreement and/or any subcontracts in excess of $100,000 must comply with the following provisions:

A. Contractor agrees to comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act [42 U.S.C. 1857(h)], section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Chapter 1).

B. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C. 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.), as amended.

70. TIME OFF FOR VOTING: The Contractor shall notify its employees, and shall require each subcontractor to notify and provide to its employees, information regarding the time off for voting law (Elections Code Section 14000). Not less than 10 days before every statewide election, every Contractor and subcontractors shall keep posted conspicuously at the place of work, if practicable, or elsewhere where it can be seen as employees come or go to their place of work, a notice setting forth the provisions of Section 14000.

71. NOTICES: All notices or demands required or permitted to be given under this Agreement shall be in writing and shall be hand delivered with signed receipt or mailed by first class, registered or certified mail, postage pre-paid, addressed to the parties at the following addresses and to the attention of the persons named. Director shall have the authority to execute all notices or demands which are required or permitted by County under this Agreement. Addresses and persons to be notified may be changed by either party by giving ten (10) days prior written notice thereof to the other party.

For the County, please use the following contact information:

County of Los Angeles – Department of Mental Health
Contracts Development and Administration Division
550 South Vermont Avenue, 5th Floor
Los Angeles, CA 90020
Attention: Chief of Contracts

For the Contractor, please use the following contact information:

Pasadena Hospital Association LTD.
dba Huntington Memorial Hospital
100 West California Blvd.
Pasadena, CA 91105
Attention: James S. Noble

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Agreement to be subscribed by County's Director of Mental Health or the Director's designee, and Contractor has caused this Agreement to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By REDACTED

MARVIN J. SOUTHARD D.S.W.
Director of Mental Health

Pasadena Hospital Association LTD.
dba Huntington Memorial Hospital

By REDACTED

Name James S. Noble

Title Chief Operating Officer
(AFFIX CORPORATE SEAL HERE)

APPROVED AS TO FORM
OFFICE OF THE COUNTY COUNSEL

APPROVED AS TO CONTRACT
ADMINISTRATION:

DEPARTMENT OF MENTAL HEALTH

REDACTED

ef, Contracts Development
Administration Division

FEE-FOR-SERVICE MEDI-CAL
ACUTE PSYCHIATRIC INPATIENT HOSPITAL SERVICES

DEFINITIONS

A. "Acute Psychiatric Inpatient Hospital Services" means those services as described in Service Exhibit A (Acute Psychiatric Inpatient Hospital Services) See attachment II, Paragraph 16 (Program Elements for Acute Psychiatric Inpatient Hospital Services);

B. "Administrative Day Services" means those services as described in Service Exhibit A (Acute Psychiatric Inpatient Hospital Services) See attachment II, Paragraph 17 (Program Elements for Administrative Day Services);

C. "Beneficiary" means any patient/client who is certified as eligible for Medi-Cal pursuant to CCR Title 22, Section 51001, and may include any patient/client who is eligible for Medi-Cal and who is enrolled in a prepaid health plan or other fee for services psychiatric/inpatient hospital services health system which contracts with State approved local physica health care Medi-Cal Managed Care Plans pursuant to applicable law. Beneficiary shall also include any patient/client whose Medi-Cal eligibility was determined after the rendition of inpatient services. Any patient/client who is eligible for Medi-Cal, who is also eligible for Medicare hospital benefits under Title XVIII of the Social Security Act, 42 United States Code Section 1395 et seq., and who has not exhausted those benefits, shall not be considered a Beneficiary. Any patient/client receiving skilled nursing facility services or long-term care services shall not be considered a Beneficiary for the purpose of this contract/agreement;

D. "CIOB" means Chief Information Office Bureau;

E "CCR" means the California Code of Regulations;

"Contract Allowable Rate" ("CAR") means the gross rate of reimbursement for Contractor's delivery of a day of service of Acute Psychiatric Inpatient Hospital Services or Administrative Day Services, as set forth in Paragraph 6. (Financial Provisions) of this Agreement, and shall be the amount of reimbursement which is allowed under this Agreement for a delivery of a day of said services. The Contract Allowable Rates do not include the cost of physician services and psychologist services rendered to Beneficiaries or the cost of transportation services for providing Acute Psychiatric Inpatient Hospital Services or Administrative Day Services;

F. "DHCS" means California Department of Health Care Services;

G. "County's Claims Processing Information System" means the current system employed by the Department of Mental Health to submit and process claims;

H. "Day(s)" means calendar day(s) unless otherwise specified;

I. "Director" means County's Director of Mental Health or Director's authorized designee;

J. "DMH" means County's Department of Mental Health;

K. "EPSDT" means the Early and Periodic Screening, Diagnosis, and Treatment program, which is a

requirement of the Medicaid program to provide comprehensive health care. Such State funds are specifically designated for this program;

L. "FFP" means Federal Financial Participation for Fee-For-Service Medi-Cal Services as authorized by Title XIX of the Social Security Act, 42 United States Code Section 1396 et. seq;

M. "Fiscal Intermediary" means the person or entity which has contracted with State to perform fiscal intermediary services related to this Agreement;

N. "Fiscal Year" means County's Fiscal Year which commences July 1 and ends the following June 30;

O. "MHMIS" Means DMH'S Mental Health Management Information System which is the Legacy clinical information and billing system also referred to as the Data Collections and Billing System;

P. "Title XIX" means Title XIX of the Social Security Act, 42 United States Code Section 1396 et seq.

Q. "Provider Manual" means DMH's Provider Manual for Medi-Cal Fee-For-Service Inpatient Mental Health Services. The Provider Manual contains the formal requirements, policies and procedures governing FFS Medi-Cal Inpatient Hospital Services for the Local Mental Health Plan and is incorporated into this agreement by reference;

R. "Psychiatric Inpatient Hospital Services" means the following mental health services when rendered to a Beneficiary in accordance with this Agreement: (1) Acute Psychiatric Inpatient Hospital Services; and (2) Administrative Day Services. Psychiatric Inpatient Hospital Services shall be provided in either a licensed acute psychiatric hospital or a distinct acute psychiatric part of a licensed general acute care hospital. Psychiatric Inpatient Hospital Services provided in an acute psychiatric hospital which is larger than sixteen beds shall be reimbursed only for Beneficiaries age 20 or younger or 65 and older;

S. "State" means the State of California;

T. "Title XIX" means Title XIX of the Social Security Act, 42 United States Code Section 1396 et seq;

V. "W&I" means the California Welfare and Institutions Code.

ATTACHMENT II

SERVICE EXHIBIT A

ACUTE PSYCHIATRIC INPATIENT HOSPITAL SERVICES

(MODE OF SERVICE 05)

1. STATEMENT OF WORK:

The quality improvement efforts of the Medi-Cal system, as operated by the County of Los Angeles Department of Mental Health (DMH), designated by the California Department of Health Care Services (DHCS) as the Local Mental Health Plan (LMHP), includes ensuring comprehensive quality services for Medi-Cal plan beneficiaries. DMH agreements for Acute Inpatient Hospital Services, Administrative Day Services provided by Lanterman-Petris-Short (LPS) designated hospitals to detain, evaluate and provide treatment to patients pursuant to Welfare and Institutions Code (WIC) Section 5150. The purpose of this agreement is to contract with qualified providers of Acute Psychiatric Inpatient Hospital Services, Administrative Day Services provided by hospitals with LPS designation to detain, evaluate and provide treatment to patients pursuant to Welfare and Institutions Code (WIC) Section 5150.

2. GENERAL: Psychiatric Inpatient Hospital Services include Acute Psychiatric Inpatient Hospital Services and Administrative Day Services. Each Contractor facility that renders Acute Psychiatric Inpatient Hospital Services shall: (1) be either a licensed acute psychiatric hospital or a distinct acute psychiatric part of a licensed general acute care hospital, (2) be secure, (3) meet all CCR Titles 9 and 22 staffing standards for inpatient services, (4) provide a twenty-four hour psychiatric treatment program and (5) be eligible, as determined by DMH, as a facility to detain and treat patients under WIC Section 5150.

LPS designation is authorized by state law through the Local Mental Health Director (Director). This designation allows facilities to evaluate and treat persons involuntarily detained under the Lanterman-Petris-Short (LPS) Act. This designation will be granted to those facilities, who fully comply with the criteria and process requirements set forth in the "County of Los Angeles Department of Mental Health LPS Designation Guidelines and Process for Facilities within County of Los Angeles", Third Edition effective September 2004 and subsequent informing material.

Acute Psychiatric Inpatient Hospital Services shall not include any services related to alcohol or substance abuse and these services shall not be reimbursable under this Agreement, except where the services related to alcohol or substance abuse are incidental to a primary diagnosis of mental illness. Where alcohol and substance abuse, and mental illness, are dually diagnosed, Acute Psychiatric Inpatient Hospital Services may be reimbursed under this Agreement only if the primary diagnosis is mental illness.

Notwithstanding any other provision of this Agreement, except as specifically approved in writing

by the Director or his designee, Contractor shall assure that at no time: (1) shall any child or adolescent under the age of 18 years receive any Acute Psychiatric Inpatient Hospital Services in a ward or unit designated for adults receiving Acute Psychiatric Inpatient Hospital Services and (2) shall any adult receive any Acute Psychiatric Inpatient Hospital Services in a ward or unit designated for children or adolescents under the age of 18 years receiving Acute Psychiatric Inpatient Hospital Services.

Acute Psychiatric Inpatient Hospital Services are generally described in the CCR, Title 9, Chapter 11, Section 1820.100 through 1820.225.

3. PERSONS TO BE SERVED:

A. Contractor shall provide Acute Psychiatric Inpatient Hospital Services to those Beneficiaries: (1) who are in need of Acute Psychiatric Inpatient Hospital Services, (2) who have the characteristics described in the Contract Package and any addenda thereto, as approved in writing by the Director, or his designee, (3) for whom provider has verified eligibility for Medi-Cal in accordance with CCR Title 22, and (4) who are referred to Contractor by practitioners in the community or admitted with the consent of the Director or his designee.

B. Contractor shall provide Administrative Day Services to those Beneficiaries: (1) who have been provided Acute Psychiatric Inpatient Hospital Services and are ready for non-acute psychiatric services, (2) who have the characteristics described in the Contract Package and any addenda thereto, as approved in writing by the Director or his designee, (3) for whom provider is responsible for verifying eligibility for Medi-Cal in accordance with CCR Title 22, and (4) who are referred to Contractor by practitioners in the community or admitted with the consent of the Director or his designee .

C. The duration of any Beneficiary's Acute Psychiatric Inpatient Hospital Services hereunder shall not exceed the lesser of: (1) those days necessary to ensure that the Beneficiary is not a danger to self or others or gravely disabled due to a mental disability or (2) those days when it is unsafe or inappropriate to treat the Beneficiary at a non-acute lower level of care, or (3) those days authorized by the Director or his designee. The duration of any Beneficiary's Administrative Day Services hereunder shall not exceed those days necessary to obtain placement options at appropriate residential treatment facilities. Contractor shall document placement contacts made at appropriate treatment facilities (see Medi-Cal Fee-for-Service Inpatient Hospital Provider Manual for more details)Beneficiary.

4. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA):

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), Contractor(s) shall have effective systems and procedures fully implemented to ensure the confidentiality, security, integrity, and accessibility of patient health information, including a plan for the storage and protection of filed medical records to protect against any/all unauthorized access, intrusion and damage.

5. PERSONNEL/STAFFING: The minimum ratio of full-time professional personnel/staff to resident patients shall at all times be in conformance with all relevant laws, regulations, rules and DMH policies and procedures.

In addition, the facility must determine staffing requirements based on assessment of patient needs, as per CCR, Title 22, Sections 71213 and 71215. Contractor(s) shall, upon request, make available for review to the Director or his designee documentation of the methodology used in making staffing determinations.

6. PSYCHIATRIC EMERGENCY RESPONSE: Contractors shall not maintain, utilize, or otherwise arrange for mobile 5150 assessment personnel or processes outside the confines of the Contractor's facility without the written consent of the Director, or his designee.

7. TEMPORARY ABSENCES OF BENEFICIARIES FROM CONTRACTOR'S FACILITY(IES): Contractor may not be reimbursed for temporary absences of Beneficiaries from Contractor's facility(ies) where: (1) the Beneficiaries are expected to return to Contractor's facility(ies) and (2) the temporary absences are therapeutically indicated and approved in writing by the Director or his designee. Reimbursement for temporary absences shall be claimed by Contractor at the DHCS established Administrative Day Rate.

The purpose and plan of each temporary absence, including, but not limited to, specified leave and return dates, shall be incorporated in progress notes in the Beneficiary's case record.

8. EMERGENCY MEDICAL TREATMENT: Beneficiaries who are provided services hereunder and who require emergency medical care for physical illness or accident shall be transported to an appropriate medical facility. The cost of such transportation as well as the cost of any emergency medical care shall not be a charge to, nor reimbursable under, this Agreement. Contractor shall establish and post written procedures describing appropriate action to be taken in the event of a medical emergency. Contractor shall also post and maintain a disaster and mass casualty plan of action in accordance with CCR Title 22, Section 80023. Such plan and procedures shall be submitted to the DMH's Disaster Coordinator, Emergency Outreach Bureau, at least ten days prior to the commencement of services under this Agreement.

9. NOTICE OF ACTION:

A. & B. Pursuant to the DHCS regulations, Contractor shall give a Beneficiary, and the

individual(s) responsible for the Beneficiary, a written notice of action in a manner and form as required by DHCS, whenever reimbursement for an admission and/or services is denied, and/or whenever continued stay services are reduced or terminated while the Beneficiary remains in Contractor facility(ies). To confirm such notices have been provided to the Beneficiary and the individual(s) responsible for the Beneficiary, Contractor shall submit a copy of such notices to the DMH's Patients Rights Bureau no later than three (3) working days following notice to the Beneficiary of any denial of reimbursement, reduction or termination of services.

10. BENEFICIARY PROBLEM RESOLUTION PROCESSES: Contractor shall comply and cooperate with the procedures and requirements for Beneficiary problem resolution process as described in CCR, Title 9, Chapter 11, Section(s) 1850.205 through 1850.215.

11. NOTIFICATION OF DEATH: Contractor shall immediately notify the Agency of Primary Responsibility (APR) as identified in the Data Collections and Information System, upon becoming aware of the death of any Beneficiary provided services hereunder. Notice shall be made by Contractor immediately by telephone and in writing upon learning of such a death. The verbal and written notice shall include the name of the deceased, the deceased's Data Collections and Information System identification number, the date of death, a summary of the circumstances thereof, and the name(s) of all Contractor's staff with knowledge of the circumstances.

12. QUALITY ASSURANCE AND IMPROVEMENT: Contractor shall comply and cooperate with all applicable provisions of WIC, CCR, Code of Federal Regulations, DHCS policies and procedures, and DMH Quality Improvement and Quality Assurance policies and procedures, to establish and maintain a complete and integrated quality improvement system. Contractor shall comply and cooperate with LMHP's quality assurance efforts and specified procedures regarding hospitalization of Assertive Community Treatment (ACT) AB 2034 and Intensive Service Recipients (ISRs) (those clients with six (6) or more acute psychiatric hospitalizations in a twelve (12) month period) intended to ensure quality of care for plan beneficiaries. Specifically Contractor shall make every reasonable effort to contact the Agency of Primary Responsibility (APR) prior to admission but no later than 24 hours after admission to coordinate treatment and discharge planning. In conformance with these provisions, Contractor shall establish: (1) a utilization review process as described in CFR 42, Subpart D, Part 456; (2) an interdisciplinary peer review of the quality of Beneficiary care; and (3) monitoring of medication regimens of Beneficiaries. Medication monitoring shall be conducted in accordance with County policy. A copy of Contractor's quality improvement system plan shall be available to DMH for review and written approval prior to Contractor's submission of any claims for services hereunder.

13. BENEFICIARY EVALUATION OF CONTRACTOR'S SERVICES: Contractor shall provide a

written questionnaire to certain Beneficiaries at the time of admission in accordance with DMH policies and procedures. The questionnaire shall be approved by State DHCS and offer the Beneficiary the opportunity to evaluate the care given. The questionnaire shall be collected at the time of discharge and maintained in Contractor's file for at least four years and shall be made available to authorized agents of County, State and/or Federal governments.

14. CONTRACTOR'S OBLIGATION TO ATTEND/PARTICIPATE IN MEETINGS: Contractor's appropriately qualified clinical staff shall regularly attend and participate in all discharge planning meetings/activities involving the Los Angeles County Departments of Children and Family Services, Mental Health, Probation and other meetings DMH determines relevant to the provision of services.

Contractor(s) staff, representing the facility and specifically the Acute Inpatient Psychiatric program, shall work collaboratively with Geographic/Service Area Managers to develop a partnership for the purpose of improving continuity and quality of care for Beneficiaries. Such collaboration shall include attendance at Service Area Impact Unit meetings and Service Area Quality Improvement Committee meetings.

Contractor shall provide weekly meetings for hospitalized Beneficiaries to discuss the treatment plan, interventions, progress toward goals, and suggested modifications of same. To ensure coordination of care, Contractor shall include the APR for intensive case management clients (e.g. ACT ISRs, and AB 2034) in weekly treatment planning meetings.

15. NOTIFICATION OF EVALUATION AND/OR ADMISSION:

Contractor(s) shall request information from, and must involve, mental health care entities providing services to the Beneficiary in order to support continuity of care.

If the Beneficiary is receiving care from DMH, Contractor's evaluating professional staff must first attempt to obtain information regarding treatment from the DMH designated APR as indicated in the DMH Data Collections and Information System, or from the Beneficiary, or significant other. If such information cannot be obtained from the Data Collections and Information System client identification screen, Beneficiary, or significant other, then the evaluating professional staff must contact 1-800-854-7771 to request information regarding the DMH designated APR.

Contractor shall notify and coordinate care with the APR regarding all Medi Cal acute psychiatric inpatient admissions in conformance with DMH policies and procedures relative to admission, inpatient care planning, discharge and follow-up related to the status of the client as identified on the Data Collections and Information System Client Identification Screen. Failure to notify the APR may result in negative consequences. For clients identified as ISR, the Contractor shall participate in Service Area planning meetings (e.g. Impact Unit meetings) to coordinate and improve the coordination of care for this population. If the Beneficiary has been pre-assigned to a specific hospital, contractor will transfer the

Beneficiary as directed by the APR, unless transfer is deemed to seriously compromise the safety of Beneficiary or the community.

Contractor will notify Office of the Public Guardian of the admission of any Beneficiaries who are publicly conserved. In the event Beneficiaries are not publicly conserved, Contractor shall, as deemed necessary by the contractor, evaluate clients regarding their need for conservatorship and will be obligated to pursue conservatorship for qualifying individuals. Contractor shall notify Office of the Public Guardian in a timely manner of any Beneficiaries with a need to be conserved (e.g., on the 10th day of a 14 day hold Contractor will have responsibility for transporting inpatients to and from conservatorship hearings).

16. PROGRAM ELEMENTS FOR ACUTE PSYCHIATRIC INPATIENT HOSPITAL SERVICES: Contractor shall provide Acute Psychiatric Inpatient Hospital Services to Beneficiaries in accordance with Contractor's Contract Package and any addenda thereto, as approved in writing by the Director or his designee, for the term of this Agreement.

Acute Psychiatric Inpatient Hospital Services consist of twenty-four hours intensive service in a facility, which is a licensed acute psychiatric hospital or a distinct acute psychiatric part of a licensed general acute care hospital, that provides psychiatric treatment with the specific intent to ameliorate the symptoms of danger to self, others, or the inability to provide for food, clothing and shelter due to a mental disability as determined by qualified mental health professional staff of the facility. Acute Psychiatric Inpatient Hospital Services shall include, but are not limited to:

A. Twenty-four (24) hour a day, seven day a week mental health admission, evaluation, referral, and treatment services, and all necessary mental health treatment and care required for the entire period the individual is in the facility (WIC 5152);

B. Services provided in conformance to all provisions in the Welfare and Institutions Code Division 5, and accompanying regulations, and Department policies regarding treatment, evaluations, patients' rights, and due process;

C. Safe and clean living environment with adequate lighting, clean toilet and bathing facilities, hot and cold water, toiletries, and a change of laundered bedding;

D. Three balanced and complete meals each day;

E. Twenty-four hour supervision of all Beneficiaries by properly trained personnel. Such supervision shall include, but is not limited to, personal assistance in such matters as eating, personal hygiene, dressing and undressing, and taking of prescribed medications;

F. Physical examination and medical history within twenty-four hours of admission;

G. Laboratory services when medically indicated;

H. X-Rays;

I. Electrocardiograms (EKG) and electroencephalograms (EEG);

J. Medication supervision and/or maintenance program;

K. Support to psychiatric treatment services, including, but not limited to, daily patient review;

L. Support to psychological services;

M. Social work services;

N. Nursing services;

O Recreational therapy services;

P. Occupational therapy services;

Q. Electroconvulsive therapy services when appropriate in accordance with WIC Section 5326.7 et seq.;

R. Ongoing self-monitoring and analysis of numbers of seclusion and restraint episodes involving the staff on the unit(s) so the staff are apprised of the results of the ongoing monitoring of Compliance with all Seclusion and Restraints statutes and regulations;

S. Recommendation for further treatment, conservatorship, or referral to other existing programs, as appropriate (i.e., day care, outpatient, etc.), relative to Beneficiary needs; (The form that will be used to convey this aftercare plan will be the DMH form titled, AFTERCARE/DISCHARGE PLAN AND RECOMMENDATIONS);

T. Honoring the preference of the Beneficiary and/or the parent of a minor, conservator, or legal guardian for the type and location of the desired treatment facility if administratively feasible and clinically appropriate;

U. Substantial consideration of the proximity of the designated facility to the patient's own community, family and support system. Alternatives to taking a patient to a more distant facility should be considered and documented on the off-site assessment form;

V. Contractor shall as required by the DHCS, provide upon admission the Therapeutic Behavioral Services (TBS) notice, and the general Early Periodic Screening Diagnosis and Treatment (EPDST) informational notice, both prepared by the SDMH pertaining to all children qualified as Medi-Cal beneficiaries under the age of 21, admitted with an emergency psychiatric condition to the Beneficiary's representative and/or adult responsible for the child at the same time such notices are provided to the child being treated by the Contractor and document in the patient record that these notifications have been made.

W. Beneficiary Treatment Plan:

1) Contractor shall include documentation of the Beneficiaries' participation in and

agreement with their client plans. Documentation of participation in and agreement with the client plan may include, but is not limited to reference in the client plan to the Beneficiary's participation in and agreement with the client plan, the beneficiary's signature on the client plan, or a description in the medical record of the beneficiary's participation and agreement with the client plan.

2) When the Beneficiary's signature or the signature of the Beneficiary's legal representative is required on the client plan and the Beneficiary refuses or is unavailable for signature, the client plan shall include a written explanation of the refusal or unavailability.

X Aftercare/discharge plan and procedures:

1) Contractor(s) shall ensure that Beneficiaries have a discharge plan. The DMH APR will participate in the development of the discharge plan. Reasonable efforts shall be made to ensure that all beneficiaries have appropriate housing or residence upon discharge. This plan will include a specific appointment or time at which Beneficiaries are expected to appear at an outpatient site. If the patient has a conservator, either a private conservator or the Public Guardian as temporary conservator or permanent conservator, the hospital must involve the conservator in the discharge process, give prior notice before discharge and obtain, or document efforts to obtain, the conservator's approval prior to discharge.

2) Contractor shall maintain a comprehensive and current referral source list, including all relevant treatment resources in the Beneficiary's area.

3) If the Beneficiary requires continuous care and treatment, Contractor(s) shall insure that, upon discharge, Beneficiaries receive appropriate referrals to community agencies and suitable placement, as evidenced by documentation in the Discharge and Aftercare Plan stipulating the following:

   a.) Beneficiaries will only be placed in licensed facilities;

   b.) Contractor(s) shall implement and administer procedures for ensuring that all referrals to community placements, for continued care and treatment are to clean, safe and supervised environments; and

   c.) Contractor(s) serving older adults will adhere to the following recommendations developed by the DMH Office of the Medical

Director: "Parameters for the Initial Psychiatric Assessment of Older Adults in Emergency Rooms and on Inpatient Units" and "Parameters for Discharge Planning for Older Adults

Y. Subsequent to discharge of a Medi-Cal Beneficiary, submission of a formal written aftercare plan to the LMHP's system of care, appropriate area DMH program agency responsible for coordinating care for the Medi-Cal Beneficiary being discharged. A copy of the aftercare plan shall be attached to the Provider's completed Treatment Authorization Request (TAR) form which is submitted to the LMHP upon discharge of the Beneficiary from the Provider's facility.

Z. Submission of a formal written aftercare plan to the Director, or his designee, at the time of discharge of the Beneficiary.

AA. Maintenance of a daily attendance log and appropriate documentation of each day of service provided hereunder in accordance with State regulatory (Title 9, Chapter 11) medical necessity reimbursement requirements.

17. PROGRAM ELEMENTS FOR ADMINISTRATIVE DAY SERVICES: Contractor shall provide Administrative Day Services to Beneficiaries in accordance with Contractor's Contract Package and any addenda thereto, as approved in writing by the Director, for the term of this Agreement.

Administrative Day Services consist of twenty-four hour service for a room in a facility, which is a licensed acute psychiatric hospital or a distinct acute psychiatric part of a licensed general acute care hospital, with less than full psychiatric treatment being provided where the Beneficiary is ready for a lower level of psychiatric services. Administrative Day Services are the services necessary to provide room and board after all attempts at providing non-acute psychiatric services have been exhausted and shall apply to a Beneficiary awaiting placement to non-acute residential psychiatric treatment facilities. The facility shall implement and document an active placement effort or contacts on behalf of each Beneficiary with a minimum of five appropriate, non-acute residential treatment facilities per week. The requirement of five contacts per week may be waived if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the Beneficiary until such time as the Beneficiary is successfully placed or no longer requires additional treatment. In no case shall there be less than one contact per week. Beneficiary

Administrative Day Services shall include, but are not limited to:

A. Safe and clean living environment with adequate lighting, toilet and bathing facilities, hot and cold water, toiletries, and a change of laundered bedding;

B. Three balanced and complete meals each day;

C. Twenty-four hour supervision of Medi-Cal Beneficiaries by properly trained personnel. Such supervision shall include, but is not limited to, personal assistance in such matters as eating, personal hygiene, dressing and undressing, and taking of prescribed medications;

D. Social work services;

E. Nursing services;

F Recommendation for further treatment, conservatorship, or referral to other existing programs, as appropriate (i.e., day care, outpatient, etc.), relative to Beneficiary needs;

G. Subsequent to discharge of a Medi-Cal Beneficiary, submission of a formal written aftercare plan to the LMHP's system of care, appropriate area DMH program agency responsible for coordinating care for the Medi-Cal Beneficiary being discharged. A copy of the aftercare plan shall be attached to the Provider's completed Treatment Authorization Request (TAR) form which is submitted to the LMHP upon discharge of the Beneficiary from the Provider's facility;

H. Submission of a formal written aftercare plan to the Director, or his designee, at the time of discharge of the Beneficiary.

I. Maintenance of a daily attendance log and appropriate documentation for each day of service provided hereunder in accordance with State regulatory (Title 9, Chapter 11) medical necessity reimbursement requirements.

ATTACHMENT III

ATTESTATION REGARDING FEDERALLY FUNDED PROGRAMS

In accordance with the DMH FFS Hospital Agreement's Paragraph 55 (CONTRACTOR'S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM):

I, the undersigned certify that I am not presently excluded from participation in Federally funded health care programs, nor is there an investigation presently pending or recently concluded of me which is likely to result in my exclusion from any Federally funded health care program, nor am I otherwise likely to be found by a Federal or State agency to be ineligible to provide goods or services under the Federally funded health care programs.

I further certify as the official responsible for the administration of Pasadena Hospital Assoc. LTD dba Huntington Memorial Hospital (hereafter "Contractor") that all of its officers, employees, agents and/or sub-contractors are not presently excluded from participation in any Federally funded health care programs, nor is there an investigation presently pending or recently concluded of any such officers, employees, and/or agents which is likely to result in an exclusion from any Federally funded health care program, nor are any of its officers, employees, and/or agents otherwise likely to be found by a Federal or State agency to be ineligible to provide goods or services under the Federally funded health care programs.

I understand and certify that I will notify DMH within thirty (30) calendar days, in writing of:

- Any event that would require Contractor or any of its officers, employees, and/or agents exclusion or suspension under federally funded health care programs, or
- Any suspension or exclusionary action taken by an agency of the federal or state government against Contractor, or one or more of its officers, employees, and/or agents, barring it or its officers, employees, agents and/or sub-contractors from providing goods or services for which federally funded healthcare program payment may be made.

Name of authorized official (Official Name) James S. Noble
Please print name

Signature of authorized official REDACTED Date 6/9/15

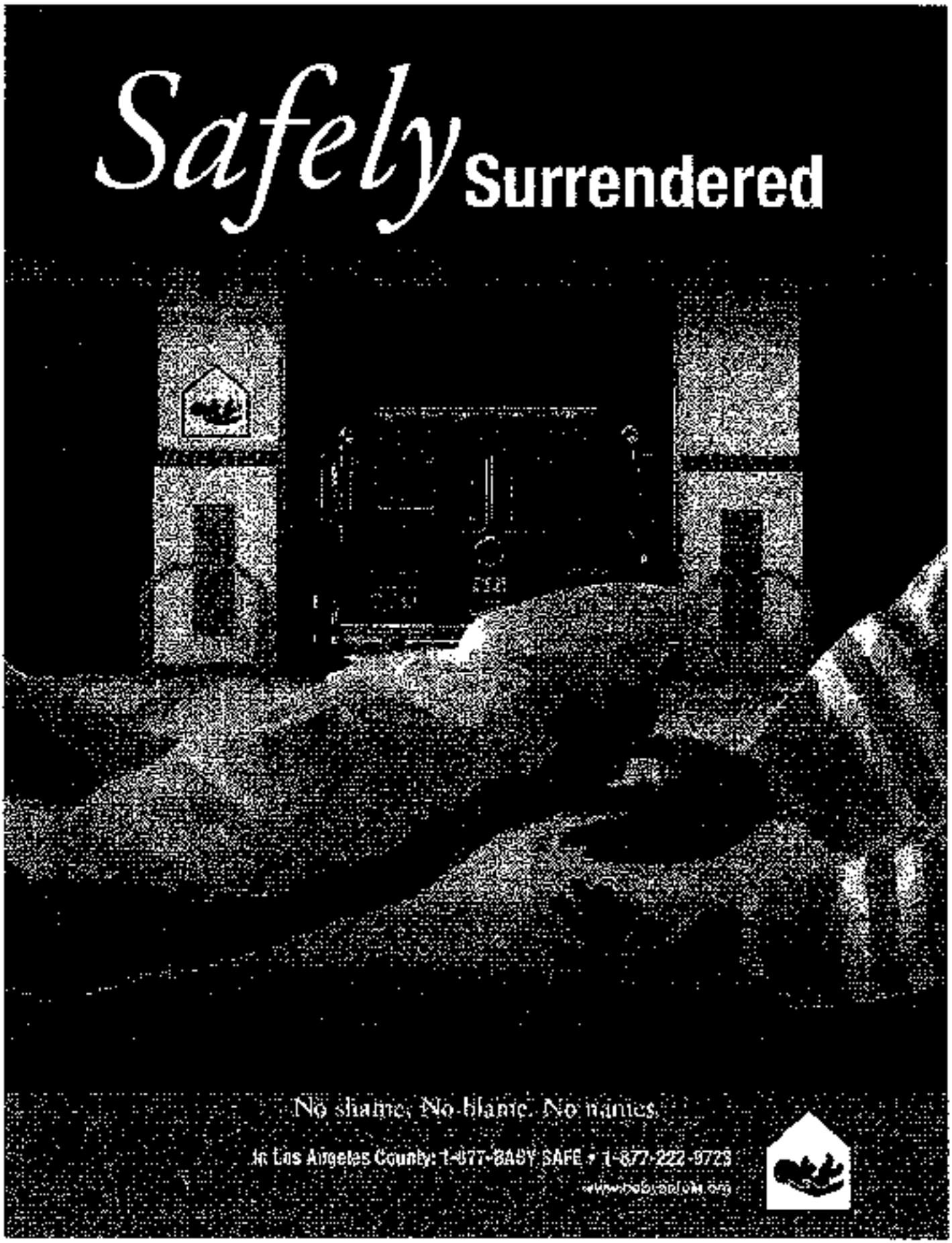
ATTACHMENT IV

SAFELY SURRENDERED BABY LAW

Posters and Fact Sheets are available in English and Spanish for printing purposes at the following website:

www.babysafela.org

Safely Surrendered



No shame. No blame. No names.

In Los Angeles County: 1-877-BABY SAFE • 1-877-222-9723

www.babysafela.org

In Los Angeles County, 1-877-SAFE-SAFE • 1-877-723-3723
www.babysafela.org

Safely Surrendered *Baby Law*

What is the Safely Surrendered Baby Law?

How does it work?

A distressed parent who is unable or unwilling to care for a baby can legally, confidentially, and safely surrender a baby within three days (72 hours) of birth. The baby must be handed to an employee at a hospital or fire station in Los Angeles County as long as the baby shows no sign of abuse or neglect. No name or other information is required. In case the parent changes his or her mind at a later date and wants the baby back, staff will use bracelets to help reconnect them to each other. One bracelet will be placed on the baby, and a matching bracelet will be given to the parent or other surrendering adult.

What if a parent wants the baby back?

Parents who change their minds can begin the process of reclaiming their baby within 14 days. These parents should call the Los Angeles County Department of Children and Family Services at 1-800-540-4000.

Can only a parent bring in the baby?

No. While in most cases a parent will bring in the baby, the Law allows other people to bring in the baby if they have lawful custody.

Does the parent or surrendering adult have to call before bringing in the baby?

No. A parent or surrendering adult can bring in a baby anytime, 24 hours a day, 7 days a week, as long as the parent or surrendering adult surrenders the baby to someone who works at the hospital or fire station.

Does the parent or surrendering adult have to tell anything to the people taking the baby?

No. However, hospital or fire station personnel will ask the surrendering party to fill out a questionnaire designed to gather important medical history information, which is very useful in caring for the baby. The questionnaire includes a stamped return envelope and can be sent in at a later time.

What happens to the baby?

The baby will be examined and given medical treatment. Upon release from the hospital, social workers immediately place the baby in a safe and loving home and begin the adoption process.

What happens to the parent or surrendering adult?

Once the parent or surrendering adult surrenders the baby to hospital or fire station personnel, they may leave at any time.

Why is California doing this?

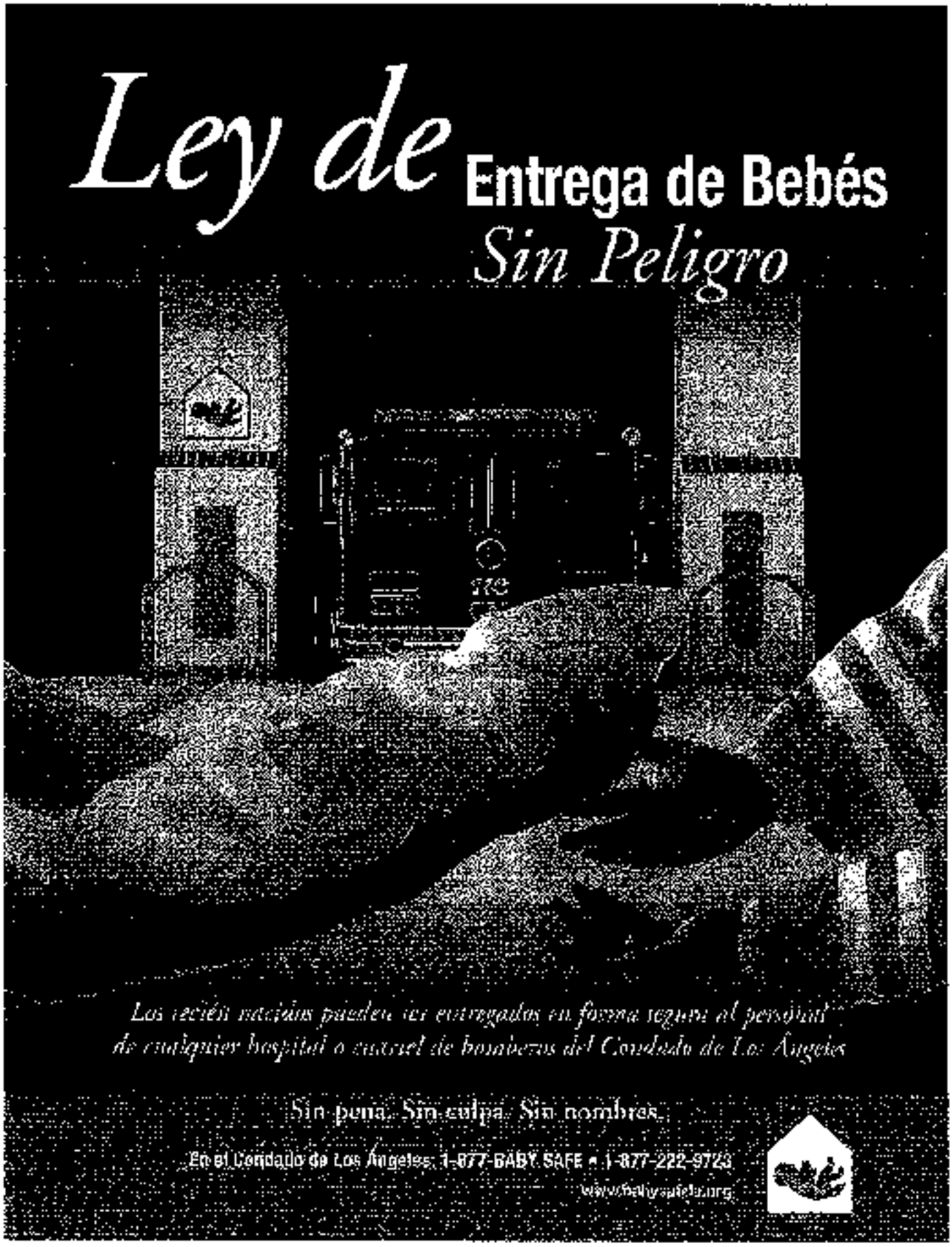
The purpose of the Safely Surrendered Baby Law is to prevent babies from being abandoned, hurt or killed by their parents. You may have heard tragic stories of babies left in dumpsters or public bathrooms. Their parents may have been under severe emotional distress. The mothers may have hidden their pregnancies, fearful of what would happen if their families found out. Because they were afraid and had no one they knew to turn for help, they abandoned their babies. Abandoning a baby is illegal and places the baby in extreme danger. Too often, it results in the baby's death. The Safely Surrendered Baby Law prevents this tragedy from ever happening again in California.

A baby's story

Early in the morning on April 9, 2005, a healthy baby boy was safely surrendered to nurses at Harbor-UCLA Medical Center. The woman who brought the baby to the hospital identified herself as the baby's aunt and stated the baby's mother had asked her to bring the baby to the hospital on her behalf. The aunt was given a bracelet with a number matching the anklet placed on the baby; this would provide some identification in the event the mother changed her mind about surrendering the baby and wished to reclaim the baby in the 14-day period allowed by the Law. The aunt was also provided with a medical questionnaire and told the mother to complete and mail back in the stamped return envelope provided. The baby was examined by medical staff and pronounced healthy and full-term. He was placed with a loving family that had been approved to adopt him by the Department of Children and Family Services.



Ley de Entrega de Bebés *Sin Peligro*



Los recién nacidos pueden ser entregados en forma segura al personal de cualquier hospital o cuartel de bomberos del Condado de Los Ángeles

Sin pena. Sin culpa. Sin nombres.

En el Condado de Los Angeles: 1-877-BABY SAFE • 1-877-222-9723

www.babysafela.org

En el Condado de Los Angeles: 1-877-BABY SAFE • 1-877-222-9723
www.BabySafeLA.org

Ley de Entrega de Bebés *Sin Peligro*

¿Qué es la Ley de Entrega de Bebés sin Peligro?

Cada recién nacido se merece la oportunidad de tener una vida saludable. Si alguien que usted conoce está pensando en abandonar a un recién nacido, infórmele que tiene otras opciones. Hasta los siete días (72 horas) después del nacimiento, se puede entregar un recién nacido al personal de cualquier hospital o cuartel de bomberos del condado de Los Angeles.

¿Cómo funciona?

El padre/madre con dificultades que no puede o no quiere cuidar de un recién nacido puede entregar o ceder legal, confidencial y seguramente dentro de los siete días (72 horas) del nacimiento. El bebé debe ser entregado a un empleado de cualquier hospital o cuartel de bomberos del Condado de Los Angeles. Siempre que el bebé no presente signos de abuso o negligencia, no será necesario establecer contacto ni información alguna. Si el padre/madre cambia de opinión posteriormente y desea recuperar a su bebé, los trabajadores sociales tratarán de hallarlos para poder vincularlos. El bebé llevará un brazalete y el padre/madre o el adulto que lo entregue recibirá un brazalete igual.

¿Qué pasa si el padre/madre desea recuperar a su bebé?

Los padres que cambien de opinión pueden comenzar el proceso de reclamar a su recién nacido dentro de los 14 días. Estos padres deberán llamar al Departamento de Servicios para Niños y Familias (Department of Children and Family Services) del Condado de Los Angeles al 1-800-540-4000.

¿Sólo los padres podrán llevar al recién nacido?

No. Si bien en la mayoría de los casos son los padres los que llevan al bebé, la ley permite que otras personas lo hagan *si tienen custodia legal.*

¿Los padres o el adulto que entrega al bebé deben llamar antes de llevar al bebé?

No. El padre/madre o adulto puede llevar al bebé en cualquier momento, las 24 horas del día, los 7 días de la semana, siempre y cuando entreguen a su bebé a un empleado del hospital o cuartel de bomberos.

¿Es necesario que el padre/madre o adulto diga algo a las personas que reciben al bebé?

No. Sin embargo, el personal del hospital o cuartel de bomberos le pedirá a la persona que entregue al bebé que llene un cuestionario con la finalidad de recabar antecedentes médicos importantes, que ayudan de gran utilidad para cuidar bien del bebé. El cuestionario incluye un sobre con el sello postal pagado para enviarlo en otro momento.

¿Qué pasará con el bebé?

El bebé será examinado y le brindarán atención médica. Cuando le den el alta del hospital, los trabajadores sociales inmediatamente ubicarán al bebé en un hogar seguro donde estará bien atendido, y se comenzará el proceso de adopción.

¿Qué pasará con el padre/madre o adulto que entregue al bebé?

Una vez que los padres o adultos hayan entregado al bebé al personal del hospital o cuartel de bomberos, pueden irse en cualquier momento.

¿Por qué se está haciendo esto en California? ?

La finalidad de la Ley de Entrega de Bebés sin Peligro es proteger a los bebés para que no sean abandonados, lastimados o muertos por sus padres. Usted probablemente haya escuchado historias trágicas sobre bebés abandonados en basureros o en baños públicos. Los padres de esos bebés probablemente hayan estado pasando por dificultades emocionales graves. Las madres pueden haber ocultado su embarazo, por temor a lo que pensarán sus familiares o vecinos. Abandonan a su bebé porque tienen miedo y no tienen nadie a quien pedir ayuda. El abandono de un recién nacido es ilegal y pone al bebé en una situación de peligro extremo. Muy a menudo el abandono provoca la muerte del bebé. La Ley de Entrega de Bebés sin Peligro impide que mucha a suceder esa tragedia en California.

Historia de un bebé

A la mañana temprano del día 9 de abril de 2005, se entregó un recién nacido saludable a los enfermeros del Harbor-UCLA Medical Center. La mujer que llevó al recién nacido al hospital no dio su nombre ni el del bebé, y dijo que la madre le había pedido que llevara al bebé al hospital en su nombre. La entregaron a la sala de urgencias y un número que coincidía con la pulsera del bebé se imprimió como identificación en caso de que la madre cambiara de opinión con respecto a la entrega del bebé y decidiera recuperarlo dentro del período de 14 días que permite esta ley. También le dieron a la tía un cuestionario médico, y ella dijo que la madre lo llenaría y lo enviaría de vuelta dentro del sobre con franqueo pagado que le habían dado. El personal médico examinó al bebé y se determinó que estaba saludable y a término. El bebé fue ubicado con una buena familia que ya había sido aprobada para adopción por el Departamento de Servicios para Niños y Familias.



DMH LEGAL ENTITY AGREEMENT
ATTACHMENT V

CHARITABLE CONTRIBUTIONS CERTIFICATION

Pasadena Hospital Association LTD, dba Huntington Memorial Hospital
Company Name

100 W. California BLVD., Pasadena, CA 91105
Address

95-1644036
Internal Revenue Service Employer Identification Number

California Registry of Charitable Trusts "CT" number (if applicable)

The Nonprofit Integrity Act (SB 1262, Chapter 919) added requirements to California's Supervision of Trustees and Fundraisers for Charitable Purposes Act which regulates those receiving and raising charitable contributions.

Check the Certification below that is applicable to your company.

☑ Proposer or Contractor has examined its activities and determined that it does not now receive or raise charitable contributions regulated under California's Supervision of Trustees and Fundraisers for Charitable Purposes Act. If Proposer engages in activities subjecting it to those laws during the term of a County contract, it will timely comply with them and provide County a copy of its initial registration with the California State Attorney General's Registry of Charitable Trusts when filed.

OR

☐ Proposer or Contractor is registered with the California Registry of Charitable Trusts under the CT number listed above and is in compliance with its registration and reporting requirements under California law. Attached is a copy of its most recent filing with the Registry of Charitable Trusts as required by Title 11 California Code of Regulations, sections 300-301 and Government Code sections 12585-12586.

REDACTED

Signature

6/9/15
Date

James S. Noble, Chief Operating Officer
Name and Title of Signer (Official Name, Official Title) Please print

ATTACHMENT VI

ATTESTATION REGARDING STAFFING RATIO

In accordance with the DMH Mental Health Services Agreement's Paragraph 9 (STAFFING):

I, the undersigned certify that Name of the Hospital Pasadena Hospital Assoc LTD, dba Huntington Memorial Hospital meet the staffing requirement as required by WIC and CCR. Our staff shall be qualified and shall possess all appropriate licenses in accordance with WIC Sections 14718 and all other applicable requirements of the California Business and Professions Code, WIC, CCR and State Policy Letters, and function within the scope of practice as dictated by licensing boards/bodies.

I further certify as the official responsible for the administration of Pasadena Hospital Assoc, LTD, dba Huntington Memorial Hospital hereafter "Contractor") that we shall have available and shall provide upon request to authorized representatives of County, a list of all persons by name, title, professional degree, and experience, who are providing any services under the agreement.

I understand and certify that we meet the staffing requirements as required by WIC and CCR.

Name of certifying official James S. Noble
Please print name

Title of certifying official Chief Operating Officer
Please print title

Signature of certifying official REDACTED Date 6/9/15

CROSSWALK FACT SHEET
OMH FFS HOSPITAL AGREEMENT

Current Language	New Language
○ Health Care Financing Administration (HCFA)	○ Centers for Medicare and Medicaid Services (CMS)
○ Explanation of Benefits (EOB)	○ Remittance Advice (RA)
○ Mode of Service and Service Function Code (SFC) ○ Activity Code	○ CPT Codes: Current Procedural Terminology published by the American Medical Association is a list of codes representing procedures or services. ○ **HCPCS Codes (Level II):** HCFA and other Common Procedure Coding System (HCPCS) Codes are used and approved by the Centers for Medicare and Medicaid to describe and accurately report procedures and services. **A crosswalk of HCPCS and CPT Codes to SFC's is available in legacy files.** **UB92:** Refers to coding standards designated by HIPAA.
○ DSM IV	○ **ICD-9 Codes:** (International Classification of Diseases), 9th Revision Codes, issued and authorized by the Centers for Medicare and Medicaid, to describe and accurately report health related procedures and Diagnoses.
○ Clinical Staff and Discipline Code	○ Rendering Provider and Taxonomy
○ MHMIS or Mental Health Management Information System AND MIS Management Information System	○ IS or Integrated System
○ References to entering data into the MIS	○ Entering data into the IS
○ RGMS	○ IS

CONTRACTOR ACKNOWLEDGEMENT AND CONFIDENTIALITY AGREEMENT

CONTRACTOR NAME Pasadena Hospital Association, dba Huntington Memorial Hospital Contract No. MH062087

GENERAL INFORMATION:

The Contractor referenced above has entered into a contract with the County of Los Angeles to provide certain services to the County. The County requires the Corporation to sign this Contractor Acknowledgement and Confidentiality Agreement.

CONTRACTOR ACKNOWLEDGEMENT:

Contractor understands and agrees that the Contractor employees, consultants, Outsourced Vendors and Independent contractors (Contractor's Staff) that will provide services in the above referenced agreement are Contractor's sole responsibility. Contractor understands and agrees that Contractor's Staff must rely exclusively upon Contractor for payment of salary and any and all other benefits payable by virtue of Contractor's Staff's performance of work under the above-referenced contract.

Contractor understands and agrees that Contractor's Staff are not employees of the County of Los Angeles for any purpose whatsoever and that Contractor's Staff do not have and will not acquire any rights or benefits of any kind from the County of Los Angeles by virtue of my performance of work under the above-referenced contract. Contractor understands and agrees that Contractor's Staff will not acquire any rights or benefits from the County of Los Angeles pursuant to any agreement between any person or entity and the County of Los Angeles.

CONFIDENTIALITY AGREEMENT:

Contractor and Contractor's Staff may be involved with work pertaining to services provided by the County of Los Angeles and, if so, Contractor and Contractor's Staff may have access to confidential data and information pertaining to persons and/or entities receiving services from the County. In addition, Contractor and Contractor's Staff may also have access to proprietary information supplied by other vendors doing business with the County of Los Angeles. The County has a legal obligation to protect all such confidential data and information in its possession, especially data and information concerning health, criminal, and welfare recipient records. Contractor and Contractor's Staff understand that if they are involved in County work, the County must ensure that Contractor and Contractor's Staff, will protect the confidentiality of such data and information. Consequently, Contractor must sign this Confidentiality Agreement as a condition of work to be provided by Contractor's Staff for the County.

Contractor and Contractor's Staff hereby agrees that they will not divulge to any unauthorized person any data or information obtained while performing work pursuant to the above-referenced contract between Contractor and the County of Los Angeles. Contractor and Contractor's Staff agree to forward all requests for the release of any data or information received to County's Project Manager.

Contractor and Contractor's Staff agree to keep confidential all health, criminal, and welfare recipient records and all data and information pertaining to persons and/or entities receiving services from the County, design concepts, algorithms, programs, formats, documentation, Contractor proprietary information and all other original materials produced, created, or provided to Contractor and Contractor's Staff under the above-referenced contract. Contractor and Contractor's Staff agree to protect these confidential materials against disclosure to other than Contractor or County employees who have a need to know the information. Contractor and Contractor's Staff agree that if proprietary information supplied by other County vendors is provided to me during this employment, Contractor and Contractor's Staff shall keep such information confidential.

Contractor and Contractor's Staff agree to report any and all violations of this agreement by Contractor and Contractor's Staff and/or by any other person of whom Contractor and Contractor's Staff becomes aware.

Contractor and Contractor's Staff acknowledge that violation of this agreement may subject Contractor and Contractor's Staff to civil and/or criminal action and that the County of Los Angeles may seek all possible legal redress.

SIGNATURE: _____ DATE: ____/____/____

PRINTED NAME: James S. Noble

POSITION: Chief Operating Officer

CONTRACTOR EMPLOYEE ACKNOWLEDGEMENT AND CONFIDENTIALITY AGREEMENT

(Note – for Contractor's record; shall be made available within three (3) business days upon DMH request)

Contractor Name _____ Contract No. _____

Employee Name _____

GENERAL INFORMATION:

Your employer referenced above has entered into a contract with the County of Los Angeles to provide certain services to the County. The County requires your signature on this Contractor Employee Acknowledgement and Confidentiality Agreement.

EMPLOYEE ACKNOWLEDGEMENT:

I understand and agree that the Contractor referenced above is my sole employer for purposes of the above-referenced contract. I understand and agree that I must rely exclusively upon my employer for payment of salary and any and all other benefits payable to me or on my behalf by virtue of my performance of work under the above-referenced contract.

I understand and agree that I am not an employee of the County of Los Angeles for any purpose whatsoever and that I do not have and will not acquire any rights or benefits of any kind from the County of Los Angeles by virtue of my performance of work under the above-referenced contract. I understand and agree that I do not have and will not acquire any rights or benefits from the County of Los Angeles pursuant to any agreement between any person or entity and the County of Los Angeles.

I understand and agree that I may be required to undergo a background and security investigation(s). I understand and agree that my continued performance of work under the above-referenced contract is contingent upon my passing, to the satisfaction of the County, any and all such investigations. I understand and agree that my failure to pass, to the satisfaction of the County, any such investigation shall result in my immediate release from performance under this and/or any future contract.

CONFIDENTIALITY AGREEMENT:

I may be involved with work pertaining to services provided by the County of Los Angeles and, if so, I may have access to confidential data and information pertaining to persons and/or entities receiving services from the County. In addition, I may also have access to proprietary information supplied by other vendors doing business with the County of Los Angeles. The County has a legal obligation to protect all such confidential data and information in its possession, especially data and information concerning health, criminal, and welfare recipient records. I understand that if I am involved in County work, the County must ensure that I, too, will protect the confidentiality of such data and information. Consequently, I understand that I must sign this agreement as a condition of my work to be provided by my employer for the County. I have read this agreement and have taken due time to consider it prior to signing.

I hereby agree that I will not divulge to any unauthorized person any data or information obtained while performing work pursuant to the above-referenced contract between my employer and the County of Los Angeles. I agree to forward all requests for the release of any data or information received by me to my immediate supervisor.

I agree to keep confidential all health, criminal, and welfare recipient records and all data and information pertaining to persons and/or entities receiving services from the County, design concepts, algorithms, programs, formats, documentation, Contractor proprietary information and all other original materials produced, created, or provided to or by me under the above-referenced contract. I agree to protect these confidential materials against disclosure to other than my employer or County employees who have a need to know the information. I agree that if proprietary information supplied by other County vendors is provided to me during this employment, I shall keep such information confidential.

I agree to report to my immediate supervisor any and all violations of this agreement by myself and/or by any other person of whom I become aware. I agree to return all confidential materials to my immediate supervisor upon completion of this contract or termination of my employment with my employer, whichever occurs first.

SIGNATURE: _____ DATE: ____/____/____

PRINTED NAME: _____

POSITION: _____

CONTRACTOR NON-EMPLOYEE ACKNOWLEDGEMENT AND CONFIDENTIALITY AGREEMENT

(Note – for Contractor's record; shall be made available within three (3) business days upon DMH request)

Contractor Name _____ Contract No. _____

Non-Employee Name _____

GENERAL INFORMATION:

The Contractor referenced above has entered into a contract with the County of Los Angeles to provide certain services to the County. The County requires your signature on this Contractor Non-Employee Acknowledgement and Confidentiality Agreement.

NON-EMPLOYEE ACKNOWLEDGEMENT:

I understand and agree that the Contractor referenced above has exclusive control for purposes of the above-referenced contract. I understand and agree that I must rely exclusively upon the Contractor referenced above for payment of salary and any and all other benefits payable to me or on my behalf by virtue of my performance of work under the above-referenced contract.

I understand and agree that I am not an employee of the County of Los Angeles for any purpose whatsoever and that I do not have and will not acquire any rights or benefits of any kind from the County of Los Angeles by virtue of my performance of work under the above-referenced contract. I understand and agree that I do not have and will not acquire any rights or benefits from the County of Los Angeles pursuant to any agreement between any person or entity and the County of Los Angeles.

I understand and agree that I may be required to undergo a background and security investigation(s). I understand and agree that my continued performance of work under the above-referenced contract is contingent upon my passing, to the satisfaction of the County, any and all such investigations. I understand and agree that my failure to pass, to the satisfaction of the County, any such investigation shall result in my immediate release from performance under this and/or any future contract.

CONFIDENTIALITY AGREEMENT:

I may be involved with work pertaining to services provided by the County of Los Angeles and, if so, I may have access to confidential data and information pertaining to persons and/or entities receiving services from the County. In addition, I may also have access to proprietary information supplied by other vendors doing business with the County of Los Angeles. The County has a legal obligation to protect all such confidential data and information in its possession, especially data and information concerning health, criminal, and welfare recipient records. I understand that if I am involved in County work, the County must ensure that I, too, will protect the confidentiality of such data and information. Consequently, I understand that I must sign this agreement as a condition of my work to be provided by the above-referenced Contractor for the County. I have read this agreement and have taken due time to consider it prior to signing.

I hereby agree that I will not divulge to any unauthorized person any data or information obtained while performing work pursuant to the above-referenced contract between the above-referenced Contractor and the County of Los Angeles. I agree to forward all requests for the release of any data or information received by me to the above-referenced Contractor.

I agree to keep confidential all health, criminal, and welfare recipient records and all data and information pertaining to persons and/or entities receiving services from the County, design concepts, algorithms, programs, formats, documentation, Contractor proprietary information, and all other original materials produced, created, or provided to or by me under the above-referenced contract. I agree to protect these confidential materials against disclosure to other than the above-referenced Contractor or County employees who have a need to know the information. I agree that if proprietary information supplied by other County vendors is provided to me, I shall keep such information confidential.

I agree to report to the above-referenced Contractor any and all violations of this agreement by myself and/or by any other person of whom I become aware. I agree to return all confidential materials to the above-referenced Contractor upon completion of this contract or termination of my services hereunder, whichever occurs first.

SIGNATURE: _____ DATE: ____/____/____

PRINTED NAME: _____

POSITION: _____

ATTACHMENT IX

CONTRACTOR'S EEO CERTIFICATION

Pasadena Hospital Assoc LTD, dba Huntington Memorial Hospital
Contractor Name

Address 100 W. California Blvd., Pasadena, CA 91105

95-1644036
Internal Revenue Service Employer Identification Number

51398901
Vendor Number

GENERAL CERTIFICATION

In accordance with Section 4.32.010 of the Code of the County of Los Angeles, the Contractor, supplier, or vendor certifies and agrees that all persons employed by such firm, its affiliates, subsidiaries, or holding companies are and will be treated equally by the firm without regard to or because of race, religion, ancestry, national origin, or sex and in compliance with all anti-discrimination laws of the United States of America and the State of California.

CONTRACTOR'S SPECIFIC CERTIFICATIONS

1.	The Contractor has a written policy statement prohibiting discrimination in all phases of employment.	Yes ☑	No ☐
2.	The Contractor periodically conducts a self-analysis or utilization analysis of its work force.	Yes ☑	No ☐
3.	The Contractor has a system for determining if its employment practices are discriminatory against protected groups.	Yes ☑	No ☐
4.	Where problem areas are identified in employment practices, the Contractor has a system for taking reasonable corrective action, to include establishment of goals or timetables.	Yes ☑	No ☐

James S. Noble, Chief Operating Officer
Authorized Official's Printed Name and Title

REDACTED

Authorized Official's Signature

6/9/15
Date

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

CHIEF INFORMATION OFFICE BUREAU

ELECTRONIC TRADING PARTNER AGREEMENT

This Trading Partner Agreement ('Agreement') is made and entered by and between the Legal Entity or Network Provider named Pasadena Hospital Association dba Huntington Memorial Hospital ("Trading Partner"), whose legal entity or Network Provider number is N/A and the County of Los Angeles – Department of Mental Health ("DMH").

WHEREAS, DMH and Trading Partner exchange information and data electronically in connection with certain healthcare transactions; and

WHEREAS, DMH and Trading Partner will be readily equipped at their own expense with the Systems and trained personnel necessary to engage in the successful exchange of electronic information and data; and

WHEREAS, in the electronic transmission of information and data, the confidentiality and security of the data which is exchanged between the Parties is of the highest priority to both Parties; and

WHEREAS, it is anticipated by DMH that the Trading Partner may use, in the performance of this Agreement, various third parties as the Trading Partner's Agents in the electronic exchange of information;

NOW THEREFORE, in consideration for the mutual promises herein, the Parties agree as follows:

1. DEFINITIONS

1.1. Agents
Third parties or organizations that contract with the Trading Partner to perform designated services in order to facilitate the electronic transfer of data. Examples of Agents include, claims clearinghouses, vendors, and billing services.

1.2. Confidential Information
Information relating to specific Individuals which is exchanged by and between DMH, the Trading Partner, and/or the Agents for various business purposes, but which is protected from disclosure to unauthorized persons or entities by The Privacy Act of 1974, The Administrative Simplification Provisions of the federal Health Insurance Portability and Accountability Act and regulations promulgated there under ("HIPAA"). The Insurance Information and Privacy Protections Act, or other applicable state and federal statutes and regulations, which shall hereinafter be collectively referred to as "Privacy Statutes and Regulations."

1.3. Covered Individuals
Individual persons who are eligible for payment of certain services or prescriptions rendered or sold to them under the terms, conditions, limitations and exclusions of a health benefit program administered by DMH or by some other Payor.

1.4. Data
A formalized representation of specific facts or concepts suitable for communication, interpretation, or processing by people or by automatic means.

1.5. Data Log
A complete written summary of Data and Data Transmissions exchanged between the Parties over the period of time this Agreement is in effect and, including, without limitation, sender and receiver information, the date and time of transmission and the general nature of the transmission.

1.6. Data Transmission
The automated transfer or exchange of data between Trading Partners or their agents, by means of their Systems which are compatible for that purpose, pursuant to the terms and conditions set forth in this Agreement.

1.7. Data Universal Numbering System ("DUNS")
Data Universal Numbering System (DUNS) – A unique nine digit identification number assigned by Dun & Bradstreet (D&B) to a Trading Partner or Agent for the purpose of identifying a business entity. The DUNS can be requested at: http://fedgov.dnb.com/webform

1.8. Digital Key Certificate
Software that resides on Tracing Partner's workstation or server assigned to the Trading Partner by DMH for the purpose of successfully executing Data Transmissions or otherwise carrying out the express terms of this Agreement.

1.9. Electronic Data Interchange ("EDI")
The automated exchange of business data from application to application in an ANSI approved or other mutually agreed format.

1.10. Electronic Remittance Advice ("ERA")
A transaction containing information pertaining to the disposition of a specific claim filed with DMH by Providers for payment of services rendered to an Individual.

1.11. Envelope
A control structure in a mutually agreed format for the electronic interchange of one or more encoded Data Transmissions either sent or received by the Parties to this Agreement.

1.12. Individual
An individual person(s) whose claims for payment of services may be eligible to be paid, under the terms of the applicable federal, state or local governmental program for which DMH processes or administers claims. It is acknowledged and agreed between the Parties that claim payments for purposes of this Agreement will be made directly to Providers on behalf of such Individuals.

1.13. Lost or Indecipherable Transmission
A Data Transmission which is never received by or cannot be processed to completion by the receiving Party in the format or composition received because it is garbled or incomplete, regardless of how or why the message was rendered garbled or incomplete.

1.14. Payee National Provider Identifier ("NPI")
The National Provider Identifier that is specific to the Legal Entity, FFS Group, or FFS Organization. Solo practitioners will enter their individual NPI number in this field.

1.15. Payor
A business organization that provides benefit payments on behalf of Covered Individuals eligible for payment for certain services to Covered Individuals.

1.16. Provider
Hospitals, clinics or persons duly licensed or certified to provide mental health services to Covered Individuals of Los Angeles County.

1.17. Secure Identification Cards
Those cards assigned to the Trading Partner or Agent by DMH for allowing the Trading Partner to transfer files electronically to DMH.

1.18. Source Documents
Documents containing Data which is or may be required as part of Data Transmission with respect to a claim for payment for mental health services rendered to an eligible Individual. Examples of Data contained within a specific Source Document include, without limitation, the following: Individual's name and identification number, claim number, diagnosis code for the service rendered, dates of service, procedure code, applicable charges, the Provider's name and/or provider number.

1.19. Submitter ID Number
A unique number assigned by DMH to the Trading Partner or Agent for the purpose of identifying the Trading Partner for Data Transmissions.

1.20. System
The equipment and software necessary for a successful electronic Data Transmission.

1.21. Trading Partner
A Provider who has entered into this Agreement with DMH in order to satisfy all or part of its obligations under a Legal Entity Agreement or Network Provider Agreement by means of EDI.

2. TERM AND TERMINATION

2.1. Term of Agreement
This Agreement will be effective on the day the Trading Partner Agreement is approved by the Department of Mental Health, and shall continue in full force until terminated by either party.

2.2. Voluntary Termination
Either Party may terminate this Agreement for its own convenience on thirty (30) days advance written notice to the other Party.

2.3. Termination for Cause

Either party may terminate this Agreement upon ten (10) working days advance written notice to the other Party upon the default by the other Party of any material obligation hereunder, which default is incapable of cure or which, being capable of cure, has not been cured within 30 days after receipt of written notice with reasonable specificity of such default (or such additional cure period as the non-defaulting Party may authorize). However, in the event of a breach by the Trading Partner of the terms of Article IV, Section 4.3 (Express Warranties Regarding Agents) or any Section of Article V (CONFIDENTIALITY AND SECURITY), or in the event a change of ownership of the Trading Partner or its Agents as defined by Article VII Section 7.12 (Change in Ownership of Trading Partner or its Agents) takes place, DMH shall have the unilateral right to terminate this Agreement immediately without prior notice to the Trading Partner. However, in its right to exercise immediate termination, DMH shall provide the Trading Partner with written notice the day the termination occurs.

3. OBLIGATIONS OF THE PARTIES

3.1. Mutual Obligations

In addition to the obligations of the respective Parties which are set forth elsewhere in this Agreement, the mutual obligations of DMH, the Trading Partner and/or the Trading Partner's Agents collectively referred to as "the Parties" shall include, but not be limited to, the following:

(a) Accuracy of EDI Transmission

The Parties shall take reasonable care to ensure that Data and Data Transmissions are timely, complete, accurate and secure, and shall take reasonable precautions to prevent unauthorized access to the System of the other Party, the Data Transmission itself or the contents of an Envelope which is transmitted either to or from either Party pursuant to this Agreement

(b) Re-transmission of Indecipherable Transmissions

Where there is evidence that a Data Transmission is Lost or Indecipherable Transmission, the sending Party shall make best efforts to trace and re-transmit the original Data Transmission in a manner which allows it to be processed by the receiving Party as soon as practicable.

(c) Cost of Equipment

Each Party shall, at its own expense, obtain and maintain its own System and shall update its System as recommended by the manufacturer/owner/licensor of said System. Furthermore, each Party shall pay its own costs for any and all charges related to Data Transmission under this Agreement and specifically including, without limitation, charges for System equipment, software and services, charges for maintaining an electronic mailbox, connect time, terminals, connections, telephones, modems, and any applicable minimum use charges. Each Party shall also be responsible for any and all expenses it incurs for translating, formatting, or sending and receiving communications over the electronic network to the electronic mailbox, if any, of the other Party.

(d) Back-up Files

Each Party shall maintain adequate back-up files and/or electronic tapes or other means sufficient to re-create a Data Transmission in the event that such re-creation becomes necessary for any purpose at any time. Such back-up files and/or tapes shall be subject to the terms of this Agreement to the same extent as the original Data Transmission.

(e) **Format of Transmissions**
Except as otherwise provided herein, each Party shall send and receive all Data Transmissions in the ANSI approved format, or such other format as DMH shall designate in writing to the Trading Partner.

(f) **Testing**
Each Party shall, prior to the initial Data Transmission and throughout the term of this Agreement, test and cooperate with the other Party in the testing of the Systems of both Parties as DMH considers reasonably necessary to ensure the accuracy, timeliness, completeness and confidentiality of each Data Transmission.

3.2. Trading Partner Obligations
In addition to the requirements of Section 3.1 and 5.1 and this section (3.2), the Trading Partner shall also be specifically obligated as follows:

(a) To refrain from copying, reverse engineering, disclosing, publishing, distributing or altering any Data, Data Transmissions or the contents of an Envelope, except as necessary to comply with the terms of this Agreement, or use the same for any purpose other than that for which the Trading Partner was specifically given access and authorization by DMH;
(b) To refrain from obtaining by any means to any Data, Data Transmission, Envelope or DMH's System for any purpose other than that which the Trading Partner has received express authorization to receive access. Furthermore, in the event that the Trading Partner receives Data or Data Transmissions, which are clearly not intended for the receipt of the Trading Partner, the Trading Partner shall immediately notify DMH and make arrangements to return the Data or Data Transmission or re-transmit the Data or Data Transmission to DMH. After such re-transmission, the Trading Partner shall immediately delete the Data contained in such Data Transmission from its System
(c) To install necessary security precautions to ensure the security of the System or records relating to the System of both DMH and the Trading Partner when the System is not in active use by the Trading Partner.
(d) To protect and maintain at all times the confidentiality of Secure Identification Cards issued by DMH to the Trading Partner or Agent.
(e) To provide special protection for security and other purposes where appropriate, by means of authentication, encryption, the use of passwords or by other mutually agreed means, to those specific Data Transmissions which the Parties agree should be so protected shall use at least the same level of protection for any subsequent transmission of the original Data Transmission.
(f) Prior to or upon execution of this Agreement, to provide DMH in writing with all of the information requested in the Trading Partner Information section of the Trading Partner Agreement (TPA) online application. While this Agreement is in effect, the Trading Partner shall notify DMH in writing within five (5) business days of any material changes in the information originally provided by the Trading Partner in the TPA online application.

3.3. DMH Obligations
In addition to the obligations of DMH which are set forth herein, DMH shall also be specifically obligated as follows:

(a) **Availability of Data**
DMH shall subject to the terms of this Agreement, make available to the Trading Partner by electronic means those types of Data and Data Transmissions to which the

Trading Partner is entitled to receive by mutual agreement of the Parties or as provided by law.

(b) **Notices Regarding Formats**
DMH shall provide Trading Partners a written listing of acceptable electronic data transmission formats (e.g., PDF, XLS, Doc). Should the need arise for DMH to make changes to these transmission formats, the trading Partner will receive no less than 14 days written notice.

4. AGENTS

4.1. Responsibility for Agents
If the Trading Partner uses the services of an Agent in any capacity in order to receive, transmit, store or otherwise process Data or Data Transmissions or perform related activities, the Trading Partner shall be fully liable to DMH or for any acts, failures or omissions of the Agent in providing said services as though they were the Trading Partner's own acts, failures, or omissions.

4.2. Notices Regarding Agents
Prior to the commencement of the Agent's services in the performance of this Agreement, the Trading Partner shall designate, in the TPA online application, its specific Agents who are authorized to send and/or receive Data Transmissions in the performance of this Agreement on behalf of the Trading Partner. Except as provided otherwise in the Agreement, the Trading Partner shall notify DMH of any material changes in the information contained in the TPA online application, no less than 14 days prior to the effective date of such changes. The information within the TPA application, when fully executed shall be incorporated into this Agreement by reference and shall be effective on the date of its execution, unless specified otherwise. The Trading Partner's designation of its Agent for purposes of this Agreement is expressly subject to the approval of DMH, which approval shall not be unreasonably withheld.

4.3. Express Warranties Regarding Agents
The Trading Partner expressly warrants that the Agent will make no changes in the Data content of any and all Data Transmissions or the contents of an Envelope, and further that such Agent will take all appropriate measures to maintain the timeliness, accuracy, confidentiality and completeness of each Data Transmission. Furthermore, the Trading Partner expressly warrants that its Agents will be specifically advised of, and will comply in all respects with, the terms of this Agreement.

4.4. Indemnification Regarding Agents
The Trading Partner shall indemnify, defend and hold harmless DMH from any and all claims, actions, damages, liabilities, costs and expenses, specifically including, without limitation, reasonable attorney's fees and costs resulting from the acts or omissions of the Trading Partner, its Agents, employees, subcontractors in the performance of this Agreement; provided however, that DMH shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of the Trading Partner. DMH for its part shall provide the Trading Partner with timely notice of the existence of such proceedings and such information, documents and other cooperation as reasonably necessary to assist the Trading Partner in establishing a defense to such action. These indemnities shall survive termination of this Agreement and DMH reserves the right, at its option and expense, to participate in the defense of any suit or proceeding through counsel of its own choosing.

5. CONFIDENTIALITY AND SECURITY

5.1 General Requirements

In addition to the requirements of Section 3.1 and 3.2, the Trading Partner shall maintain adequate security procedures to prevent unauthorized access to Data, Data Transmissions, or the System of DMH, and shall immediately notify DMH of any and all unauthorized attempts by any person or entity to obtain access to or otherwise tamper with the Data, Data Transmissions or the System of DMH.

(a) Confidential Information

The Trading Partner further agrees to hold DMH harmless for any and all claims or causes of action brought by any party, including third parties, arising from any unauthorized disclosure of Confidential Information by or on behalf of the Trading Partner. In addition, the Trading Partner shall in its performance under this Agreement, comply with any and all applicable Privacy Statutes and Regulations (as defined in Article I, Section 1.4 (Confidential Information) relating to Confidential Information and agrees to maintain the confidentiality of such Confidential Information for the benefit of such Individuals or of DMH as is required by such Privacy Statutes and Regulations. Such Confidential Information concerning Individuals includes, but is not limited to, medical records and information regarding claims and payment of the claims of Individuals.

(b) Notice of Unauthorized Disclosures

The Trading Partner will promptly notify DMH of any and all unlawful or unauthorized disclosures of Confidential Information that comes to its attention and will cooperate with DMH in the event any litigation arises concerning the unauthorized use, transfer or disclosure of Confidential Information.

6. RECORDS RETENTION AND AUDIT

6.1 Records Retention

The Trading Partner shall maintain, for a period of no less than seven (7) years from the date of its receipt complete, (except for children for whom records should be retained until 18 years of age) or until the audit is settled, accurate and unaltered copies of any and all Source Documents from all Data Transmissions.

6.2 Electronic Transmission and Audit Logs

Both Parties shall establish and maintain Logs which shall record any and all Data Transmissions taking place between the Parties during the term of this Agreement. Each Party will take necessary and reasonable steps to ensure that all Logs constitutes a current, accurate, complete and unaltered record of any and all Data Transmissions between the Parties, and shall be retained by each Party for no less than twenty-four (24) months following the date of the Data Transmission. The Log may be maintained on computer media or other suitable means provided that, if it is necessary to do so, the information contained in the Log may be timely retrieved and presented in readable form.

7. MISCELLANEOUS

7.1 Amendments
This Agreement may not be changed or modified in any manner except by an instrument in writing signed by a duly authorized officer of each of the Parties hereto

7.2 Dispute Resolution
With the exception of disputes which are the subject of immediate termination as set forth in this Agreement, the Parties hereby agree that, in the event of a dispute or alleged breach of the terms of this Agreement between the Parties, they will work together in good faith first, to resolve the matter internally and within a reasonable period of time by escalating it as reasonably necessary to higher levels of management of each of the respective Parties, and, then if necessary, to use a mutually agreed alternative dispute resolution technique prior to resorting to litigation, with the exception of disputes involving either fraud or breaches of the requirements of Article V. (CONFIDENTIALITY AND SECURITY), in which case either Party shall be free to seek available remedies in any appropriate forum at any time.

7.3 Mutual Compliance With Applicable Laws and Regulations
The Parties hereby mutually agree that they will, in the performance of the terms of this Agreement, comply in all respects with any and all applicable local, state and federal ordinances, statutes, regulations, or orders of courts of competent jurisdiction.

7.4 Force Majeure
Each Party shall be excused from performance for any period of time during this Agreement to the extent that it is prevented from performing any obligation of service, in whole or in part, as a result of causes beyond the reasonable control and without the fault or negligence of such Party Such acts include without limitation, strikes, lockouts, riots, acts of war, epidemics, fire, communication line failures, power failures, earthquakes, floods or natural disasters Delays in performance due to the occurrence of such events shall automatically extend such dates for a period equal to the duration of such events. However, such automatic extension shall have no effect on the exercise of either Party's right of voluntary termination as set forth in Article II, Section 2.2 (Term of Agreement).

7.5 Change of Ownership of Trading Partner
The Trading Partner shall notify DMH no less than ten days in advance of any transfer of ownership interest in the Trading Partner's business or any transfer of ownership in the business of the Tracing Partner's Agent. Furthermore, notwithstanding the providing of notice regarding changes in the ownership of the Trading Partner as required by this section, no such changes in ownership or other information provided by the Trading Partner will alter in any way the obligations of the Parties under the terms of this Agreement without prior written agreement of DMH.

7.6 Notices
Any notices pertaining to this Agreement shall be given in writing and shall be deemed duly given when personally delivered to the Trading Partner or the Trading Partner's authorized representative.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

CHIEF INFORMATION OFFICE BUREAU

ELECTRONIC TRADING PARTNER AGREEMENT

By execution hereof by duly authorized representatives of both Parties, the Parties hereby acknowledge, agree to and shall be bound by all the terms, provisions and conditions of the Trading Partner Agreement.

Agreed To:

Pasadena Hospital Association dba Huntington Memorial Hospital

Trading Partner Name (Legal Entity / Network Provider)
(Type or Print)

REDACTED

James S. Noble

Authorized Personnel
(Type or Print)

Authorized Signature

Chief Operating Officer

Title
(Type or Print)

June 11, 2015

Date

Agreed To:

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
695 S. VERMONT AVE., LOS ANGELES CA 90005

Please complete form, print, scan and attach to TPA request for processing.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
CHIEF INFORMATION OFFICE BUREAU
Information Security Division

CONFIDENTIALITY OATH

Non-LAC-DMH Workforce Members

The intent of this Confidentiality Form is to ensure that all County Departments, Contractors, LAC-DMH Non-Governmental Agencies (NGA), Fee-For-Service Hospital (FFS1), Fee-For-Service Outpatient (FFS2) and Pharmacy users are aware of their responsibilities and accountability to protect the confidentiality of clients' sensitive information viewed, maintained and/or accessed by any DMH on-line systems.

Further, the Department's Medi-Cal and MEDS access policy has been established in accordance with Federal and State laws governing confidentiality.

The California Welfare and Institutions (W&I) Code, Section 14100.2, cites the information to be regarded confidential. This information includes applicant/beneficiary names, addresses, services provided, social and economic conditions or circumstances, agency evaluation of personal information, and medical data. (See also 22 California Code of Regulations (C.C.R.), Sections 50111 and 51009)

The Medi-Cal Eligibility Manual, Section 2-H, titled "Confidentiality of Medi-Cal Case Records," referring to Section 14100.2, a, b, f, and h, W&I Code, provides in part that:

"(a) All types of information, whether written or oral, concerning a person, made or kept by any public office or agency in connection with the administration of any provision of this chapter *... shall be confidential, and shall not be open to examination other than for purposes directly connected with administration of the Medi-Cal program."

"(b) Except as provided in this section and to the extent permitted by Federal Law or regulation, all information about applicants and recipients as provided for in subdivision (a) to be safeguarded includes, but is not limited to, names and addresses, medical services provided, social and economic conditions or circumstances, agency evaluation or personal information, and medical data, including diagnosis and past history of disease or disability."

"(f) The State Department of Health Services may make rules and regulations governing the custody, use and preservation of all records, papers, files, and communications pertaining to the administration of the laws relating to the Medi-Cal program **...."

"(h) Any person who knowingly releases or possesses confidential information concerning persons who have applied for or who have been granted any form of Medi-Cal benefits ***... for which State or Federal funds are made available in violation of this section is guilty of a misdemeanor."

*, **, *** The State of California's Statute for Medicaid Confidentiality can be found at the following web address: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/Medicaidstatute.aspx

The signed copy of this agreement must be maintained by DMH Facilitators

Please read the agreement and take due time to consider it prior to signing.

I understand that County Departments, Contractors, LAC-DMH Non-Governmental Agencies (NGA), Fee-For-Service Hospital (FFS1), Fee-For-Service Outpatient (FFS2) and Pharmacy users are prohibited from sharing their unique Logon I.D. and password with co-worker or other agencies.

Further, I understand that data browsing is strictly prohibited and my access to information is restricted to the minimum necessary required to carry out my job responsibilities.

Further, I understand that County Departments, Contractors, LAC-DMH Non-Governmental Agencies (NGA), Fee-For-Service Hospital (FFS1), Fee-For-Service Outpatient (FFS2) and Pharmacy users are prohibited from obtaining, releasing, or using confidential client information from case records or computer records for purposes not specifically related to the administration of services and authorized by the California Welfare and Institutions Code (Section 14100.2).

Further, I understand the violation of the confidentiality of records or of these policies which are made for protection of the confidentiality of such records, may cause:

1. A civil action under the provision of the Welfare and Institutions Code 5330 Sections:
   a) Any person may bring an action against an individual who has willfully and knowingly released confidential information or records concerning him or her in violation of this chapter, or of Chapter 1 (commencing with Section 11860) of Part 3 of Division 10.5 of the Health and Safety Code, for the greater of the following amounts:
      1. Ten thousand Dollars ($10,000)
      2. Three times the amount of actual damages, if any sustained by the plaintiff
   b) Any person may bring an action against an individual who has negligently released confidential information or records concerning him or her in violation of this chapter, or of Chapter 1 (commencing with Section 11860) of Part 3 of Division 10.5 of the Health and Safety Code, for both of the following:
      1. One thousand dollars ($1,000) In order to recover under this paragraph, it shall not be a prerequisite that the plaintiff suffer or be threatened with actual damages.
      2. The amount of actual damages, if any, sustained by the plaintiff
   c) Any person may, in accordance with Chapter 3(commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, bring an action to enjoin the release of confidential information or records in violation of this chapter, and may in the same action seek damages as provided in this section.
   d) In addition to the amounts specified in subdivisions (a) and (b), the plaintiff shall recover court costs and reasonable attorney's fees as determined by the court.
2. Disciplinary action including suspension or termination of employment.

Further, I understand that the County will not provide legal protection if violations of these policies or procedures occur.

I hereby certify that I have read this form and I have knowledge of the requirements of State and Federal confidentiality laws and will comply with all applicable provisions of same.

I, the undersigned, hereby agree not to divulge any information or records concerning any client except in accordance with W&I Code, Section 5328 et seq. and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I acknowledge that the unauthorized release of confidential information as described in this document may result in disciplinary action up to and including termination of any office of employment. I further agree I have read as described in this document that a person may make me subject to a civil action under the provisions of the W&I Code for the unauthorized release of confidential information.

User's Name: _____ _____ _____
Print Signature Date

Phone #: ( ) _____ Ext: _____

Pharmacy, FFS, NGA Legal Entity No. or
Provider #: N/A Provider Name: _____

Address: _____ / _____ / _____ / _____
City Zip Code Service Area

COUNTY OF LOS ANGELES
AGREEMENT FOR ACCEPTABLE USE AND CONFIDENTIALITY OF COUNTY'S INFORMATION TECHNOLOGY ASSETS, COMPUTERS, NETWORKS, SYSTEMS AND DATA

As a Los Angeles County employee, contractor, vendor or other authorized user of County Information Technology (IT) assets including computers, networks, systems and data, I understand that I occupy a position of trust. I will use County IT assets for County management approved business purposes only and maintain the confidentiality of County's business and Citizen's private data. As a user of County's IT assets, I agree to the following:

1. Computer crimes: I am aware of California Penal Code 502(c) - Comprehensive Computer Data Access and Fraud Act (attached). I will immediately report any suspected computer misuse or crimes to my Management.

2. Security access controls: I will not subvert or bypass any security measure or system which has been implemented to control or restrict access to computers, networks, systems or data. I will not share my computer identification codes (log-in ID, computer access codes, account codes, ID's, etc.) or passwords.

3 Approved business purposes: I will use the County's Information Technology (IT) assets including computers, networks, systems and data for County management approved business purposes only.

4. Confidentiality: I will not access or disclose any County program code, data, information or documentation to any individual or organization unless specifically authorized to do so by the recognized information owner.

5. Computer virus and malicious code: I will not intentionally introduce any computer virus, worms or malicious code into any County computer, network, system or data. I will not disable or delete computer virus detection and eradication software on County computers, servers and other computing devices I am responsible for.

6. Offensive materials: I will not access or send any offensive materials, e.g., sexually explicit, racial, harmful or insensitive text or images, over County owned, leased or managed local or wide area networks, including the public Internet and other electronic mail systems, unless it is in the performance of my assigned job duties, e.g., law enforcement. I will report to my supervisor any offensive materials observed by me or sent to me on County systems.

7. Public Internet: I understand that the Public Internet is uncensored and contains many sites that may be considered offensive in both text and images. I will use County Internet services for approved County business purposes only, e.g., as a research tool or for electronic communication. I understand that the County's Internet services may be filtered but in my use of them I may be exposed to offensive materials. I agree to hold the County harmless should I be inadvertently exposed to such offensive materials. I understand that my Internet activities may be logged, are a public record, and are subject to audit and review by authorized individuals.

8. Electronic mail and other electronic data: I understand that County electronic mail (e-mail), and data, in either electronic or other forms, are a public record and subject to audit and review by authorized individuals. I will comply with County e-mail use policy and use proper business etiquette when communicating over e-mail systems.

9. Copyrighted materials: I will not copy any licensed software or documentation except as permitted by the license agreement.

10. Disciplinary action for non-compliance: I understand that my non-compliance with any portion of this Agreement may result in disciplinary action including my suspension, discharge, denial of service, cancellation of contracts or both civil and criminal penalties.

CALIFORNIA PENAL CODE 502(c) - "COMPREHENSIVE COMPUTER DATA ACCESS AND FRAUD ACT"

Below is a section of the "Comprehensive Computer Data Access and Fraud Act" as it pertains specifically to this Agreement. California Penal Code 502(c) is incorporated in its entirety into this Agreement by reference and all provisions of Penal Code 502(c) apply. For a complete copy, consult the Code directly at website www.leginfo.ca.gov/.

502.(c) Any person who commits any of the following acts is guilty of a public offense:

(1) Knowingly accesses and without permission alters, damages, deletes, destroys, or otherwise uses any data, computer, computer system, or computer network in order to either (A) devise or execute any scheme or artifice to defraud, deceive, or extort, or (B) wrongly control or obtain money, property, or data.

(2) Knowingly accesses and without permission takes, copies or makes use of any data from a computer, computer system, or computer network, or takes or copies supporting documentation, whether existing or residing internal or external to a computer, computer system, or computer network.

(3) Knowingly and without permission uses or causes to be used computer services.

(4) Knowingly accesses and without permission adds, alters, damages, deletes, or destroys any data, computer software, or computer programs which reside or exist internal or external to a computer, computer system, or computer network.

(5) Knowingly and without permission disrupts or causes the disruption of computer services or denies or causes the denial of computer services to an authorized user of a computer, computer system, or computer network.

(6) Knowingly and without permission provides or assists in providing a means of accessing a computer, computer system, or computer network is in violation of this section.

(7) Knowingly and without permission accesses or causes to be accessed any computer, computer system, or computer network.

(8) Knowingly introduces any computer contaminant into any computer, computer system, or computer network.

I HAVE READ AND UNDERSTAND THE ABOVE AGREEMENT:

Employee's Name	Employee's Signature	Date
Manager's Name	Manager's Signature	Date

ELECTRONIC SIGNATURE AGREEMENT

Non-LACDMH Workforce Members

This Agreement governs the rights, duties, and responsibilities of Department of Mental Health in the use of an electronic signature in County of Los Angeles. In addition, I, the undersigned, understand that my Electronic Signature will be the credential that I will be granted for accessing LAC-DMH Systems and resources. This Agreement describes my obligations to protect my electronic signature, and to notify appropriate authorities if it is stolen, lost, compromised, unaccounted for, or destroyed.

I agree to the following terms and conditions:

I agree that my electronic signature will be valid upon the date of issuance until it is revoked or terminated per the terms of this agreement. I agree that I will be required annually to renew my electronic signature and I will be notified and given the opportunity to renew my electronic signature each year and shall do so. The terms of this Agreement shall apply to each such renewal unless superseded.

I will use my electronic signature to establish my identity and sign electronic documents and forms. I am solely responsible for protecting my electronic signature. If I suspect or discover that my electronic signature has been stolen, lost, used by an unauthorized party, or otherwise compromised, then I will immediately notify DMH Helpdesk and request that my electronic signature be revoked. I will then immediately cease all use of my electronic signature. I agree to keep my electronic signature secret and secure by taking reasonable security measures to prevent it from being lost, modified or otherwise compromised, and to prevent unauthorized disclosure of, access to, or use of it or of any media on which information about it is stored.

I will immediately request that my electronic signature be revoked if I discover or suspect that it has been or is in danger of being lost, disclosed, compromised or subjected to unauthorized use in any way. I understand that I may also request revocation at any time for any other reason.

If I have requested that my electronic signature be revoked, or I am notified that someone has requested that my electronic signature be suspended or revoked, and I suspect or discover that it has been or may be compromised or subjected to unauthorized use in any way, I will immediately cease using my electronic signature. I will also immediately cease using my electronic signature upon termination of employment or termination of this Agreement.

I further agree that, for the purposes of authorizing and authenticating electronic health records, my electronic signature has the full force and effect of a signature affixed by hand to a paper document.

User's Name (print)	User's Signature	Date
CEO / Manager Name (print)	CEO / Manager Signature	Date

ATTACHMENT XI

SERVICE EXHIBIT B
PSYCHIATRIC INPATIENT HOSPITAL SERVICES
PMRT DIVERSION PROGRAM
(MODE OF SERVICE 05)

1. STATEMENT OF WORK:

Los Angeles County – Department of Mental Health (LAC-DMH) contracts for Acute Inpatient Hospital Services and Administrative Day Services provided by hospitals certified for Fee-For-Service (FFS) Medi-Cal services and designated under the Lanterman-Petris-Short (LPS) Act to detain, evaluate and provide treatment to Clients pursuant to Welfare and Institutions Code (WIC) Section 5150. The purpose of this Addendum to the FFS Medi-Cal Psychiatric Inpatient Hospital Services Mental Health Services Agreement is to contract with qualified providers for Acute Psychiatric Inpatient Hospital Services and Administrative Day Services for uninsured Clients under the Psychiatric Mobile Response Team (PMRT) Psychiatric Outreach Diversion Program (PDP).

2. GENERAL:

Psychiatric Inpatient Hospital Services include Acute Psychiatric Inpatient Hospital Services and Administrative Day Services. Each Contractor facility that renders Psychiatric Inpatient Hospital Services shall: (1) be either a licensed acute psychiatric hospital or a distinct acute psychiatric part of a licensed general acute care hospital, (2) be secure, (3) meet all California Code of Regulations (CCR), Titles 9 and 22 staffing standards for inpatient services, (4) provide a 24 hour psychiatric treatment program, and (5) be eligible, as determined by LAC-DMH, as a facility to detain and treat Clients under WIC Section 5150.

Lanterman-Petris-Short (LPS) Act designation is authorized by State law through the Local Mental Health Director (Director). Facilities and persons who meet the criteria and process requirements set forth in the LPS Designation Guidelines and Process for Facilities within Los Angeles County (Fourth Edition) are designated to evaluate and treat persons involuntarily detained under the LPS Act. The objective of this program is to: 1) Enhance the capability and overall quality of the mental health delivery system in Los Angeles County, 2) To ensure proper utilization of the designation authority by granting it to only those facilities which meet specified guidelines and 3) To establish the terms of and conditions pertaining to the delegation of authority by which individuals are taken into custody under the LPS.

Psychiatric Inpatient Hospital Services shall not include any services related to alcohol or substance abuse and these services shall not be reimbursable under this Agreement, except where the services related to alcohol or substance abuse are incidental to a primary diagnosis of mental illness. Where alcohol and drugs and mental illness. are dually diagnosed, Psychiatric Inpatient Hospital Services may be reimbursed under this Agreement only if the primary diagnosis is mental illness.

Notwithstanding any other provision of this Agreement, except as specifically approved in writing by Director, Contractor shall assure that at no time: (1) shall any child or adolescent under the age of 18 years receive any Psychiatric Inpatient Hospital Services in a ward or unit designated for adults receiving Psychiatric Inpatient Hoepital Services and (2) shall any adult receive any Psychiatric Inpatient Hospital Services in a ward or unit designated for children or adolescents under the age of 18 years receiving Psychiatric Inpatient Hospital Services.

Psychiatric Inpatient Hospital Services are generally described in the Medi-Cal Psychiatric Inpatient Hospital Services Consolidation Emergency Regulations issued by the State Department of Mental Health (SDMH).

3. PERSONS TO BE SERVED:

A. Contractor shall provide Acute Psychiatric Inpatient Hospital Services to those Clients: (1) who are in need of Acute Psychiatric Inpatient Hospital Services, (2) who have the characteristics described in the Contract Package, as approved in writing by Director, and (3) who are referred to Contractor DMH Countywide Resource Management (CRM) and brought to Contractor by DMH PMRT.

B. Contractor shall provide Administrative Day Services to those Clients: (1) who are referred to Contractor by DMH CRM and brought to Contractor by DMH PMRT, (2) who have been provided more than 17 days of Acute Psychiatric Inpatient Hospital Services, (3) who are on temporary LPS conservatorship, (4) meet medical necessity criteria, and (5) for whom appropriate residential placement has not been secured.

C. The duration of any Client's Acute Psychiatric Inpatient Hospital Services hereunder shall not exceed the lesser of: (1) those days necessary to ensure that the Client is not a danger to self or others or gravely disabled due to a mental disability or (2) those days when it is unsafe or inappropriate to treat the Client at a non-acute level of care, or (3) those days authorized by Director or his designee. The duration of any Client's Administrative Day Services hereunder shall not exceed those days necessary to obtain non-acute psychiatric services at the lowest level of care appropriate to the Client's need.

D. Contractor shall be responsible for delivering services to new clients to the extent that funding is provided by County. Where Contractor determines that services to new clients can no longer be delivered, Contractor shall provide 30 calendar days prior notice to County. Contractor shall also thereafter make referrals of new clients to County or other appropriate agencies.

Contractor shall not be required to provide the notice in the preceding paragraph when County reduces funding to Contractor, either at the beginning or during the fiscal year. In addition, when County has a reduction in funding for a particular program provided by Contractor, Contractor shall not be responsible for continuing services for those clients linked to that funding. Contractor shall also thereafter make referrals of those clients to County or other appropriate agencies.

4. FINANCIAL PROVISIONS:

Participating hospitals will be compensated with Short/Doyle funds at a pre-determined case rate. PDP funding will be allocated on a monthly basis until the monthly allocation has been fully utilized. Funding not utilized in a given month shall be available in the next month's allocation.

The participating hospital shall be reimbursed during the term of this Agreement for Psychiatric inpatient hospital services provided to clients at a case rate of $3,300 for each eligible admission. The participating hospital shall make all inpatient psychiatric beds available for the PDP. Should the Mental Health Court grant a temporary conservatorship, DMH will reimburse the hospital at an Administrative Day rate of $289.13 per day after the 17th day of hospitalization until an appropriate placement has been obtained. The rate shall cover all services, including, but not limited to, medical ancillaries provided by the hospital, physician services, psychologist services, medications, and transportation.

The hospital shall be entitled to reimbursement only: (1) if the client is referred to the participating hospital by DMH PMRT with written approval provided by DMH CRM if the client is determined to be indigent (2) if admission meets Medi-Cal medical necessity criteria and (3) if admission is not a readmission to a psychiatric inpatient service, emergency room, or psychiatric urgent care center within 24 hours of discharge from the participating hospital.

As an express condition precedent to eligibility for reimbursement under this Agreement, the participating hospital shall determine: (1) whether the Psychiatric Inpatient Hospital Services for which the claim is made are covered, in whole or in part, under any other State or Federal medical care program or under any other contractual or legal entitlement, including but not limited to, any private group indemnification or insurance program or workers' compensation and (2) whether the client for whom claim is made have any Medi-Cal Share of Cost for the particular Psychiatric Inpatient Hospital Services. Notwithstanding any other provision of this Agreement, to the extent that any third party coverage and/or Medi-Cal Share of Cost is available, the hospital's reimbursement shall be reduced.

5. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT:

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), Contractor(s) shall have effective systems and procedures fully implemented to ensure the confidentiality, security, integrity, and accessibility of Client health information, including a plan for the storage and protection of filed medical records to protect against any/all unauthorized access, intrusion and damage.

6. PERSONNEL/STAFFING:

The minimum ratio of full-time professional personnel/staff to inpatient Clients shall at all times be in conformance with all relevant laws, regulations, rules and LAC-DMH policies and procedures.

In addition, the facility must determine staffing requirements based on assessment of Client needs, as per CCR, Title 22 Sections 70213 and 70215, or 71213 and 71215, as applicable. Contractor(s) shall, upon request, make available for review to the Director or his/her designee documentation of the methodology used in making staffing

determinations.

7. PSYCHIATRIC EMERGENCY RESPONSE:

Contractors shall not maintain, utilize, or otherwise arrange for mobile 5150 assessment personnel or processes outside the confines of the Contractor's facility without the written consent of the Director or his/her designee.

8. EMERGENCY MEDICAL TREATMENT:

Clients who are provided services hereunder and who require emergency medical care for physical illness or accident shall be transported to an appropriate medical facility. The cost of such transportation as well as the cost of any emergency medical care shall not be a charge to, nor reimbursable under, this Agreement. Contractor shall establish and post written procedures describing appropriate action to be taken in the event of a medical emergency. Contractor shall also post and maintain a disaster and mass casualty plan of action in accordance with CCR Title 22, Section 80023. Such plan and procedures shall be submitted to DMH's Contracts Development and Administration Division at least ten (10) days prior to the commencement of services under this Agreement.

9. NOTIFICATION OF DEATH:

Contractor shall immediately notify the Director or his designee, upon becoming aware of the death of any Client provided services hereunder. Notice shall be made by Contractor immediately by telephone and in writing upon learning of such a death. The verbal and written notice shall include the name of the deceased, the deceased's Integrated System (IS) identification number, the date of death, a summary of the circumstances thereof, and the name(s) of all Contractors' staff with knowledge of the circumstances.

10. QUALITY ASSURANCE AND IMPROVEMENT:

Contractor shall comply with all applicable provisions of WIC, CCR, Code of Federal Regulations, State Department of Health Services (SDHS) policies and procedures, SDMH policies and procedures, and DMH quality improvement and assurance policies and procedures, to establish and maintain a complete and integrated quality improvement system. Contractor shall comply with DMH's quality assurance efforts and specified procedures intended to ensure quality of care. In conformance with these provisions, Contractor shall establish: (1) a utilization review process; (2) an interdisciplinary peer review of the quality of Client care; and (3) monitoring of medication regimens of Clients. Medication monitoring shall be conducted in accordance with County policy. A copy of Contractor's quality improvement system plan shall be available to DMH's Quality and Outcome Bureau for review and written approval prior to Contractor's submission of any claims for services hereunder. The Contractor shall agree to ongoing utilization review by DMH.

11. CLIENT EVALUATION OF CONTRACTOR'S SERVICES:

Contractor shall provide a written questionnaire to certain Clients at the time of admission in accordance with DMH policies and procedures. The questionnaire shall be approved by SDHS and offer the Client the opportunity to evaluate the care given. The questionnaire shall be collected at the time of discharge and maintained in Contractor's file for at least four (4) years and shall be made available to authorized agents of County, State and/or Federal governments.

12. NOTIFICATION OF EVALUATION AND/OR ADMISSION:

Contractor(s) shall request information from, and must involve, mental health care entities providing services to the Client in order to support continuity of care.

If the Client is receiving care from LAC-DMH, Contractor's evaluating professional staff must first attempt to obtain information regarding treatment information and the LAC-DMH designated Single Fixed Point of Responsibility (SFPR) from the IS Client Identification Screen, Client, or significant other. If such information cannot be obtained from the IS Client Identification Screen, Client, or significant other, then the evaluating professional staff must contact 1-800-854-7771 to request information regarding the LAC-DMH designated SFPR.

Contractor shall notify the SFPR regarding all PDP acute psychiatric inpatient admissions in conformance with LAC-DMH policies and procedures relative to admission, inpatient care, treatment and discharge planning, and follow-up related to the status of the Client as identified on the IS Client Identification Screen. Failure to notify the SFPR of the admission of an Intensive Service Recipient (ISR) could result in administrative denial of payment.

Contractor will notify Office of the Public Guardian of the admission of any Clients who are publicly conserved. In the event Beneficiaries are not publicly conserved, as necessary in the opinion of Contractor, Contractor shall evaluate clients regarding their need for conservatorship and will be obligated to pursue conservatorship for qualifying individuals. Contractor shall notify the SFPR and the Office of the Public Guardian in a timely fashion of any Clients who need to be conserved (e.g., on the 10th day of a 14 day hold). Contractor will have responsibility for transporting inpatients to and from conservatorship hearings.

13. CONTRACTOR'S OBLIGATION TO ATTEND/PARTICIPATE IN MEETINGS:

Contractor's appropriately qualified clinical staff shall regularly attend and participate in all discharge planning meetings/activities involving the Los Angeles County Departments of Children and Family Services, Department of Mental Health,

Department of Probation, and other meetings DMH determines relevant to the provision of services.

Contractor(s) staff, representing the facility and specifically the Acute Inpatient Psychiatric program, will work collaboratively with Geographic/Service Area Managers to develop a partnership for the purpose of improving continuity and quality of care for Clients.

Contractor shall provide weekly meetings for hospitalized Clients to address the treatment plan, interventions, progress toward goals, and suggested modifications of same, and shall inform and invite the Service Area FFS Liaison and the Client's SFPR to these meetings in order to ensure continuity of care.

14. PROGRAM ELEMENTS FOR ACUTE PSYCHIATRIC INPATIENT HOSPITAL SERVICES:

Contractor shall provide Acute Psychiatric Inpatient Hospital Services to Clients in accordance with Contractor's Package and any addenda thereto, as approved in writing by the Director, for the term of this Agreement.

Acute Psychiatric Inpatient Hospital Services consist of twenty-four hour intensive service in a facility, which is a licensed acute psychiatric hospital or a distinct acute psychiatric part of a licensed general acute care hospital, that provides psychiatric treatment with the specific intent to ameliorate the symptoms of danger to self, others, or the inability to provide for food, clothing and shelter due to a mental disability as determined by qualified mental health professional staff of the facility. Acute Psychiatric Inpatient Hospital Services shall include, but are not limited to:

A. Twenty-four (24) hour a day, seven day a week mental health admission, evaluation, referral, and treatment services, and all necessary mental health treatment and care required for the entire period the individual is in the facility. (WIC 5152);

B. Services provided in conformance to all provisions in the Welfare and Institutions Code Division 5, and accompanying regulations, and Department policies regarding evaluation, treatment, patients' rights, and due process;

C. Safe and clean living environment with adequate lighting, toilet and bathing facilities, hot and cold water, toiletries, and a change of laundered bedding;

D. Three balanced and complete meals each day;

E. Twenty-four hour supervision of all Clients by properly trained personnel. Such supervision shall include, but is not limited to, personal assistance in such matters as eating, personal hygiene, dressing and undressing, and taking of prescribed medications;

F. Physical examination and medical history within twenty-four hours of admission;

G. Laboratory services when medically indicated;

H. X-Rays when medically indicated;

I. Electrocardiograms (EKG) and electroencephalograms (EEG) when medically indicated;

J. Medication supervision and/or maintenance program;

K. Support to psychiatric treatment services, including, but not limited to, daily patient review;

L. Support to psychological services;

M. Social work services;

N. Nursing services;

O. Recreational therapy services;

P. Occupational therapy services;

Q. Ongoing self-monitoring and analysis of numbers of seclusion and restraint episodes involving the staff on the unit(s), including ensuring staff are apprised of the results of the ongoing monitoring;

R. Contractor shall, as required by the SDMH, provide the Therapeutic Behavioral Services (TBS) notice, and the general Early Periodic Screening Diagnosis and Treatment (EPDST) informational notice, both prepared by the SDMH pertaining to all children qualified as Medi-Cal beneficiaries under the age of 21 at the time of their emergency psychiatric hospitalization to the adult responsible for the child at the same time such notices are provided to the child being treated by the Contractor. Contractor shall provide written documentation that adult and child received these notices to the Children's System of Care Countywide Services Bureau of the LAC-DMH within three (3) days of any admission;

S. Recommendation for further treatment, conservatorship, or referral to other existing programs, as appropriate (i.e., day care, outpatient, etc.), relative to Client needs (The form that will be used to convey this aftercare plan will be the LAC-DMH form titled, AFTERCARE/DISCHARGE PLAN AND RECOMMENDATIONS);

T. For discharge planning, honoring the preference of the Client and/or the

parent of a minor, conservator, or legal guardian for the type and location of the desired aftercare facility if administratively feasible and clinically appropriate.

U. For discharge planning, consideration of the proximity of the aftercare facility to the client's own community, family and support system.

V. Aftercare/discharge plan and procedures:

1) Contractor(s) shall ensure that all Clients have a discharge plan. The LAC DMH FFS liaison and the SFPR will participate in the development of the discharge plan. Reasonable efforts shall be made to ensure that all Clients have appropriate housing or residence upon discharge. The plan shall include a specific appointment or time at which Clients are expected to appear at an outpatient site. If the Client has either a private conservator or the Public Guardian as temporary or permanent conservator, the hospital must involve the conservator in the discharge process, give prior notice before discharge and obtain, or document efforts to obtain, the conservator's approval prior to discharge.

2) Contractor shall maintain a comprehensive and current referral source list, including all relevant treatment resources in the Client's area.

3) If the Client requires continued care and treatment, Contractor(s) shall ensure that, upon discharge, Clients receive appropriate referrals to community agencies and suitable placement, as evidenced by documentation in the Discharge and Aftercare Plan stipulating the following:

a) Clients requiring care and supervision will only be placed in licensed facilities;

b) Contractor(s) shall implement and administer procedures for

ensuring that all referrals to community placements, are clean, safe and, if necessary, supervised environments; and

c) Contractor(s) serving older adults will adhere to the following recommendations developed by the Office of the Medical Director: "Parameters for the Initial Psychiatric Assessment of Older Adults in Emergency Rooms and on Inpatient Units" and "Parameters for Discharge Planning for Older Adults".

W. At the time of discharge of a Client, submission of a formal written aftercare plan to the SFPR and/or appropriate LAC-DMH program agency responsible for coordinating care for the Client being discharged.

X. Submission of a formal written aftercare plan to the Director or his/her designee, at the time of discharge of the Client.

Y. Maintenance of a daily census log and appropriate documentation of each day of service provided hereunder, in accordance with State regulatory (Title 9, Chapter 11) medical necessity reimbursement requirements.

16. PROGRAM ELEMENTS FOR ADMINISTRATIVE DAY SERVICES:

Contractor shall provide Administrative Day Services to Clients in accordance with Contractor's Package and any addenda thereto, as approved in writing by the Director, for the term of this Agreement.

Administrative Day Services consist of 24-hour service for a room in a facility, which is a licensed acute psychiatric hospital or a distinct acute psychiatric part of a licensed general acute care hospital, with less than full psychiatric treatment being provided where the Client is ready for a lower level of psychiatric services. Administrative Day Services are the services necessary to provide room and board after all attempts at

providing alternative non-acute psychiatric services have been exhausted and shall apply to a Client awaiting such alternative non-acute psychiatric services. The facility shall implement and document an active placement effort on behalf of each Client each day, excluding Saturdays, Sundays, and County-observed holidays, until such time as the Client is successfully placed or no longer requires additional treatment.

Administrative Day Services shall include, but are not limited to:

A. Safe and clean living environment with adequate lighting, toilet and bathing facilities, hot and cold water, toiletries, and a change of laundered bedding;

B. Three balanced and complete meals each day;

C. Twenty-four hour supervision of all Clients by properly trained personnel. Such supervision shall include, but is not limited to, personal assistance in such matters as eating, personal hygiene, dressing and undressing, and taking of prescribed medications;

D. Social work services, including discharge planning and referral;

E. Nursing services;

F. Recommendation for further treatment, conservatorship, or referral to other existing programs, as appropriate (i.e., day care, outpatient, etc.), relative to Client needs;

G. At the time of discharge of a Client, submission of a formal written aftercare plan to the SFPR and/or the appropriate LAC-DMH program agency responsible for coordinating care for the Client being discharged.

H. Submission of a formal written aftercare plan to the Director or his/her designee, at the time of discharge of the Client.

I. Maintenance of a daily census log and appropriate documentation for each day of service provided hereunder in accordance with State regulatory (Title 9, Chapter 11) medical necessity reimbursement requirements.

J. Compliance with DMH's quality assurance efforts intended to ensure quality of care for Clients.

CONTRACTOR'S COPY

CONTRACT NO. MH060067

AMENDMENT NO. 3

THIS AMENDMENT is made and entered into this 2nd day of June 2020, by and between the COUNTY OF LOS ANGELES (hereafter "County"), and Pasadena Hospital Association LTD. dba Huntington Memorial Hospital (hereafter "Contractor").

WHEREAS, County and Contractor have entered into a written Agreement, dated July 1, 2015, identified as County Agreement No. MH060067, including all amendments, (hereafter collectively "Agreement"); and

WHEREAS, on June 9, 2020, the Board of Supervisors delegated authority to the Director of Mental Health, or designee, to execute amendments to the Agreement; and

WHEREAS, said Agreement provides that changes may be made in the form of a written amendment which is formally approved and executed by the parties; and

WHEREAS, for Fiscal Year (FY) 2020-21 only, County and Contractor intends to amend this Agreement only as described hereunder; and

WHEREAS, County and Contractor intend to amend the Agreement to extend the term of this Agreement for the first six months of FY 2020-21, on a month-to-month basis, beginning July 1, 2020 through December 31, 2020; and

WHEREAS, Contractor warrants that it continues to possess the competence, expertise, and personnel necessary to provide services consistent with the requirements of this Agreement and consistent with the professional standard of care for these services.

NOW, THEREFORE, County and Contractor agree that this Agreement shall be amended only as follows:

1. The Amendment is hereby incorporated into the original Agreement, and all of its terms and conditions, including capitalized terms defined therein, shall be given full force and effect as if fully set forth herein.
2. The Agreement is extended for the first six months of FY 2020-21, on a month-to-month basis, beginning July 1, 2020 through December 31, 2020.
3. Contractor shall provide services in accordance with Contractor's FY 2015-16 Contract Package for this Agreement and any addenda thereto approved in writing by County's Director of Mental Health or his designee.
4. Except as provided in this Amendment, all other terms and conditions of the Agreement shall remain in full force and effect.

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be subscribed by the County's Director of Mental Health or his designee, and Contractor has caused this Amendment to be subscribed on its behalf by its duly authorized officer, on the day, month, and year first above written.

COUNTY OF LOS ANGELES

By REDACTED

Jonathan E. Sherin, M.D., Ph.D.
Director of Mental Health

Pasadena Hospital Association LTD. dba Huntington Memorial Hospital

CONTRACTOR

By REDACTED

Name Leci J. Mercao, MD, MBA

Title President and CEO

(AFFIX CORPORATE SEAL HERE)

APPROVED AS TO FORM:
OFFICE OF THE COUNTY COUNSEL

By: Vicki Kozikoujekian
Senior Deputy County Counsel

Exhibit 23-D

Master Agreement No. H-707421 for Comprehensive Stroke System

Agreement No. H-707421

DEPARTMENT OF HEALTH SERVICES

AGREEMENT

BY AND BETWEEN

COUNTY OF LOS ANGELES

AND

PASADENA MEMORIAL HOSPITAL DBA HUNTINGTON MEMORIAL HOSPITAL

FOR

COMPREHENSIVE STROKE SYSTEM

AGREEMENT PROVISIONS
TABLE OF CONTENTS

PARAGRAPH		TITLE	PAGE
RECITALS			1
1.0		APPLICABLE DOCUMENTS	2
2.0		DEFINITIONS	3
3.0		WORK	5
4.0		TERM OF AGREEMENT	5
5.0		DESIGNATION FEE	6
6.0		ADMINISTRATION OF AGREEMENT- COUNTY	6
	6.1	COUNTY'S PROJECT DIRECTOR	7
	6.2	COUNTY'S PROJECT MANAGER	7
	6.3	COUNTY'S AGREEMENT PROJECT MONITOR	7
7.0		ADMINISTRATION OF AGREEMENT – HOSPITAL	7
	7.1	HOSPITAL'S PROJECT MANAGER	7
	7.2	HOSPITAL'S AUTHORIZED OFFICIAL(S)	8
	7.3	CONFIDENTIALITY	8
	7.4	STAFF PERFORMANCE UNDER THE INFLUENCE	9
8.0		STANDARD TERMS AND CONDITIONS	9
	8.1	AMENDMENTS	9
	8.2	ASSIGNMENT AND DELEGATION	10
	8.3	AUTHORIZATION WARRANTY	10
	8.4	INTENTIONALLY OMITTED	10
	8.5	INTENTIONALLY OMITTED	10
	8.6	INTENTIONALLY OMITTED	11
	8.7	COMPLIANCE WITH APPLICABLE LAWS, RULES & REGULATIONS	11
	8.8	COMPLIANCE WITH CIVIL RIGHTS LAWS – ANTI DISCRIMINATION AND AFFIRMATIVE ACTION	11
	8.9	INTENTIONALLY OMITTED	14
	8.10	CONFLICT OF INTEREST	14
	8.11	INTENTIONALLY OMITTED	14
	8.12	CONSIDERATION OF HIRING GAIN/GROW PROGRAM PARTICIPANTS	14
	8.13	HOSPITAL RESPONSIBILITY AND DEBARMENT	15
	8.14	HOSPITAL'S ACKNOWLEDGEMENT OF COUNTY'S	

TABLE OF CONTENTS

COMMITMENT TO THE SAFELY SURRENDERED BABY LAW 17

8.15 INTENTIONALLY OMITTED 17

8.16 HOSPITAL'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM 17

8.17 HOSPITAL WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM 18

8.18 COUNTY'S QUALITY ASSURANCE PLAN 18

8.19 INTENTIONALLY OMITTED 18

8.20 EMPLOYMENT ELIGIBILITY VERIFICATION 19

8.21 FACSIMILE REPRESENTATIONS 19

8.22 FAIR LABOR STANDARDS 19

8.23 INTENTIONALLY OMITTED 20

8.24 FORCE MAJEURE 20

8.25 GOVERNING LAW, JURISDICTION, AND VENUE 20

8.26 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) 20

8.27 INDEPENDENT CONTRACTOR STATUS 21

8.28 INDEMNIFICATION 22

8.29 GENERAL PROVISIONS FOR ALL INSURANCE COVERAGE 22

8.30 INSURANCE COVERAGE 26

8.31 LICENSES, PERMITS, RESITRATIONS, ACCREDITATIONS, AND CERTIFICATES 27

8.32 INTENTIONALLY OMITTED 28

8.33 INTENTIONALLY OMITTED 28

8.34 INTENTIONALLY OMITTED 28

8.35 INTENTIONALLY OMITTED 28

8.36 NOTICE OF DISPUTES 28

8.37 NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT 28

8.38 NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY LAW 28

8.39 NOTICES 28

8.40 PROHIBITION AGAINST INDUCEMENT OR PERSUASION 29

8.41 PUBLIC RECORDS ACT 29

8.42 PUBLICITY 29

TABLE OF CONTENTS

8.43 RECORD RETENTION 30

8.44 RECYCLED BOND PAPER 30

8.45 RESTRICTION ON LOBBYING 30

8.46 INTENTIONALLY OMITTED 31

8.47 SURVIVAL 31

8.48 TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S DEFAULT PROPERTY TAX REDUCTION PROGRAM 31

8.49 TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM 32

8.50 TERMINATION FOR CONVENIENCE 32

8.51 TERMINATION FOR DEFAULT 32

8.52 TERMINATION FOR IMPROPER CONSIDERATION 34

8.53 TERMINATION FOR INSOLVENCY 34

8.54 TERMINATION FOR NON-ADHERENCE OF COUNTY LOBBYIST ORDINANCE 35

8.55 INTENTIONALLY OMITTED 35

8.56 TIME OFF FOR VOTING 35

8.57 UNLAWFUL SOLICITATION 35

8.58 VALIDITY 35

8.59 WAIVER 36

8.60 WARRANTY AGAINST CONTINGENT FEES 36

8.61 COMPLIANCE WITH COUNTY'S ZERO TOLERANCE POLICY OF HUMAN TRAFFICKING 36

9.0 UNIQUE TERMS AND CONDITIONS 37

9.1 DUE PROCESS 37

9.2 RESPONSIBILITY FOR INDIGENT PATIENTS 39

SIGNATURES 40

TABLE OF CONTENTS

STANDARD EXHIBITS

A STATEMENT OF WORK

B INTENTIONALLY OMITTED

C INTENTIONALLY OMITTED

D HOSPITAL'S EEO CERTIFICATION

E COUNTY'S ADMINISTRATION

F HOSPITAL'S ADMINISTRATION

G HOSPITAL ACKNOWLEDGEMENT AND CONFIDENTIALITY AGREEMENT

H INTENTIONALLY OMITTED

I SAFELY SURRENDERED BABY LAW

AGREEMENT BETWEEN
COUNTY OF LOS ANGELES
AND
PASADENA MEMORIAL HOSPITAL DBA HUNTINGTON MEMORIAL HOSPITAL
FOR
COMPREHENSIVE STROKE SYSTEM

This Agreement and Exhibits made and entered into this 8th day of January, 2018 by and between the County of Los Angeles, hereinafter referred to as County and Pasadena Memorial Hospital dba Huntington Memorial Hospital, hereinafter referred to as Hospital (or Contractor). Hospital is located at 100 W. California Blvd, Pasadena, CA 91105.

RECITALS

WHEREAS, the County may contract with private businesses for Comprehensive Stroke System (CSS) when certain requirements are met; and

WHEREAS, the Hospital both public and private firms which are uniquely staffed and equipped to provide appropriate care to emergency patients who suffer major stroke; and

WHEREAS, Hospital is willing to accept and care for stroke patients at Hospital under the County's CSS in accordance with the terms and conditions which follow herein; and

WHEREAS, pursuant to the authority granted under the Emergency Medical Services and Prehospital Emergency Medical Care Personnel Act (Act) (Health and Safety Code, Sections 1797. et seq.), County maintains an Advanced Life Support (ALS) system providing services utilizing Emergency Medical Technicians-Paramedics; and

WHEREAS, County has designated its Department of Health Services (DHS) as the local Emergency Medical Services (EMS) Agency; and

WHEREAS, various general acute care hospitals, both public and private, in Los Angeles County have been designated by the EMS Agency to participate in the CSS pursuant to a selection procedure developed and implemented with the assistance of qualified agencies and organizations; and

WHEREAS, Hospital, by virtue of its qualifications pursuant to such selection process and its execution of this Agreement, is a County-designated CSS participant; and

WHEREAS, Hospital is currently certified as a Comprehensive Stroke Center by an approved EMS Agency certifying body or will receive certification as a Thrombectomy-Capable Stroke Center by a certifying body approved by the EMS Agency; and

WHEREAS, the Act and related implementing regulations require commitment of hospital administration, emergency department, and medical staff to meet requirements for program participation as specified by EMS Agency policies, procedures and protocols; and

WHEREAS, the parties wish to cooperate with each other and with paramedic provider agencies in the joint development and operation of a CSS in Los Angeles County in order to efficiently and appropriately meet the needs of Los Angeles County residents for high stroke care services; and

WHEREAS, a CSS collects prehospital and hospital data specified in the Stroke Data Dictionary; and

WHEREAS, in exchange, County agrees to provide countywide standardized stroke management reports and to make available countywide statistical data; and

WHEREAS, Hospital agrees to share in a portion of costs required to implement and maintain a countywide CSS as specified in this Agreement; and

WHEREAS, this Agreement is therefore authorized under California Code, Government Code Section 31000 which authorizes the Board of Supervisors to contract for Comprehensive Stroke Center Services; and

NOW THEREFORE, in consideration of the mutual covenants contained herein, and for good and valuable consideration, the parties agree to the following:

1.0 APPLICABLE DOCUMENTS

Exhibits A, B, C, D, E, F, G, and I are attached to and form a part of this Agreement. In the event of any conflict or inconsistency in the definition or interpretation of any word, responsibility, schedule, or the contents or description of any task, deliverable, goods, service, or other work, or otherwise between the CSS Agreement and the Exhibits, or between Exhibits, such conflict or inconsistency shall be resolved by giving precedence first to the Agreement and then to the Exhibits according to the following priority.

Standard Exhibits:

1.1 EXHIBIT A – Statement of Work

1.2 EXHIBIT B – Intentionally Omitted

1.3 EXHIBIT C – Intentionally Omitted

1.4 EXHIBIT D – Hospital's EEO Certification

1.5 EXHIBIT E – County's Administration

1.6 EXHIBIT F – Hospital's Administration

1.7 EXHIBIT G – Hospital Acknowledgement and Confidentiality Agreement

1.8 EXHIBIT H – Intentionally Omitted

1.9 EXHIBIT I – Safely Surrendered Baby Law

2.0 DEFINITIONS

The headings herein contained are for convenience and reference only and are not intended to define the scope of any provision thereof. The following words as used herein shall be construed to have the following meaning, unless otherwise apparent from the context in which they are used.

2.1 **Agreement:** Agreement executed between County and Hospital. It sets forth the terms and conditions for the issuance and performance of the Statement of Work, Exhibit A.

2.2 **Ambulance:** Motor vehicle specially constructed, modified, equipped, or arranged for the purpose of transporting sick, injured, convalescent, infirm, or otherwise incapacitated persons, authorized by the state and licensed by LA County EMS Agency or operated by Jurisdictional Fire Department as an emergency vehicle, and used, or having the potential for being used, in emergency or nonemergency medical service to the public, regardless of level of service.

2.3 **Ambulance Patient Offload Time:** The time interval between the arrival of ambulance patient at the emergency department and the time the patient is transferred to the emergency department gurney, bed, chair or other acceptable location and the emergency department assumes the responsibility for care of the patient.

2.4 **Comprehensive Stroke Center:** An acute care hospital designated by an EMS Agency approved certifying body with the capability to provide advanced interventions, including thrombectomy and neurosurgery, for patients experiencing a stroke.

2.5 **Comprehensive Stroke System:** A regionalized system of care for patients exhibiting signs of a stroke. The system comprises of highly specialized hospitals that provide advanced stroke care and has specific prehospital

protocols and procedures for EMS providers. Coordination and management of system participants is the responsibility of the EMS Agency.

2.6 **County Agreement Project Monitor:** Person with responsibility to oversee the day-to-day activities of this Agreement. Responsibility for inspections of any and all tasks, deliverables, goods, services and other work provided by Hospital.

2.7 **County Project Director:** Person designated by County with authority for County on contractual or administrative matters relating to this Agreement that cannot be resolved by the County's Project Manager.

2.8 **County Project Manager:** Person designated by County's Project Director to manage the operations under this Agreement.

2.9 **Day(s):** Calendar day(s) unless otherwise specified.

2.10 **DHS:** Department of Health Services.

2.11 **Director:** Director of Health Services or his/her authorized designee.

2.12 **Emergency Medical Services Agency:** The County of Los Angeles Department of Health Services, designated by the Board as the local EMS agency pursuant to Health and Safety Code Sections 1797, et seq. having responsibility for administration of EMS in LA County.

2.13 **Hospital/Contractor:** The sole proprietor, partnership, or corporation that has entered into an agreement with the County to provide all services under this Agreement.

2.14 **Hospital's Project Manager:** The individual designated by the Hospital to administer the Agreement operations after the Agreement award.

2.15 **Medical Alert Center (MAC):** coordinates the transfer of patients from private hospitals to county operated hospitals and tracks the bed availability and diversion status of 9-1-1 receiving hospitals 24 hours a day. It serves as the control point for the VMED28 and ReddiNet systems.

2.16 **Primary Stroke Center (PSC):** A 9-1-1 receiving hospital that has been designated as a Primary Stroke Center by an EMS Agency approved accrediting body, meets the Primary Stroke Center requirements in LA County EMS Agency Reference No. 322, and is designated by the EMS Agency as a Primary Stroke Center.

2.17 **Stroke Center Advisory Committee:** A forum comprised of stroke care stakeholders that provides specialized advice to the Medical Director of the EMS Agency on all matters regarding the practice, operation and administration of stroke care.

2.18 **Stroke Center Database**: Electronic database that captures patient level data from designated stroke centers.

2.19 **Stroke Referral Facility**: Acute care hospital that is unable to provide necessary stroke-specific care and would be required to transfer stroke patients to a designated CSC.

2.20 **Thrombectomy-Capable Stroke Centers**: An acute care hospital designated by an EMS Agency approved certifying body with the capability to provide advanced interventions, including thrombectomy, for patients experiencing a stroke.

3.0 WORK

3.1 Pursuant to the provisions of this Agreement, Hospital shall fully perform, complete, and deliver on time, all tasks, deliverables, services and other work as set forth herein.

3.2 If Hospital provides any tasks, deliverables, goods, services, or other work, other than as specified in this Agreement, the same shall be deemed to be a gratuitous effort on the part of the Hospital, and Hospital shall have no claim whatsoever against the County.

4.0 TERM OF AGREEMENT

4.1 This Agreement is effective upon execution by the Director of Health Services or his/her designee, as authorized by the Board of Supervisors. The Agreement shall expire on December 31, 2022, unless sooner terminated or extended, in whole or in part, as provided in this Agreement.

4.2 The County shall have the sole option to extend this Agreement term for up to two (2) additional one-year periods through December 31, 2024. Each such option and extension shall be exercised at the sole discretion of the Director or his designee as authorized by the Board of Supervisors and must be agreed to and executed in writing by both parties.

4.3 The County maintains databases that track/monitor Contractor performance history. Information entered into such databases may be used for a variety of purposes, including determining whether the County will exercise an Agreement term extension option.

4.4 The Contractor shall notify DHS when this Agreement is within six (6) months from the expiration of the term as provided for hereinabove. Upon occurrence of this event, the Contractor shall send written notification to the DHS at the address herein provided in Exhibit E - County's Administration.

5.0 DESIGNATION FEE

5.1 To provide ongoing financial support to County for system data collection, monitoring, and evaluation of the stroke system, all of which benefit Hospital in provision of stroke care, Hospital agrees to offset a portion of the cost attributed thereto. The **NON-REFUNDABLE** amount payable to County by Hospital shall be **Twenty-Three Thousand, Eight Hundred and Ten Dollars ($23,810) annually** for each calendar year (January to December). The first program management fee will be due within sixty (60) days of the Agreement effective date; thereafter, within sixty (60) days of the beginning of each calendar year. If applicable, the first year program management fee will be prorated accordingly. **The Designation Fee may, at the sole discretion of the County, be adjusted annually, with a ten percent (10%) annual cap for potential increases to reflect changes in operating costs.**

5.2 The Designation Fee shall be made payable to County of Los Angeles and sent to the following address:

County of Los Angeles-DHS
Emergency Medical Services Agency
10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670
Attention: Accounting Unit

5.3 Hospital shall not be entitled to payment or reimbursement for any tasks or services performed, nor for any incidental or administrative expenses whatsoever incurred in or incidental to performance hereunder, except as specified herein. Assumption or takeover of any of Hospital's duties, responsibilities, or obligations, or performance of same by any entity other than Hospital, whether through assignment, subcontract, delegation, merger, buyout, or any other mechanism, with or without consideration for any reason whatsoever, shall occur only with the County's express prior written approval.

6.0 ADMINISTRATION OF AGREEMENT - COUNTY

COUNTY ADMINISTRATION

The Director shall have the authority to administer this Agreement on behalf of the County. Director retains professional and administrative responsibility for the services rendered under this Agreement. A listing of all County Administration referenced in the following sub-paragraphs are designated in Exhibit E - County's Administration. The County shall notify Hospital in writing of any change in the names or addresses shown.

6.1 County's Project Director

Responsibilities of the County's Project Director include:

- ensuring that the objectives of this Agreement are met; and
- providing direction to Hospital in the areas relating to County policy, information requirements, and procedural requirements.

6.2 County's Project Manager

6.2.1 The responsibilities of the County's Project Manager include:

- meeting with Hospital's Project Manager on a regular basis; and
- inspecting any and all tasks, deliverables, goods, services, or other work provided by or on behalf of Hospital.

6.2.2 The County's Project Manager is not authorized to make any changes in any of the terms and conditions of this Agreement and is not authorized to further obligate County in any respect whatsoever.

6.3 County's Agreement Project Monitor

The County's Project Monitor is responsible for overseeing the day-to-day administration of this Agreement. The Project Monitor reports to the County's Project Manager.

7.0 ADMINISTRATION OF AGREEMENT - HOSPITAL

7.1 Hospital's Project Manager

7.1.1 The Hospital's Project Manager is designated in Exhibit F - Hospital's Administration. The Hospital shall notify the County in writing of any change in the name or address of the Hospital's Project Manager.

7.1.2 The Hospital's Project Manager shall be responsible for the Hospital's day-to-day activities as related to this Agreement and shall coordinate with County's Project Manager and County's Agreement Project Monitor on a regular basis.

7.2 Hospital's Authorized Official(s)

7.2.1 Hospital's Authorized Official(s) are designated in Exhibit F. Hospital shall promptly notify County in writing of any change in the name(s) or address(es) of Hospital's Authorized Official(s).

7.2.2 Hospital represents and warrants that all requirements of Hospital have been fulfilled to provide actual authority to such officials to execute documents under this Agreement on behalf of Hospital.

7.3 Confidentiality

7.3.1 Hospital shall maintain the confidentiality of all records and information, including, but not limited to, billings, County records, and patient records, in accordance with all applicable Federal, State and local laws, rules, regulations, ordinances, directives, guidelines, policies and procedures relating to confidentiality, including, without limitation, County policies concerning information technology security and the protection of confidential records and information.

7.3.2 Hospital shall indemnify, defend, and hold harmless County, its Special Districts, elected and appointed officers, employees, and agents, from and against any and all claims, demands, damages, liabilities, losses, costs and expenses, including, without limitation, defense costs and legal, accounting and other expert, consulting, or professional fees, arising from, connected with, or related to any failure by Hospital, its officers, employees, agents, or subcontractors, to comply with this Paragraph 7.3, as determined by County in its sole judgment. Any legal defense pursuant to Hospital's indemnification obligations under this Paragraph 7.3 shall be conducted by Hospital and performed by counsel selected by Hospital and approved by County. Notwithstanding the preceding sentence, County shall have the right to participate in any such defense at its sole cost and expense, except that in the event Hospital fails to provide County with a full and adequate defense, as determined by County in its sole judgment, County shall be entitled to retain its own counsel, including, without limitation, County Counsel, and reimbursement from Hospital for all such costs and expenses incurred by County in doing so. Hospital shall not have the right to enter into any settlement, agree to any injunction, or make any admission, in each case, on behalf of County without County's prior written approval.

7.3.3 Hospital shall inform all of its officers, employees, agents and subcontractors providing services hereunder of the confidentiality and indemnification provisions of this Agreement.

7.3.4 Hospital shall sign and adhere to the provisions of the Exhibit G - Hospital Acknowledgement and Confidentiality Agreement.

7.4 Staff Performance under the Influence

Hospital shall not knowingly permit any employee to perform services under this Agreement while under the influence of any alcoholic beverage, medication, narcotic, or other substance which might impair their physical or mental performance.

8.0 STANDARD TERMS AND CONDITIONS

8.1 AMENDMENTS

8.1.1 For any change which affects the scope of work, term, payments, or any term or condition included under this Agreement, an Amendment shall be prepared by the County and then executed by the Hospital and by the Director or his designee.

8.1.2 The County's Board of Supervisors or Chief Executive Officer or designee may require the addition and/or change of certain terms and conditions in the Agreement during the term of this Agreement. The County reserves the right to add and/or change such provisions as required by the County's Board of Supervisors, Chief Executive Officer or designee. To implement such changes, an Amendment to the Agreement shall be prepared by the County and then executed by the Hospital and by the Director or his/her designee.

8.1.3 The Director or his/her designee may at his/her sole discretion, authorize extensions of time as defined in Paragraph 4.0 - Term of Agreement. The Hospital agrees that such extensions of time shall not change any other term or condition of this Agreement during the period of such extensions. To implement an extension of time, an Amendment to the Agreement shall be prepared by the County and then executed by the Hospital and by the Director or his/her designee.

8.1.4 The Director or his/her designee may require, at his sole discretion, the addition and/or change of certain terms and conditions in the Agreement to conform to changes in federal or State law or regulation, during the term of this Agreement. The County reserves the unilateral right to add and/or change such provisions as required by law or regulation, without the need for the Hospitals' written consent, to preserve this Agreement's conformity and compliance to federal and State law or regulation. To implement such changes, an Amendment to the Agreement shall be prepared by the County and then executed by the Hospital and by the Director or his/her designee.

8.2 ASSIGNMENT AND DELEGATION

8.2.1 The Hospital shall not assign its rights or delegate its duties under this Agreement, or both, whether in whole or in part, without the prior written consent of the County, in its discretion, and any attempted assignment or delegation without such consent shall be null and void. For purposes of this sub-paragraph, the County consent shall require a written Amendment to the Agreement, which is formally approved and executed by the parties. Any payments by the County to any approved delegate or assignee on any claim under this Agreement shall be deductible, at the County's sole discretion, against the claims, which the Hospital may have against the County.

8.2.2 Shareholders, partners, members, or other equity holders of the Hospital may transfer, sell, exchange, assign, or divest themselves of any interest they may have therein. However, in the event any such sale, transfer, exchange, assignment, or divestment is effected in such a way as to give majority control of the Hospital to any person(s), corporation, partnership, or legal entity other than the majority controlling interest therein at the time of execution of the Agreement, such disposition is an assignment requiring the prior written consent of the County in accordance with applicable provisions of this Agreement.

8.2.3 Any assumption, assignment, delegation, or takeover of any of the Hospital's duties, responsibilities, obligations, or performance of same by any entity other than the Hospital, whether through assignment, subcontract, delegation, merger, buyout, or any other mechanism, with or without consideration for any reason whatsoever without County's express prior written approval, shall be a material breach of the Agreement which may result in the termination of this Agreement. In the event of such termination, the County shall be entitled to pursue the same remedies against the Hospital as it could pursue in the event of default by the Hospital.

8.3 AUTHORIZATION WARRANTY

The Hospital represents and warrants that the person executing this Agreement for the Hospital is an authorized agent who has actual authority to bind the Hospital to each and every term, condition, and obligation of this Agreement and that all requirements of the Hospital have been fulfilled to provide such actual authority.

8.4 INTENTIONALLY OMITTED

8.5 INTENTIONALLY OMITTED

8.6 INTENTIONALLY OMITTED

8.7 COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

8.7.1 In the performance of this Agreement, Hospital shall comply with all current and applicable Federal, State and local laws, rules, regulations, ordinances, directives, guidelines, policies and procedures, including, but not limited to standards of The Joint Commission, its National Patient Safety Goals, California Code of Regulations, Title 22, Division 5 regulations and all other applicable industry best practices standards. All provisions required thereby to be included in this Agreement are incorporated herein by reference.

8.7.2 Hospital shall indemnify, defend, and hold harmless County, its officers, employees, and agents, from and against any and all claims, demands, damages, liabilities, losses, administrative penalties and fines assessed, costs, and expenses, including, without limitation, defense costs and legal, accounting and other expert, consulting or professional fees, arising from, connected with, or related to any failure by Hospital, its officers, employees, agents, or subcontractors, to comply with any such laws, rules, regulations, ordinances, directives, guidelines, policies, or procedures, as determined by County in its sole judgment. Any legal defense pursuant to Hospital's indemnification obligations under this sub-paragraph 8.7 shall be conducted by Contractor and performed by counsel selected by Hospital and approved by County. Notwithstanding the preceding sentence, County shall have the right to participate in any such defense at its sole cost and expense, except that in the event Contractor fails to provide County with a full and adequate defense, as determined by County in its sole judgment, County shall be entitled to retain its own counsel, including, without limitation, County Counsel, and reimbursement from Hospital for all such costs and expenses incurred by County in doing so the Hospital shall not have the right to enter into any settlement, agree to any injunction or other equitable relief, or make any admission, in each case, on behalf of County without County's prior written approval.

8.8 COMPLIANCE WITH CIVIL RIGHTS LAWS- ANTI-DISCRIMINATION AND AFFIRMATIVE ACTION LAWS

8.8.1 Hospital hereby assures that it will comply with Subchapter VI of the Civil Rights Act of 1964, 42 USC Sections 2000 (e) (1) through 2000 (e) (17); the Fair Employment & Housing Act, Government Code Section 12920-12922; and Affirmative Action in County Agreements, Chapter 4.32 of the Los Angeles County Code to the

end that no person shall, on the grounds of race, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Agreement or under any project, program, or activity supported by this Agreement.

8.8.2 Hospital certifies and agrees that all persons employed by it, its affiliates, subsidiaries, or holding companies are and shall be treated equally without regard to or because of race, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation, in compliance with all applicable Federal and State anti-discrimination laws and regulations.

8.8.3 Hospital shall take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to race, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation, in compliance with all applicable Federal and State anti-discrimination laws and regulations. Such action shall include, but is not limited to: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.

8.8.4 Hospital certifies and agrees that it will deal with its subcontractors, bidders, or vendors without regard to or because of race, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation.

8.8.5 Hospital certifies and agrees that it, its affiliates, subsidiaries, or holding companies shall comply with all applicable Federal and State laws and regulations to the end that no person shall, on the grounds of race, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Agreement or under any project, program, or activity supported by this Agreement.

8.8.6 Hospital shall allow County representatives access to the Hospital's employment records during regular business hours to verify

compliance with the provisions of this sub-paragraph 8.8 when so requested by the County.

8.8.7 If the County finds that any provisions of this sub-paragraph 8.8 have been violated, such violation shall constitute a material breach of this Agreement upon which the County may terminate or suspend this Agreement. While the County reserves the right to determine independently that the anti-discrimination provisions of this Agreement have been violated, in addition, a determination by the California Fair Employment Practices Commission or the Federal Equal Employment Opportunity Commission that the Contractor has violated Federal or State anti-discrimination laws or regulations shall constitute a finding by the County that the Hospital has violated the anti-discrimination provisions of this Agreement.

8.8.8 The parties agree that in the event the Hospital violates any of the anti-discrimination provisions of this Agreement, the County shall, at its sole option, be entitled to the sum of Five Hundred Dollars ($500) for each such violation pursuant to California Civil Code Section 1671 as liquidated damages in lieu of terminating or suspending this Agreement.

8.8.9 **Anti-discrimination in Services:**

Hospital shall not discriminate in the provision of services hereunder because of race, color, religious creed, national origin, ethnic group identification, ancestry, age, sex, sexual orientation, medical condition, marital status, political affiliation, or physical or mental disability in accordance with requirements of federal and State laws. For the purpose of this sub-paragraph, discrimination in the provision of services may include, but is not limited to, the following: Denying any person any service or benefit or the availability of a facility; providing any service or benefit to a person which is not equivalent or is provided in a non-equivalent manner or at a non-equivalent time, from that provided to others; subjecting any person to segregation or separate treatment in any manner related to the receipt of any service; restricting any person in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit; and treating any person differently from others in determining admission, enrollment, quota, eligibility, membership, or any other requirements or conditions which persons must meet in order to be provided any service or benefit. The Hospital shall take affirmative action to ensure that intended beneficiaries of this Agreement are provided services without regard to race, color, religious creed, national origin, ethnic group, identification, ancestry, ex, sexual orientation, age, medical

condition, marital status, political affiliation, physical or mental disability.

8.8.10 Hospital shall certify to, and comply with, the provisions of Exhibit D – Hospital's EEO Certification.

8.9 INTENTIONALLY OMITTED

8.10 CONFLICT OF INTEREST

8.10.1 No County employee whose position with the County enables such employee to influence the award of this Agreement or any competing Agreement shall participate in the negotiation of this Agreement. No County employee with a spouse or economic dependent employed in any capacity by Hospital herein shall participate in the negotiation of this Agreement, or have a direct or indirect interest in this Agreement. No officer or employee of the Hospital who may financially benefit from the performance of work hereunder shall in any way participate in the County's approval, or ongoing evaluation, of such work, or in any way attempt to unlawfully influence the County's approval or ongoing evaluation of such work.

8.10.2 Hospital shall comply with all conflict of interest laws, ordinances, and regulations now in effect or hereafter to be enacted during the term of this Agreement. The Hospital warrants that it is not now aware of any facts that create a conflict of interest. If the Hospital hereafter becomes aware of any facts that might reasonably be expected to create a conflict of interest, it shall immediately make full written disclosure of such facts to the County. Full written disclosure shall include, but is not limited to, identification of all persons implicated and a complete description of all relevant circumstances. Failure to comply with the provisions of this sub-paragraph shall be a material breach of this Agreement.

8.11 INTENTIONALLY OMITTED

8.12 CONSIDERATION OF HIRING GAIN/GROW PROGRAM PARTICIPANTS

8.12.1 Should the Hospital require additional or replacement personnel after the effective date of this Agreement, the Hospital shall give consideration for any such employment openings to participants in the County's Department of Public Social Services (DPSS) Greater Avenues for Independence (GAIN) Program or General Relief Opportunity for Work (GROW) Program who meet the Hospital's minimum qualifications for the open position. For this purpose, consideration shall mean that the Contractor will interview qualified

candidates. The County will refer GAIN/GROW participants by job category to the Contractor. The Contractors shall report all job openings with job requirements to: GAINGROW@dpss.lacounty.gov to obtain a list of qualified GAIN/GROW job candidates.8.12.2 In the event that both laid-off County employees and GAIN/GROW participants are available for hiring, referred County employees shall be given first priority.

8.13 HOSPITAL RESPONSIBILITY AND DEBARMENT

8.13.1 Responsible Hospital

A responsible Hospital is a Hospital who has demonstrated the attribute of trustworthiness, as well as quality, fitness, capacity and experience to satisfactorily perform the agreement. It is the County's policy to conduct business only with responsible Hospitals.

8.13.2 Chapter 2.202 of the County Code

The Hospital is hereby notified that, in accordance with Chapter 2.202 of the County Code, if the County acquires information concerning the performance of the Hospital on this or other contracts which indicates that the Hospital is not responsible, the County may, in addition to other remedies provided in the contract, debar the Hospital from bidding or proposing on, or being awarded, and/or performing work on County contracts for a specified period of time, which generally will not exceed five (5) years but may exceed five (5) years or be permanent if warranted by the circumstances, and terminate any or all existing Contracts the Hospital may have with the County.

8.13.3 Non-responsible Hospital

The County may debar a Hospital if the Board of Supervisors finds, in its discretion, that the Hospital has done any of the following: (1) violated a term of an agreement with the County or a nonprofit corporation created by the County, (2) committed an act or omission which negatively reflects on the Contractor's quality, fitness or capacity to perform an agreement with the County, any other public entity, or a nonprofit corporation created by the County, or engaged in a pattern or practice which negatively reflects on same, (3) committed an act or offense which indicates a lack of business integrity or business honesty, or (4) made or submitted a false claim against the County or any other public entity.

8.13.4 Contractor Hearing Board

1. If there is evidence that the Hospital may be subject to debarment, the Department will notify the Hospital in writing of the evidence which is the basis for the proposed debarment and will advise the Hospital of the scheduled date for a debarment hearing before the Contractor Hearing Board.

2. The Contractor Hearing Board will conduct a hearing where evidence on the proposed debarment is presented. The Hospital and/or the Hospital's representative shall be given an opportunity to submit evidence at that hearing. After the hearing, the Contractor Hearing Board shall prepare a tentative proposed decision, which shall contain a recommendation regarding whether the Hospital should be debarred, and, if so, the appropriate length of time of the debarment. The Hospital and the Department shall be provided an opportunity to object to the tentative proposed decision prior to its presentation to the Board of Supervisors.

3. After consideration of any objections, or if no objections are submitted, a record of the hearing, the proposed decision, and any other recommendation of the Contractor Hearing Board shall be presented to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of the Contractor Hearing Board.

4. If a Hospital has been debarred for a period longer than five (5) years, that Hospital may after the debarment has been in effect for at least five (5) years, submit a written request for review of the debarment determination to reduce the period of debarment or terminate the debarment. The County may, in its discretion, reduce the period of debarment or terminate the debarment if it finds that the Hospital has adequately demonstrated one or more of the following: (1) elimination of the grounds for which the debarment was imposed; (2) a bona fide change in ownership or management; (3) material evidence discovered after debarment was imposed; or (4) any other reason that is in the best interests of the County

5. The Contractor Hearing Board will consider a request for review of a debarment determination only where (1) the Hospital has been debarred for a period longer than five (5) years; (2) the debarment has been in effect for at least five (5) years; and (3) the request is in writing, states one or more of the grounds for reduction of the debarment period or

termination of the debarment, and includes supporting documentation. Upon receiving an appropriate request, the Contractor Hearing Board will provide notice of the hearing on the request. At the hearing, the Contractor Hearing Board shall conduct a hearing where evidence on the proposed reduction of debarment period or termination of debarment is presented. This hearing shall be conducted and the request for review decided by the Contractor Hearing Board pursuant to the same procedures as for a debarment hearing.

6. The Contractor Hearing Board's proposed decision shall contain a recommendation on the request to reduce the period of debarment or terminate the debarment. The Contractor Hearing Board shall present its proposed decision and recommendation to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of the Contractor Hearing Board.

8.13.5 Subcontractors of Contractor

These terms shall also apply to Subcontractors of County Contractors.

8.14 HOSPITAL'S ACKNOWLEDGEMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW

The Hospital acknowledges that the County places a high priority on the implementation of the Safely Surrendered Baby Law. The Hospital understands that it is the County's policy to encourage all County Contractors to voluntarily post the County's "Safely Surrendered Baby Law" poster in a prominent position at the Hospital's place of business. The Hospital will also encourage its Subcontractors, if any, to post this poster in a prominent position in the Subcontractor's place of business. The County's Department of Children and Family Services will supply the Hospital with the poster to be used. Information on how to receive the poster can be found on the Internet at www.babysafela.org.

8.15 INTENTIONALLY OMITTED

8.16 HOSPITAL'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM

8.16.1 The Hospital acknowledges that the County has established a goal of ensuring that all individuals who benefit financially from the County through Agreement are in compliance with their court-ordered child, family and spousal support obligations in order to

mitigate the economic burden otherwise imposed upon the County and its taxpayers.

8.16.2 As required by the County's Child Support Compliance Program (County Code Chapter 2.200) and without limiting the Hospital's duty under this Agreement to comply with all applicable provisions of law, the Hospital warrants that it is now in compliance and shall during the term of this Agreement maintain in compliance with employment and wage reporting requirements as required by the Federal Social Security Act (42 USC Section 653a) and California Unemployment Insurance Code Section 1088.5, and shall implement all lawfully served Wage and Earnings Withholding Orders or Child Support Services Department Notices of Wage and Earnings Assignment for Child, Family or Spousal Support, pursuant to Code of Civil Procedure Section 706.031 and Family Code Section 5246(b).

8.17 HOSPITAL WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM

8.17.1 Hospital acknowledges that County has established a goal of ensuring that all individuals and businesses that benefit financially from County through agreement are current in paying their property tax obligations (secured and unsecured roll) in order to mitigate the economic burden otherwise imposed upon County and its taxpayers.

8.17.2 Unless Hospital qualifies for an exemption or exclusion, Hospital warrants and certifies that to the best of its knowledge it is now in compliance, and during the term of this agreement will maintain compliance, with Los Angeles County Code Chapter 2.206.

8.18 COUNTY'S QUALITY ASSURANCE PLAN

The County or its agent will monitor the Hospital's performance under this Agreement on not less than an annual basis. Such evaluation will include assessing the Hospital's compliance with all Agreement terms and conditions and performance standards. The Hospital's deficiencies which the County determines are severe or continuing and that may place performance of the Agreement in jeopardy if not corrected will be reported to the Board and listed in the appropriate contractor performance database. The report to the Board will include improvement/corrective action measures taken by the County and the Hospital. If improvement does not occur consistent with the corrective action measures, the County may terminate this Agreement or impose other penalties as specified in this Agreement.

8.19 INTENTIONALLY OMITTED

8.20 EMPLOYMENT ELIGIBILITY VERIFICATION

8.20.1 The Hospital warrants that it fully complies with all federal and State statutes and regulations regarding the employment of aliens and others and that all its employees performing work under this Agreement meet the citizenship or alien status requirements set forth in federal and State statutes and regulations. The Hospital shall obtain, from all employees performing work hereunder, all verification and other documentation of employment eligibility status required by federal and State statutes and regulations including, but not limited to, the Immigration Reform and Control Act of 1986, (P.L. 99-603), or as they currently exist and as they may be hereafter amended. The Hospital shall retain all such documentation for all covered employees for the period prescribed by law.

8.20.2 The Hospital shall indemnify, defend, and hold harmless, the County, its agents, officers, and employees from employer sanctions and any other liability which may be assessed against the Hospital or the County or both in connection with any alleged violation of any federal or State statutes or regulations pertaining to the eligibility for employment of any persons performing work under this Agreement.

8.21 FACSIMILE, SCANNED REPRESENTATIONS

The County and the Hospital hereby agree to regard facsimile and or scanned (sent via electronic mail) representations of original signatures of authorized officers of each party, when appearing in appropriate places on the Amendments prepared pursuant to sub-paragraph 8.1, and received via communications facilities, as legally sufficient evidence that such original signatures have been affixed to Amendments to this Agreement, such that the parties need not follow up facsimile or scanned transmissions of such documents with subsequent (non-facsimile or non-scanned) transmission of "original" versions of such documents.

8.22 FAIR LABOR STANDARDS

The Hospital shall comply with all applicable provisions of the Federal Fair Labor Standards Act and shall indemnify, defend, and hold harmless the County and its agents, officers, and employees from any and all liability, including, but not limited to, wages, overtime pay, liquidated damages, penalties, court costs, and attorneys' fees arising under any wage and hour law, including, but not limited to, the Federal Fair Labor Standards Act, for work performed by the Hospital's employees for which the County may be found jointly or solely liable.

8.23 INTENTIONALLY OMITTED

8.24 FORCE MAJEURE

8.24.1 Neither party shall be liable for such party's failure to perform its obligations under and in accordance with this Agreement, if such failure arises out of fires, floods, epidemics, quarantine restrictions, other natural occurrences, strikes, lockouts (other than a lockout by such party or any of such party's subcontractors), freight embargoes, or other similar events to those described above, but in every such case the failure to perform must be totally beyond the control and without any fault or negligence of such party (such events are referred to in this Sub-paragraph as "force majeure events").

8.24.2 Notwithstanding the foregoing, a default by a subcontractor of the Contractor shall not constitute a force majeure event, unless such default arises out of causes beyond the control of both Contractor and such subcontractor, and without any fault or negligence of either of them. In such case, the Contractor shall not be liable for failure to perform, unless the goods or services to be furnished by the subcontractor were obtainable from other sources in sufficient time to permit the Contractor to meet the required performance schedule. As used in this Sub-paragraph, the term "subcontractor" and "subcontractors" mean subcontractors at any tier.

8.24.3 In the event the Hospital's failure to perform arises out of a force majeure event, the Hospital agrees to use commercially reasonable best efforts to obtain goods or services from other sources, if applicable, and to otherwise mitigate the damages and reduce the delay caused by such force majeure event.

8.25 GOVERNING LAW, JURISDICTION, AND VENUE

This Agreement shall be governed by, and construed in accordance with, the laws of the State of California. The Hospital agrees and consents to the exclusive jurisdiction of the courts of the State of California for all purposes regarding this Agreement and further agrees and consents that venue of any action brought hereunder shall be exclusively in the County of Los Angeles.

8.26 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

8.26.1 The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations. The Contractor understands and agrees that, as a provider of medical treatment services, it is a "covered

entity" under HIPAA and, as such, has obligations with respect to the confidentiality, privacy, and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, including the use of appropriate consents and authorizations specified under HIPAA.

8.26.2 The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. The Hospital understands and agrees that it is separately and independently responsible for compliance with HIPAA in all these areas and that the County has not undertaken any responsibility for compliance on the Hospital's behalf. The Hospital has not relied, and will not in any way rely, on the County for legal advice or other representations with respect to the Hospital's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

8.26.3 The Hospital and the County understand and agree that each is independently responsible for HIPAA compliance and agree to take all necessary and reasonable actions to comply with the requirements of the HIPAA laws and implementing regulations related to transactions and code sets, privacy, and security.

8.26.4 Each party further agrees that, should it fail to comply with its obligations under HIPAA, it shall indemnify and hold harmless the other party (including the other party's officers, employees, and agents), for damages to the other party that are attributable to such failure.

8.27 INDEPENDENT CONTRACTOR STATUS

8.27.1 This Agreement is by and between the County and the Hospital and is not intended, and shall not be construed, to create the relationship of agent, servant, employee, partnership, joint venture, or association, as between the County and the Hospital. The employees and agents of one party shall not be, or be construed to be, the employees or agents of the other party for any purpose whatsoever.

8.27.2 The Hospital shall be solely liable and responsible for providing to, or on behalf of, all persons performing work pursuant to this Agreement all compensation and benefits. The County shall have no liability or responsibility for the payment of any salaries, wages, unemployment benefits, disability benefits, Federal, State, or local

taxes, or other compensation, benefits, or taxes for any personnel provided by or on behalf of the Hospital.

8.27.3 The Hospital understands and agrees that all persons performing work pursuant to this Agreement are, for purposes of Workers' Compensation liability, solely employees of the Hospital and not employees of the County. The Hospital shall be solely liable and responsible for furnishing any and all Workers' Compensation benefits to any person as a result of any injuries arising from or connected with any work performed by or on behalf of the Hospital pursuant to this Agreement.

8.27.4 The Contractor shall adhere to the provisions stated in Sub-paragraph 7.3 - Confidentiality.

8.28 INDEMNIFICATION

The Hospital shall indemnify, defend and hold harmless the County, its Special Districts, elected and appointed officers, employees, and agents and volunteers ("County Indemnitees") from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, and expenses (including attorney and expert witness fees), arising from and/or relating to this Agreement, expect for such loss or damage arising from the sole negligence or willful misconduct of the County Indemnitees.

8.29 GENERAL PROVISIONS FOR ALL INSURANCE COVERAGE

Without limiting Hospital's indemnification of County, and in the performance of this Agreement and until all of its obligations pursuant to this Agreement have been met, Hospital shall provide and maintain at its own expense insurance coverage satisfying the requirements specified in Sections 8.29 and 8.30 of this Agreement. These minimum insurance coverage terms, types and limits (the "Required Insurance") also are in addition to and separate from any other contractual obligation imposed upon Hospital pursuant to this Agreement. The County in no way warrants that the Required Insurance is sufficient to protect the Hospital for liabilities which may arise from or relate to this Agreement.

8.29.1 Evidence of Coverage and Notice to County

- Certificate(s) of insurance coverage (Certificate) satisfactory to the County, and a copy of an Additional Insured endorsement confirming the County and its Agents (defined below) has been given Insured status under the Hospital's General Liability policy, shall be delivered to County at the address shown below and provided prior to commencing services under this Agreement.

- Renewal Certificates shall be provided to County not less than 10 days prior to Hospital's policy expiration dates. The County reserves the right to obtain complete, certified copies of any required Hospital and/or Sub-Contractor insurance policies at any time.

- Certificates shall identify all Required Insurance coverage types and limits specified herein, reference this Agreement by name or number, and be signed by an authorized representative of the insurer(s). The Insured party named on the Certificate shall match the name of the Hospital identified as the contracting party in this Agreement. Certificates shall provide the full name of each insurer providing coverage, its NAIC (National Association of Insurance Commissioners) identification number if, its financial rating, the amounts of any policy deductibles or self-insured retentions exceeding fifty thousand ($50,000.00) dollars, and list any County required endorsement forms.

- Neither the County's failure to obtain, nor the County's receipt of, or failure to object to a non-complying insurance certificate or endorsement, or any other insurance documentation or information provided by the Hospital, its insurance broker(s) and/or insurer(s), shall be construed as a waiver of any of the Required Insurance provisions.

Certificates and copies of any required endorsements shall be sent to:

County of Los Angeles
Department of Health Services
Contracts and Grants Division
313 N. Figueroa Street, 6E
Los Angeles, CA 90012
Attention: Kathy K. Hanks, C.P.M.
Director, Contracts and Grants

And

County of Los Angeles-DHS
Emergency Medical Services Agency
10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670
Attention: Administrative Services

Hospital also shall promptly report to County any injury or property damage accident or incident, including any injury to a Hospital employee occurring on County property, and any loss, disappearance, destruction, misuse, or theft of County property,

monies or securities entrusted to Hospital. Hospital also shall promptly notify County of any third party claim or suit filed against Hospital or any of its Sub-Contractors which arises from or relates to this Agreement, and could result in the filing of a claim or lawsuit against Hospital and/or County.

8.29.2 Additional Insured Status and Scope of Coverage

The County of Los Angeles, its Special Districts, Elected Officials, Officers, Agents, Employees and Volunteers (collectively County and its Agents) shall be provided additional insured status under Hospital's General Liability policy with respect to liability arising out of Hospital's ongoing and completed operations performed on behalf of the County. The County and its Agents additional insured status shall apply with respect to liability and defense of suits arising out of the Contractor's acts or omissions, whether such liability is attributable to the Contractor or to the County. The full policy limits and scope of protection also shall apply to the County and its Agents as an additional insured, even if they exceed the County's minimum Required Insurance specifications herein. Use of an automatic additional insured endorsement form is acceptable providing it satisfies the Required Insurance provisions herein.

8.29.3 Cancellation of or Changes in Insurance

Hospital shall provide County with, or Hospital's insurance policies shall contain a provision that County shall receive, written notice of cancellation or any change in Required Insurance, including insurer, limits of coverage, term of coverage or policy period. The written notice shall be provided to County at least ten (10) days in advance of cancellation for non-payment of premium and thirty (30) days in advance for any other cancellation or policy change. Failure to provide written notice of cancellation or any change in Required Insurance may constitute a material breach of the Agreement, in the sole discretion of the County, upon which the County may suspend or terminate this Agreement.

8.29.4 Failure to Maintain Insurance

Hospital's failure to maintain or to provide acceptable evidence that it maintains the Required Insurance shall constitute a material breach of the Agreement, upon which County immediately may suspend or terminate this Agreement. The County, at its sole discretion, may obtain damages from the Contractor resulting from said breach. Alternatively, the County may purchase the Required Insurance, and without further notice to the Contractor, deduct the

premium cost from sums due to the Contractor or pursue the Contractor reimbursement.

8.29.5 Insurer Financial Ratings

Coverage shall be placed with insurers acceptable to the County with A.M. Best ratings of not less than A:VII unless otherwise approved by County.

8.29.6 Hospital's Insurance Shall Be Primary

Hospital's insurance policies, with respect to any claims related to this Agreement, shall be primary with respect to all other sources of coverage available to Hospital. Any County maintained insurance or self-insurance coverage shall be in excess of and not contribute to any Hospital coverage.

8.29.7 Waivers of Subrogation

To the fullest extent permitted by law, the Hospital hereby waives its rights and its insurer(s)' rights of recovery against County under all the Required Insurance for any loss arising from or relating to this Agreement. The Hospital shall require its insurers to execute any waiver of subrogation endorsements which may be necessary to effect such waiver.

8.29.8 Sub-Contractor Insurance Coverage Requirements

The Hospital shall include all Sub-Contractors as insureds under the Hospital's own policies, or shall provide the County with each Sub-Contractor's separate evidence of insurance coverage. The Hospital shall be responsible for verifying each Sub-Contractor complies with the Required Insurance provisions herein, and shall require that each Sub-Contractor name the County and the Hospital as additional insureds on the Sub-Contractor's General Liability policy. The Hospital shall obtain the County's prior review and approval of any Sub-Contractor request for modification of the Required Insurance.

8.29.9 Deductibles and Self-Insured Retentions (SIRs)

Hospital's policies shall not obligate the County to pay any portion of any Hospital deductible or SIR. The County retains the right to require the Hospital to reduce or eliminate policy deductibles and SIRs as respects the County, or to provide a bond guaranteeing the Hospital's payment of all deductibles and SIRs, including all related claims investigation, administration and defense expenses.

Such bond shall be executed by a corporate surety licensed to transact business in the State of California.

8.29.10 Claims Made Coverage

If any part of the Required Insurance is written on a claims made basis, any policy retroactive date shall precede the effective date of this Agreement. Hospital understands and agrees it shall maintain such coverage for a period of not less than three (3) years following Agreement expiration, termination or cancellation.

8.29.11 Application of Excess Liability Coverage

Hospitals may use a combination of primary, and excess insurance policies which provide coverage as broad as ("follow form" over) the underlying primary policies, to satisfy the Required Insurance provisions.

8.29.12 Separation of Insureds

All liability policies shall provide cross-liability coverage as would be afforded by the standard ISO (Insurance Services Office, Inc.) separation of insureds provision with no insured versus insured exclusions or limitations.

8.29.13 Alternative Risk Financing Programs

The County reserves the right to review, and then approve, Hospital use of self-insurance, risk retention groups, risk purchasing groups, pooling arrangements and captive insurance to satisfy the Required Insurance provisions. The County and its Agents shall be designated as an Additional Covered Party under any approved program.

8.29.14 County Review and Approval of Insurance Requirements

The County reserves the right to review and adjust the Required Insurance provisions, conditioned upon the County's determination of changes in risk exposures.

8.30 INSURANCE COVERAGE

8.30.1 Commercial General Liability insurance (providing scope of coverage equivalent to ISO policy form CG 00 01), naming County and its Agents as an additional insured, with limits of not less than:

General Aggregate:	**$2 million**

Products/Completed Operations Aggregate:	$1 million
Personal and Advertising Injury:	$1 million
Each Occurrence:	$1 million

8.30.2 **Automobile Liability** insurance (providing scope of coverage equivalent to ISO policy form CA 00 01) with limits of not less than $1 million for bodily injury and property damage, in combined or equivalent split limits, for each single accident. Insurance shall cover liability arising out of Hospital's use of autos pursuant to this Agreement, including owned, leased, hired, and/or non-owned autos, as each may be applicable.

8.30.3 **Workers Compensation and Employers' Liability** insurance or qualified self-insurance satisfying statutory requirements, which includes Employers' Liability coverage with limits of not less than $1 million per accident. If Hospital will provide leased employees, or, is an employee leasing or temporary staffing firm or a professional employer organization (PEO), coverage also shall include an Alternate Employer Endorsement (providing scope of coverage equivalent to ISO policy form WC 00 03 01 A) naming the County as the Alternate Employer, and the endorsement form shall be modified to provide that County will receive not less than thirty (30) days advance written notice of cancellation of this coverage provision. If applicable to Hospital's operations, coverage also shall be arranged to satisfy the requirements of any federal workers or workmen's compensation law or any federal occupational disease law.

8.30.4 **Unique Insurance Coverage**

- **Professional Liability/Errors and Omissions**

  Insurance covering Hospital's liability arising from or related to this Agreement, with limits of not less than $1 million per claim and $3 million aggregate. Further, Hospital understands and agrees it shall maintain such coverage for a period of not less than three (3) years following this Agreement's expiration, termination or cancellation.

8.31 LICENSES, PERMITS, REGISTRATIONS, ACCREDITATIONS, AND CERTIFICATES

Hospital shall obtain and maintain in effect during the term of this Agreement, all valid licenses, permits, registrations, accreditations, and certificates required by law which are applicable to its performance of this Agreement, and shall ensure that all of its officers, employees, and agents

who perform services hereunder obtain and maintain in effect during the term of this Agreement, all licenses, permits, registrations, accreditations, and certificates required by law which are applicable to their performance of services hereunder. All such licenses, permits, registrations, accreditations, and certifications relating to services hereunder shall be made available to the County upon request.

8.32 INTENTIONALLY OMITTED

8.33 INTENTIONALLY OMITTED

8.34 INTENTIONALLY OMITTED

8.35 INTENTIONALLY OMITTED

8.36 NOTICE OF DISPUTES

Hospital shall bring to the attention of the EMS Agency Director any dispute between the County and the Contractor regarding the performance of services as stated in this Agreement. If the EMS Agency Director is not able to resolve the dispute, the Director or his/her designee shall resolve it.

8.37 NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT

Hospital shall notify its employees, and shall require each Subcontractor to notify its employees, that they may be eligible for the Federal Earned Income Credit under the federal income tax laws. Such notice shall be provided in accordance with the requirements set forth in Internal Revenue Service Notice No. 1015.

8.38 NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY LAW

The Hospital shall notify and provide to its employees, and shall require each Subcontractor to notify and provide to its employees, a fact sheet regarding the Safely Surrendered Baby Law, its implementation in Los Angeles County, and where and how to safely surrender a baby. The fact sheet is set forth in Exhibit I of this Agreement and is also available on the Internet at www.babysafela.org for printing purposes.

8.39 NOTICES

All notices or demands required or permitted to be given or made under this Agreement shall be in writing and shall be hand delivered with signed receipt or mailed by first-class registered or certified mail, postage prepaid, addressed to the parties as identified in Exhibits E - County's Administration

and F - Hospital's Administration. Addresses may be changed by either party giving ten (10) days' prior written notice thereof to the other party.

Electronic Notice: In addition, and in lieu of written notification, the Director, or his/her designee, shall have the authority to issue any notice to Hospital electronically via e-mail at the designated email address as identified in Exhibit F – Hospital's Administration. This includes all notices or demands required or permitted by the County under this Agreement.

8.40 PROHIBITION AGAINST INDUCEMENT OR PERSUASION

Notwithstanding the above, the Hospital and the County agree that, during the term of this Agreement and for a period of one year thereafter, neither party shall in any way intentionally induce or persuade any employee of one party to become an employee or agent of the other party. No bar exists against any hiring action initiated through a public announcement.

8.41 PUBLIC RECORDS ACT

8.41.1 Any documents submitted by the Contractor; all information obtained in connection with the County's right to audit and inspect the Contractor's documents, books, and accounting records pursuant to Sub-paragraph 8.43 - Record Retention of this Agreement; as well as any documents that may have been submitted in response to a solicitation process for this Agreement, become the exclusive property of the County. All such documents become a matter of public record and shall be regarded as public records. Exceptions will be those elements in the California Government Code Section 6250 et seq. (Public Records Act) and which are marked "trade secret", "confidential", or "proprietary". The County shall not in any way be liable or responsible for the disclosure of any such records including, without limitation, those so marked, if disclosure is required by law, or by an order issued by a court of competent jurisdiction.

8.41.2 In the event the County is required to defend an action on a Public Records Act request for any of the aforementioned documents, information, books, records, and/or contents of a proposal marked "trade secret", "confidential", or "proprietary", the Contractor agrees to defend and indemnify the County from all costs and expenses, including reasonable attorney's fees, in an action or liability arising under the Public Records Act.

8.42 PUBLICITY

8.42.1 The Hospital shall not disclose any details in connection with this Agreement to any person or entity except as may be otherwise

provided hereunder or required by law. However, in recognizing the Hospital's need to identify its services and related clients to sustain itself, the County shall not inhibit the Hospital from publishing its role under this Agreement within the following conditions:

- The Hospital shall develop all publicity material in a professional manner; and

- During the term of this Agreement, the Hospital shall not, and shall not authorize another to, publish or disseminate any commercial advertisements, press releases, feature articles, or other materials using the name of the County without the prior written consent of the County's Project Director. The County shall not unreasonably withhold written consent.

8.42.2 The Hospital may, without the prior written consent of County, indicate in its proposals and sales materials and signs that it has been awarded this Agreement with the County of Los Angeles.

8.43 RECORD RETENTION

Hospital shall submit copies of all records and logs pertaining to care of patients with suspected stroke and personnel involved in the care of the stroke patient at the request of representatives of the EMS Agency. Records obtained from Hospital may be used for, but are not limited to, audit, investigation, statistical analysis or education. Representatives of the EMS Agency shall comply with all applicable State and federal laws relating to confidentiality and shall maintain the confidentiality of all records and logs submitted in compliance with this subparagraph.

Hospital shall retain the receiving hospital copy of the EMS Report Form for a minimum of seven (7) years and include such reports with patient charts for patients brought to Hospital as part of the EMS system. Such records, if for a minor, shall be retained for a minimum of seven (7) years, or one (1) year past the age of majority, whichever is greater.

8.44 RECYCLED BOND PAPER

Consistent with the Board of Supervisors' policy to reduce the amount of solid waste deposited at the County landfills, the Hospital agrees to use recycled-content paper to the maximum extent possible on this Agreement.

8.45 RESTRICTIONS ON LOBBYING

If any Federal funds are to be used to pay for the Contractor's services under this Agreement, the Contractor shall fully comply with all certification and disclosure requirements prescribed by Section 319 of Public Law 101-121 (31 United States Code Section 1352) and any implementing regulations,

and shall ensure that each of its subcontractors receiving funds provided under this Agreement also fully complies with all such certification and disclosure requirements.

8.46 INTENTIONALLY OMITTED

8.47 SURVIVAL

In addition to any provisions of this Agreement which specifically state that they will survive the termination or expiration of this Agreement and any rights and obligations under this Agreement which by their nature should survive, the following Sub-paragraphs shall survive any termination or expiration of this Agreement:

Sub-paragraph 7.3 (Confidentiality)

Sub-paragraph 8.7 (Compliance with Applicable Laws, Rules and Regulations

Sub-paragraph 8.25 (Governing Law, Jurisdiction, and Venue)

Sub-paragraph 8.28 (Indemnification)

Sub-paragraph 8.29 (General Provisions for all Insurance Coverage)

Sub-paragraph 8.30 (Insurance Coverage)

Sub-paragraph 8.43 (Record Retention)

Sub-paragraph 8.47 (Survival)

8.48 TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM

Failure of the Hospital to maintain compliance with the requirements set forth in sub-paragraph 8.16 - Hospital's Warranty of Adherence to County's Child Support Compliance Program, shall constitute default under this Agreement. Without limiting the rights and remedies available to the County under any other provision of this Agreement, failure of the Hospital to cure such default within ninety (90) calendar days of written notice shall be grounds upon which the County may terminate this Agreement pursuant to sub-paragraph 8.51 - Termination for Default and pursue debarment of the Hospital, pursuant to County Code Chapter 2.202.

8.49 TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM

Failure of the Contractor to maintain compliance with the requirements set forth in Sub-paragraph 8.17 - Contractor's Warranty of Compliance with County's Defaulted Property Tax Reduction Program shall constitute default under this Agreement. Without limiting the rights and remedies available to the County under any other provision of this Agreement, failure of the Contractor to cure such default within ten (10) days of notice shall be grounds upon which the County may terminate this Agreement and/or pursue debarment of the Contractor, pursuant to County Code Chapter 2.206.

8.50 TERMINATION FOR CONVENIENCE

The EMS Agency may elect to restructure the CSS as it deems necessary in accordance with paragraphs 6.3 and 6.4 of Exhibit A, Statement of Work.

8.51 TERMINATION FOR DEFAULT

8.51.1 The County may, by written notice to the Hospital, terminate the whole or any part of this Agreement, if, in the judgment of the Director or his/her designee:

- Hospital has materially breached a requirement under this Agreement; or
- Hospital fails to obtain Thrombectomy-Capable Stroke Center certification from a certifying body acceptable to the EMS Agency, within one (1) year from the time the final release of the Thrombectomy-Capable Stroke Center Certification Standards; or
- Hospital fails to timely provide and/or satisfactorily perform any task, deliverable, service, maintain Comprehensive Stroke Center or Thrombectomy-Capable Stroke Center certification, or other work required under this Agreement; or
- Hospital fails to demonstrate a high probability of timely fulfillment of performance requirements under this Agreement, or of any obligations of this Agreement and in either case, fails to demonstrate convincing progress toward a cure within five (5) working days (or such longer period as the County may authorize in writing) after receipt of written notice from the County specifying such failure; or

- Hospital expressly repudiates this Agreement by an unequivocal refusal to perform.

In the event the County intends to terminate this Agreement in accordance with Paragraph 8.51, it shall give thirty (30) days' notice to the Hospital that it is in material breach and/or anticipatory breach of the Agreement. In the notice of intended termination, the Director shall set forth the facts underlying its claim that the Hospital is in material breach and/or anticipatory breach. Remedy of the breach or convincing progress towards a cure within twenty (20) days (or such longer period as the County may authorize in writing) of receipt of said notice shall revive the Agreement in effect for the remaining term.

8.51.2 In the event that the County terminates this Agreement in whole or in part as provided in sub-paragraph 8.51.1, the County may procure, upon such terms and in such manner as the County may deem appropriate, goods and services similar to those so terminated. The Hospital shall be liable to the County for any and all excess costs incurred by the County, as determined by the County, for such similar goods and services. The Hospital shall continue the performance of this Agreement to the extent not terminated under the provisions of this sub-paragraph. The parties agree that the Hospital's liability to the County for excess costs described under this sub-paragraph 8.51.2 shall be limited to excess costs incurred for the twelve (12) months following the County's termination of this Agreement or the remaining period of this Agreement after breach, whichever time period is less.

8.51.3 Except with respect to defaults of any subcontractor, the Hospital shall not be liable for any such excess costs of the type identified in sub-paragraph 8.51.2 if its failure to perform this Agreement arises out of causes beyond the control and without the fault or negligence of the Hospital. Such causes may include, but are not limited to: acts of God or of the public enemy, acts of the County in either its sovereign or Contractual capacity, acts of Federal or State governments in their sovereign capacities, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, and unusually severe weather; but in every case, the failure to perform must be beyond the control and without the fault or negligence of the Hospital. If the failure to perform is caused by the default of a subcontractor, and if such default arises out of causes beyond the control of both the Hospital and subcontractor, and without the fault or negligence of either of them, the Hospital shall not be liable for any such excess costs for failure to perform, unless the goods or services to be furnished by the subcontractor were obtainable from other sources in sufficient time to permit the Hospital to meet the

required performance schedule. As used in this sub-paragraph, the term "subcontractor(s)" means subcontractor(s) at any tier.

8.51.4 If, after the County has given notice of termination under the provisions of this sub-paragraph 8.51, it is determined by the County that the Hospital was not in default under the provisions of this sub-paragraph 8.51, or that the default was excusable under the provisions of Sub-paragraph 8.51.3, the rights and obligations of the parties shall be the same as if the notice of termination had been issued pursuant to sub-paragraph 8.50 - Termination for Convenience.

8.51.5 The rights and remedies of the County provided in this sub-paragraph 8.51 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

8.52 TERMINATION FOR IMPROPER CONSIDERATION

8.52.1 The County may, by written notice to the Hospital, immediately terminate the right of the Hospital to proceed under this Agreement if it is found that consideration, in any form, was offered or given by the Hospital, either directly or through an intermediary, to any County officer, employee, or agent with the intent of securing this Agreement or securing favorable treatment with respect to the award, amendment, or extension of this Agreement or the making of any determinations with respect to the Hospital's performance pursuant to this Agreement. In the event of such termination, the County shall be entitled to pursue the same remedies against the Hospital as it could pursue in the event of default by the Hospital.

8.52.2 The Hospital shall immediately report any attempt by a County officer or employee to solicit such improper consideration. The report shall be made either to the County manager charged with the supervision of the employee or to the County Auditor-Controller's Employee Fraud Hotline at (800) 544-6861 or www.lacountyfraud.org.

8.52.3 Among other items, such improper consideration may take the form of cash, discounts, service, the provision of travel or entertainment, or tangible gifts.

8.53 TERMINATION FOR INSOLVENCY

8.53.1 The County may terminate this Agreement forthwith in the event of the occurrence of any of the following:

- Insolvency of the Hospital. The Hospital shall be deemed to be insolvent if it has ceased to pay its debts for at least sixty (60) days in the ordinary course of business or cannot pay its debts as they become due, whether or not a petition has been filed under the Federal Bankruptcy Code and whether or not the Hospital is insolvent within the meaning of the Federal Bankruptcy Code;

- The filing of a voluntary or involuntary petition regarding the Hospital under the Federal Bankruptcy Code;

- The appointment of a Receiver or Trustee for the Hospital; or

- The execution by the Hospital of a general assignment for the benefit of creditors.

8.53.2 The rights and remedies of the County provided in this sub-paragraph 8.53 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

8.54 TERMINATION FOR NON-ADHERENCE OF COUNTY LOBBYIST ORDINANCE

The Hospital, and each County Lobbyist or County Lobbying firm as defined in County Code Section 2.160.010 retained by the Hospital, shall fully comply with the County's Lobbyist Ordinance, County Code Chapter 2.160. Failure on the part of the Hospital or any County Lobbyist or County Lobbying firm retained by the Hospital to fully comply with the County's Lobbyist Ordinance shall constitute a material breach of this Agreement, upon which the County may in its sole discretion, immediately terminate or suspend this Agreement.

8.55 INTENTIONALLY OMITTED

8.56 TIME OFF FOR VOTING

The Contractor shall notify its employees, and shall require each subcontractor to notify and provide to its employees, information regarding the time off for voting law (Elections Code Section 14000). Not less than 10 days before every statewide election, every Contractor and subcontractors shall keep posted conspicuously at the place of work, if practicable, or elsewhere where it can be seen as employees come or go to their place of work, a notice setting forth the provisions of Section 14000.

8.57 INTENTIONALLY OMITTED

8.58 VALIDITY

If any provision of this Agreement or the application thereof to any person or circumstance is held invalid, the remainder of this Agreement and the application of such provision to other persons or circumstances shall not be affected thereby.

8.59 WAIVER

No waiver by the County of any breach of any provision of this Agreement shall constitute a waiver of any other breach or of such provision. Failure of the County to enforce at any time, or from time to time, any provision of this Agreement shall not be construed as a waiver thereof. The rights and remedies set forth in this sub-paragraph 8.59 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

8.60 WARRANTY AGAINST CONTINGENT FEES

8.60.1 The Hospital warrants that no person or selling agency has been employed or retained to solicit or secure this Agreement upon any Agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by the Hospital for the purpose of securing business.

8.60.2 For breach of this warranty, the County shall have the right to terminate this Agreement and, at its sole discretion, deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, brokerage, or contingent fee.

8.61 COMPLIANCE WITH COUNTY'S ZERO TOLERANCE POLICY ON HUMAN TRAFFICKING

8.61.1 Hospital acknowledges that the County has established a Zero Tolerance Policy on Human Trafficking prohibiting Contractors from engaging in human trafficking.

8.61.2 If a Contractor or member of Hospital's staff is convicted of a human trafficking offense, the County shall require that Hospital or member of Hospital's staff be removed immediately from performing services under this Agreement. The County will not be under any obligation to disclose confidential information regarding the offenses other than those required by law.

8.61.3 Disqualification of any member of Hospital's staff pursuant to this Sub-paragraph shall not relieve Hospital of its obligation to

complete all work in accordance with the terms and conditions of this Agreement.

9.0 UNIQUE TERMS AND CONDITIONS

9.1 DUE PROCESS

9.1.1 Notice of Proposed Adverse Action: In all cases in which the EMS Agency has the authority to, and pursuant to this authority, take any of the actions constituting grounds for hearing as set forth in Paragraph 9.1.2, Hospital shall promptly be given written notice of the specific charges and factual basis upon which the EMS Agency action is based. The Director may implement an interim order of suspension pending the exhaustion of Hospital's due process right provided herein. Hospital shall be afforded its due process right to a hearing before implementation of any of the actions which constitute grounds for a hearing. Hospital shall have thirty (30) calendar days following the receipt of such notice within which to file with Director a written request for hearing before the EMS Commission (EMSC).

9.1.2 Grounds for Hearing: Any one or more of the following actions constitute grounds for a hearing before the EMSC (EMSC hearing):

1) Suspension

2) Suspension with intent to terminate

3) Termination for cause

9.1.3 Suspension or Suspension with Intent to Terminate: In the case of suspensions or suspensions with intent to terminate, Hospital, at its election, shall have the right to request Director in writing to reconsider the suspension action. Director shall act on this request for reconsideration within ten (10) calendar days after the receipt of the reconsideration request. Hospital shall be given an opportunity to meet with Director. The meeting shall not be a full hearing but is intended to identify the alleged basis for the action.

Within ten (10) calendar days following the meeting with Director, Director shall issue to Hospital a written recommendation regarding the suspension. The Director may recommend that the suspension be continued for a particular time or upon particular conditions, that Hospital's agreement be terminated, that other conditions be imposed on Hospital, that the suspension is not warranted and abate the Notice of Proposed Adverse Action, or take such other action as may be deemed warranted. If Director recommends any

action other than immediate return of Hospital to unsuspended status, Hospital may request a hearing on the suspension before the EMSC, as provided in this Paragraph. Such request shall be in writing and addressed to Director. Any such request shall be delivered within five (5) calendar days after the Director's delivery of his/her written recommendation to Hospital.

9.1.4 Time and Place of Hearing: Director shall, within fifteen (15) calendar days of receipt of a Hospital's request for hearing as set forth above, apply to the EMSC for such hearing. Director shall give notice to Hospital of the time, place, and date of the hearing in accordance with EMSC rules and procedures. The date of commencement of the hearing shall be not less than thirty (30) calendar days, nor more than ninety (90) calendar days from the receipt of the request for hearing, subject to the convenience of the EMSC. However, if the request is received from Hospital when under a suspension then in effect, Director shall attempt to arrange a hearing before the EMSC as soon as possible. In situations involving a suspension, Director shall use his/her best efforts to schedule a hearing within forty-five (45) calendar days of receipt of a request for hearing.

9.1.5 Notice of Charges: As part of, or together with the notice of hearing, Director shall state in writing, in concise language, the acts or omissions with which Hospital is charged or reasons for substantial operational change or restructuring. If either party, by written notice, requests a list of individuals who will appear on behalf of the other, then each party within ten (10) calendar days of such request shall furnish to the other a list, in writing, of the names and addresses of the individuals, so far as is then reasonably known, who will give testimony or evidence in support of that party at the hearing.

9.1.6 Hearing Procedure: At the hearing, subject to the rules of the EMSC, both sides shall have the following rights: to call and examine witnesses, to introduce exhibits, and to rebut any evidence. The EMSC may question witnesses.

9.1.7 Memorandum of Points and Authorities: Subject to the rules of EMSC, each party shall have the right to submit to the EMSC a memorandum of points and authorities.

9.1.8 Basis of Decision: Subject to the rules of the EMSC, the EMSC decision on a hearing under this Agreement shall be based upon the evidence produced at the hearing. The evidence may consist of the following:

1) Oral testimony of the parties' representatives;

2) Documentary evidence introduced at the hearing;

3) Briefs or memoranda of points and authorities presented in connection with the hearing;

4) Policies and procedures of the EMS Agency; and

5) All officially noticed matters.

9.1.9 Record of Hearing: The parties understand that the EMSC maintains a record of hearings by one or more of the following methods: a shorthand reporter, an audio or disc recording, or by its clerk's minutes of the proceedings. If a shorthand reporter is specifically requested in writing by Hospital or by Director, the costs of same shall be borne by such party. The parties understand that the EMSC may, but shall not be required to, order that oral evidence shall be taken only by oath or affirmation administered by any person designated by such body and entitled to notarize documents in the State of California.

9.1.10 Decision of the EMSC: The decision of the EMSC shall be effective and binding on the parties to the extent permitted and prescribed in County Code Section 3.20.070 B.

9.2 RESPONSIBILITY FOR INDIGENT PATIENTS

Nothing contained in this Agreement is intended nor shall it be construed to affect either party's existing rights, obligations, and responsibilities with respect to care required by or provided to indigent patients.

/

/

/

/

/

/

/

/

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Agreement to be executed by its Director of Health Services and the Hospital has caused this Agreement to be executed on its behalf by its duly authorized officers, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By: REDACTED for

Christina R. Ghaly, M.D.
Acting Director of Health Services

PASADENA MEMORIAL HOSPITAL
DBA HUNTINGTON MEMORIAL HOSPITAL

By: REDACTED

Signature

Gloria Sanchez-Rico
Printed Name

VP, CNE
Title

APPROVED AS TO FORM:

MARY C. WICKHAM
County Counsel

By: REDACTED

Brian T. Chu, Principal Deputy County Counsel

AGREEMENT FOR
COMPREHENSIVE STROKE SYSTEM

TABLE OF CONTENTS OF EXHIBITS

STANDARD EXHIBITS

A STATEMENT OF WORK

B INTENTIONALLY OMITTED

C INTENTIONALLY OMITTED

D HOSPITAL'S EEO CERTIFICATION

E COUNTY'S ADMINISTRATION

F HOSPITAL'S ADMINISTRATION

G HOSPITAL ACKNOWLEDGEMENT AND CONFIDENTIALITY AGREEMENT

H INTENTIONALLY OMITTED

I SAFELY SURRENDERED BABY LAW

EXHIBIT A

STATEMENT OF WORK

TABLE OF CONTENTS

SECTION	TITLE	PAGE
1.0	SCOPE OF WORK	1
2.0	DEFINITIONS	1
3.0	ADDITION AND/OR CHANGES TO CSS(S), SPECIFIC TASKS AND/OR DATA REQUIREMENTS	1
4.0	RESPONSIBILITIES – HOSPITAL	1
4.1	Project Manager	2
4.2	Personnel	2
4.3	Materials and Equipment	4
4.4	General Requirements	4
4.5	Data Collection	4
4.6	Program Monitoring	6
4.7	Written Transfer Agreement	7
4.8	Written Transportation Agreement	8
4.9	Telemedicine Capabilities	8
4.10	Quality Improvement (QI)	8
4.11	Stroke Certification	9
4.12	Ambulance Patient Offload Time	9
4.13	Community Education Programs	9
4.14	Contractor's Office	9
5.0	QUALITY CONTROL	9
6.0	RESPONSIBILITIES – COUNTY	10
6.1	Personnel	10
6.2	Policies, Procedures, and Protocols	10
6.3	Interim CSS Re-Configuration	10
6.4	CSS Configuration	11
6.5	Data Management	11
6.6	Staff Designation	11

Attachment A.1 – Intentionally Omitted

Attachment A.2 – Procedure for Non-Compliance with Data Collection Requirements

EXHIBIT A

STATEMENT OF WORK

1.0 SCOPE OF WORK

The Comprehensive Stroke System (CSS) will be comprised of Comprehensive Stroke Centers (CSCs) and Thrombectomy-Capable Stroke Centers (TSCs) to provide acute care for suspected stroke patients in Los Angeles County (County) who access the 9-1-1 system for emergency medical care. Implementation of the CSS will facilitate the EMS Agency's implementation of higher-level standards for the CSCs and TSCs to provide neurosurgery and/or thrombectomy procedures and improve outcomes for patients suffering the debilitating effects of stroke. These higher-level standards are designed to improve stroke patient care while enabling both the Hospitals and the Los Angeles County (County) to better target and track the affected population and meet the guidelines developed by the American Heart Association/American Stroke Association.

2.0 DEFINITIONS

Throughout this Statement of Work (SOW), references are made to certain persons, groups, or departments/agencies. For convenience, specific terms and definitions can be found in the Agreement, Paragraph 2.0 Definitions.

3.0 ADDITION AND/OR CHANGES TO CSS(S), SPECIFIC TASKS AND/OR DATA REQUIREMENTS

3.1 The EMS Agency may elect to restructure the CSS as it deems necessary in accordance with Paragraphs 6.3 and 6.4 of this Exhibit A, SOW.

3.2 All changes must be made in accordance with Paragraph 8.0, Standard Terms and Conditions, Sub-paragraph 8.1, Amendments, of the Agreement.

4.0 RESPONSIBILITIES - HOSPITAL

4.1 Project Manager

4.1.1 Contractor shall provide a full-time Project Manager or designated alternate. County must have access to the Project Manager during all hours, 365 days per year. Contractor shall provide a telephone number where the Project Manager may be reached on a twenty-four (24) hour per day basis.

4.1.2 Project Manager shall act as a central point of contact with the County.

4.1.3 Project Manager/alternate shall have full authority to act for Hospital on all matters relating to the daily operation of the Agreement. Project Manager/alternate shall be able to effectively communicate, in English, both orally and in writing.

4.2 Personnel

4.2.1 Hospital shall assign a sufficient number of employees to perform the required work. **At least one employee on site shall be authorized to act for Contractor in every detail and must speak and understand English.**

4.2.2 Stroke Program Medical Director

Hospital shall designate a physician on Hospital staff to direct and coordinate the functions of the CSC or TSC (including without limitation, the quality improvement program for the services provided herein), and to ensure compliance with policies, procedures, and protocols established by the EMS Agency. This physician, who shall have the title of "Stroke Program Medical Director", shall:

1) Be a licensed physicien in the State of California.

2) Be Board Certified in Neurology or Neurosurgery by the American Board of Psychiatry and Neurology; or the American Board of Neurological Surgery by the American Board of Medical Specialties.

3) Be privileged by Hospital in interventional procedures according to their specialty.

4) Provide medical oversight and ongoing performance of stroke quality improvement (QI) programs and adherence to the requirements of this Agreement.

5) Participate in the Hospital Stroke Committee and other committees associated with stroke care.

6) Collaborate with the Stroke Program Manager to ensure adherence to the Stroke Receiving Center Standards and provisions set forth in the Los Angeles County Prehospital Care Manual.

7) Act as a liaison with hospital administration, Stroke Program Manager, Medical and Clinical Staff across stroke patient's continuums of care.

8) Attend 100% of EMS Agency Stroke Center Advisory Committee. Fifty percent (50%) of meetings may be attended by an alternate physician, who is involved in Hospital's stroke program.

9) Ensure continued certification as a CSC or TSC by a certifying body deemed acceptable by Los Angeles County EMS Agency.

4.2.3 Hospital Staff Physicians

1) Hospital shall have a dedicated on-call endovascular neurosurgeon, neurointensivist, neurologist, and interventional neuroradiologist. These physicians cannot be concurrently on-call at any other hospital or specialty service (e.g. trauma).

2) Hospital shall have a neurosurgeon with expertise in cerebrovascular/ endovascular surgery to perform on-site surgical interventions. Neurosurgery must be available within 30 minutes, 24 hours per day and 7 days per week. These physicians cannot be concurrently on-call at any other hospital or specialty service (e.g. trauma).

4.2.4 Stroke Program Manager

1) Hospital shall designate a Stroke Program Manager who shall:

a) Be responsible for managing all CSC activities sponsored by Hospital to ensure compliance with this Agreement, and policies, procedures and protocols established by the EMS Agency.

b) Be a licensed Registered Nurse (RN) in the State of California.

c) Be knowledgeable in critical care and interventional stroke care procedures.

d) Collaborate with the Stroke Program Medical Director to ensure development of stroke care policies, procedures, and protocols.

e) Maintain up-to-date continuous stroke QI program and disseminating EMS Agency reports to pertinent program participants.

f) Participate in Hospital Stroke Committee and other committees associated with stroke care.

g) Ensure compliance with data collection requirements.

h) Attend 100% of EMS Agency Stroke Center Advisory Committee. Fifty percent (50%) of meetings may be attended by an alternate RN, who is involved in Hospital's stroke program.

i) Collaborate with the emergency department to ensure processes are in place to capture patients transported

to the Stroke Center by EMS providers or other acute care hospitals.

j) Develop relationships and collaborating with surrounding Primary Stroke Centers and Stroke Referral Facilities to facilitate interfacility transfers.

k) Assure stroke diversion is appropriate and processes are in place to minimize the need for diversion.

l) Collaborate with the Stroke Program Medical Director to ensure continued certification as a CSC or TSC by a certifying body deemed acceptable by Los Angeles County EMS Agency.

4.3 Materials and Equipment

The purchase of all materials/equipment to provide the needed services is the responsibility of the Hospital. Hospital shall use materials and equipment that are safe for the environment and safe for use by the employee.

4.4 General Requirements

4.4.1 Hospital shall comply with all the requirements specified in the Los Angeles County EMS Agency Stroke Standards.

4.4.2 Hospital shall publicly report outcomes related to interventional procedures, as determined by the Hospital

4.4.3 Hospital shall participate in the ReddiNet® and VMED28 communication systems.

4.4.4 Hospital shall have a dedicated telephone line to facilitate direct communication with EMS personnel, paramedic base hospitals and the Medical Alert Center.

4.4.5 Hospital shall implement and monitor the policies and procedures of the EMS Agency related to the services performed by Hospital under this Agreement.

4.4.6 Hospital administration, medical staff and hospital staff shall meet the requirements under applicable State regulations and the EMS Agency's policies and procedures for the provision of services under this Agreement.

4.5 Data Collection

4.5.1 Hospital shall collect and submit patient level data as specified in the most current version of the Prehospital Care Manual Reference No. 650, Stroke Center Data Dictionary.

4.5.2 Data collection shall be conducted through: 1) Los Angeles County Stroke Center Database or 2) Get With The Guidelines®-Stroke registry. Hospital shall only utilize one system and not a combination of both systems.

4.5.3 Hospital shall comply with all changes or modifications in the data collection process identified by the EMS Agency. All modifications or request for additional data identified by the EMS Agency must first be reviewed by the Stroke Center Advisory Committee.

4.5.4 Hospital shall submit stroke patient data within sixty (60) calendar days following patient discharge to hospital.

4.5.5 Hospital shall submit a monthly tally of newly diagnosed stroke patients to the EMS Agency by the end of the month for the previous month (For example: January tally is due February 28th).

4.5.6 Hospital must maintain a minimum 90% compliance for:

1) Capture of patients meeting the inclusion criteria for data collection

2) Data field completion

3) Data field accuracy

4) Timely data collection

5) Timely tally submission

4.5.7 Hospital shall collect stroke data on all patients who are initially identified in the prehospital setting by EMS or transported by EMS and identified in the emergency department as meeting one or more of the following:

1) Treated under Prehospital Care Manual Policy Reference No. 1251, Treatment Protocol: Stroke/Acute Neurological Deficits;

2) Final hospital (if admitted) or emergency department (if not admitted) diagnosis of ischemic stroke, transient ischemic attack, intracerebral hemorrhage, intraventricular hemorrhage, or subarachnoid hemorrhage;

3) Transported to CSC or TSC for acute stroke care either primarily by 9-1-1 or interfacility transport; or

4) Transferred from another acute care facility to the CSC or TSC for acute stroke care.

4.5.8 Hospital shall seek assistance from County's Project Manager or designee, whenever County's Stroke Center Database application is not functioning correctly.

4.5.9 Hospital shall assign adequate data collection personnel, who will work collaboratively with Emergency Department personnel, to assure capture and entry of patient stroke data on an ongoing basis. Hospital shall identify qualified back-up personnel, excluding Stroke Program Manager, to collect data, as reasonably appropriate for Hospital to meet Hospital's data collection responsibilities described herein. Furthermore, Hospital shall permit adequate time for complete training of such personnel. Arrangements for training of new or replacement Hospital personnel shall be the primary responsibility of Hospital.

4.5.10 Patient Outcome:

Hospital shall provide the EMS Agency patient outcome of ALL patients transported to the Hospital via the 9-1-1 system. Outcome data shall include all variables listed in the most current 9-1-1 Receiving Hospital Data Dictionary. Outcome data shall be provided utilizing the EMS Agency online data collection tool.

4.5.11 Non-Compliance with Data Collection Requirements:

Procedures for non-compliance of data collection requirements shall be in accordance with Attachment A.2 – Procedure for Non-Compliance with Data Collection Requirements.

4.6 Program Monitoring

4.6.1 Hospital extends to County the right to monitor Hospital's programs and procedures with respect to this Agreement, and to inspect its facilities for contractual compliance with State and EMS Agency policies, procedures, protocols, and regulations.

4.6.2 Program Review

At minimum, program review shall be conducted by EMS Agency every three (3) years to ensure compliance with State and EMS Agency policies, procedures, protocols, and regulations. Hospital shall be given no less than ten (10) calendar days' notice in advance of said review. Hospital's director of utilization review and director of medical records shall be permitted to participate in the review and Hospital and its staff shall fully cooperate with EMS Agency representatives. In the conduct of such audit and review, Hospital shall allow such EMS Agency representatives access to all reports, audio recordings, medical records, and other reports pertaining to this Agreement, and shall allow photocopies to be made of these documents, utilizing Hospital's photocopier.

4.6.3 Focus Reviews

Notwithstanding the above program reviews, County reserves the right to conduct focus reviews due to complaints, failure to meet data requirement, or other term of the Agreement by EMS Agency representatives during County's normal business hours and only after County has given Hospital at least three (3) working days prior written notice thereof. In computing the three (3) working days, a Saturday, Sunday, or legal holiday shall not be included. Said notice need not be given where County determines that the health and welfare of patients may be jeopardized by waiting the three-day period.

4.6.4 Exit Conference for Program Reviews and Focus Reviews

An exit conference shall be held following the performance of program reviews or focus reviews by EMS Agency representatives and results of the program review or focus review shall be discussed with Hospital's Administrator or his or her authorized designee prior to the generation of any final written report or action by Director, or designee, or other EMS Agency representatives based on such review. The exit conference shall be held on site prior to the departure of the reviewers and Hospital shall be provided with an oral or written list of preliminary findings at the exit conference. A written report of the program monitoring review shall be prepared and provided to Hospital. Hospital shall permit periodic unscheduled site visits by EMS Agency representatives for monitoring stroke diversion status, quality improvement and/or continuing education programs and stroke care meetings.

4.7 Written Transfer Agreements

4.7.1 Hospital shall have written transfer agreements with its Stroke Referral Facilities, including but not limited to Primary Stroke Centers. Written transfer agreements shall include, at a minimum, the following:

1) List the specific responsibilities of the CSC or TSC and the Stroke Referral Facility;

2) Notification procedures including communication between facilities at the physician and nursing level;

3) Patient care procedures prior to the transfer of the patient;

4) Process to provide copies of all medical records and imaging to the receiving facility;

5) Notification of transport agency, unit and transport team;

4.7.2 Hospital shall have a written transfer agreement with at least one other CSC that includes the following:

1) Contact names;

2) Contact phone numbers; and

3) Allows for timely transfer 24 hours a day, 7 days a week

4.8 Written Transportation Agreements

Hospital shall have written transportation agreements with transport agency/private ambulance companies licensed in Los Angeles County to ensure timely transport of patient occurs. Written agreements shall include provisions to ensure the type of transport vehicle (Ambulance) and appropriate level of transport medical personnel (advanced life support: e.g., paramedic, nurse, physician) is available at the Stroke Referral Facility within 60 minutes, 24 hours per day and 7 days per week. Utilization of the 9-1-1 system to conduct interfacility transports of stroke patients is not acceptable.

4.9 Telemedicine Capabilities

Hospital shall have telemedicine capabilities to deliver health care services and clinical information to Stroke Referral Facilities. This includes a wide array of clinical services using internet, wireless, satellite and telephone media.

4.10 Quality Improvement (QI)

4.10.1 Hospital shall have a current comprehensive stroke care QI plan approved by the EMS Agency and ensure participation in the EMS Agency's system-wide QI program by designating a representative for the meetings.

4.10.2 Hospital shall have a process developed, with input from the stroke center medical director, Hospital physician staff, stroke nurses, paramedics, and Hospital administration to:

1) Identify important aspects of stroke care issues.

2) Identify indicators for those important aspects.

3) Evaluate the stroke care and service, including trends, to identify opportunities for improvement.

4) Take action to improve care and service, or to solve problems, and evaluate the effectiveness of those actions.

4.10.3 Hospital shall also participate in the EMS Agency's QI Program, with records provided by Hospital in accordance with the terms of this Agreement.

4.10.4 Hospital shall develop a comprehensive-multidisciplinary QI Committee which shall include at minimum; EMS, emergency department, nursing, intensive care, neurology, neurosurgery and neuroradiology.

4.11 Stroke Certification

Hospital shall provide the EMS Agency results of the subsequent certification review(s) conducted by the certifying body, which shall include but not limited to, action plans to correct any identified issue(s) and final approval by the certifying body showing compliance with all requirements.

4.12 Ambulance Patient Offload Time

Hospital will be placed on diversion to stroke patients if three ambulance units from the same emergency medical services provider have been waiting to offload more than 30 minutes.

4.13 Community Education Programs

Hospital shall offer at least two annual programs to educate the public about stroke prevention, diagnosis and/or the availability of acute therapies. Community education programs are designed to be delivered through various means to address:

1) Risk factors, signs and symptoms for stroke or other cardiovascular diseases.

2) General prevention efforts that target smoking cessation, obesity and diabetes.

3) Management of hypertension, lipid levels, atrial fibrillation and medication adherence.

4) Other issues as identified by Hospital.

4.14 Contractor's Office

Contractor shall maintain an office with a telephone in the company's name where Contractor conducts business. The office shall be staffed during the hours of 8:00 a.m. to 5:00 p.m., Monday through Friday, by at least one employee who can respond to inquiries and complaints which may be received about the Contractor's performance of the Agreement.

5.0 QUALITY CONTROL

The Contractor shall establish and utilize a comprehensive Quality Control Plan (Plan) to assure the County a consistently high level of service throughout the term of the Agreement. The Plan shall be submitted to the Facility Project Monitor for review and approval. The Plan shall include, but may not be limited to the following:

5.1 Method of monitoring to ensure that Agreement requirements are being met.

5.2 A record of all inspections conducted by the Contractor, any corrective action taken, the time a problem was first identified, a clear description of the problem, and the time elapsed between identification and completed corrective action, shall be provided to the County upon request.

6.0 RESPONSIBILITIES - COUNTY

6.1 Personnel

The County will administer the Agreement according to the Agreement, Paragraph 6.0, Administration of Agreement - County. Specific duties will include:

6.1.1 Monitoring Hospital's performance in the daily operation of this Agreement.

6.1.2 Preparing Amendments in accordance with the Agreement, Paragraph 8.0, Standard Terms and Conditions, Sub-paragraph 8.1 Amendments.

6.2 Policies, Procedures, and Protocols

6.2.1 Maintain policies, procedures, and protocols consistent with State and County laws, regulations, and standards to assure adequate access and provision of stroke care.

6.2.2 Review and revise policies, at minimum, every three years; more frequently as needed.

6.2.3 Make available to Hospital a complete manual containing all policies, procedures, and protocols which the EMS Agency currently considers to be applicable to participants in the CSS.

6.3 Interim CSS Re-Configuration

County may, on an interim basis, re-configure the CSS as it deems necessary in those instances when a designated CSC or TSC gives notice that it is withdrawing from the CSS or when a designated CSC or TSC is suspended or terminated from the CSS. In the event that an interim re-configuration occurs, Hospital, if affected by the re-configuration, shall be given the immediate opportunity to provide written and oral statements to the Director, or designee and shall be provided with the "due process" procedures specified in Paragraph 9.1, Due Process of the Agreement. Nothing herein however, is intended to prevent implementation by Director, or designee, on an emergency basis of such changes as he/she may find measurably necessary to preserve the integrity of the CSS and to protect the health and safety of County residents.

6.4 CSS Configuration

County shall notify Hospital of proposals for substantial operational or structural changes in the components of the CSS or in the overall operation or configuration of such system. This shall include, but not be limited to, decreasing the number of hospitals in the event that a re-configuration of the CSS is deemed necessary. In the event the number of hospitals is decreased, and unless otherwise agreed upon by the parties, written notice shall be given to Hospital at least sixty (60) calendar days prior to the effective date of any resulting substantial operational or structural changes to the CSS. If the need for Hospital to serve as a CSC or TSC can no longer be substantiated, Hospital, upon request, shall be provided with "due process" as specified in Paragraph 9.1, Due Process of the Agreement.

6.5 Data Management

6.5.1 County, after consultation with and advice from the Stroke Center Advisory Committee, and its bylaws, if duly constituted, shall continue maintenance of a Stroke Center Database.

County Stroke Center Database includes:

1) Stroke Center Data Dictionary

2) Los Angeles County online data collection software

3) Data use agreement with Get With The Guidelines®-Stroke to provide the EMS Agency Hospital-Identified Limited Data Set via an online System Report/Downloader

6.6 Staff Designation

The EMS Agency shall assign staff to provide direction and review, monitor, communicate and coordinate matters affecting the CSS under the jurisdiction of the EMS Agency. EMS staff shall periodically attend Hospital's meetings related to the CSS and shall perform contract compliance reviews as specified in this Agreement.

Attachment A.1

INTENTIONALLY OMITTED

PROCEDURE FOR NON-COMPLIANCE WITH DATA COLLECTION REQUIREMENTS

Month	Action 1	Audit Result	Action 2
1st	Hospital starts data collection and submission of variables contained in the Stroke Data Dictionary on all patients that meet inclusion criteria occurring in the 1st month.		
2nd	Hospital starts data collection and submission of variable contained in the Stroke Data Dictionary on all patients that meet inclusion criteria occurring in the 2nd month.		
3rd	EMS Agency reviews Hospital's 1st month data compliance	Hospital does not meet 90% compliance in: 1. Submitting required stroke data within sixty (60) calendar days of patient admission 2. Submitting accurate and valid data on all mandatory data fields. 3. Submitting monthly tally by the end of the month for the previous month	EMS Agency notifies Hospital's Stroke Program Manager, via email or telephone, of audit results, requests corrective action plan and assists in determining solutions.
4th	EMS Agency reviews Hospital's 2nd month data compliance	No significant improvement Significant Improvement	EMS Agency sends a written notice to Hospital administrator who oversees the Stroke Program notifying them of audit results and continued non-compliance. Monitor
5th	EMS Agency reviews Hospital's 3rd month data compliance	No significant improvement Significant Improvement	EMS Agency notifies Hospital's Stroke Program Manager in writing of audit results and request to submit within 15 calendar days a plan to correct deficiency. Monitor

Month	Action 1	Audit Result	Action 2
6th	EMS Agency reviews Hospital's 4th month data compliance	No significant improvement	Within 15 days of County's receipt of Hospital's plan, the County will provide Hospital a written approval or request additional modifications to Hospital's plan.
		Significant improvement	Monitor
7th	EMS Agency reviews Hospital's 5th month data compliance	No significant improvement	County will notify Hospital CEO in writing of continued non-compliance and advise that a penalty will be assessed if compliance is not improved.
		Significant Improvement	Monitor
8th	EMS Agency reviews Hospital's 6th month data compliance	No significant improvement	County will assess $2,600 penalty for non-compliance
		Improvement based on approved corrective action plan	Monitor
9th	EMS Agency reviews Hospital's 7th month data compliance	No significant improvement	Still non-compliant
		Improvement based on approved corrective action plan	Monitor
10th	EMS Agency reviews Hospital's 8th month data compliance	No significant improvement	Still non-compliant
		Improvement based on approved corrective action plan	Monitor
11th	EMS Agency reviews Hospital's 9th month data compliance	No significant improvement	County will assess additional $1,300 penalty for non-compliance
		Improvement based on approved corrective action plan	Monitor
12th	EMS Agency reviews Hospital's 10th month data compliance	No significant improvement	Still non-compliant
		Improvement based on approved corrective action plan	Monitor
13th	EMS Agency reviews Hospital's 11th month data compliance	No significant improvement	Still non-compliant
		Improvement based on approved corrective action plan	Monitor
14th	EMS Agency reviews Hospitals 12th month data compliance	No significant improvement	County will assess additional $1,300 penalty for non-compliance
		Improvement based on approved corrective action plan	Monitor two additional months of data[1]

[1] If two additional months of data show that Hospital remains non-compliant, Hospital will be evaluated for agreement termination

INTENTIONALLY OMITTED

INTENTIONALLY OMITTED

EXHIBIT D

HOSPITAL'S EEO CERTIFICATION

Pasadena Memorial Hospital dba Huntington Memorial Hospital
Hospital Name

100 W. California Blvd., Pasadena, CA 91105
Address

95-1644036
Internal Revenue Service Employer Identification Number

GENERAL CERTIFICATION

In accordance with Section 4.32.010 of the Code of the County of Los Angeles, the Hospital, supplier, or vendor certifies and agrees that all persons employed by such firm, its affiliates, subsidiaries, or holding companies are and will be treated equally by the firm without regard to or because of race, religion, ancestry, national origin, or sex and in compliance with all anti-discrimination laws of the United States of America and the State of California.

HOSPITAL'S SPECIFIC CERTIFICATIONS

1.	The Hospital has a written policy statement prohibiting discrimination in all phases of employment.	Yes ☒	No ☐
2.	The Hospital periodically conducts a self analysis or utilization analysis of its work force.	Yes ☒	No ☐
3.	The Hospital has a system for determining if its employment practices are discriminatory against protected groups.	Yes ☒	No ☐
4.	Where problem areas are identified in employment practices, the Hospital has a system for taking reasonable corrective action, to include establishment of goals or timetables.	Yes ☒	No ☐

Debbie Ortega, CHRO & Vice President Administrative Services
Authorized Official's Printed Name and Title

REDACTED

Authorized Official's Signature

11-13-2017
Date

Exhibit E

COUNTY'S ADMINISTRATION

AGREEMENT NO. H-707421

COUNTY'S PROJECT DIRECTOR:

Name: Richard Tadeo
Title: Assistant Director, EMS Programs
Address: 10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670
Telephone: (562) 347-1610 Facsimile: (562) 941-2306
E-Mail Address: rtadeo@dhs.lacounty.gov

COUNTY'S PROJECT MANAGER:

Name: Christine Clare
Title: Chief for Hospital Programs/Interim Chief EMS System Data Management
Address: 10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670
Telephone: (562) 347-1661 Facsimile: (562) 946-6701
E-Mail Address: cclare@dhs.lacounty.gov

COUNTY'S PROJECT MONITOR:

Name: Lorrie Perez
Title: Stroke Coordinator
Address: 10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670
Telephone: (562) 347-1655 Facsimile: (562) 946-6701
E-Mail Address: LLPerez@dhs.lacounty.gov

HOSPITAL'S ADMINISTRATION

HOSPITAL'S NAME: Huntington Hospital
AGREEMENT NO: H-707421

HOSPITAL'S PROJECT MANAGER:

Name: Candy Corral
Title: Director of Clinical Partnerships
Address: 100 W. California Blvd., Pasadena CA 91105
Telephone: 626-397-2516
Facsimile: NA
E-Mail Address: candy.corral@huntingtonhospital.com

HOSPITAL'S AUTHORIZED OFFICIAL(S)

Name: Lori J. Morgan, MD, MBA
Title: President & CEO
Address: 100 W. California Blvd., Pasadena, CA, 91105
Telephone: 626-397-5555
Facsimile: 626-397-2995
E-Mail Address: lori.morgan@huntingtonhospital.com

Name: Gloria Sanchez-Rico, RN, BSN, MBA
Title: Vice President, CNE
Address: 100 W. California Blvd., Pasadena, CA 91105
Telephone: 626-397-5058
Facsimile: 626-397-2916
E-Mail Address: gloria.sanchez-rico@huntingtonhospital.com

Notices to Hospital shall be sent to the following:

Name: Candy Corral
Title: Director of Clinical Partnerships
Address: 100 W. California Blvd, Pasadena, CA 91105
Telephone: 626-397-2516
Facsimile: NA
E-Mail Address: candy.corral@huntingtonhospital.com

EXHIBIT G

HOSPITAL ACKNOWLEDGEMENT AND CONFIDENTIALITY AGREEMENT

HOSPITAL NAME Huntington Hospital Agreement No. H-707421

GENERAL INFORMATION:

The Hospital referenced above has entered into anAgreement with the County of Los Angeles to provide certain services to the County. The County requires the Corporation to sign this Hospital Acknowledgement and Confidentiality Agreement.

HOSPITAL ACKNOWLEDGEMENT:

Hospital understands and agrees that the Hospital employees, consultants, Outsourced Vendors and independent contractors (Hospital's Staff) that will provide services in the above referenced agreement are Hospital's sole responsibility. Hospital understands and agrees that Hospital's Staff must rely exclusively upon Hospital for payment of salary and any and all other benefits payable by virtue of Hospital's Staff's performance of work under the above-referenced contract.

Hospital understands and agrees that Hospital's Staff are not employees of the County of Los Angeles for any purpose whatsoever and that Hospital's Staff do not have and will not acquire any rights or benefits of any kind from the County of Los Angeles by virtue of performance of work under the above-referenced contract. Hospital understands and agrees that Hospital's Staff will not acquire any rights or benefits from the County of Los Angeles pursuant to any agreement between any person or entity and the County of Los Angeles.

CONFIDENTIALITY AGREEMENT:

Hospital and Hospital's Staff may be involved with work pertaining to services provided by the County of Los Angeles and, if so, Hospital and Hospital's Staff may have access to confidential data and information pertaining to persons and/or entities receiving services from the County. In addition, Hospital and Hospital's Staff may also have access to proprietary information supplied by other vendors doing business with the County of Los Angeles. The County has a legal obligation to protect all such confidential data and information in its possession, especially data and information concerning health, criminal, and welfare recipient records. Hospital and Hospital's Staff understand that if they are involved in County work, the County must ensure that Hospital and Hospital's Staff, will protect the confidentiality of such data and information. Consequently, Hospital must sign this Confidentiality Agreement as a condition of work to be provided by Hospital's Staff for the County.

Hospital and Hospital's Staff hereby agrees that they will not divulge to any unauthorized person any data or information obtained while performing work pursuant to the above-referenced Agreement between Hospital and the County of Los Angeles. Hospital and Hospital's Staff agree to forward all requests for the release of any data or information received to County's Project Manager

Hospital and Hospital's Staff agree to keep confidential all health, criminal, and welfare recipient records and all data and information pertaining to persons and/or entities receiving services from the County, design concepts, algorithms, programs, formats, documentation, Hospital proprietary information and all other original materials produced, created, or provided to Hospital and Hospital's Staff under the above-referenced contract. Hospital and Hospital's Staff agree to protect these confidential materials against disclosure to other than Hospital or County employees who have a need to know the information. Hospital and Hospital's Staff agree that if proprietary information supplied by other County vendors is provided during this employment, Hospital and Hospital's Staff shall keep such information confidential.

Hospital and Hospital's Staff agree to report any and all violations of this agreement by Hospital and Hospital's Staff and/or by any other person of whom Hospital and Hospital's Staff become aware.

Hospital and Hospital's Staff acknowledge that violation of this agreement may subject Hospital and Hospital's Staff to civil and/or criminal action and that the County of Los Angeles may seek all possible legal redress.

SIGNATURE: REDACTED DATE: 11-15-2017

PRINTED NAME: Gloria Sanchez-Rico

POSITION: Vice President, CNE

INTENTIONALLY OMITTED

SAFELY SURRENDERED BABY LAW

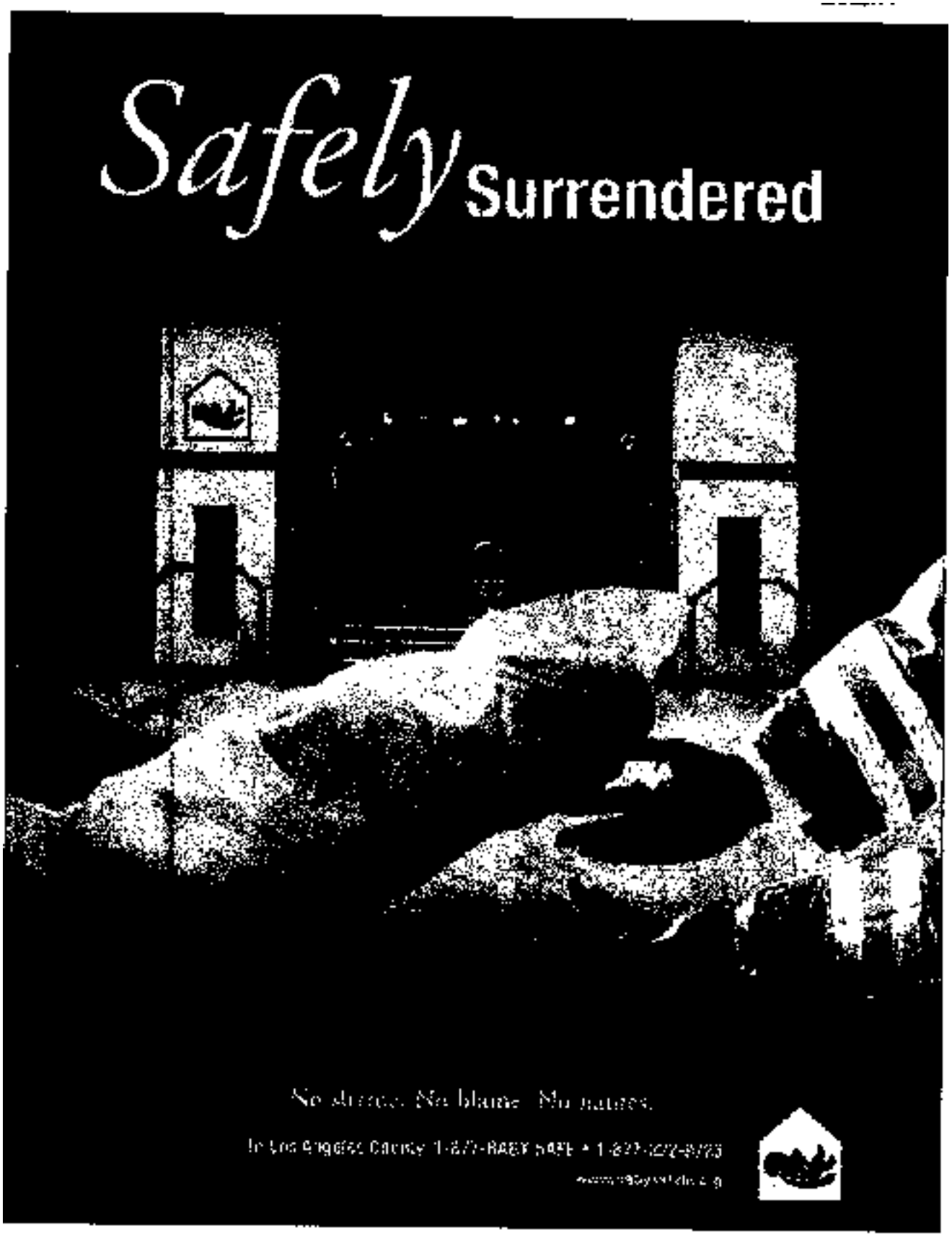

Safely Surrendered
No Shame. No Blame. No names.

EXHIBIT I

Los Angeles County • 877 BABY SAFE • 1-877-222-2923

www.babysafela.org

Safely Surrendered *Baby Law*

What is the Safely Surrendered Baby Law?

How does it work?

A distressed parent who is unable or unwilling to care for a baby can legally, confidentially, and safely surrender a baby within three days (72 hours) of birth. The baby must be handed to an employee at a hospital or fire station in Los Angeles County. As long as the baby shows no signs of abuse or neglect, no name or other information is required. In case the parent changes his or her mind at a later date and wants the baby back, staff will use bracelets to help reunite them with each other. One bracelet will be placed on the baby, and a matching bracelet will be given to the parent or other surrendering adult.

What if a parent wants the baby back?

Parents who change their minds can begin the process of reclaiming their baby within 14 days. These parents should call the Los Angeles County Department of Children and Family Services at 1-800-540-4000.

Can only a parent bring in the baby?

No. While in most cases a parent will bring in the baby, the Law allows other people to bring in the baby if they have lawful custody.

Does the parent or surrendering adult have to call before bringing in the baby?

No. A parent or surrendering adult can bring in a baby anytime, 24 hours a day, 7 days a week, as long as the parent or surrendering adult surrenders the baby to a staff member at the hospital or fire station.

Does the parent or surrendering adult have to tell anything to the people taking the baby?

No. However, hospital or fire station personnel will ask the surrendering party to fill out a questionnaire designed to gather important medical history information, which is very useful in caring for the baby. The questionnaire includes a postpaid return envelope and can be sent in at a later time.

What happens to the baby?

The baby will be examined and given medical treatment. Upon release from the hospital, social workers immediately place the baby in a safe and loving home and begin the adoption process.

What happens to the parent or surrendering adult?

Once the parent or surrendering adult surrenders the baby to hospital or fire station personnel, they may leave at any time.

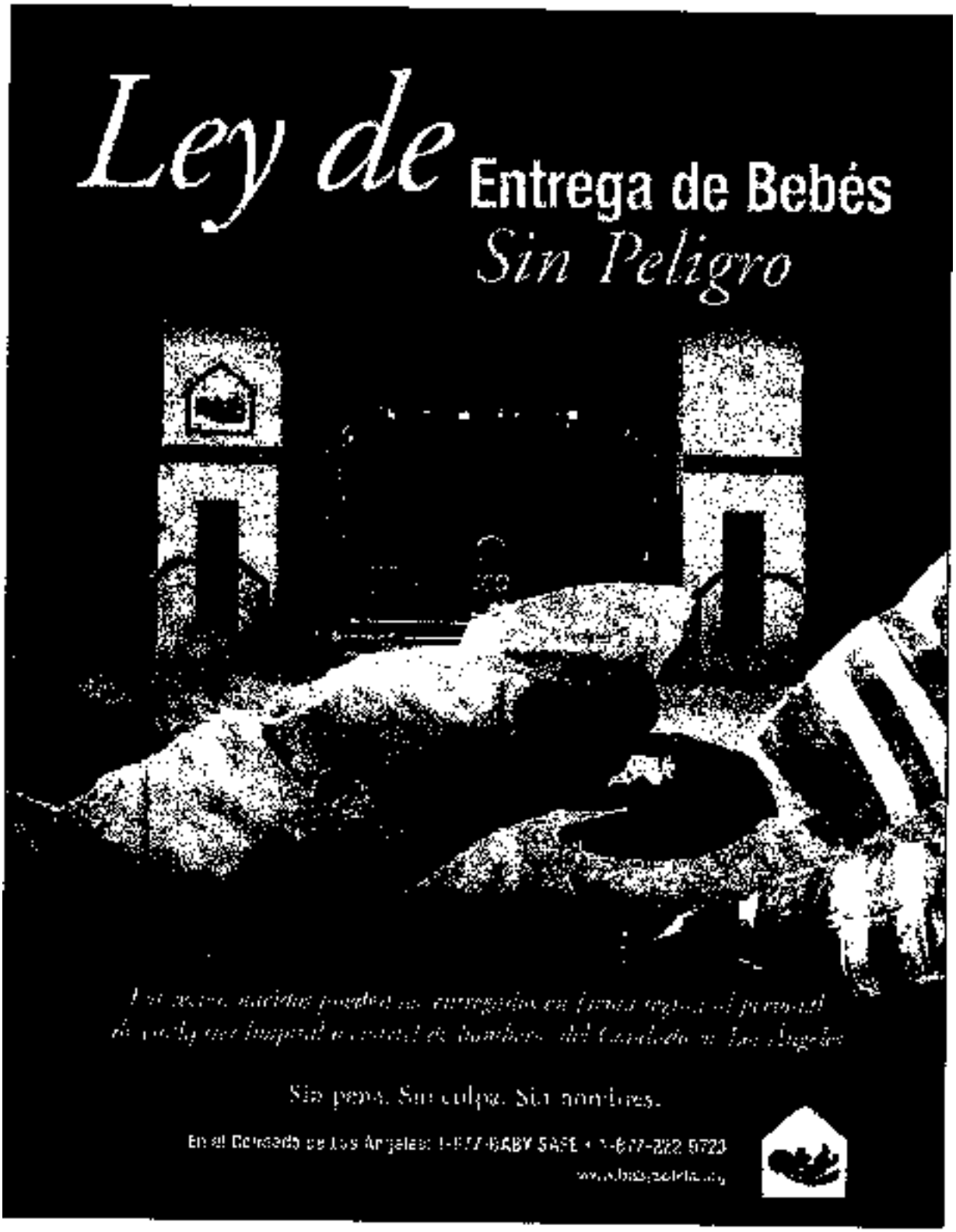
Why is California doing this?

The purpose of the *Safely Surrendered Baby Law* is to prevent babies from being abandoned, hurt or killed by their parents. You may have heard tragic stories of babies left in dumpsters or public bathrooms. These parents may have been under severe emotional distress. The mothers may have hidden their pregnancies, fearful of what would happen if their families found out. Because they were afraid and had no one to help them, they abandoned their babies. Abandoning a baby is illegal and places the baby in extreme danger. Too often, it results in the baby's death. The *Safely Surrendered Baby Law* prevents this tragedy from ever happening again in California.

A baby's story

Early in the morning on April 9, 2005, a healthy baby boy was safely surrendered to nurses at Harbor-UCLA Medical Center. The woman who brought the baby to the hospital identified herself as the baby's aunt and stated the baby's mother had asked her to bring the baby to the hospital on her behalf. The aunt was given a bracelet with a matching one being the athlet placed on the baby; she would provide some identification in the case the mother changed her mind about surrendering the baby and wished to reclaim the baby in the 14-day period allowed by the Law. The nurse was also provided with a medical questionnaire and told the would have the mother complete and mail back in the postpaid return envelope provided. The baby was examined by medical staff and pronounced healthy and full-term. He was placed with a foster family that had been approved to adopt him by the Department of Children and Family Services.




Ley de Entrega de Bebés
Sin Peligro
Sin pena. Sin culpa. Sin nombres.

Ley de Entrega de Bebés *Sin Peligro*

¿Qué es la Ley de Entrega de Bebés sin Peligro?

Cada año son dejados en lugares peligrosos y no seguros muchos bebés recién nacidos. La entrega en virtud de la Ley de Entrega de Bebés sin Peligro es una opción segura y confidencial. Un padre/madre o adulto que entregue a un bebé recién nacido al personal de enfermería de un hospital o cuartel de bomberos del Condado de Los Ángeles

¿Cómo funciona?

El padre/madre que definitivamente que no puede o no quiere cuidar de su recién nacido puede entregarlo en forma legal, confidencial y segura dentro de los primeros siete días (72 horas) del nacimiento. El bebé debe ser entregado a un empleado de cualquier hospital o cuartel de bomberos del Condado de Los Ángeles. Siempre que el bebé no presente signos de abuso o negligencia, no será necesario suministrar nombres ni información alguna. Si el padre/madre cambia de opinión posteriormente y desea recuperar a su bebé, los trabajadores utilizarán brazaletes para poder vincularlos. El bebé llevará un brazalete y el padre/madre o el adulto que lo entregue recibirá un brazalete igual.

¿Qué pasa si el padre/madre desea recuperar a su bebé?

Los padres que cambien de opinión pueden comenzar el proceso de reclamo a los 14 días. Estos padres deberán llamar al Departamento de Servicios para Niños y Familias (Department of Children and Family Services) del Condado de Los Ángeles al 1-800-540-4000

¿Sólo los padres podrán llevar al recién nacido?

No. Si bien en la mayoría de los casos son los padres los que llevan al bebé, la ley permite que otras personas lo hagan a menos que exista un motivo legal.

¿Los padres o el adulto que entrega al bebé deben llenar antes de llevar al bebé?

No. El padre/madre o adulto puede llevar al bebé en cualquier momento, las 24 horas del día, los 7 días de la semana, siempre y cuando entreguen a su bebé a un empleado del hospital o cuartel de bomberos.

¿Es necesario que el padre/madre o adulto diga algo a las personas que reciben al bebé?

No. Sin embargo, el personal del hospital o cuartel de bomberos le pedirá a la persona que entregue al bebé que llene un cuestionario con la finalidad de recibir información médica importante que podría ser de gran utilidad para cuidar bien del bebé. El cuestionario incluye un sobre con el sello postal pagado para enviarlo en otro momento.

¿Qué pasará con el bebé?

El bebé será examinado y le brindarán atención médica. Cuando le den el alta del hospital, los trabajadores sociales inmediatamente ubicarán al bebé en un lugar seguro donde estará bien atendido, y se comenzará el proceso de adopción.

¿Qué pasará con el padre/madre o adulto que entregue al bebé?

Una vez que los padres o adulto hayan entregado al bebé al personal del hospital o cuartel de bomberos, podrán irse en cualquier momento.

¿Por qué se está haciendo esto en California? ?

La finalidad de la Ley de Entrega de Bebés sin Peligro es proteger a los bebés para que no sean abandonados, lastimados o asesinados por sus padres. Unos/as pediatras/enfermeras/os hacen estadísticas sobre bebés abandonados en basureros o en baños públicos. Los golpes de recién nacidos prematuramente hayan sido causado por dificultades emocionales graves. Las madres pueden haber ocultado su embarazo, por temor a lo que pasaría si su familia se enterara. Abandonan a su bebés porque están asustadas y no saben cuidar a quien podría ayudar. El abandono de un recién nacido es ilegal y pone al bebé en una situación de peligro extremo. Muy a menudo el abandono provoca la muerte del bebé. La Ley de Entrega de Bebés sin Peligro impide que nuevos y recientes casos ocurran en California.

Historia de un bebé



A la mañana temprano del día 5 de abril de 2005 se entregó un recién nacido saludable a los enfermeros del Hutton UCLA Medical Center. La mujer que llevó el recién nacido al hospital no dio a conocer cuál era la edad del bebé, y dijo que ni siquiera le habían puesto nombre. Le entregaron a la madre un brazalete con un número igual que el del bebé, con la petición de que lo conservara en caso de que la madre cambiara de opinión con respecto a la entrega del bebé y decidiera recuperarlo durante el período de 14 días que prevé la ley. También le dieron a la mujer cuestionario médico, y ella dijo que lo llenaría y lo enviaría. El sobre con franqueo pagado que le habían dado. El pediatra médico examinó al bebé y se determinó que estaba saludable y sin riesgo. El bebé fue trasladado con una buena familia que había sido aprobada para adopción por el Departamento de Servicios para Niños y Familias.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

To ensure timely, compassionate and quality emergency and disaster medical services.

January 08, 2018

Lori Morgan, M.D.
President and CEO
Pasadena Memorial Hospital
dba Huntington Memorial
100 W. California Blvd.
Pasadena CA 91105

Dear Dr. Morgan:

COMPREHENSIVE STROKE SYSTEM FEE
FOR CALENDAR YEAR 2018

In accordance with Paragraph 5.0, Designation Fee, of the Comprehensive Stroke System Agreement H-707421, Hospital agrees to offset a portion of the costs associated with the County's data collection, monitoring, and evaluation of the stroke system, all of which benefit Hospital in the provision of stroke care. The non-refundable fee for the period January 2018 to December 2018, is $23,810. Please forward payment to:

Emergency Medical Services Agency
10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670
Attention: Accounting Unit

Payment Due Date: March 09, 2018

If you have any questions, please contact Maria Morales, Finance Manager, at (562) 347-1591.

Sincerely,

REDACTED

Cathy Chidester
Director

Enclosure

cc:mm

Health Services
http://ems.dhs.lacounty.gov

Health Services
LOS ANGELES COUNTY

January 8, 2018

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Christina R. Ghaly, M.D.
Acting Director

Mitchell H. Katz, M.D.
Health Agency Director

Hal F. Yee, Jr., M.D., Ph.D.
Chief Medical Officer

Contracts & Grants Division
313 N. Figueroa Street
6th Floor East
Los Angeles, CA 90012

Tel: (213) 240-7819
Fax: (213) 250-2958

www.dhs.lacounty.gov

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

www.dhs.lacounty.gov

Candy Corral, RN, MSN, CNS-BC, SCRN
Pasadena Memorial Hospital dba Huntington Memorial Hospital
100 W. California Blvd.
Pasadena, CA 91105

Dear Ms. Corral:

Enclosed is your Hospital's fully executed Agreement H-707421 for the Comprehensive Stroke System, effective on January 8, 2018. Also, enclosed is your invoice for the 2018 calendar year. If you have any questions, please feel free to contact me. Thank you.

Sincerely,

REDACTED

Stacey Asada, Contract Analyst
Contracts and Grants Division

SA

Enclosure

Agreement No.: H-707421

COMPREHENSIVE STROKE SYSTEM

Amendment No. 1

THIS AMENDMENT is made and entered into this 28th day of June, 2019,

By and between COUNTY OF LOS ANGELES (hereafter "County"),

And PASADENA MEMORIAL HOSPITAL DBA HUNTINGTON MEMORIAL HOSPITAL (hereafter "Hospital")

Business Address:

100 West California Boulevard
Pasadena, CA 91105

WHEREAS, reference is made to that certain document entitled "Comprehensive Stroke System," dated January 8, 2018 and further identified as Agreement No. H-707421 and any amendments thereto (all hereafter referred to as "Agreement"); and

WHEREAS, on December 19, 2017, the Board of Supervisors (Board) delegated authority to the Director of Health Services (Director), or her designee, to execute amendments to all Agreements to: (i) exercise the two one-year optional extensions; (ii) add, delete, and/or change certain terms and conditions as required under Federal or State law or regulation, County policy, the Board, and/or the Chief Executive Office (CEO); (iii) incorporate necessary changes within the scope of work; and (iv) adjust the annual Hospital designation fee, with a ten percent (10%) annual cap for potential increases; and

WHEREAS, it is the intent of the parties hereto to amend the Agreement to reduce the designation fee identified in Subparagraph 5.1 due to decreased program operating costs and to provide for the other changes set forth herein; and

WHEREAS, Agreement provides that changes in accordance to Paragraph 8.1, Amendments may be made in the form of an Amendment which is formally approved and executed by the parties; and

WHEREAS, Hospital warrants that it possesses the competence, expertise and personnel necessary to provide services consistent with the requirements of this Agreement and consistent with the professional standard of care for these services.

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

1. This Amendment shall commence and be effective upon execution.

2. Agreement, Paragraph 2.0, DEFINITIONS, Definition 2.11, is revised to read: "Director: Director of Health Services (acting, interim or permanent) or his/her authorized designee."

3. Agreement Subparagraph 5.1 is deleted in its entirety and replaced as follows:

"5.1 To provide ongoing financial support to County for system data collection, monitoring, and evaluation of the stroke system, all of which benefit Hospital in provision of stroke care, Hospital agrees to offset a portion of the cost attributed thereto. The NON-REFUNDABLE amount payable to County by Hospital shall be Twenty-Three Thousand Eight Hundred and Ten Dollars ($23,810) annually for each calendar year (January to December) until December 31, 2018. The NON-REFUNDABLE amount payable to County by Hospital as of January 1, 2019 shall be Twenty-One Thousand Thirty-Seven Dollars ($21,037) annually for each calendar year (January to December). The first program management fee will be due within sixty (60) days of the Agreement effective date; thereafter, within sixty (60) days of the beginning of each calendar year. If applicable, the first year program management fee will be prorated accordingly. The Designation Fee may, at the sole discretion of the County, be adjusted annually, with a ten percent (10%) annual cap for potential increases to reflect changes in operating costs."

4. Agreement, Paragraph **8.2**, **ASSIGNMENT AND DELEGATION** is deleted in its entirety and replaced as follows:

"**8.2. ASSIGNMENT AND DELEGATION/MERGERS OR ACQUISITIONS**

8.2.1 The Hospital shall notify the County of any pending acquisitions/mergers of its company unless otherwise legally prohibited from doing so. If the Hospital is restricted from legally notifying the County of pending acquisitions/mergers, then it should notify the County of the actual acquisitions/mergers as

soon as the law allows and provide to the County the legal framework that restricted it from notifying the County prior to the actual acquisitions/mergers.

8.2.2 The Hospital shall not assign its rights nor delegate its duties under this Agreement, or both, whether in whole or in part, without the prior written consent of the County, in its discretion, and any attempted assignment or delegation without such consent shall be null and void. For purposes of this Sub-paragraph, the County consent shall require a written Amendment to the Agreement, which is formally approved and executed by the parties. Any payments by the County to any approved delegate or assignee on any claim under this Agreement shall be deductible, at the County's sole discretion, against the claims, which the Hospital may have against the County.

8.2.3 Shareholders, partners, members, or other equity holders of the Hospital may transfer, sell, exchange, assign, or divest themselves of any interest they may have therein. However, in the event any such sale, transfer, exchange, assignment, or divestment is effected in such a way as to give majority control of the Hospital to any person(s), corporation, partnership, or legal entity other than the majority controlling interest therein at the time of execution of the Agreement, such disposition is an assignment requiring the prior written consent of the County in accordance with applicable provisions of this Agreement."

8.2.4 Any assumption, assignment, delegation, or takeover of any of the Hospital's duties, responsibilities, obligations, or performance of same by any entity other than the Hospital, whether through assignment, subcontract, delegation, merger, buyout, or any other mechanism, with or without consideration for any reason whatsoever without the County's express prior written approval, shall be a material breach of the Agreement which may result in the termination of this Agreement. In the event of such termination, the County shall be entitled to pursue the same remedies against the Hospital as it could pursue in the event of default by the Hospital."

5. Agreement, Paragraph **8.12**, **CONSIDERATION OF HIRING GAIN/GROW PARTICIPANTS** is deleted in its entirety and replaced as follows:

"**8.12 CONSIDERATION OF HIRING GAIN/GROW PARTICIPANTS FOR**

EMPLOYMENT

8.12.1 Should the Hospital require additional or replacement personnel after the effective date of this Agreement, the Hospital shall give consideration for any such employment openings to participants in the County's Department of Public Social Services (DPSS) Greater Avenues for Independence (GAIN) Program or General Relief Opportunity for Work (GROW) Program who meet the Hospital's minimum qualifications for the open position. For this purpose, consideration shall mean that the Hospital will interview qualified candidates. The County will refer GAIN/GROW participants by job category to the Hospital. The Hospital shall report all job openings with job requirements to: GAINGROW@dpss.lacounty.gov and bservices@wdacs.lacounty.gov and DPSS will refer qualified GAIN/GROW job candidates.

8.12.2 In the event that both laid-off County employees and GAIN/GROW participants are available for hiring, County employees shall be given first priority."

6. Agreement, Paragraph **8.14**, **HOSPITAL'S ACKNOWLEDGEMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW**

"**8.14 HOSPITAL'S ACKNOWLEDGEMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW**

The Hospital acknowledges that the County places a high priority on the implementation of the Safely Surrendered Baby Law. The Hospital understands that it is the County's policy to encourage all County contractors to voluntarily post the County's "Safely Surrendered Baby Law" poster in a prominent position at the contractor's place of business. The Hospital will also encourage its subcontractors, if any, to post this poster in a prominent position in the subcontractor's place of business. The Hospital, and its subcontractors, can access posters and other campaign material at www.babysafela.org."

7. Agreement, Paragraph **8.18**, **COUNTY'S QUALITY ASSURANCE PLAN** is deleted in its entirety and replaced as follows:

"**8.18 COUNTY'S QUALITY ASSURANCE PLAN**

The County or its agent will monitor the Hospital's performance under this Agreement on not less than an annual basis. Such monitoring

will include assessing the Hospital's compliance with all Agreement terms and conditions and performance standards. The Hospital deficiencies which the County determines are significant or continuing and that may place performance of the Agreement in jeopardy if not corrected will be reported to the Board and listed in the appropriate contractor performance database. The report to the Board will include improvement/corrective action measures taken by the County and the Hospital. If improvement does not occur consistent with the corrective action measures, the County may terminate this Agreement or impose other penalties as specified in this Agreement."

8. Agreement, Paragraph **8.21, FACSIMILE REPRESENTATIONS** is deleted in its entirety and replaced as follows:

"**8.21 FACSIMILE AND/OR PORTABLE DOCUMENT FORMAT REPRESENTATIONS**

The County and the Hospital hereby agree to regard signed Amendments received via facsimile transmission and/or in Portable Document Format (PDF) via e-mail, as representations of original signatures of authorized officers of each party, when appearing in appropriate places on the Amendments prepared pursuant to Sub-paragraph 8.1, as legally sufficient evidence that such original signatures have been affixed to Amendments to this Agreement, and as such, the parties need not exchange with each other the signed original Amendment(s)."

9. Agreement, Sub-paragraph **8.29.1, Evidence of Coverage and Notice to County**, is deleted in its entirety and replaced as follows:

"**8.29.1 Evidence of Coverage and Notice to County**

Certificate(s) of insurance coverage (Certificate) satisfactory to the County, and a copy of an Additional Insured endorsement confirming the County and its Agents (defined below) has been given Insured status under the Hospital's General Liability policy, shall be delivered to the County at the e-mail address shown below and provided prior to commencing services under this Agreement.

Renewal Certificates shall be provided to the County not less than 10 days prior to the Hospital's policy expiration dates. The County reserves the right to obtain complete, certified copies of any required Hospital and/or Sub-Contractor insurance policies at any time.

Certificates shall identify all Required Insurance coverage types and limits specified herein, reference this Agreement by name or number, and be signed by an authorized representative of the insurer(s). The Insured party named on the Certificate shall match the name of the Hospital identified as the contracting party in this Agreement. Certificates shall provide the full name of each insurer providing coverage, its NAIC (National Association of Insurance Commissioners) identification number, its financial rating, the amounts of any policy deductibles or self-insured retentions exceeding fifty thousand ($50,000.00) dollars, and list any County required endorsement forms.

Neither the County's failure to obtain, nor the County's receipt of, or failure to object to a non-complying insurance certificate or endorsement, or any other insurance documentation or information provided by the Hospital, its insurance broker(s) and/or insurer(s), shall be construed as a waiver of any of the Required Insurance provisions.

Certificates and copies of any required endorsements shall be e-mailed to:

cgcontractorinsurance@dhs.lacounty.gov

The Hospital also shall promptly report to the County any injury or property damage accident or incident, including any injury to a Hospital employee occurring on County property, and any loss, disappearance, destruction, misuse, or theft of County property, monies or securities entrusted to the Hospital. The Hospital also shall promptly notify the County of any third party claim or suit filed against the Hospital or any of its Sub-Contractors which arises from or relates to this Agreement, and could result in the filing of a claim or lawsuit against the Hospital and/or the County."

10. Agreement, is revised to add Paragraph **8.62**, **COMPLIANCE WITH FAIR CHANCE EMPLOYMENT PRACTICES** as follows:

"**8.62 COMPLIANCE WITH FAIR CHANCE EMPLOYMENT PRACTICES**

Hospital shall comply with fair chance employment hiring practices set forth in California Government Code Section 12952, Employment Discrimination: Conviction History. Hospital's violation of this paragraph of the Agreement may constitute a material breach of the Agreement. In the event of such material breach, County may, in its sole discretion, terminate the Agreement."

11. Agreement, is revised to add Paragraph **8.63**, **COMPLIANCE WITH THE COUNTY POLICY OF EQUITY** as follows:

"**8.63 COMPLIANCE WITH THE COUNTY POLICY OF EQUITY**

The Hospital acknowledges that the County takes its commitment to preserving the dignity and professionalism of the workplace very seriously, as set forth in the County Policy of Equity (CPOE) (https://ceop.lacounty.gov/). The Hospital further acknowledges that the County strives to provide a workplace free from discrimination, harassment, retaliation and inappropriate conduct based on a protected characteristic, and which may violate the CPOE. The Hospital, its employees and subcontractors acknowledge and certify receipt and understanding of the CPOE. Failure of the Hospital, its employees or its subcontractors to uphold the County's expectations of a workplace free from harassment and discrimination, including inappropriate conduct based on a protected characteristic, may subject the Hospital to termination of contractual agreements as well as civil liability."

12. Except for the changes set forth hereinabove, Agreement shall not be changed in any respect by this Amendment.

/

/

/

/

/

/

/

/

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be executed by the County's Director of Health Services and Hospital has caused this Amendment to be executed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By: REDACTED

Christina R. Ghaly, M.D.
Director of Health Services

PASADENA MEMORIAL HOSPITAL DBA HUNTINGTON MEMORIAL HOSPITAL

By: REDACTED

Signature

Lori J. Morgan, MD, MBA
Printed Name

President and CEO
Title

APPROVED AS TO FORM:

MARY C. WICKHAM
County Counsel

By: REDACTED

Brian T. Chu, Principal Deputy County Counsel

Exhibit 23-E

Master Agreement No. H-708207 for Specialty Care Center Designations

Agreement No. H-708207

MASTER AGREEMENT

BY AND BETWEEN

COUNTY OF LOS ANGELES

AND

PASADENA HOSPITAL ASSOCIATION, LTD. DBA HUNTINGTON HOSPITAL

FOR

SPECIALTY CARE CENTER DESIGNATIONS

TABLE OF CONTENTS

PARAGRAPH	TITLE	PAGE
RECITALS		**1**
1.0	**APPLICABLE DOCUMENTS**	**3**
2.0	**DEFINITIONS**	**3**
3.0	**SPECIALTY CARE CENTER DESIGNATIONS**	**4**
4.0	**TERM OF AGREEMENT**	**5**
5.0	**AGREEMENT SUM, BILLING AND PAYMENT**	**5**
6.0	**ADMINISTRATION OF AGREEMENT- COUNTY**	**6**
6.1	COUNTY'S PROJECT DIRECTOR	6
6.2	COUNTY'S PROJECT MANAGER	6
6.3	COUNTY'S PROJECT MONITOR	6
7.0	**ADMINISTRATION OF AGREEMENT – CONTRACTOR**	**7**
7.1	CONTRACTOR'S PROJECT MANAGER	7
7.2	CONTRACTOR'S AUTHORIZED OFFICIAL	7
7.3	APPROVAL OF CONTRACTOR'S STAFF (INTENTIONALLY OMITTED)	7
7.4	CONTRACTOR'S STAFF IDENTIFICATION (INTENTIONALLY OMITTED)	7
7.5	BACKGROUND AND SECURITY INVESTIGATIONS (INTENTIONALLY OMITTED)	7
7.6	CONFIDENTIALITY	7
7.7	STAFF PERFORMANCE UNDER THE INFLUENCE	8
8.0	**STANDARD TERMS AND CONDITIONS**	**8**
8.1	AMENDMENTS	8
8.2	ASSIGNMENT AND DELEGATION/MERGERS OR ACQUISITIONS	9
8.3	AUTHORIZATION WARRANTY	10
8.4	BUDGET REDUCTIONS(INTENTIONALLY OMITTED)	10
8.5	CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION – LOWER TIER COVERED TRANSACTIONS (2 C.F.R. PART 373) (INTENTIONALLY OMITTED)	10
8.6	INTENTIONALLY OMITTED	10
8.7	COMPLIANCE WITH APPLICABLE LAWS, RULES & REGULATIONS	10
8.8	COMPLIANCE WITH CIVIL RIGHTS LAWS – ANTI DISCRIMINATION	

TABLE OF CONTENTS

PARAGRAPH	TITLE	PAGE
	AND AFFIRMATIVE ACTION LAWS	11
8.9	COMPLIANCE WITH THE COUNTY'S JURY SERVICE PROGRAM (INTENTIONALLY OMITTED)	13
8.10	CONFLICT OF INTEREST (INTENTIONALLY OMITTED)	13
8.11	CONSIDERATION OF HIRING COUNTY EMPLOYEES TARGETED FOR LAYOFF/OR RE-EMPLOYMENT LIST (INTENTIONALLY OMITTED)	13
8.12	CONSIDERATION OF HIRING GAIN/GROW PARTICIPANTS (INTENTIONALLY OMITTED)	13
8.13	CONTRACTOR RESPONSIBILITY AND DEBARMENT	13
8.14	CONTRACTOR'S ACKNOWLEDGEMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW	16
8.15	CONTRACTOR'S EXCLUSION FROM PARTICIPATING IN A FEDERALLY FUNDED PROGRAM	16
8.16	CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM	17
8.17	CONTRACTOR'S WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM (INTENTIONALLY OMITTED)	17
8.18	COUNTY'S QUALITY ASSURANCE PLAN	17
8.19	DAMAGE TO COUNTY FACILITIES, BUILDINGS OR GROUNDS (INTENTIONALLY OMITTED)	18
8.20	EMPLOYMENT ELIGIBILITY VERIFICATION	18
8.21	FACSIMILE REPRESENTATIONS	18
8.22	FAIR LABOR STANDARDS	18
8.23	FEDERAL ACCESS TO RECORDS (INTENTIONALLY OMITTED)	19
8.24	FORCE MAJEURE	19
8.25	GOVERNING LAW, JURISDICTION, AND VENUE	19
8.26	HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) (INTENTIONALLY OMITTED)	20
8.27	INDEPENDENT CONTRACTOR STATUS (INTENTIONALLY OMITTED)	20
8.28	INDEMNIFICATION	20
8.29	GENERAL PROVISIONS FOR ALL INSURANCE COVERAGE	20

TABLE OF CONTENTS

PARAGRAPH	TITLE	PAGE
8.30	INSURANCE COVERAGE	24
8.31	NOTICE OF DISPUTES (INTENTIONALLY OMITTED)	25
8.32	LIQUIDATED DAMAGES (INTENTIONALLY OMITTED)	25
8.33	MOST FAVORED PUBLIC ENTITY (INTENTIONALLY OMITTED)	25
8.34	NONDISCRIMINATION AND AFFIRMATIVE ACTION (INTENTIONALLY OMITTED)	25
8.35	NON-EXCLUSIVITY (INTENTIONALLY OMITTED)	25
8.36	NOTICE OF DELAYS (INTENTIONALLY OMITTED)	26
8.37	NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT	26
8.38	NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY LAW	26
8.39	NOTICES	26
8.40	PROHIBITION AGAINST INDUCEMENT OR PERSUASION (INTENTIONALLY OMITTED)	26
8.41	PUBLIC RECORDS ACT (INTENTIONALLY OMITTED)	26
8.42	PUBLICITY	26
8.43	RECORD RETENTION AND INSPECTION/AUDIT SETTLEMENT (INTENTIONALLY OMITTED)	27
8.44	RECYCLED BOND PAPER (INTENTIONALLY OMITTED)	27
8.45	RESTRICTIONS ON LOBBYING (INTENTIONALLY OMITTED)	27
8.46	SUBCONTRACTING	27
8.47	SURVIVAL	27
8.48	TERMINATION FOR BREACH OF WARRANTY TO MAINTAINCOMPLIANCE WITH COUNTY'S CHILD SUPPORTCOMPLIANCE PROGRAM	28
8.49	TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM (INTENTIONALLY OMITTED)	28
8.50	TERMINATION FOR CONVENIENCE	28
8.51	TERMINATION FOR DEFAULT	29
8.52	TERMINATION FOR IMPROPER CONSIDERATION	31
8.53	TERMINATION FOR INSOLVENCY	31

TABLE OF CONTENTS

PARAGRAPH	TITLE	PAGE
8.54	TERMINATION FOR NON-ADHERENCE OF COUNTY LOBBYIST ORDINANCE	32
8.55	TERMINATION FOR NON-APPROPRIATION OF FUNDS (INTENTIONALLY OMITTED)	32
8.56	TIME OFF FOR VOTING	32
8.57	UNLAWFUL SOLICITATION	32
8.58	VALIDITY	33
8.59	WAIVER	33
8.60	WARRANTY AGAINST CONTINGENT FEES	33
8.61	COMPLIANCE WITH COUNTY'S ZERO TOLERANCE POLICY ON HUMAN TRAFFIKING	34
8.62	COMPLIANCE WITH FAIR CHANCE EMPLOYMENT PRACTICES	34
8.63	COMPLIANCE WITH THE COUNTY POLICY OF EQUITY	34
9.0	**UNIQUE TERMS AND CONDITIONS**	**34**
9.1	DUE PROCESS	34
9.2	RESPONSIBILITY FOR INDIGENT PATIENTS	37
9.3	STATUS OF CONTRACTOR	37
SIGNATURES		39

STANDARD EXHIBITS

A SPECIALTY CARE CENTER DESIGNAITONS EXHIBIT

B (INTENTIONALLY OMITTED)

C (INTENTIONALLY OMITTED)

D CONTRACTOR'S EEO CERTIFICATION

E COUNTY'S ADMINISTRATION

F CONTRACTOR'S ADMINISTRATION

G FORM(S) REQUIRED AT THE TIME OF AGREEMENT EXECUTION

H JURY SERVICE ORDINANCE (INTENTIONALLY OMITTED)

I SAFELY SURRENDERED BABY LAW

MASTER AGREEMENT BETWEEN
COUNTY OF LOS ANGELES
AND
PASADENA HOSPITAL ASSOCIATION, LTD. DBA HUNTINGTON HOSPITAL
FOR
SPECIALTY CARE CENTER DESIGNATION

This Master Agreement and Exhibits made and entered into this 1st day of July, 2019 by and between the County of Los Angeles, hereinafter referred to as County and Pasadena Hospital Association, LTD. DBA Huntington Hospital, hereinafter referred to as Contractor. Pasadena Hospital Association, LTD. DBA Huntington Hospital is located at 100 West California Boulevard, Pasadena, CA 91105.

RECITALS

WHEREAS, the County may contract with private healthcare facilities or hospitals for specialty care center designations when certain requirements are met; and

WHEREAS, Contractor is a private or a public healthcare facility or hospitals specializing in providing certain specialty healthcare services; and

WHEREAS, County has designated its Department of Health Services as the local Emergency Medical Services Agency (hereafter " EMS Agency"); and

WHEREAS, pursuant to the authority granted under the Emergency Medical Services System and Prehospital Emergency Medical Care Personnel Act ("Act") (Health and Safety [H&S] Code, Sections 1797, et seq.), the EMS Agency serves as the lead agency for coordinating an Emergency Medical System for the County consisting of both private and public healthcare facilities and hospitals possessing Specialty Care Center Designations; and

WHEREAS, pursuant to the Act, the County may award Specialty Care Center Designations to qualified private and public healthcare facilities and hospitals when certain requirements are met; and

WHEREAS, Contractor is an acute care hospital or a healthcare facility, licensed to operate in the State of California; and

WHEREAS, the Act and related implementing regulations require the commitment of Contractor's administration, emergency department, and medical staff to meet requirements for program participation as specified by law and by EMS Agency policies and procedures; and

WHEREAS, the parties wish to cooperate with each other, other healthcare facilities, and provider agencies in the joint development and operation of the EMS system in Los Angeles County in order to efficiently and appropriately meet the needs of Los Angeles County residents for high quality EMS services; and

WHEREAS, the parties desire to carry out their respective obligations under this Agreement in an efficient cost-effective manner; and

WHEREAS, Contractor agrees to share in a portion of costs required to implement and maintain a countywide computerized data collection, monitoring, evaluation, and information management system (costs specified per designation program); and

WHEREAS, Contractor agrees to share in a portion of costs associated with managing and administering these Specialty Care Center Designation Programs (costs specified per designation program); and

WHEREAS, in exchange, County agrees to provide countywide standardized reports and to make available countywide statistical data; and

WHEREAS, this Master Agreement is authorized by H&S Code Sections 1797.67, 1797.78, 1797.204, 1797.252; and

WHEREAS, this Master Agreement is therefore authorized under California Government Code Section 3100 which authorizes the Board of Supervisors to contract for medical services; and

WHEREAS, the Board of Supervisors has authorized the Director of the Department of Health Services or designee to execute and administer this Master Agreement; and

WHEREAS, Contractor warrants that it possesses the competence, expertise and personnel necessary to provide services consistent with the requirements of this Master Agreement and with the professional standard of care for these services.

NOW THEREFORE, in consideration of the mutual covenants contained herein, and for good and valuable consideration, the parties agree to the following:

1.0 APPLICABLE DOCUMENTS

Exhibits A, D, E, F, G, are attached to and form a part of this Agreement. In the event of any conflict or inconsistency in the definition or interpretation of any word, responsibility, schedule, or the contents or description of any task, deliverable, goods, service, or other work, or otherwise between the Master Agreement and the Exhibits, or between Exhibits, such conflict or inconsistency shall be resolved by giving precedence first to the Master Agreement and then to the Exhibits according to the following priority.

Standard Exhibits:

1.1 EXHIBIT A - Specialty Care Center Designation Agreements

1.2 EXHIBIT B - (INTENTIONALLY OMITTED

1.3 EXHIBIT C - Contractor's Proposed Schedule (INTENTIONALLY OMITTED)

1.4 EXHIBIT D - Contractor's EEO Certification

1.5 EXHIBIT E - County's Administration

1.6 EXHIBIT F - Contractor's Administration

1.7 EXHIBIT G - Forms Required at the Time of Agreement Execution

1.8 EXHIBIT H - Jury Service Ordinance (INTENTIONALLY OMITTED)

1.9 EXHIBIT I - Safely Surrendered Baby Law

This Master Agreement and the Exhibits hereto constitute the complete and exclusive statement of understanding between the parties, and supersedes all previous Agreements, written and oral, and all communications between the parties relating to the subject matter of this Master Agreement. No change to this Master Agreement shall be valid unless prepared pursuant to sub-paragraph 8.1 - Amendments and signed by both parties.

2.0 DEFINITIONS

2.1 **Contractor:** The sole proprietor, partnership, corporation, or public hospital or healthcare center that has entered into this Master Agreement with the County to obtain a Specialty Care Center Designation and comply with the respective designation's requirements, standards, protocols, perform or execute any performance requirements, and/or other tasks specified in the respective Specialty Care Center Designation in Exhibit A.

2.3 **Contractor's Project Manager:** The individual designated by Contractor, a healthcare facility or hospital, to administer the Master Agreement operations after the Master Agreement award.

2.4 **Day(s):** Calendar day(s) unless otherwise specified.

2.5 **DHS:** Department of Health Services

2.6 **Director:** Director of Health Services (acting, interim or permanent) or authorized designee.

2.7 **County's Project Director:** Person designated by County with authority for County on contractual or administrative matters relating to this Master Agreement that cannot be resolved by the County's Project Manager.

2.8 **County's Project Manager:** Person designated by County's Project Director to manage the operations under this Master Agreement.

2.9 **County's Project Monitor:** Person with responsibility to oversee the day to day activities of this Master Agreement. Responsibility for inspections of any and all tasks, deliverables, goods, services and other work provided by the healthcare facility or hospital.

2.10 **Fiscal Year:** The twelve (12) month period beginning July 1st and ending the following June 30th.

2.11 **Master Agreement:** Agreement executed between County and Contractor, a healthcare facility or hospital. It sets forth the terms and conditions for the issuance and performance of the Specialty Care Center Designation in Exhibit A.

3.0 SPECIALTY CARE CENTER DESIGNATIONS

3.1 Pursuant to the provisions of this Master Agreement, Contractor shall fully comply with all requirements, standards, and policies and shall perform, complete and deliver on time, all tasks, deliverables, and other specific items as set forth in herein and as set forth in any Specialty Care Center Designation Agreements in Exhibit A Contractor is subsequently awarded pursuant to this Master Agreement.

3.2 If Contractor provides any tasks, deliverables, goods, services, or other work, other than as specified in this Master Agreement, the same shall be deemed to be a gratuitous effort on the part of the

Contractor, and Contractor shall have no claim whatsoever against the County.

4.0 TERM OF AGREEMENT

4.1 The term of this Master Agreement shall be five (5) years or less commencing after execution by the Director as authorized by the County's Board of Supervisors, and shall terminate on June 30, 2024 unless sooner terminated or extended, in whole or in part, as provided in this Agreement (hereinafter "Initial Term"). The County shall have the sole option to extend this Master Agreement term for up to five (5) additional one-year extension options, through June 30, 2029 (hereafter "Optional Term") for a maximum total Agreement term of ten (10) years. Each such option and extension shall renew automatically, unless sooner terminated or extended, in whole or in part, as provided in the Master Agreement, Sub-paragraph 4.4.

4.3 The County maintains databases that track/monitor Contractor's performance history and compliance with Health and Safety Code, Division 2.5.,. Information entered into such databases may be used for a variety of purposes, including determining whether the County will exercise an agreement term extension option.

4.4 Notwithstanding any other provision of this Master Agreement, Director may suspend this Master Agreement immediately upon giving written notice to Contractor if Contractor's license to operate as a general acute care hospital or its permit to operate basic or comprehensive emergency service is revoked or suspended. Any such action by the EMS Agency shall be subject to the review procedures for suspensions established in Paragraph 9.1, Due Process, herein below. If such a suspension order has been issued and remains in effect for a period of at least sixty (60) calendar days, Director may terminate this Master Agreement upon giving at least thirty (30) calendar days prior written notice thereof to Contractor.

5.0 AGREEMENT SUM, BILLING AND PAYMENT

5.1 To provide ongoing financial support to County for data collection, monitoring, and evaluation of the respective Specialty Care Center Designation Agreement of this Master Agreement. Contractor shall not be entitled to payment or reimbursement for any tasks or services performed, nor for any incidental or administrative expenses whatsoever incurred in or incidental to performance

hereunder, except as specified herein. Assumption or takeover of any of Contractor's duties, responsibilities, or obligations, or performance of same by any entity other than Contractor, whether through assignment, subcontract, delegation, merger, buyout, or any other mechanism, with or without consideration for any reason whatsoever, shall occur only with the County's express prior written approval.

6.0 ADMINISTRATION OF AGREEMENT - COUNTY

COUNTY ADMINISTRATION

The Director shall have the authority to administer this Master Agreement on behalf of the County. The Director retains professional and administrative responsibility for the services rendered under this Master Agreement. A listing of all County Administration referenced in the following Sub-paragraphs are designated in Exhibit E - County's Administration. The County shall notify Contractor in writing of any change in the names or addresses shown.

6.1 County's Project Director

Responsibilities of the County's Project Director include:

- ensuring that the objectives of this Master Agreement are met; and
- providing direction to Contractor in the areas relating to County policy, information requirements, and procedural requirements.

6.2 County's Project Manager

6.2.1 The responsibilities of the County's Project Manager include:

- meeting with Contractor's Project Manager on a regular basis; and
- inspecting any and all tasks, deliverables, goods, services, or other work provided by or on behalf of Contractor.

6.2.1 The County's Project Manager is not authorized to make any changes in any of the terms and conditions of this Master Agreement and is not authorized to further obligate County in any respect whatsoever.

6.3 County's Project Monitor

The County's Project Monitor is responsible for overseeing the day-to-day administration of this Master Agreement. The Project Monitor reports to the County's Project Manager.

7.0 ADMINISTRATION OF AGREEMENT - CONTRACTOR

7.1 Contractor's Project Manager

7.1.1 Contractor's Project Manager is designated in Exhibit F – Contractor's Administration. Contractor shall notify the County in writing of any change in the name or address of Contractor's Project Manager within five (5) business days of such change.

7.1.2 Contractor's Project Manager shall be responsible for Contractor's day-to-day activities as related to this Master Agreement and shall coordinate with County's Project Manager and County's Agreement Project Monitor on a regular basis.

7.2 Contractor's Authorized Official (s)

7.2.1 Contractor's Authorized Official(s) are designated in Exhibit F. Contractor shall promptly notify the County in writing of any change in the name(s) or address(es) of Contractor's Authorized Official(s) within five (5) business days of such change.

7.2.2 Contractor represents and warrants that all requirements of Contractor have been fulfilled to provide actual authority to such officials to execute documents under this Master Agreement on behalf of Contractor.

7.3 Approval of Contractor's Staff (INTENTIONALLY OMITTED)

7.4 Contractor's Staff Identification (INTENTIONALLY OMITTED)

7.5 Background and Security Investigations (INTENTIONALLY OMITTED)

7.6 Confidentiality

7.6.1 Contractor shall maintain the confidentiality of all records and information, including, but not limited to, billings, the County records, and patient records, in accordance with all applicable Federal, State and local laws, rules, regulations, ordinances, directives, guidelines, policies and procedures relating to confidentiality, including, without limitation, County policies concerning information technology security and the protection of confidential records and information.

7.6.2 Contractor shall indemnify, defend, and hold harmless County, its Special Districts, elected and appointed officers, employees, and agents, from and against any and all claims, demands, damages, defense costs and legal fines arising from any material breach by Contractor, its officers,

employees, agents, or subcontractors, to comply with this Sub-paragraph 7.6, as determined by County in its sole judgment. Any legal defense pursuant to Contractor's indemnification obligations under this Sub-paragraph 7.6 shall be conducted by Contractor and performed by counsel selected by Contractor and approved by County. Notwithstanding the preceding sentence, the County shall have the right to participate in any such defense at its sole cost and expense, except that in the event Contractor fails to provide the County with a full and adequate defense, as determined by County in its sole judgment, the County shall be entitled to retain its own counsel, including, without limitation, County Counsel, and reimbursement from Contractor for all such costs and expenses incurred by County in doing so. Contractor shall not have the right to enter into any settlement, agree to any injunction, or make any admission, in each case, on behalf of the County without the County's prior written approval.

7.6.3 Contractor shall inform all of its officers, employees, agents and subcontractors providing services hereunder of the confidentiality provisions of this Master Agreement.

7.6.4 Contractor shall sign and adhere to the provisions of Exhibit G1 - Contractor Acknowledgement and Confidentiality Agreement.

7.7 Staff Performance under the Influence

Contractor shall not knowingly permit any employee to perform services under this Master Agreement while under the influence of any alcoholic beverage, medication, narcotic, or other substance which might impair their physical or mental performance.

8.0 STANDARD TERMS AND CONDITIONS

8.1 AMENDMENTS

8.1.1 For any change which affects the scope of work, term, Master Agreement Sum, payments, or any term or condition included under this Master Agreement, an Amendment shall be prepared, mutually agreed to in writing, and then executed by Contractor and by the Board of Supervisors or its authorized designee.

8.1.2 The County's Board of Supervisors or Chief Executive Officer or designee may require the addition and/or change of certain terms and conditions in the Master Agreement during the term of this Master Agreement. The County reserves the right to add and/or change such provisions as required by the County's Board of Supervisors or Chief

Executive Officer or designee. To implement such changes, an Amendment to the Master Agreement shall be prepared and executed by Contractor and by Director or his/her designee.

8.1.3 The Director or his/her designee, may at his/her sole discretion, authorize extensions of time as defined in Paragraph 4.0 - Term of Agreement. Contractor agrees that such extensions of time shall not change any other term or condition of this Master Agreement during the period of such extensions. To implement an extension of time, an Amendment to the Master Agreement shall be prepared by the County, mutually agreed to in writing, and then executed by Contractor and by the Director or his/her designee.

8.1.4 The Director or his/her designee may require, at his/her sole discretion, the addition and/or change of certain terms and conditions in the Master Agreement to conform to changes in federal or state law or regulation, during the term of this Master Agreement. The County reserves the unilateral right to add and/or change such provisions as required by law or regulation, without the need for Contractor's written consent, to preserve this Master Agreement's conformity and compliance to federal and state law or regulation. To implement such changes, an Amendment to the Master Agreement shall be prepared by the County and then executed by Contractor and by the Director or his/her designee.

8.2 ASSIGNMENT AND DELEGATION/MERGERS OR ACQUISITIONS

8.2.1 Contractor shall notify the County of any pending acquisitions/mergers of its company unless otherwise legally prohibited from doing so. If Contractor is restricted from legally notifying the County of pending acquisitions/mergers, then it should notify the County of the actual acquisitions/mergers as soon as the law allows.

8.2.2 Contractor's assignment of its rights or delegation of its duties under this Master Agreement, or both, whether in whole or in part, is not allowed.

8.2.3 The surviving entity of an acquisition or merger, if not Contractor, will be required to enter into a new Master Agreement, if it is qualified, to obtain any Specialty Care Center Designation(s) that Contractor was granted under this Master Agreement.

8.3 AUTHORIZATION WARRANTY

Contractor represents and warrants that the person executing this Master Agreement for Contractor is an authorized agent who has actual authority to bind Contractor to each and every term, condition, and obligation of this Master Agreement and that all requirements of Contractor have been fulfilled to provide such actual authority.

8.4 BUDGET REDUCTIONS (INTENTIONALLY OMITTED)

8.5 CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION – LOWER TIER COVERED TRANSACTIONS (2 C.F.R. PART 376) (INTENTIONALLY OMITTED)

8.6 COMPLAINTS (INTENTIONALLY OMITTED)

8.7 COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

8.7.1 In the performance of this Master Agreement, Contractor shall comply with all applicable Federal, State and local laws, rules, regulations, ordinances, directives, guidelines, policies and procedures, including, but not limited to standards of a Centers for Medicare and Medicaid Services (CMS) approved accrediting body (i.e., The Joint Commission), California Code of Regulations, Title 22, Division 5 regulations and all other applicable industry best practices and standards. All provisions required thereby to be included in this Master Agreement are incorporated herein by reference.

8.7.2 Contractor and County shall indemnify, defend, and hold harmless each party, its officers, employees, and agents, from and against any and all claims, demands, damages, defense costs and legal fines, arising from any material breach, connected with, or related to any failure by Contractor, its officers, employees, agents, or subcontractors, to comply with any such laws, rules, regulations, ordinances, directives, guidelines, policies, or procedures. Any legal defense pursuant to Contractor's indemnification obligations under this Sub-paragraph 8.7 shall be conducted by Contractor and performed by counsel selected by Contractor and approved by the County. Notwithstanding the preceding sentence, County shall have the right to participate in any such defense at its sole cost and expense, except that in the event Contractor fails to provide County with a full and adequate defense as determined by the County in its sole judgement, the County shall be entitled to retain its own counsel, including, without limitation, County Counsel, and reimbursement from

Contractor for all such costs and expenses incurred by County in doing so. Contractor shall not have the right to enter into any settlement, agree to any injunction or other equitable relief, or make any admission, in each case, on behalf of County without County's prior written approval.

8.8 COMPLIANCE WITH CIVIL RIGHTS LAWS – ANTI-DISCRIMIATION AND AFFIRMATIVE ACTION

8.8.1 Contractor hereby assures that it will comply with Subchapter VI of the Civil Rights Act of 1964, 42 USC Sections 2000(e)(1) through 2000(e)(17), the Fair Employment & Housing Act, Government Code Sections 12920-12922; and Affirmative Action in County Agreements, Chapter 4.32 of the Los Angeles County Code, to the end that no person shall, on the grounds of race, creed, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Master Agreement or under any project, program, or activity supported by this Master Agreement.

8.8.2 Contractor certifies and agrees that all persons employed by it, its affiliates, subsidiaries, or holding companies are and shall be treated equally without regard to or because of race, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation, in compliance with all applicable Federal and State anti-discrimination laws and regulations.

8.8.3 Contractor shall take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to race, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation, in compliance with all applicable Federal and State anti-discrimination laws and regulations. Such action shall include, but is not limited to: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.

8.8.4 Contractor certifies and agrees that it will deal with its subcontractors, bidders, or vendors without regard to or because of race, color, religious creed, ancestry, national

origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation.

8.8.5 Contractor certifies and agrees that it, its affiliates, subsidiaries, or holding companies shall comply with all applicable Federal and State laws and regulations to the end that no person shall, on the grounds of race, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Master Agreement or under any project, program, or activity supported by this Master Agreement.

8.8.6 Contractor shall allow County representatives access to Contractor's employment records during regular business hours to verify compliance with the provisions of this Sub-paragraph 8.8 when so requested by the County.

8.8.7 If the County finds that any provisions of this Sub-paragraph 8.8 have been violated, such violation shall constitute a material breach of this Master Agreement upon which the County may terminate or suspend this Master Agreement. While the County reserves the right to determine independently that the anti-discrimination provisions of this Master Agreement have been violated, in addition, a determination by the California Fair Employment Practices Commission or the Federal Equal Employment Opportunity Commission that Contractor has violated Federal or State anti-discrimination laws or regulations shall constitute a finding by the County that Contractor has violated the anti-discrimination provisions of this Master Agreement.

8.8.8 The parties agree that in the event Contractor violates any of the anti-discrimination provisions of this Master Agreement, the County shall, at its sole option after considering any written evidence in mitigation or explanation of the violation presented by Contractor, be entitled to the sum of Five Hundred Dollars ($500) for each such violation or a maximum of One Thousand Five Hundred ($1,500) for any continuing course of violations, pursuant to California Civil Code Section 1671 as liquidated damages in lieu of terminating or suspending this Master Agreement.

8.8.9 **Anti-discrimination in Services:**

Contractor shall not discriminate in the provision of services hereunder because of race, color, religious creed, national

origin, ethnic group identification, ancestry, age, sex, sexual orientation, medical condition, marital status, political affiliation, or physical or mental disability in accordance with requirements of Federal and State laws. For the purpose of this Sub-paragraph, discrimination in the provision of services may include, but is not limited to, the following: Denying any person any service or benefit or the availability of a facility; providing any service or benefit to a person which is not equivalent or is provided in a non-equivalent manner or at a non-equivalent time, from that provided to others; subjecting any person to segregation or separate treatment in any manner related to the receipt of any service; restricting any person in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit; and treating any person differently from others in determining admission, enrollment quota, eligibility, membership, or any other requirements or conditions which persons must meet in order to be provided any service or benefit. Contractor shall take affirmative action to ensure that intended beneficiaries of this Master Agreement are provided services without regard to race, color, religious creed, national origin, ethnic group identification, ancestry, sex, sexual orientation, age, medical condition, marital status, political affiliation, physical or mental disability.

8.8.10 Contractor shall certify to, and comply with, the provisions of Exhibit D - Contractor's EEO Certification.

8.9 COMPLIANCE WITH THE COUNTY'S JURY SERVICE ROGRAM (INTENTIONALLY OMITTED)

8.10 CONFLICT OF INTEREST (INTENTIONALLY OMITTED)

8.11 CONSIDERATION OF HIRING COUNTY EMPLOYEES TARGETED FOR LAYOFF/OR RE-EMPLOYMENT LIST (INTENTIONALLY OMITTED)

8.12 CONSIDERATION OF HIRING GAIN/GROW PARTICIPANTS (INTENTIONALLY OMITTED)

8.13 CONTRACTOR RESPONSIBILITY AND DEBARMENT

8.13.1 Responsible Contractor

A responsible Contractor is a Contractor who has demonstrated the attribute of trustworthiness, as well as quality, fitness, capacity and experience to satisfactorily perform the agreement. It is the County's policy to conduct business only with responsible Contractors.

8.13.2 **Chapter 2.202 of the County Code**

Contractor is hereby notified that, in accordance with Chapter 2.202 of the County Code, if the County acquires information concerning the performance of Contractor on this or other contracts which indicates that Contractor is not responsible, the County may, in addition to other remedies provided in the Master Agreement, debar Contractor from bidding or proposing on, or being awarded, and/or performing work on County contracts for a specified period of time, which generally will not exceed five (5) years but may exceed five (5) years or be permanent if warranted by the circumstances, and terminate any or all existing Contracts Contractor may have with the County.

8.13.3 **Non-responsible Contractor**

The County may debar a Contractor if the Board of Supervisors finds, in its discretion, that Contractor has done any of the following: (1) violated a term of an agreement with the County or a nonprofit corporation created by the County, (2) committed an act or omission which negatively reflects on Contractor's quality, fitness or capacity to perform an agreement with the County, any other public entity, or a nonprofit corporation created by the County, or engaged in a pattern or practice which negatively reflects on same, (3) committed an act or offense which indicates a lack of business integrity or business honesty, or (4) made or submitted a false claim against the County or any other public entity.

8.13.4 **Contractor Hearing Board**

1. If there is evidence that Contractor may be subject to debarment, the Department will notify Contractor in writing of the evidence which is the basis for the proposed debarment and will advise Contractor of the scheduled date for a debarment hearing before Contractor Hearing Board.

2. Contractor Hearing Board will conduct a hearing where evidence on the proposed debarment is presented. Contractor and/or Contractor's representative shall be given an opportunity to submit evidence at that hearing. After the hearing, Contractor Hearing Board shall prepare a tentative proposed decision, which shall contain a recommendation regarding whether Contractor should be debarred, and, if so, the appropriate length of time of the debarment. Contractor and the Department shall be

provided an opportunity to object to the tentative proposed decision prior to its presentation to the Board of Supervisors.

3. After consideration of any objections, or if no objections are submitted, a record of the hearing, the proposed decision, and any other recommendation of Contractor Hearing Board shall be presented to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of Contractor Hearing Board.

4. If a Contractor has been debarred for a period longer than five (5) years, that Contractor may after the debarment has been in effect for at least five (5) years, submit a written request for review of the debarment determination to reduce the period of debarment or terminate the debarment. The County may, in its discretion, reduce the period of debarment or terminate the debarment if it finds that Contractor has adequately demonstrated one or more of the following: (1) elimination of the grounds for which the debarment was imposed; (2) a bona fide change in ownership or management; (3) material evidence discovered after debarment was imposed; or (4) any other reason that is in the best interests of the County.

5. Contractor Hearing Board will consider a request for review of a debarment determination only where (1) Contractor has been debarred for a period longer than five (5) years; (2) the debarment has been in effect for at least five (5) years; and (3) the request is in writing, states one or more of the grounds for reduction of the debarment period or termination of the debarment, and includes supporting documentation. Upon receiving an appropriate request, Contractor Hearing Board will provide notice of the hearing on the request. At the hearing, Contractor Hearing Board shall conduct a hearing where evidence on the proposed reduction of debarment period or termination of debarment is presented. This hearing shall be conducted and the request for review decided by Contractor Hearing Board pursuant to the same procedures as for a debarment hearing.

6. Contractor Hearing Board's proposed decision shall contain a recommendation on the request to reduce

the period of debarment or terminate the debarment. Contractor Hearing Board shall present its proposed decision and recommendation to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of Contractor Hearing Board.

8.13.5 **Subcontractors of Contractor**

These terms shall also apply to Subcontractors of County Contractors.

8.14 CONTRACTOR'S ACKNOWLEDGEMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW

Contractor acknowledges that the County places a high priority on the implementation of the Safely Surrendered Baby Law. Contractor understands that it is the County's policy to encourage all County Contractors to voluntarily post the County's "Safely Surrendered Baby Law" poster in a prominent position at Contractor's place of business. Contractor will also encourage its Subcontractors, if any, to post this poster in a prominent position in the Subcontractor's place of business. Contractor, and its subcontractors, can access posters and other campaign material at www.babysafela.org.

8.15 CONTRACTOR'S EXCLUSION FROM PARTICIPATING IN A FEDERALLY FUNDED PROGRAM

8.15.1 Contractor hereby warrants that neither it nor any of its Subcontractors' owners, officers, partners, directors, other principals, employees or independent contractors is restricted or excluded from providing services under any health care program funded by the Federal government, directly or indirectly, in whole or in part, (which includes Medicare, Medi-Cal and Healthy Families) and that Contractor will notify Director within ten (10) calendar days in writing of Contractor's knowledge of such restriction or exclusion of: (1) any event that would require Contractor or any of the aforementioned parties' mandatory exclusion from participation in a Federally funded health care program; and (2) any exclusionary or suspension action taken by any agency of the Federal or State governments against any of the aforementioned parties' barring these parties from participating in a Federally funded health care program, whether such bar is direct or indirect, or whether such bar is in whole or in part.

8.15.2 Contractor shall indemnify and hold the County harmless against any and all loss or damage the County may suffer arising from any exclusion or suspension of Contractor or its

Subcontractors' owners, officers, partners, directors, other principals, employees or independent contractors from such participation in a Federally funded health care program.

8.15.3 Failure by Contractor to meet the requirements of this Sub-paragraph shall constitute a material breach of contract upon which the County may immediately terminate or suspend this Master Agreement.

8.16 CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM

8.16.1 Contractor acknowledges that the County has established a goal of ensuring that all individuals who benefit financially from the County through agreement are in compliance with their court-ordered child, family and spousal support obligations in order to mitigate the economic burden otherwise imposed upon the County and its taxpayers.

8.16.2 As required by the County's Child Support Compliance Program (County Code Chapter 2.200) and without limiting Contractor's duty under this Master Agreement to comply with all applicable provisions of law, Contractor warrants that it is now in compliance and shall during the term of this Master Agreement maintain in compliance with employment and wage reporting requirements as required by the Federal Social Security Act (42 USC Section 653a) and California Unemployment Insurance Code Section 1088.5, and shall implement all lawfully served Wage and Earnings Withholding Orders or Child Support Services Department Notices of Wage and Earnings Assignment for Child, Family or Spousal Support, pursuant to Code of Civil Procedure Section 706.031 and Family Code Section 5246(b).

8.17 CONTRACTOR'S WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM (INTENTIONALLY OMITTED)

8.18 COUNTY'S QUALITY ASSURANCE PLAN

The County or its agent will monitor Contractor's performance under this Master Agreement on not less than a three year basis. Such evaluation will include assessing Contractor's compliance with all Master Agreement terms and conditions and performance standards. Contractor deficiencies which the County determines are significant or continuing and that may place performance of the Master Agreement in jeopardy if not corrected will be reported to the Board and listed in the appropriate contractor performance database. The report to the Board will include improvement/corrective action measures taken by the County and Contractor. If improvement does

not occur consistent with the corrective action measures, the County may terminate this Master Agreement or impose other penalties as specified in this Master Agreement.

8.19 DAMAGE TO COUNTY FACILITIES, BUILDINGS OR GROUNDS (INTENTIONALLY OMITTED)

8.20 EMPLOYMENT ELIGIBILITY VERIFICATION

8.20.1 Contractor warrants that it fully complies with all Federal and State statutes and regulations regarding the employment of aliens and others and that all its employees performing work under this Master Agreement meet the citizenship or alien status requirements set forth in Federal and State statutes and regulations. Contractor shall obtain, from all employees performing work hereunder, all verification and other documentation of employment eligibility status required by Federal and State statutes and regulations including, but not limited to, the Immigration Reform and Control Act of 1986, (P.L. 99-603), or as they currently exist and as they may be hereafter amended. Contractor shall retain all such documentation for all covered employees for the period prescribed by law.

8.20.2 Contractor shall indemnify, defend, and hold harmless, the County, its agents, officers, and employees from employer sanctions and any other liability which may be assessed against Contractor or the County or both in connection with any alleged violation of any Federal or State statutes or regulations pertaining to the eligibility for employment of any persons performing work under this Master Agreement.

8.21 FACSIMILE REPRESENTATIONS

The County and Contractor hereby agree to regard facsimile representations of original signatures of authorized officers of each party, when appearing in appropriate places on the Amendments prepared pursuant to sub-paragraph 8.1, and received via a facsimile communicative, as legally sufficient evidence that such original signatures have been affixed to Amendments to this Master Agreement, such that the parties need not follow up facsimile transmissions of such documents with subsequent (non-facsimile) transmission of “original” versions of such documents.

8.22 FAIR LABOR STANDARDS

Contractor shall comply with all applicable provisions of the Federal Fair Labor Standards Act and shall indemnify, defend, and hold harmless the County and its agents, officers, and employees from

any and all liability, including, but not limited to, wages, overtime pay, liquidated damages, penalties, court costs, and attorneys' fees arising under any wage and hour law, including, but not limited to, the Federal Fair Labor Standards Act, for work performed by Contractor's employees for which the County may be found jointly or solely liable.

8.23 FEDERAL ACCESS TO RECORDS (INTENTIONALLY OMITTED)

8.24 FORCE MAJEURE

8.24.1 Neither party shall be liable for such party's failure to perform its obligations under and in accordance with this Master Agreement, if such failure arises out of fires, floods, epidemics, quarantine restrictions, other natural occurrences, strikes, lockouts (other than a lockout by such party or any of such party's subcontractors), freight embargoes, or other similar events to those described above, but in every such case the failure to perform must be totally beyond the control and without any fault or negligence of such party (such events are referred to in this Sub-paragraph as "force majeure events").

8.24.2 Notwithstanding the foregoing, a default by a subcontractor of Contractor shall not constitute a force majeure event, unless such default arises out of causes beyond the control of both Contractor and such subcontractor, and without any fault or negligence of either of them. In such case, Contractor shall not be liable for failure to perform, unless the goods or services to be furnished by the subcontractor were obtainable from other sources in sufficient time to permit Contractor to meet the required performance schedule. As used in this Sub-paragraph, the term "subcontractor" and "subcontractors" mean subcontractors at any tier.

8.24.3 In the event Contractor's failure to perform arises out of a force majeure event, Contractor agrees to use commercially reasonable best efforts to obtain goods or services from other sources, if applicable, and to otherwise mitigate the damages and reduce the delay caused by such force majeure event.

8.25 GOVERNING LAW, JURISDICTION, AND VENUE

This Master Agreement shall be governed by, and construed in accordance with, the laws of the State of California. Contractor agrees and consents to the exclusive jurisdiction of the courts of the State of California for all purposes regarding this Master Agreement and further agrees and consents that venue of any action brought

hereunder shall be exclusively in the County of Los Angeles.

8.26 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) (INTENTIONALLY OMITTED)

8.27 INDEPENDENT CONTRACTOR STATUS (INTENTIONALLY OMITTED)

8.28 INDEMNIFICATION

Contractor shall indemnify, defend and hold harmless the County, its Special Districts, elected and appointed officers, employees, and agents and volunteers ("County Indemnitees") from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, and expenses (including attorney and expert witness fees), arising out of the performance of this Master Agreement, but only in proportion to and to the extent such demands, claims, actions, fees, costs, and expenses are causes by or result from the negligent or intentional acts and/or omissions of Contractor, its officers, employees, or agents.

The County shall indemnify, defend and hold harmless Contractor, and its agents and employees from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, and expenses (including attorney and expert witness fees), arising from or connected with the County's acts and/or omissions arising out of the performance of this Master Agreement, but only in proportion to and to the extent such demands, claims, actions, fees, costs, and expenses are causes by or result from the negligent or intentional out of the performance of this Agreement, but only in proportion to and to the extent such demands, claims, actions, fees, costs, and expenses are caused by or result from the negligent or intentional acts or omissions of County, its officers, employees, or agents.

8.29 GENERAL PROVISIONS FOR ALL INSURANCE COVERAGE

Without limiting the Contractor's indemnification of County, and in the performance of this Master Agreement and until all of its obligations pursuant to this Master Agreement have been met, the Contractor shall and will be required provide and maintain at its own expense insurance coverage satisfying the requirements specified in Subparagraphs 8.29 and 8.30 of this Master Agreement. These minimum insurance coverage terms, types and limits (the "Required Insurance") also are in addition to and separate from any other Contractual obligation imposed upon the Contractor pursuant to this Master Agreement and Specialty Care Center Designation Agreement. The County in no way warrants that the Required Insurance is sufficient to protect the Contractor for liabilities which may arise from or relate to this Master Agreement.

8.29.1 **Evidence of Coverage and Notice to County**

- Certificate(s) of insurance coverage (Certificate) or other evidence of coverage satisfactory to County, and a copy of an Additional Insured endorsement confirming County and its Agents (defined below) has been given Insured status under the Contractor's General Liability policy, shall be delivered to County at the e-mail address shown below and provided prior to commencing services under this Agreement.
- Renewal Certificates shall be provided to County prior to the Contractor's policy expiration dates. The County reserves the right to obtain complete, certified copies of any required Contractor and/or Sub-Contractor insurance policies at any time.
- Certificates shall identify all Required Insurance coverage types and limits specified herein, reference this Agreement by name or number, and be signed by an authorized representative of the insurer(s). The Insured party named on the Certificate shall match the name of the Contractor identified as the contracting party in this Agreement. Certificates shall provide the full name of each insurer providing coverage, its NAIC (National Association of Insurance Commissioners) identification number if applicable, , the amounts of any policy deductibles or self-insured retentions exceeding fifty thousand ($50,000.00) dollars, and list any County required endorsement forms.
- Neither the County's failure to obtain, nor the County's receipt of, or failure to object to a non-complying insurance certificate or endorsement, or any other insurance documentation or information provided by the Contractor, its insurance broker(s) and/or insurer(s), shall be construed as a waiver of any of the Required Insurance provisions.

Certificates and copies of any required endorsements shall be e-mailed to:

cgcontractorinsurance@dhs.lacounty.gov

The Contractor also shall promptly report to County any injury or property damage accident or incident, including any injury to a Contractor employee occurring on County property, and any loss, disappearance, destruction, misuse, or theft of County property, monies or securities entrusted to the Contractor. The Contractor also shall

promptly notify County of any third party claim or suit filed against the Contractor or any of its Sub-Contractors which arises from or relates to this Agreement, and could result in the filing of a claim or lawsuit against the Contractor and/or County.

8.29.2 **Additional Insured Status and Scope of Coverage**

Unless insured under a program of self-insurance, the County of Los Angeles, its Special Districts, Elected Officials, Officers, Agents, Employees and Volunteers (collectively County and its Agents) shall be provided additional insured status under the Contractor's General Liability policy with respect to liability arising out of the Contractor's ongoing and completed operations performed on behalf of the County. The County and its Agents additional insured status shall apply with respect to liability and defense of suits arising out of the Contractor's acts or omissions, whether such liability is alleged to be attributable to the Contractor or to the County. The full policy limits and scope of protection also shall apply to the County and its Agents as an additional insured, even if they exceed the County's minimum Required Insurance specifications herein. Use of an automatic additional insured endorsement form is acceptable provided it satisfies the Required Insurance provisions herein.

8.29.3 **Cancellation of or Changes in Insurance**

The Contractor shall provide County with, or the Contractor's insurance policies shall contain a provision that County shall receive, written notice of cancellation or any change in Required Insurance, including insurer, limits of coverage, term of coverage or policy period. The written notice shall be provided to County at least ten (10) days in advance of cancellation for non-payment of premium and thirty (30) days in advance for any other cancellation or policy change. Failure to provide written notice of cancellation or any change in Required Insurance may constitute a material breach of the Agreement, in the sole discretion of the County, upon which the County may suspend or terminate this Agreement.

8.29.4 **Failure to Maintain Insurance**

The Contractor's failure to maintain or to provide acceptable evidence that it maintains the Required Insurance shall constitute a material breach of the Agreement, upon which County immediately may withhold payments due to the Contractor, and/or suspend or

terminate this Agreement. The County, at its sole discretion, may obtain damages from the Contractor resulting from said breach. Alternatively, the County may purchase the Required Insurance, and without further notice to the Contractor, pursue the Contractor reimbursement.

8.29.5 **Insurer Financial Ratings**

Coverage shall be placed with insurers acceptable to the County with A.M. Best ratings of not less than A:VII unless otherwise approved by County.

8.29.6 **Contractor's Insurance Shall Be Primary**

The Contractor's insurance policies, with respect to any claims related to this Agreement, shall be primary with respect to all other sources of coverage available to the Contractor. Any County maintained insurance or self-insurance coverage shall be in excess of and not contribute to any Contractor coverage.

8.29.7 **Waivers of Subrogation**

To the fullest extent permitted by law, the Contractor hereby waives its rights and its insurer(s)' rights of recovery against the County under all the Required Insurance for any loss arising from or relating to this Agreement. The Contractor shall require its insurers to execute any waiver of subrogation endorsements which may be necessary to effect such waiver.

8.29.8 **Sub-Contractor Insurance Coverage Requirements (INTENTIONALLY OMITTED)**

8.29.9 **Deductibles and Self-Insured Retentions (SIRs)**

The Contractor's policies shall not obligate the County to pay any portion of any Contractor deductible or SIR. County retains the right to require the Contractor to reduce or eliminate policy deductibles and SIRs as respects the County, or to provide a bond guaranteeing the Contractor's payment of all deductibles and SIRs, including all related claims investigation, administration and defense expenses. Such bond shall be executed by a corporate surety licensed to transact business in the State of California.

8.29.10 **Claims Made Coverage**

If any part of the Required Insurance is written on a claims made basis, any policy retroactive date shall precede the effective date of this Agreement. The Contractor understands and agrees it shall maintain such coverage for

a period of not less than three (3) years following Agreement expiration, termination or cancellation.

8.29.11 **Application of Excess Liability Coverage**

The Contractors may use a combination of primary, and excess insurance policies which provide coverage as broad as ("follow form" over) the underlying primary policies, to satisfy the Required Insurance provisions.

8.29.12 **Separation of Insureds**

All liability policies shall provide cross-liability coverage as would be afforded by the standard ISO (Insurance Services Office, Inc.) separation of insureds provision with no insured versus insured exclusions or limitations.

8.29.13 **Alternative Risk Financing Programs**

The County reserves the right to review, and then approve, the Contractor use of self-insurance, risk retention groups, risk purchasing groups, pooling arrangements and captive insurance to satisfy the Required Insurance provisions. The County and its Agents shall be designated as an Additional Covered Party under any approved program.

8.29.14 **County Review and Approval of Insurance Requirements**

The County reserves the right to review and adjust the Required Insurance provisions, conditioned upon County's determination of changes in risk exposures.

8.30 INSURANCE COVERAGE

8.30.1 **Commercial General Liability** insurance (providing scope of coverage equivalent to ISO policy form CG 00 01), naming County and its Agents as an additional insured, with limits of not less than:

General Aggregate:	$2 million
Products/Completed Operations Aggregate:	$1 million
Personal and Advertising Injury:	$1 million
Each Occurrence:	$1 million

8.30.2 **Automobile Liability** insurance (providing scope of coverage equivalent to ISO policy form CA 00 01) with limits of not less than $1 million for bodily injury and property damage, in combined or equivalent split limits, for each single accident. Insurance shall cover liability arising out of the Contractor's use of autos pursuant to this Agreement,

including owned, leased, hired, and/or non-owned autos, as each may be applicable.

8.30.3 **Workers Compensation and Employers' Liability** insurance or qualified self-insurance satisfying statutory requirements, which includes Employers' Liability coverage with limits of not less than $1 million per accident. If the Contractor will provide leased employees, or, is an employee leasing or temporary staffing firm or a professional employer organization (PEO), coverage also shall include an Alternate Employer Endorsement (providing scope of coverage equivalent to ISO policy form WC 00 03 01 A) naming the County as the Alternate Employer, and the endorsement form shall be modified to provide that the County will receive not less than thirty (30) days advance written notice of cancellation of this coverage provision. If applicable to the Contractor's operations, coverage also shall be arranged to satisfy the requirements of any federal workers or workmen's compensation law or any federal occupational disease law.

8.30.4 **Unique Insurance Coverage**

- **Sexual Misconduct Liability (Intentionally Omitted)**
- **Professional Liability/Errors and Omissions**

  Insurance covering the Contractor's liability arising from or related to this Agreement, with limits of not less than $1 million per claim and $3 million aggregate. Further, Contractor understands and agrees it shall maintain such coverage for a period of not less than three (3) years following this Agreement's expiration, termination or cancellation.
- **Property Coverage (Intentionally Omitted)**
- **Miscellaneous Coverage (Intentionally Omitted)**

8.31 NOTICE OF DISPUTES (INTENTIONALLY OMITTED)

8.32 LIQUIDATED DAMAGES (INTENTIONALLY OMITTED)

8.33 MOST FAVORED PUBLIC ENTITY (INTENTIONALLY OMITTED)

8.34 NONDISCRIMINATION AND AFFIRMATIVE ACTION (INTENTIONALLY OMITTED)

8.35 NON EXCLUSIVITY (INTENTIONALLY OMITTED)

8.36 NOTICE OF DELAYS (INTENTIONALLY OMITTED)

8.37 NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT

Contractor shall notify its employees, and shall require each Subcontractor to notify its employees, that they may be eligible for the Federal Earned Income Credit under the federal income tax laws. Such notice shall be provided in accordance with the requirements set forth in Internal Revenue Service Notice No. 1015.

8.38 NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY LAW

Contractor shall notify and provide to its employees, and shall require each Subcontractor to notify and provide to its employees, a fact sheet regarding the Safely Surrendered Baby Law, its implementation in Los Angeles County, and where and how to safely surrender a baby. The fact sheet is set forth in Exhibit I of this Master Agreement and is also available on the Internet at www.babysafela.org for printing purposes.

8.39 NOTICES

All notices or demands required or permitted to be given or made under this Master Agreement shall be in writing and shall be hand delivered with signed receipt or mailed by first-class registered or certified mail, postage prepaid, addressed to the parties as identified in Exhibits E - County's Administration and F – Contractor's Administration. Addresses may be changed by either party giving ten (10) days' prior written notice thereof to the other party.

Notwithstanding the foregoing, in addition, and in lieu of written notification, the Director, or designee, shall have the authority to issue any notice to Contractor electronically via e-mail at the designated email address as identified in Exhibit F – Contractor's Administration. This includes all notices or demands required or permitted by the County under this Master Agreement.

8.40 PROHIBITION AGAINST INDUCEMENT OR PERSUASION (INTENTIONALLY OMITTED)

8.41 PUBLIC RECORDS ACT (INTENTIONALLY OMITTED)

8.42 PUBLICITY

8.42.1 Contractor shall not disclose any details in connection with this Master Agreement to any person or entity except as may be otherwise provided hereunder or required by law. However, in recognizing Contractor's need to identify its services and related clients to sustain itself, the County shall not inhibit Contractor from publishing its role

under this Master Agreement within the following conditions:

- Contractor shall develop all publicity material in a professional manner; and
- During the term of this Master Agreement, Contractor shall not, and shall not authorize another to, publish or disseminate any commercial advertisements, press releases, feature articles, or other materials using the name of the County without the prior written consent of the Director or his/her designee. The County shall not unreasonably withhold written consent.

8.42.2 Contractor may, without the prior written consent of County, indicate in its proposals and sales materials and signs that it has been awarded this Master Agreement with the County of Los Angeles, provided that the requirements of this Sub-paragraph 8.42 shall apply.

8.43 RECORD RETENTION AND INSPECTION/AUDIT SETTLEMENT (INTENTIONALLY OMITTED)

8.44 RECYCLED BOND PAPER (INTENTIONALLY OMITTED)

8.45 RESTRICTIONS ON LOBBYING (INTENTIONALLY OMITTED)

8.46 SUBCONTRACTING

8.46.1 The designation or participation award under this Master Agreement may not be subcontracted by Contractor.

8.47 SURVIVAL

In addition to any provisions of this Master Agreement which specifically state that they will survive the termination or expiration of this Master Agreement and any rights and obligations under this Master Agreement which by their nature should survive, the following Sub-paragraphs shall survive any termination or expiration of this Master Agreement:

Sub-paragraph 7.6 (Confidentiality)

Sub-paragraph 8.7 (Compliance with Applicable Laws, Rules and Regulations

Sub-paragraph 8.25 (Governing Law, Jurisdiction, and Venue)

Sub-paragraph 8.28 (Indemnification)

Sub-paragraph 8.29 (General Provisions for all Insurance Coverage)

Sub-paragraph 8.30 (Insurance Coverage)

Sub-paragraph 8.43 (Record Retention and Inspection/Audit Settlement)

Sub-paragraph 8.47 (Survival)

8.48 TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM

Failure of Contractor to maintain compliance with the requirements set forth in Sub-paragraph 8.16 – Contractor's Warranty of Adherence to County's Child Support Compliance Program, shall constitute default under this Master Agreement. Without limiting the rights and remedies available to the County under any other provision of this Master Agreement, failure of Contractor to cure such default within ninety (90) calendar days of written notice shall be grounds upon which the County may terminate this Master Agreement pursuant to Sub-paragraph 8.51 - Termination for Default and pursue debarment of Contractor, pursuant to County Code Chapter 2.202.

8.49 TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM (INTENTIONALLY OMITTED)

8.50 TERMINATION FOR CONVENIENCE

8.50.1 The County may terminate this Master Agreement, in whole or in part, from time to time or permanently, when such action is deemed by the County, in its sole discretion, to be in its best interest. Termination of the designation(s) hereunder shall be effected by notice of termination to Contractor specifying the extent to which the designation is terminated and the date upon which such termination becomes effective. The date upon which such termination becomes effective shall be no less than thirty (30) days after the notice is sent.

8.50.2 After receipt of a notice of termination and except as otherwise directed by the County, the Contractor shall:

- Stop operating as the designation(s) under this Master Agreement on the date and to the extent specified in such notice; and
- Transfer title and deliver to the County all completed work and work in process; and
- Complete performance of such part of the work as shall not have been terminated by such notice.

8.50.3 All material including books, records, documents, or other evidence bearing on the costs and expenses of Contractor under this Master Agreement shall be maintained by Contractor in accordance with Sub-paragraph 8.42, Record Retention and Inspection/Audit Settlement.

8.50.4 Contractor may terminate this Master Agreement, in whole or in part. Termination of the designation(s) hereunder shall be effected by notice of termination to the County specifying the extent to which the designation(s) is terminated and the date upon which such termination becomes effective. The date upon which such termination becomes effective shall be no less than thirty (30) days after the notice is sent. Contractor shall be obligated to comply with Sub-paragraphs 8.50.2 and 8.50.3 herein.

8.51 TERMINATION FOR DEFAULT

8.51.1 The County may, by written notice to Contractor, terminate the whole or any part of this Master Agreement, if, in the judgment of the Director or his/her designee:

- Contractor has materially breached this Master Agreement; or
- Contractor fails to satisfactorily meet the requirements and/or standards required under this Master Agreement; or
- Contractor fails to demonstrate a high probability of timely complying with the requirements and/or standards required under this Master Agreement, or fails to demonstrate convincing progress toward a cure within five (5) working days (or such longer period as the County may authorize in writing) after receipt of written notice from the County specifying such failure.
- Contractor expressly repudiates this Master Agreement by an unequivocal refusal to perform

8.51.2 In the event the County intends to terminate this Master Agreement in accordance with Paragraph 8.51.1, it shall give thirty (30) days' notice to Contractor that it is in material breach and/or anticipatory breach of the Master Agreement. In the notice of intended termination, the Director or his/her designee shall set forth the facts underlying its claim that Contractor is in material breach and/or anticipatory breach. Remedy of the breach or convincing progress towards a cure within twenty (20) days (or such longer period as the

County may authorize in writing) of receipt of said notice shall revive the Master Agreement in effect for the remaining term.

8.51.3 In the event that the County terminates this Master Agreement in whole or in part as provided in Sub-paragraph 8.51.1, the County may procure, upon such terms and in such manner as the County may deem appropriate, goods and services similar to those so terminated. Contractor shall be liable to the County for any and all excess costs incurred by the County, as determined by the County, for such similar goods and services. Contractor shall continue the performance of this Master Agreement to the extent not terminated under the provisions of this sub-paragraph. The parties agree that this particular damage provision (i.e., that the costs incurred by the County) shall be limited to a time period of twelve (12) months or the remaining period this Master Agreement after breach or whichever time period is less.

8.51.4 Except with respect to defaults of any Subcontractor, Contractor shall not be liable for any such excess costs of the type identified in Sub-paragraph 8.51.3 if its failure to perform this Master Agreement arises out of causes beyond the control and without the fault or negligence of Contractor. Such causes may include, but are not limited to: acts of God or of the public enemy, acts of the County in either its sovereign or contractual capacity, acts of Federal or State governments in their sovereign capacities, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, and unusually severe weather; but in every case, the failure to perform must be beyond the control and without the fault or negligence of Contractor. If the failure to perform is caused by the default of a Subcontractor, and if such default arises out of causes beyond the control of both Contractor and Subcontractor, and without the fault or negligence of either of them, Contractor shall not be liable for any such excess costs for failure to perform, unless the goods or services to be furnished by the Subcontractor were obtainable from other sources in sufficient time to permit Contractor to meet the required performance schedule. As used in this Sub-paragraph, the term "Subcontractor(s)" means Subcontractor(s) at any tier.

8.51.5 If, after the County has given notice of termination under the provisions of this Sub-paragraph 8.51, it is determined by the County that Contractor was not in default under the provisions of this sub-paragraph 8.51, or that the default

was excusable under the provisions of sub-paragraph 8.51.4, the rights and obligations of the parties shall be the same as if the notice of termination had been issued pursuant to Sub-paragraph 8.50 - Termination for Convenience.

8.51.6 The rights and remedies of the County provided in this Sub-paragraph 8.51 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Master Agreement.

8.52 TERMINATION FOR IMPROPER CONSIDERATION

8.52.1 The County may, by written notice to Contractor, immediately terminate the right of Contractor to proceed under this Master Agreement if it is found that consideration, in any form, was offered or given by Contractor, either directly or through an intermediary, to any County officer, employee, or agent with the intent of securing this Master Agreement or securing favorable treatment with respect to the award, amendment, or extension of this Master Agreement or the making of any determinations with respect to Contractor's performance pursuant to this Master Agreement. In the event of such termination, the County shall be entitled to pursue the same remedies against Contractor as it could pursue in the event of default by Contractor.

8.52.2 Contractor shall immediately report any attempt by a County officer or employee to solicit such improper consideration. The report shall be made either to the County manager charged with the supervision of the employee or to the County Auditor-Controller's Employee Fraud Hotline at (800) 544-6861 or www.lacountyfraud.org.

8.52.3 Among other items, such improper consideration may take the form of cash, discounts, service, the provision of travel or entertainment, or tangible gifts.

8.53 TERMINATION FOR INSOLVENCY

8.53.1 The County may terminate this Master Agreement forthwith in the event of the occurrence of any of the following:

- Insolvency of Contractor: Contractor shall be deemed to be insolvent if it has ceased to pay its debts for at least sixty (60) days in the ordinary course of business or cannot pay its debts as they become due, whether or not a petition has been filed under the Federal Bankruptcy Code and whether or not Contractor is insolvent within the meaning of the Federal Bankruptcy Code;

- The filing of a voluntary or involuntary petition regarding Contractor under the Federal Bankruptcy Code;
- The appointment of a Receiver or Trustee for Contractor; or
- The execution by Contractor of a general assignment for the benefit of creditors.

8.53.2 The rights and remedies of the County provided in this Sub-paragraph 8.53 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Master Agreement.

8.54 TERMINATION FOR NON-ADHERENCE OF COUNTY LOBBYIST ORDINANCE

Contractor, and each County Lobbyist or County Lobbying firm as defined in County Code Section 2.160.010 retained by Contractor, shall fully comply with the County's Lobbyist Ordinance, County Code Chapter 2.160. Failure on the part of Contractor or any County Lobbyist or County Lobbying firm retained by Contractor to fully comply with the County's Lobbyist Ordinance shall constitute a material breach of this Master Agreement, upon which the County may in its sole discretion, immediately terminate or suspend this Master Agreement.

8.55 TERMINATION FOR NON-APPROPRIATION OF FUNDS (INTENTIONALLY OMITTED)

8.56 TIME OFF FOR VOTING

Contractor shall notify its employees, and shall require each Subcontractor to notify and provide to its employees, information regarding the time off for voting law (Elections Code Section 14000). Not less than 10 days before every statewide election, every Contractor and Subcontractors shall keep posted conspicuously at the place of work, if practicable, or elsewhere where it can be seen as employees come or go to their place of work, a notice setting forth the provisions of Section 14000.

8.57 UNLAWFUL SOLICITATION

Contractor shall inform all of its officers and employees performing services hereunder of the provisions of Article 9 of Chapter 4 of Division 3 (commencing with section 6150) of Business and Professions Code of the State of California (i.e. State Bar Act provisions regarding unlawful solicitation as a runner or capper for attorneys) and shall take positive and affirmative steps in its performance hereunder to ensure that there is no violation of said provisions by its officers and employees. Contractor agrees that if a patient requests assistance in obtaining the services of any attorney,

it will refer the patient to the attorney referral service of all those bar associations within Los Angeles County that have such a service.

8.58 VALIDITY

If any provision of this Master Agreement or the application thereof to any person or circumstance is held invalid, the remainder of this Master Agreement and the application of such provision to other persons or circumstances shall not be affected thereby.

8.59 WAIVER

No waiver by the County of any breach of any provision of this Master Agreement shall constitute a waiver of any other breach or of such provision. Failure of the County to enforce at any time, or from time to time, any provision of this Master Agreement shall not be construed as a waiver thereof. The rights and remedies set forth in this Sub-paragraph 8.59 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Master Agreement.

8.60 WARRANTY AGAINST CONTINGENT FEES

8.60.1 Contractor warrants that no person or selling agency has been employed or retained to solicit or secure this Master Agreement upon any agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by Contractor for the purpose of securing business.

8.60.2 For breach of this warranty, the County shall have the right to terminate this Master Agreement and, at its sole discretion, deduct from the Master Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, brokerage, or contingent fee.

8.61 COMPLIANCE WITH COUNTY'S ZERO TOLERANCE POLICY ON HUMAN TRAFFICKING

8.61.1 Contractor acknowledges that the County has established a Zero Tolerance Policy on Human Trafficking prohibiting Contractors from engaging in human trafficking.

8.61.2 If a Contractor or member of Contractor's staff is convicted of a human trafficking offense, the County shall require that Contractor or member of Contractor's staff be removed immediately from performing services under this Master Agreement. The County will not be under any obligation to disclose confidential information regarding the offenses other than those required by law.

8.61.3 Disqualification of any member of Contractor's staff pursuant to this Sub-paragraph shall not relieve Contractor of its obligation to complete all work in accordance with the terms and conditions of this Master Agreement.

8.62 COMPLIANCE WITH FAIR CHANCE EMPLOYMENT PRACTICES

To the extend applicable, Contractor shall comply with fair chance employment hiring practices set forth in California Government Code Section 12952, Employment Discrimination: Conviction History. Contractor's violation of this paragraph of the Master Agreement may constitute a material breach of the Master Agreement. In the event of such material breach, County may, in its sole discretion, terminate the Master Agreement.

8.63 COMPLIANCE WITH THE COUNTY POLICY OF EQUITY

Contractor acknowledges that the County takes its commitment to preserving the dignity and professionalism of the workplace very seriously, as set forth in the County Policy of Equity (CPOE) (https://ceop.lacounty.gov/). Contractor further acknowledges that the County strives to provide a workplace free from discrimination, harassment, retaliation and inappropriate conduct based on a protected characteristic, and which may violate the CPOE. Contractor, its employees and subcontractors acknowledge and certify receipt and understanding of the CPOE. Failure of Contractor, its employees or its subcontractors to uphold the County's expectations of a workplace free from harassment and discrimination, including inappropriate conduct based on a protected characteristic, may subject Contractor to termination of contractual agreements as well as civil liability.

9.0 UNIQUE TERMS AND CONDITIONS

9.1 DUE PROCESS

9.1.1 Notice of Proposed Adverse Action: In all cases in which the EMS Agency has the authority to, and pursuant to this authority, has taken any of the actions constituting grounds for hearing as set forth in Paragraph 9.1.2 herein below, Contractor shall promptly be given written notice of the specific charges and factual basis upon which the EMS Agency action is based. With the exception of summary suspensions, summary suspensions with intent to terminate Master Agreement, or interim system re-configuration, Contractor shall be afforded its due process right to a hearing before implementation of any of the

actions which constitute grounds for a hearing. Contractor shall have thirty (30) calendar days following the receipt of such notice within which to file with Director a written request for hearing before the Emergency Medical Services Commission (EMSC).

9.1.2 Grounds for Hearing: Any one or more of the following actions constitute grounds for a hearing:

REMEDIAL HEARING:

1) Summary Suspension
2) Summary Suspension with intent to terminate
3) Suspension
4) Suspension with intent to terminate
5) Termination for cause

OTHER:

6) Substantial operational changes in the ALS program (interim system re-configuration and system re-configuration).
7) Restructuring, including deletions, additions, or substitution of base hospitals in the system.
8) Agency requests to modify existing forms, logs, and documentation or Agency's request for additional data as specified in Appendix B, Paragraph 6.20.

9.1.3 Summary Suspension or Summary Suspension with Intent to Terminate: In the case of summary suspensions or summary suspensions with intent to terminate, Contractor, at its election, shall have the right to request Director in writing to reconsider the summary suspension action. Director shall act on this request for reconsideration within ten (10) calendar days after the receipt of the reconsideration request. Contractor shall be given an opportunity to meet with Director. The meeting shall not be a full hearing but is intended to identify the alleged basis for the summary action.

Within ten (10) calendar days following the meeting with Director, Director shall issue to Contractor a written recommendation regarding the summary suspension. This recommendation may be that the suspension be continued for a particular time or upon particular conditions, that the summary suspension be terminated, that Contractor's Master Agreement be terminated, that other conditions be imposed on Contractor, or such other action as may seem

warranted. If Director recommends any action other than immediate return of Contractor to full base hospital status, Contractor may request a hearing on the summary suspension before the EMSC, as provided in this Paragraph. Such request shall be in writing and addressed to Director. Any such request shall be delivered within five (5) calendar days of Director's delivery to Contractor of their written decisions.

9.1.4 Time and Place of Hearing: Director shall, within fifteen (15) calendar days of receipt of a Contractor request for hearing as set forth above, apply to the EMSC for such hearing. Director shall give notice to Contractor of the time, place, and date of the hearing in accordance with EMSC rules and procedures. The date of commencement of the hearing shall be not less than thirty (30) calendar days, nor more than ninety (90) calendar days from the receipt of the request for hearing, subject to the convenience and approval, however, of the EMSC. However, if the request is received from Contractor when under a summary suspension then in effect, Director shall attempt to arrange a hearing before the EMSC as soon as possible. In situations involving a summary suspension, Director shall use his/her best efforts to schedule a hearing within forty-five (45) calendar days of receipt of a request for hearing.

9.1.5 Notice of Charges: As part of, or together with the notice of hearing, Director shall state in writing, in concise language, the acts or omissions with which Contractor is charged or reasons for substantial operational change or restructuring. If either party, by written notice, requests a list of individuals who will appear on behalf of the other, then each party within ten (10) calendar days of such request shall furnish to the other a list, in writing, of the names and addresses of the individuals, so far as is then reasonably known, who will give testimony or evidence in support of that party at the hearing.

9.1.6 Hearing Procedure: At the hearing, subject to the rules of the EMSC, both sides shall have the following rights: to call and examine witnesses, to introduce exhibits, and to rebut any evidence. The EMSC may question witnesses.

9.1.7 Memorandum of Points and Authorities: Subject to the rules of EMSC, each party shall have the right to submit to the EMSC a memorandum of points and authorities.

9.1.8 Basis of Decision: Subject to the rules of the EMSC, the EMSC decision on a hearing under this Master Agreement shall be based upon the evidence produced at the hearing. The evidence may consist of the following:

1) Oral testimony of the parties' representatives;
2) Documentary evidence introduced at the hearing;
3) Briefs or memoranda of points and authorities presented in connection with the hearing;
4) Policies and procedures of the EMS Agency; and
5) All officially noticed matters.

9.1.9 Record of Hearing: The parties understand that the EMSC maintains a record of hearings by one or more of the following methods: a shorthand reporter, an audio or disc recording, or by its clerk's minutes of the proceedings. If a shorthand reporter is specifically requested in writing by Contractor or by Director, the costs of same shall be borne by such party. The parties understand that the EMSC may, but shall not be required to, order that oral evidence shall be taken only by oath or affirmation administered by any person designated by such body and entitled to notarize documents in the State of California.

9.1.10 Decision of the EMSC: The decision of the EMSC shall be effective and binding on the parties to the extent permitted and prescribed in County Code Section 3.20.070 B.

9.2 RESPONSIBILITY FOR INDIGENT PATIENTS

Nothing contained in this Master Agreement is intended nor shall it be construed to affect either party's existing rights, obligations, and responsibilities with respect to care required by or provided to indigent patients.

9.3 STATUS OF CONTRACTOR

The parties hereto agree that Contractor, its officers, agents, and employees, including its professional and non-professional personnel, shall act in an independent capacity and not as officers, agents, or employees of County and shall not have the benefit of County employees. Except as may otherwise expressly be provided hereunder, Contractor shall employ all personnel (excluding physicians), assure physicians availability, provide supplies, equipment, equipment space, furniture, insurance, utilities, and telephones necessary for performance of Contractor's responsibilities as set forth in this Master Agreement. This Paragraph shall not preclude or limit Contractor from seeking reimbursement, contributions, tuition, or other payment from public

or private paramedic provider agencies for services provided by Contractor. However, this Paragraph shall not be interpreted to mean that any such reimbursement, contributions, or payment is required or mandated.

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Master Agreement to be executed by the County's Director of Health Services and Contractor has caused this Master Agreement to be executed in its behalf by its duly authorized officer, the day, month and year first above written.

COUNTY OF LOS ANGELES

BY REDACTED for
Christina R. Ghaly, M.D.
Director of Health Services

CONTRACTOR

PASADENA HOSPITAL ASSOCIATION
LTD. DBA HUNTINGTON HOSPITAL

By REDACTED
Signature

Lori J. Morgan, MD, MBA
Printed Name

President and CEO
Title

APROVED AS TO FORM:
MARY C WICKMAN
County Counsel

By _____
Brian Chu, Principal Deputy County Counsel

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Master Agreement to be executed by the County's Director of Health Services and Contractor has caused this Master Agreement to be executed in its behalf by its duly authorized officer, the day, month and year first above written.

COUNTY OF LOS ANGELES

BY _____ for
Christina R. Ghaly, M.D.
Director of Health Services

CONTRACTOR

PASADENA HOSPITAL ASSOCIATION LTD. DBA HUNTINGTON HOSPITAL

By _____
Signature

_____
Printed Name

_____
Title

APROVED AS TO FORM:
MARY C. WICKMAN
County Counsel

By REDACTED
Brian Chu, Principal Deputy County Counsel

SPECIALTY CARE CENTER DESIGNATIONS EXHIBIT

SUB-EXHIBIT NUMBER	DESIGNATION EXHIBIT
PBH	Paramedic Base Hospital
9-1-1	9-1-1 Receiving Facility (PLACEHOLDER FOR POSSIBLE FUTURE DESIGNATION)
SC	Stroke Center (PLACEHOLDER FOR POSSIBLE FUTURE DESIGNATION)
TC	Trauma Center (PLACEHOLDER FOR POSSIBLE FUTURE DESIGNATION)
PMC	Pediatric Medical Center (PLACEHOLDER FOR POSSIBLE FUTURE DESIGNATION)
SRC	STEMI Receiving Center (PLACEHOLDER FOR POSSIBLE FUTURE DESIGNATION)
SARTC	Sexual Assault Response Team Center (PLACEHOLDER FOR POSSIBLE FUTURE DESIGNATION)
HPP	Hospital Preparedness Program Participant (PLACEHOLDER FOR POSSIBLE FUTURE DESIGNATION)
EDAP	Emergency Department Approved for Pediatrics (PLACEHOLDER FOR POSSIBLE FUTURE DESIGNATION)

EXHIBIT A

SUB-EXHIBIT - PBH

SPECIALTY CARE CENTER DESIGNATION EXHIBIT

FOR

PARAMEDIC BASE HOSPITAL

SECTION **TITLE** **PAGE**

1.0 PURPOS....1
2.0 SCOPE OF AGREEMENT....1
3.0 General Requirements....1
4.0 TERM OF SPECIALTY CARE CENTER DESIGNATIOn....2
5.0 ANNUAL FEES....2
6.0 ADDITION AND/OR DELETION OF FACILITIES, SPECIFIC TASKS AND/OR WORK HOURS....3
7.0 QUALITY CONTROL....3
8.0 QUALITY ASSURANCE PLAN....3
9.0 DEFINITIONS....4
10.0 RESPONSIBILITIES....4
10.1 Personnel....4
10.2 Furnished Items....4
10.3 Policies and Procedures....5
10.4 Interim System Re-Configuration....5
10.5 System Configuration....5
10.6 Data Management....6
10.7 Staff Designation....7
10.8 Assignment of ALS Units....7
10.9 Paramedic Communication System Management....8
10.10 Responsibilities of County through ISD....8
10.11 Agreement Compliance....8
10.12 Project Manager....9
10.13 Personnel....9
10.14 Uniforms/Identification Badges....9
10.15 Materials and Equipment....9
10.16 Contractor's Office....9
10.17 Standards and Protocols....10
10.18 Data Collection....10
10.19 Program Monitoring....12
10.20 Communication between Base Hospital and Receiving Hospital....13
10.21 Reimbursement for ALS Direction....13
10.22 Base Hospital Assignment of ALS units....13
10.23 Continuing Education (CE) Provider Program....13
10.24 Hospital Minutes/Attendance Rosters/Newsletters and Other Communication Related Materials....15
10.25 Base Hospital Medical Director....15
10.26 Base Hospital Physicians....16
10.27 Mobile Intensive Care Nurses (MICNs)....16
10.28 Prehospital Care Coordinator (PCC)....17
10.29 EMS Agency Notification of Hiring/Termination of MICNs....17
10.30 Quality Improvement (QI)....18

10.31 Paramedic Communication System (PCS) 18
11.0 HOURS/DAY OF WORK 19
12.0 WORK SCHEDULES 19
13.0 UNSCHEDULED WORK 19
14.0 PROCEDURE FOR NON-COMPLIANCE AND PENALTIES 20

LISTING OF ATTACHMENTS

ATTACHMENT	ATTACHMENT NAME
1	PREHOSPITAL CARE POLICY REFERENCE NO. 316, EMERGENCY DEPARTMENT APPROVED FOR PEDIATRICS (EDAP) STANDARDS
2	CONTRACT DISCREPANCY REPORT
3	CURRENT TEMIS HOSPITAL HARDWARE AND SOFTWARE SPECIFICATIONS
4	COMMUNICATIONS MANAGEMENT COMMITTEE (Ad Hoc)
5	BASE HOSPITAL FORM
6	BASE HOSPITAL FORM (PAGE 2)
7	MCI BASE HOSPITAL FORM
8	BASE HOSPITAL DOCUMENTATION MANUAL
9	BASE HOSPITAL COMMUNICATIONS EQUIPTMENT
10	REMOSTE BASE STATION RADIO SITES
11	CURRENT TEMIS HOSPITAL HARDWARE AND SOFTWARE SPECIFICATIONS
12	BASE HOSPITAL CHANNEL, ASSIGNMENT/PARAMEDIC TELEPHONE NUMBERS
13	PARAMEDIC COMMUNICATIONS SYSTEM TROUBLE CONTROL PROCEDURES
14	PROCEDURE FOR NON-COMPLIANCE WITH DATA COLLECTION REQUIREMENTS

SPECIALTY CARE CENTER DESIGNATION EXHIBIT FOR PARAMEDIC BASE HOSPITAL

1.0 PURPOSE

Pursuant to the Emergency Medical Services System and Prehospital Emergency Medical Care Personnel Act ("Act") (Health and Safety Code, Sections 1797, et seq.) the Emergency Medical Services (EMS) Agency serves as the lead Agency for coordination of the emergency medical services system in the County of Los Angeles (County). In this role, the EMS Agency awards Paramedic Base Hospital designations to qualified general acute hospitals to support the County's Advanced Life Support (ALS) programs. Title 22 of the California Code of Regulations, requires a paramedic base hospital to provide immediate medical direction to paramedic personnel via direct two-way voice communication with field units assigned to the hospital. Each Paramedic Base Hospital in the County pays the EMS Agency an annual fee to offset County's costs for data collection, monitoring, and evaluation of Advanced Life Support (ALS) programs.

2.0 SCOPE OF AGREEMENT

The basis of this Master Agreement is the desire and intention of the parties to cooperate in the operation of each party's component of the paramedic delivery system, consistent with each party's other health services activities and fiscal requirements and the duties and responsibilities of the County. Its purposes are to establish, in a manner reflective of that cooperation, the specific duties and responsibilities of the parties with respect to the matters addressed herein and to provide mechanisms and procedures for: (a) resolution of disputes, (b) communications regarding the operation of the system, (c) consideration of future development of the system in response to change in circumstances, (d) interaction with other system participants, and (e) quality improvement.

3.0 GENERAL REQUIREMENTS

3.1 Contractor must be licensed by the California Department of Public Health as a general acute care hospital.

3.2 Contractor must be accredited by the Joint Commission or other accrediting body deemed acceptable by the Centers for Medicare and Medicaid Services (CMS).

3.3 Contractor must have a special permit for Basic or Comprehensive Emergency Medical Service pursuant to the provisions of Title 22, Division 5, California Code of Regulations.

3.4 Contractor must meet or exceed standards for Emergency Departments Approved for Pediatrics (Attachment 1).

3.5 Contractor must subscribe and have access to ReddiNet® and VMED28 communication systems.

3.6 Contractor administration, medical staff and emergency room staff shall meet the requirements under applicable State regulations and the EMS Agency's policies and procedures for the provision of services under this Master Agreement.

4.0 TERM OF SPECIALTY CARE CENTER DESIGNATION

4.1 The term of this Designation shall be five (5) years or less commencing after execution by the Director as authorized by the County's Board of Supervisors, and shall terminate on June 30, 2024, unless sooner terminated or extended, in whole or in part, as provided in the Master Agreement, Sub-paragraph 8.1, Amendments.

4.2 The County shall have the sole option to extend this Designation term commensurate with the five (5) additional one-year extension options exercised under Sub-paragraph 4.1 of the Master Agreement, through June 30, 2029 (hereafter "Optional Term") for a maximum total Master Agreement term of ten (10) years. Such option and extension shall renew automatically, unless sooner terminated or extended, in whole or in part, as provided in the Master Agreement, Sub-paragraph 4.4.

5.0 ANNUAL FEES

5.1 Contractor shall pay annual fees to provide ongoing financial support to County for data collection, monitoring, and evaluation of the ALS programs, all of which benefit Contractor in the provision of base hospital services. Contractor understands that its fees offset a portion of the County's costs.

5.2 The annual fees payable to County by Contractor under this Master Agreement shall be Twelve Thousand Five Hundred and Thirtyfive Dollars ($12,535), which shall be prorated if the beginning year is less than twelve months. These fees may be increased in future FY's based upon a review of the actual costs under this Agreement.

5.3 For any Contractor that is a designated Trauma Center, the base hospital fee is waived.

6.0 ADDITION AND/OR DELETION OF FACILITIES, SPECIFIC TASKS AND/OR WORK HOURS

6.1 The EMS Agency may elect to restructure the prehospital care system as it deems necessary in accordance with paragraph 7.4 and 7.5 of this Sub-Exhibit PBH, Specialty Care Center Designation Exhibit.

6.2 All changes must be made in accordance with sub-paragraph 8.1 Amendments of the Master Agreement.

7.0 QUALITY CONTROL

The Contractor shall establish and utilize a comprehensive Quality Control Plan to assure it complies with the general requirements, terms, and conditions in this Master Agreement throughout the term. Upon request, the Plan shall be submitted to the County Contract Project Monitor for review. The plan shall include, but may not be limited to the following:

7.1 Method of monitoring to ensure that Master Agreement requirements are being met.

7.2 A record of all inspections conducted by Contractor, any corrective action taken, the time a problem was first identified, a clear description of the problem, and the time elapsed between identification and completed corrective action, shall be provided to the County upon request.

8.0 QUALITY ASSURANCE PLAN

The County will evaluate Contractor's performance under this Master Agreement using the quality assurance procedures as defined in the Master Agreement, Paragraph 8, Standard Terms and Conditions, Sub-paragraph 8.15, County's Quality Assurance Plan.

8.1 Monthly Meetings

Intentionally Omitted

8.2 Contract Discrepancy Report (Attachment 2)

8.2.1. Verbal notification of a Master Agreement discrepancy will be made to the Agreement Project Monitor as soon as possible whenever a Master Agreement discrepancy is identified. The problem shall be resolved within a time period mutually agreed upon by the County and Contractor.

8.2.2. The County Agreement Project Monitor will determine whether a formal Contract Discrepancy Report shall be issued. Upon receipt of this

document, Contractor is required to respond in writing to the County Agreement Project Monitor within thirty (30) workdays, acknowledging the reported discrepancies or presenting contrary evidence. A plan for correction of all deficiencies identified in the Contract Discrepancy Report shall be submitted to the County Agreement Project Monitor within thirty (30) workdays.

8.3 County Observations

In addition to departmental contracting staff, other County personnel may observe performance, activities, and review documents relevant to this Master Agreement at any time during normal business hours. However, these personnel may not unreasonably interfere with Contractor's performance.

9.0 DEFINITIONS

Intentionally Omitted

10.0 RESPONSIBILITIES

The County's and Contractor's responsibilities are as follows:

COUNTY

10.1 Personnel

The County will administer the Master Agreement according to Master Agreement, Paragraph 6.0, Administration of Agreement - County. Specific duties will include:

10.1.1. Monitoring Contractor's performance in the daily operation of this Agreement.

10.1.2. Providing direction to Contractor in areas relating to policy, information and procedural requirements.

10.1.3. Preparing Amendments in accordance with the Master Agreement, Paragraph 8.0, Standard Terms and Conditions, Sub-paragraph 8.1 Amendments.

10.2 Furnished Items

Intentionally Omitted

10.3 Policies and Procedures

10.3.1 Establish policies and procedures consistent with State and County laws, regulations, and standards to assure medical control of ALS personnel.

10.3.2 Review and revise policies every three years or as needed.

10.3.3 Make available to Contractor upon execution of this Master Agreement all protocols and policies which the EMS Agency currently considers to be applicable to participants in the ALS system as posted on the EMS Agency's website.

10.4 Interim System Re-Configuration

EMS Agency may, on an interim basis, restructure the prehospital care system as it deems necessary, including reassignment of ALS Units to or from Contractor as the primary directing base hospital, in those instances when a designated base hospital gives notice that it is withdrawing from the system or when a designated base hospital is suspended or terminated from the prehospital care system. In the event that an interim restructuring occurs, Contractor, if affected by the restructuring, shall be given the immediate opportunity to provide written and oral statements to Director regarding the restructuring to the EMS Agency and shall be provided with the "due process" procedures specified in Paragraph 9.1, Due Process of the Agreement. Nothing herein, however, is intended to prevent implementation by Director on an emergency basis of such changes as he/she may find measurably necessary to preserve the integrity of the prehospital care system and to protect the health and safety of County residents.

10.5 System Configuration

Director shall notify Contractor of proposals for substantial operational or structural changes in the components of the ALS system or in the overall operation or configuration of such system. This shall include, but not be limited to, increasing or decreasing the number of base hospitals in the event that a restructuring of the prehospital care system is deemed necessary. In the event the number of base hospitals is increased or decreased, and unless otherwise agreed upon by the parties, written notice shall be given to Contractor at least one-hundred and twenty (120) calendar days prior to the effective date of any resulting substantial operational or structural changes to the EMS Agency. If the need for Contractor to serve as a base hospital can no longer be substantiated, or if Contractor is adversely affected by the addition of a new base hospital, Contractor, upon request, shall be provided with "due process" as specified in Paragraph 9.8, Due Process of the Agreement.

10.6 Data Management

10.6.1 DHS, after consultation with and advice from the Emergency Medical Services Commission ("EMSC") Data Advisory Committee, as defined by the EMS Commission bylaws, if duly constituted, shall continue maintenance of a comprehensive Base Hospital Documentation Manual.

The DHS base hospital data collection system includes:

1. A base hospital documentation manual.

2. A minimum of eight (8) hours Trauma and Emergency Medicine Information System ("TEMIS") basic software training, up to twenty-four (24) hours of intermediate/advanced training for all necessary persons identified by Contractor, and additional training as agreed upon by County, to enable Contractor personnel to perform data entry, database maintenance, and basic report generation functions.

3. A nonexclusive, nontransferable license to Contractor to use TEMIS software and documentation and any software updates for as long as County maintains its software license contract with TEMIS software vendor, or until this Master Agreement is terminated as set forth herein. Such license also includes the right to copy TEMIS software, data, and documentation for back-up or archive purposes, but such license further gives Contractor no right to sell, lease, sublease, donate, assign, distribute, or otherwise transfer any right in TEMIS software, data, or documentation to any other person or entity.

4. Software meeting specifications shown in Attachment 3, CURRENT TEMIS HOSPITAL HARDWARE AND SOFTWARE SPECIFICATIONS, attached hereto and incorporated herein by reference, for the purpose of base hospital data entry and/or data manipulation. In the event that this Master Agreement is terminated for any reason, DHS shall promptly remove all TEMIS software provided by County/County's TEMIS-related contractor and Contractor shall return to County all TEMIS data and documentation (and all copies thereof made by Contractor hereunder) provided by County to Contractor.

10.6.2 DHS, on behalf of County, in the event of errors in software, shall use reasonable efforts to promptly rectify the software. Whenever possible, DHS shall correct a problem in twenty-four (24) hours or less (excluding Saturday, Sunday, and Holidays). County shall have no such obligation if the problem(s) is (are) a direct or indirect result of software modifications, made without the prior written approval from Director.

10.6.3 The foregoing are the only warranties of any kind, either expressed or implied, that are made by County, and County disclaims all other warranties including, but not limited to, the implied warranties of fitness for a particular purpose. In no event shall County be liable for any direct, indirect, incidental, or consequential damages of any nature whatsoever (including, without limitation, damages for loss of business profits, business interruption, loss of information, and the like), arising out of the use or inability to use the software (including without limitation any claim of patent infringement or other similar claim), even if County has been advised of the possibility of such damages.

10.6.4 County does not warrant that operation of the software will be uninterrupted or error-free or that all errors will be corrected.

10.6.5 County does not assume and shall have no liability under this Master Agreement for failure to repair or replace defective software, the related data or documentation due directly or indirectly to causes beyond the control of, and without the fault or negligence of County, including, but not limited to, acts of God, acts of public enemy, acts of the United States, any state, or other political subdivision. fires, floods, epidemics, quarantine, restrictions, strikes, freight embargoes, or similar or other conditions beyond the control of County.

10.7 Staff Designation

Director shall designate staff within the EMS Agency to review, monitor, communicate and coordinate matters affecting the EMS delivery system under the jurisdiction of the EMS Agency. EMS staff shall periodically attend Contractor's continuing education programs, field care audits, and meetings related to the EMS system and shall perform contract compliance reviews as specified in this Master Agreement.

10.8 Assignment of ALS Units

After consultation with Contractor and provider agencies, Director shall assign designated ALS units to operate under Contractor's primary control as base hospital. These assignments may be changed from time to time by Director after consultation with Contractor. Director shall take into consideration the receiving hospital for the majority of patients handled by the ALS unit being assigned, whether the ALS unit being assigned is primarily a 9-1-1 response unit or private interfacility transport unit, and the provider agency's desire to affiliate with a particular base hospital.

10.9 Paramedic Communication System Management

10.9.1 Designate one individual within DHS as the PCS manager to provide administration and direction of the PCS.

10.9.2 Utilize County's Internal Services Department ("ISD") for ongoing design, installation, maintenance, and technical consultation.

10.9.3 Assign Contractor frequencies and private line ("PL") tones in consultation with ISD.

10.9.4 Notify Contractor of any proposals for operational or structural changes in the components of the PCS. No non-emergent substantial operational or structural change in the components of the PCS will be made without prior notification of Contractor, and until Contractor, if it wishes, has appropriately exhausted administrative due process remedies under the Agreement.

10.9.5 Promulgate PCS communications operations procedures and maintenance standards in cooperation with ISD prior to the execution of this Agreement. Any changes made during the term of this Agreement shall be reviewed and approved by the Communications Management Committee, described in Attachment 4, attached hereto and incorporated herein by reference.

10.9.6 Notify the Hospital Association of Southern California ("HASC") of any proposals for changes in policies and procedures.

10.10 Responsibilities of County through ISD

10.10.1 Assume ongoing responsibility for the design, development, timely implementation, and technical integrity of the PCS. To the extent feasible, ISD shall consult with the DHS PCS Manager and solicit input in the areas of design development, implementation, and technical integrity of the PCS.

10.10.2 Maintain and repair County-owned equipment.

10.10.3 Prepare PCS communications operating procedures and maintenance standards in cooperation with the EMS Agency.

10.11 Agreement Compliance

Should DHS, as determined by Contractor, fail to comply with any provision set forth hereunder as a DHS responsibility or obligation, Contractor may do any or all

of the following in addition to other rights which Contractor may have hereunder or at law:

1) Send Director a written statement itemizing the areas of concern and request or specify a plan for remedial action.

2) Send Director a written itemized listing of the area(s) of concern and notification of intent to terminate Master Agreement.

3) Institute the review procedures outlined in Paragraph 9.1, Due Process of the Master Agreement.

CONTRACTOR

10.12 Project Manager

10.12.1. Contractor shall provide a full-time Project Manager or designated alternate.

10.12.2. Project Manager shall act as a central point of contact with the County.

10.12.3. Project Manager/alternate shall have full authority to act for Contractor on all matters relating to the daily operation of the Master Agreement. Project Manager/ alternate shall be able to effectively communicate, in English, both orally and in writing.

10.13 Personnel

Intentionally Omitted

10.14 Uniforms/Identification Badges

Intentionally Omitted

10.15 Materials and Equipment

The purchase of all materials/equipment to provide the needed services is the responsibility of the Contractor. Contractor shall use materials and equipment that are safe for the environment and safe for use by the employee.

10.16 Contractor's Office

Intentionally Omitted

10.17 Standards and Protocols

Contractor shall implement and monitor the policies and procedures of the EMS Agency related to the services performed by Contractor under this Master Agreement.

10.18 Data Collection

Contractor shall complete and submit the following documents to Director, the completion and submission of which shall be according to DHS procedure and formats previously provided to Contractor:

1) Base Hospital Form: The MICN or emergency department physician, or both, shall complete at least one current EMS Agency approved and provided Base Hospital Form for every contact involving a patient where on-line medical direction is given. Samples of the EMS Agency approved Base Hospital Form are attached as Attachment 5, (Base Hospital Form), Attachment 6 (Page 2), Attachment 7 (MCI Form), attached hereto and incorporated herein by reference. Contractor shall submit the Base Hospital Form within sixty (60) calendar days of the incident. Upon approval of Director, Contractor may discontinue transmittal of a "hard copy" of the form when Director determines that the computer data Base Hospital Form information which is transmitted to the EMS Agency is of high quality and timely, and reflects all documentation. Base Hospital Form should be completed in accordance with the current Base Hospital Documentation Manual (Attachment 8) as posted on the EMS Agency's website.

2) Receiving Hospital Outcome Data: Contractor shall complete emergency department outcome data for all patients delivered to its emergency department via the County's 9-1-1 system. Contractor personnel shall submit the appropriate information as defined in Attachment 10, attached hereto and incorporated herein by reference, to the EMS Agency. Upon approval of Director, Contractor may discontinue collection of ED diagnosis and patient disposition on the Base Hospital Form when the Director determines alternative methods (i.e., via contractor's EMR) for submission of outcome data is of high quality and timely.
3) Required Data Elements: Contractor shall enter data elements as defined in Attachment 8 for all patients where Contractor provided base hospital medical direction into TEMIS.

4) In the event the EMS Agency determines that existing forms, logs, and documents should be modified or that additional data should be collected from Contractor, said modification or request for additional data must first be reviewed by the EMSC Data Advisory Committee, if constituted. The EMS Agency shall estimate the cost impact on Contractor of the proposed modification or request for additional data, and, if a dispute concerning same

arises, the matter may be submitted to the EMSC for arbitration in accordance with County Code Section 3.20.070.

5) Contractor shall submit required data under County's automated data collection system to the EMS Agency via EMS Agency defined media within forty-five (45) calendar days following an "incident". Data format must meet specifications defined by the EMS Agency. Should County remove all or any portion of TEMIS software required to submit Contractor's data to County via County defined media, or fail to correct any software errors that prevent Contractor from being able to perform data entry, Contractor's obligation to submit data electronically shall cease, until County has reinstalled the necessary software or corrected the software errors.

6) Contractor shall utilize TEMIS application programs and provide hardware which meets the requirements listed under TEMIS Hospital Hardware and Software Specifications described in Attachment 3. Contractor shall in no way modify the structure or function of the software as set forth in the Master Agreement without the prior written approval of Director. The software provided shall be used exclusively for the purposes intended herein and shall be maintained by Contractor in a secure location.

7) Contractor shall provide all supplies necessary for the ongoing use of their equipment (e.g., printer cartridges, printer paper, compact discs, DVDs, flash drives, etc.).

8) Contractor shall seek telephone assistance from County's Project Manager or their designee, whenever TEMIS operation failure occurs, to obtain County TEMIS maintenance services as described herein.

9) Contractor shall assign qualified back-up personnel, excluding PCC, to enter data into TEMIS, as reasonably appropriate for Contractor to meet Contractor's data collection responsibilities described herein. Furthermore, Contractor shall permit adequate time for complete training of such personnel. Arrangements for training of new or replacement Contractor personnel shall be the primary responsibility of Contractor.

10) All software application modules, all modifications, enhancements, and revisions thereto, and all materials, documents, software programs and documentation, written training documentation and aids, and other items provided by County or its agents, are "proprietary" or "confidential". Contractor shall use reasonable means to ensure that these confidential data system products are safeguarded and held in confidence. Such means shall include, but not be limited to: disclosing confidential County data system products only to employees with a need to know of such confidential County data system products in order for Contractor to exercise its rights and perform its obligation as a base hospital; and not reproducing, adapting,

modifying, disassembling, decompiling, reverse engineering, distributing, or disclosing any confidential County data system products except as expressly permitted hereunder. Copies of software, application modules, and data may be made for the sole purpose of backup only.

11) Contractor shall indemnify, hold harmless, and defend County from and against any and all liability, damages, costs, and expenses, including, but not limited to, defense costs and attorneys' fees, for or by reason of any actual or alleged infringement of any United States patent, copyright, or any actual or alleged trade secret disclosure, arising from or related to the misuse of the software license by Contractor or Contractor personnel.

10.19 Program Monitoring

10.19.1. Contractor extends to Director, or his or her designee and to authorized representatives of the State, the right to review and monitor Contractor's programs and procedures with respect to this Master Agreement, and to inspect its facilities for contractual compliance with State and EMS Agency policies and regulations.

10.19.2. Inspections by DHS staff shall be conducted during County's normal business hours and only after Director has given Contractor at least three (3) working days prior written notice thereof. In computing the three (3) working days, a Saturday, Sunday, or legal holiday shall not be included. Entry and exit conferences shall be held with Contractor's Administrator or his or her designee. Said notice need not be given where Director determines that the health and welfare of patients may be jeopardized by waiting the three days period.

10.19.3. 10.20.2 Program Review: At minimum, audits shall be conducted every three (3) years to ensure compliance with State and EMS Agency policies and regulations. Contractor shall be given no less than thirty (30) calendar days notice in advance of said review. Contractor and its staff shall fully cooperate with County representatives. In the conduct of such audit and review, Contractor shall allow such representatives access to all reports, audio recordings, medical records, and other reports pertaining to this Master Agreement, and shall allow photocopies to be made of these documents, utilizing Contractor's photocopier.

10.19.4. An exit conference shall be held following the performance of such an on-site compliance review by Director and results of the compliance review shall be discussed with Contractor's Administrator or his or her authorized designee prior to the generation of any final written report or action by Director or other DHS representatives based on such review. The exit conference shall be held on site prior to the departure of the

reviewers and Contractor shall be provided with an oral list of preliminary findings at the exit conference. A written report of the program review shall be prepared and provided to Contractor. Contractor shall permit periodic unecheduled site visits by EMS Agency representatives for monitoring ED diversion status, continuing education programs and prehospital care meetings.

10.20 Communication between Base Hospital and Receiving Hospital

Contractor shall communicate all appropriate ALS patient management information to the receiving hospital to which a patient is directed as result of on-line medical direction. Such notification shall be by telephone or ReddiNet and conveyed by a physician or MICN familiar with the treatment given, as soon as the patient destination is determined, or as soon as is practically possible.

10.21 Reimbursement for ALS Direction

Nothing in this Agreement shall prohibit Contractor from seeking reimbursement, contributions or other payments from municipalities, paramedic provider agencies, or receiving hospitals to defray costs associated with providing ALS services, including supply and resupply of ALS units. Except as expressly noted, nothing herein, however, requires reimbursement or other payment from municipalities, paramedic provider agencies, or receiving hospitals to defray such Contractor costs.

10.22 Base Hospital Assignment of ALS units

Except as otherwise noted herein, the number of ALS units assigned to Contractor on a primary basis shall be based upon the receiving hospital for the majority of patients handled by the ALS Units being assigned; whether a Base Hospital within the geographic area can reasonably accept an/any additional unit/s; whether the ALS Unit being assigned is primarily a 9-1-1 response unit or private interfacility transport unit; and the provider agency's desire to affiliate with a particular base hospital. Subject to Paragraph 9.1, Due Process of the Agreement, nothing herein, however, shall be deemed to restrict Director and County's Board of Supervisors in the exercise of their authority under applicable laws and regulations to designate additional base hospitals for the geographic area served by Contractor hereunder.

10.23 Continuing Education (CE) Provider Program

10.23.1. Contractor shall establish and maintain an EMS continuing education provider program in accordance with policies established by Director in the Prehospital Care and CE Manuals. Contractor shall provide a minimum of six (6) hours of field care audits and six (6) hours of instructor-based education per year. Contractor may require additional

field care audits which exceed EMS Agency requirements for MICN certification, to maintain MICN sponsorship.

10.23.2. Contractor shall facilitate scheduling structured field observation for MICN certification.

10.23.3. In addition, Contractor shall provide special and mandatory training programs deemed necessary in writing by Director. A minimum of three (3) classes, per mandatory training program, shall be offered.

10.23.4. Contractor shall provide supervised clinical experience for paramedic interns in accordance with State and EMS Agency policies and procedures, upon request of a Los Angeles County approved training school that has a signed Clinical Affiliation Agreement with Contractor.

10.23.5. Contractor shall coordinate a prehospital orientation program for new base hospital physician and nursing staff to the prehospital program.

10.23.6. Contractor shall facilitate the education of new MICNs by providing instructor(s) to lecture, perform radio simulations, or assist as needed at any MICN Development Course to which Contractor sends MICN candidates.

10.23.7. To the extent Contractor is required to provide mandatory formal education programs over and above those set forth in subparagraphs (1) and (2) immediately above, Contractor may seek reimbursement, contributions, or other payment to defray its costs from municipalities, paramedic provider agencies, or receiving hospitals. However, nothing herein shall be deemed to require any such reimbursement, contribution, or payment.

10.23.8. Contractor shall forward the following to the EMS Agency:

1) Monthly continuing education schedules to the Office of Certification and Program Approvals prior to scheduled date of course.

2) Yearly summaries of EMS CE classes including the date, course title, instructor or non-instructor based, and number of EMS continuing education hours to the Office of Certification and Program Approvals by January 31 of the following year.

3) Course rosters or attendance verification for County mandated training programs to the Office of Certification and Program Approvals no later than fifteen (15) calendar days after the class concludes, but not to exceed established deadline of course.

10.24 Hospital Minutes/Attendance Rosters/Newsletters and Other Communication Related Materials

Contractor shall maintain records of communications with base hospital personnel which may be inclusive of, but not limited to, base hospital meetings, e-mail communications, newsletters or other communication related materials. These records of communications shall be available to the EMS Agency during program review audits and shall be submitted to the EMS Agency upon request.

10.25 Base Hospital Medical Director

Contractor shall designate an emergency physician to direct and coordinate the medical aspects of field care and related activities of medical and emergency medical services personnel assigned to Contractor (including without limitation, the quality improvement program for the services provided here within), and to ensure compliance with policies, procedures, and protocols established by the EMS Agency. This physician, who shall have the title of "Base Hospital Medical Director", shall:

1) Be board certified in emergency medicine.

2) Be engaged in the field of emergency medicine as a full-time emergency physician, as defined by spending an average of at least ninety-six (96) hours per month in the practice of emergency medicine at Contractor's hospital, and have experience and knowledge of base hospital radio operations and EMS Agency policies and procedures. The number of prescribed hours may include administrative and or educational hours spent in meeting Base Hospital Medical Director responsibilities.

3) Comply with the provisions set forth in the Prehospital Care Manual.

4) Satisfactorily complete orientation to Contractor's prehospital care program.

5) Attend an EMS orientation course as provided by the EMS Agency within six (6) months of assuming Base Hospital Medical Director responsibilities.

6) Reimbursement for Medical Director: Nothing in this Agreement shall prohibit Contractor from seeking reimbursement, contributions, or other payment from municipalities, paramedic provider agencies, or receiving hospitals to defray Contractor's costs associated with providing ALS services, including the base hospital medical director's salary. However, nothing in this Agreement shall be deemed to require any such reimbursement, contribution, or other payment.

10.26 Base Hospital Physicians

Contractor shall have at least one (1) full-time emergency department physician on duty at all times. Such emergency department physician shall be responsible for prehospital management of patient care and patient destination. If a paramedic run is not handled directly by the base hospital physician, such physician shall be immediately available for consultation by an MICN directing a paramedic run. All of Contractor's emergency department physicians participating in Contractor's activities as a base hospital shall:

1) Satisfactorily complete Contractor's base hospital orientation program within thirty (30) days of assuming base physician responsibilities. Such a program shall include: prehospital treatment protocols, medical control guidelines and base hospital radio operations.

2) Be board certified or board eligible in emergency medicine as recognized by the American Board of Medical Specialties.

3) Comply with policies and procedures of the EMS Agency.

4) Be under the direction of the Base Hospital Medical Director.

10.27 Mobile Intensive Care Nurses (MICNs)

Contractor shall have at least one (1) MICN on duty at all times. MICNs shall:

1) Be currently certified as a MICN in Los Angeles County.

2) Be currently certified as an American Heart Association Advanced Cardiac Life Support provider or instructor.

3) Comply with policies and procedures of the EMS Agency

4) Be under the direction of the base hospital physician on duty.

5) Be employed by one of the following agencies approved to employ and utilize MICNs in Los Angeles County:

   a) Base Hospital

   b) EMS Agency

   c) Paramedic training program

   d) Paramedic provider agency

10.28 Prehospital Care Coordinator (PCC)

Contractor shall designate a dedicated MICN with experience and knowledge of base hospital radio operations and EMS Agency policies and regulations to serve as the Contractor's PCC and as a liaison to the EMS Agency, paramedic provider agencies, and the local receiving facilities. Under the direction of, and in conjunction with the Contractor's Base Hospital Medical Director, the PCC shall assist in directing and coordinating the medical aspects of field care and related activities of medical and emergency medical services personnel assigned to Contractor and shall ensure compliance with policies, procedures, and protocols established by the EMS Agency. The PCC shall:

1) Be currently certified as an MICN in Los Angeles County.

2) Have experience in, and knowledge of, base hospital radio operations and EMS Agency policies, procedures, and protocols.

3) Be sufficiently available during normal County business hours to meet the responsibilities set forth in this subparagraph.

4) Comply with the provisions set forth in the Prehospital Care Manual.

5) Attend an EMS orientation course as provided for by the EMS Agency within six (6) months of assuming PCC responsibilities.

Nothing in this Agreement shall prohibit Contractor from seeking reimbursement, contributions, or other payment from municipalities, paramedic provider agencies, or receiving hospitals to defray Contractor's costs associated with providing ALS services, including the PCC's salary. Nothing, however, in this Agreement shall be deemed to require any such reimbursement, contributions, or other payments.

10.29 EMS Agency Notification of Hiring/Termination of MICNs

Contractor shall notify the EMS Agency's Office of Prehospital Certification within fifteen (15) working days of the hiring or termination of any MICN as well as failure of the MICN to meet established guidelines set by the EMS Agency in maintaining current certification.

Failure of a MICN to meet current certification requirements established by the EMS Agency and EMS Agency mandated courses shall result in immediate suspension of their MICN certification.

10.30 Quality Improvement (QI)

Contractor shall have a current prehospital care QI plan approved by the EMS Agency and ensure participation in the EMS Agency's systemwide QI program by designating a representative for the meetings.

Contractor shall have a process developed, with input from the base hospital medical director, base hospital physician, the PCC, MICNs, paramedics, and Contractor administration to:

1) Identify important aspects of prehospital care issues.

2) Identify indicators for those important aspects.

3) Evaluate the prehospital care and service, including trends, to identify opportunities for improvement.

4) Take action to improve care and service, or to solve problems, and evaluate the effectiveness of those actions.

5) Contractor shall also participate in the EMS Agency's Quality Improvement Program, with records provided by Contractor in accordance with the terms of this Agreement.

10.31 Paramedic Communication System (PCS)

10.31.1 Provide the specific PCS base hospital communications equipment listed in Attachment 9, attached hereto and incorporated herein by reference, meeting the operational requirements and standards as determined by the County through the Director of the ISD. Any changes in required communications equipment shall be mutually agreed upon between the parties. These changes shall be made in consultation with the EMS Agency's PCS manager.

10.31.2 Acquire and maintain in effect throughout the term of this Master Agreement FCC licenses for such communications equipment in accordance with California Public Safety Radio Association ("CPSRA") procedures.

10.31.3 Operate, maintain, and repair Contractor-owned PCS equipment in accordance with standards promulgated hereunder.

10.31.4 Obtain leased lines to current or new remote control stations or to a closer termination point on new or current stations or lines jointly determined by Contractor, Director, and ISD, if Contractor is afforded capability of remote control radio stations located at a County site or

other remotely located site as shown in Attachment 10. If the remote radio stations are located at a non-County site and are owned by Contractor, then Contractor shall also pay for all costs associated with the maintenance and repair of such stations, and for all costs of the A.C. power required for operating the equipment.

10.31.5 Comply with the operating and maintenance standards for communications equipment as set forth in Attachment 11, attached hereto and incorporated herein by reference. Contractor further agrees to operate its PCS equipment in accordance with the transmitter power output and antenna specifications as shown in Attachment 9 .

10.31.6 Comply with channel assignments made by the EMS Agency for communication with paramedics Attachment 12.

10.31.7 Provide training of Contractor personnel assigned to Contractor's PCS operation on the use of communications equipment listed in Attachment 9.

10.31.8 Comply with Paramedic System Trouble Control Procedures established by the EMS Agency PCS manager listed in Attachment 13.

10.31.9 Have the capability of emergency maintenance and repair of PCS equipment, as well as periodic preventive maintenance, either by its own personnel or through a communications service company which has a service contract with Contractor and which has a demonstrated capability of providing the required services.

10.31.10 Nothing in this Agreement shall prohibit Contractor from seeking reimbursement, contributions, or other payment from municipalities, paramedic provider agencies, or receiving hospitals to defray Contractor's costs associated with providing ALS services. However, nothing in this Master Agreement shall be deemed to require any such reimbursement, contributions, or payment.

11.0 HOURS/DAY OF WORK

Intentionally Omitted

12.0 WORK SCHEDULES

Intentionally Omitted

13.0 UNSCHEDULED WORK

Intentionally Omitted

14.0 PROCEDURE FOR NON-COMPLIANCE AND PENALTIES

Contractor's failure to meet data collection requirements for base hospital data elements shall be addressed by the County in accordance with Attachment 14, Procedure for Non-Compliance with Data Collection Requirements.

ATTACHMENT 1

PREHOSPITAL CARE POLICY REFERENCE NO. 316,
EMERGENCY DEPARTMENT APPROVED FOR PEDIATRICS (EDAP) STANDARDS

SUBJECT: **EMERGENCY DEPARTMENT APPROVED FOR PEDIATRIC (EDAP) STANDARDS**

REFERENCE NO. 316

PURPOSE: To establish minimum standards for the designation of Emergency Departments Approved for Pediatrics (EDAP). These Emergency Departments (ED) provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures.

DEFINITIONS:

Advanced Pediatric Life Support (APLS): The Pediatric Emergency Medicine Resource: A continuing medical education program developed by American Academy of Pediatrics (AAP) and American College of Emergency (ACEP). APLS features an innovative modular curriculum designed to present the information physicians, nurses and allied health professionals need to assess and care for critically ill and injured children during first few hours in the ED or office-based setting. Course is valid for four years.

Board Certified (BC): Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialties (ABMS) including an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in a particular specialty.

Board Eligible (BE): Successful completion of an residency training program with progression to board certification based on the timeframe as specified by the ABMS.

Department of Children and Family Services (DCFS): A mandated component of Emergency Response Services, administered by the Los Angeles County Department of Children and Family Services. The Child Protection Hotline (CPH) intake evaluation staff is responsible for assessing any referral, whether verbal or written, which alleges child abuse, neglect or exploitation to determine whether an in-person investigation and consultation is required.

The CPH operates 24 hours a day, seven days a week. The 24 hour number (1-800-540-4000) staffed by employees of the DCFS is responsible for screening calls from the community related to issues of child abuse and neglect. In the event, CPH volume of calls received exceeds the number of social worker's available, an Overflow/callback provisional number (not an official reporting number) is given to the caller. The caller is responsible to re-contact CPH and make a referral, assuring the mandated reporting process is initiated and completed.

Emergency Departments Approved for Pediatrics (EDAP): A licensed basic or comprehensive ED that is approved by the Emergency Medical Services (EMS) Agency to receive pediatric patients via the 9-1-1 system. These emergency departments provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures, as per the guidelines outlined in Ref. No. 510, Pediatric Patient Destination.

APPROVED: REDACTED
Director, EMS Agency

REDACTED
Medical Director, EMS Agency

Emergency Nursing Pediatric Course (ENPC): Two-day course developed by the ENA that provides core-level pediatric knowledge and psychomotor skills needed to care for pediatric patients in the emergency care setting. Course is valid for four years.

Pediatric Advisory Committee (PedAC): Acts in an advisory capacity to the EMS Agency and is responsible for all matters regarding pediatric care and policy development pertinent to the practice, operation and administration of prehospital care, emergency departments, and pediatric intensive care units (PICU). Committee reviews, evaluates, and makes recommendations on issues related to EMS which impact the pediatric population.

Pediatric Emergency Course: Two-day course with topics pre-approved by the EMS Agency that provides knowledge about the acutely ill and injured child, and a minimum of 14 hours of continuing education. Course is valid for four years.

Pediatric Advanced Life Support (PALS): Instructor-based course with hands-on skills validation by American Heart Association. Course is valid for two years.

Pediatric Medical Center (PMC): A licensed acute care hospital that is approved by the EMS Agency to receive **critically ill** pediatric patients via the 9-1-1 system based on guidelines outlined in Ref. No. 510, Pediatric Patient Destination.

Pediatric Trauma Center (**PTC):** A licensed acute care hospital that is approved by the EMS Agency to receive **injured** pediatric patients via the 9-1-1 system based on guidelines outlined in Ref. No. 506, Trauma Triage. These centers provide tertiary pediatric care and serve as referral centers for critically injured pediatric patients.

Promptly Available: Able to be physically present in the ED within a period of time that is medically prudent and appropriate to the patient's clinical condition; and further, should not have a measurably harmful effect on the course of patient management or outcome. Hospital guidelines shall be established that address response time for on-call physicians.

Qualified Specialist: A physician licensed in the State of California who has become BC or BE in the corresponding specialty by ABMS or American Osteopathic Association (AOA).

Senior Resident: A physician licensed in the State of California who is in training as a member of the residency program at the designated hospital, has completed at least two years of the residency, and is in good standing.

Sexual Assault Forensic Examiner (SAFE): Examiners are trained healthcare professionals with additional training in conducting adult and adolescent sexual assault forensic medical examinations and/or child sexual abuse forensic medical examinations. SAFE encompasses several categories of examiners (e.g., physicians, nurse practitioners, physician assistants, and registered nurses).

Sexual Assault Response Team (SART) Centers: A center specializing in child abuse, neglect, and forensic examinations in the case of an acute sexual assault/abuse event (defined as occurring within 72 hours), which has the capabilities of providing comprehensive medical and psychological forensic examinations and consist of a knowledgeable staff whose training, expertise, and state-of-the-art equipment exceeds the community standards. The SART Center shall have the capabilities of being mobile in the event that the patient is medically unstable for discharge.

The EDAP shall ensure that a forensic examination and interview process for a case of acute sexual assault/abuse event (defined as occurring within 72 hours) or appropriate referral for such examination if over 72 hours.

If the EDAP cannot provide the necessary forensic examination, coordination of care with a local SART Center, which has the capabilities of providing a comprehensive medical and psychological examination for the sexually abused pediatric patient must be arranged.

POLICY:

I. EDAP Designation / Confirmation Agreement:

A. EDAP initial designation and EDAP re-confirmation is granted after a satisfactory review by the EMS Agency for a period of three years.

B. The EMS Agency reserves the right to perform scheduled site visits or request additional data of the EDAP at any time.

C. The EDAP shall immediately provide written notice to the Director of the EMS Agency if unable to adhere to any of the provisions set forth in the EDAP Standards.

D. The EDAP shall provide a 90-day, written notice to the EMS Agency Director of intent to withdraw from the EDAP program.

E. The EDAP shall notify the EMS Agency within 15 days in writing of any change in status of the EDAP Medical Director, ED Nurse Manager/Director, Designated Pediatric Consultant, and Pediatric Liaison Nurse (PdLN) by submitting Ref. No. 621.1, Notification of Personnel Change Form.

II. EDAP Approval Process

A. General Hospital Requirements:

1. Licensed by the State of California Department of Public Health (CDPH) as a General Acute Care Hospital, and

a. Be approved for Basic or Comprehensive Emergency Medical Services pursuant to the provisions of Title 22, Division 5, California Code of Regulations

b. Accredited by a Centers for Medicare & Medicaid Services (CMS) recognized Hospital Accreditation Organization

B. EDAP Leadership Requirements:

1. EDAP Medical Director is a qualified specialist in Emergency Medicine (EM) or Pediatric Emergency Medicine (PEM).

Responsibilities:

a. Oversee EDAP quality improvement (QI) program and monitor to ensure adherence to the EDAP Standards

b. Promote and verify adequate skills and current knowledge of ED staff physicians and mid-level practitioners in pediatric emergency care and resuscitation

c. Member of both the ED and pediatric committees (if applicable) to ensure that pediatric care needs are addressed and communicated across disciplines

d. Liaison with PMCs, PTCs, base hospitals, community hospitals, prehospital care providers, and the EMS Agency to ensure pediatric care needs are addressed

e. Collaborates with the ED Nurse Manager/Director and the PdLN to ensure adherence to the EDAP Standards for staffing, medication, equipment, supplies, and other resources for children in the ED

f. May also be assigned others roles in the ED

g. Committee Participation:

The EMS Agency's Pediatric Advisory Committee meets quarterly in March, June, September, and December to address pediatric care issues related to prehospital care, emergency departments, and pediatric intensive care units (PICU). Committee members are appointed to ensure that the five EDAP regions are represented. For non-committee member EDAP Medical Directors, attendance is highly encouraged.

2. Designated Pediatric Consultant – A qualified specialist in pediatrics and/or subspecialty in PEM

a. Responsibilities:

i. Promptly available for consultation

ii. Participate in the development and monitoring of pediatric QI program, and pediatric policies and procedures

iii. Collaborate with the EDAP Medical Director and PdLN as needed

iv. May also be the EDAP Medical Director

3. ED Nurse Manager/Director - Licensed as a Registered Nurse (RN) in the State of California

a. Responsibilities:

i. Ensure compliance with the EDAP Standards, EDAP Agreement, and EMS Agency policies and procedures

ii. Oversee the EDAP QI program

iii. Appoint an ED RN as the PdLN and provide a written description of responsibilities to ensure compliance with EDAP Standards

iv. Ensure that the PdLN is allocated the appropriate time and resources necessary to comply with the EDAP Standards. Allocation of time/hours may be based on the ED's annual pediatric volume:

1) Low: <1800
2) Medium: 1800 - 4999
3) Medium-High: 5000 - 9999
4) High: >10,000

v. Collaborate with the PdLN to develop and implement policies and procedures for all aspects of pediatric care

vi. Ensure opportunities for the staff to meet the EDAP educational requirements

vii. Ensure that the QI reports are presented at applicable hospital committees (e.g., ED, hospital-wide QI, and/or pediatric committees)

viii. Ensure that the appropriate documentation is readily available for the EMS Agency during the review process (e.g., physicians' credentials, nursing and respiratory care practitioners' continuing education)

ix. Serves as a contact person for the EMS Agency and available upon request to respond to County business

4. Pediatric Liaison Nurse (PdLN) – Nurse Coordinator for pediatric emergency care

a. Qualifications:

i. Licensed as an RN in the State of California

ii. At least two years of experience working in pediatrics, or in an ED that provides care for pediatric patients, within the previous five years

iii. Current PALS provider or instructor

iv. Completion of a two-day pediatric emergency course within the last four years

v. Completion of seven hours of pediatric continuing education (CE) approved by the Board of Registered Nursing (BRN) every two years

b. Responsibilities:

i. Collaborate with the EDAP Medical Director, ED Nurse Manager/Director, and Designated Pediatric Consultant to

ensure compliance with Ref. No. 316, EDAP Standards, Ref. No. 312, Pediatric Liaison Nurse, and policies and procedures established by the EMS Agency

ii. Maintain and monitor the EDAP QI program

iii. Serve as a liaison and maintain effective lines of communication with:

1) ED management, physicians, and personnel
2) Hospital pediatric management, physicians, and personnel
3) Paramedic base hospital personnel, as applicable
4) System PdLNs
5) Prehospital care coordinators (PCCs), as needed, to follow up with pediatric treatment/transport concerns
6) Prehospital care providers as needed, to follow up with pediatric treatment and/or transport concerns
7) Other EDAPs and PMCs
8) EMS Agency

iv. Serve as a contact person for the EMS Agency and be available upon request to respond to County business

v. Monitor Pediatric Education:

1) Develop a mechanism to track and monitor pediatric continuing education for the ED staff
2) Maintain continuing education documentation, to be readily available to the EMS Agency during the review process

vi. Committee Participation:

The EMS Agency's Pediatric Advisory Committee meets quarterly in March, June, September, and December to address pediatric care issues related to prehospital care, emergency departments, and pediatric intensive care units (PICU). Committee members are appointed to ensure the five EDAP regions are represented. For non-committee member PdLNs, attendance is highly encouraged.

C. Personnel

1. ED Physicians

a. Twenty-four hour ED coverage shall be provided or directly supervised by physicians functioning as emergency physicians, or pediatricians experienced in emergency care, or senior residents.

b. At least 75% of the physicians attending in the ED shall be BC or BE in EM or PEM.

c. ED physicians who are not EM or PEM BC or BE shall have current PALS or APLS providers or instructors.

2. Pediatricians (applies to EDAPs with associated pediatric admission unit)

a. There shall be a call panel for telephone consultation and a qualified specialist in pediatrics to be promptly available to the ED twenty-four hours per day.

b. Those pediatricians who are not BC or BE shall be current PALS or APLS provider or instructor.

3. Pediatric Subspecialty Services

Pediatric subspecialty physicians shall be available through in-house panel, phone consultation, telemedicine, or transfer agreements.

4. Mid-Level Practitioners (Physician Assistants and Nurse Practitioners)

a. Mid-level practitioners shall be licensed by the State of California.

b. All mid-level practitioners assigned to the ED caring for pediatric patients must be current PALS or APLS provider or instructors.

5. Registered Nurses

a. All RN staff in the ED caring for pediatric patients must be current PALS providers or instructors. In addition, all nurses assigned to the ED shall attend at least 14 hours of BRN-approved pediatric education every four years.

b. At least one RN per shift shall have completed a two-day Pediatric Emergency Course within the last 4 years and be available for patient care. It is highly recommended that all nurses regularly assigned to the ED complete this course as well.

III. Two-Day Pediatric Emergency Course – Continuing Education

A. May be completed in-house or off-site

B. The interval between Day/Part 1 and Day/Part 2 must be completed within a six month period

If the interval between Day/Part 1 and Day/Part 2 is greater than six months, this will only fulfill the 14 hour requirement in Section C.5.a above.

C. Curriculum should be selected from this broad spectrum of pediatric topics which have been pre-approved by the EMS Agency:
1. Airway management
2. Brief Resolved Unexplained Event (BRUE) and previously called Apparent life-threatening event (ALTE) $\leq$ 12 months of age
3. Child Maltreatment (suspected child abuse, neglect, and sexual assault) to

include the mandated reporting process
4. Coordination of care with an SART Center for an acute suspected sexual assault victim requiring a forensic examination
5. Death
6. Fever/Sepsis/Shock
7. Female presenting with signs & symptoms of recent delivery and no history of giving birth / newborn abandonment
8. Human trafficking
9. Injury prevention
10. Medical conditions (e.g., diabetic ketoacidosis, inborn errors of metabolism, etc.)
11. Medication safety
12. Neonatal emergencies
13. Pain Management
14. Disaster response
15. Poisonings
16. Procedural Sedation
17. Respiratory emergencies
18. Resuscitation
19. Seizures
20. SIDS/SUID
21. Special health care needs
22. Submersions
23. Surgical emergencies
24. Trauma/Burns
25. Triage

IV. Quality Improvement (QI) Program Requirements

QI program shall be developed as per Ref. No. 620, EMS Quality Improvement Program, and monitored by the EDAP Medical Director, ED Nurse Manager/Director, and PdLN with input as needed from the Designated Pediatric Consultant.

A. Develop a mechanism to easily identify pediatric (14 years of age and under) visits to the ED.

B. Identification and trending of important aspects of pediatric care requiring improvement, to include 100% medical record review of:

1. Deaths
2. Child Maltreatment (suspected child abuse, neglect, and sexual assault) to include the mandated reporting process
3. Transfers to higher level of care
4. Admissions from the ED to an adult medical surgical unit and/or adult intensive care unit (ICU)
5. Unscheduled/unplanned return visits to the ED within 48 hours that are admitted or transferred

C. Hospital and EMS Agency quality of care review may include, but is not limited to the following high-risk patients and important aspects of care:

1. Patients requiring critical care or PICU
2. Pediatric patients transported via the 9-1-1 requiring admission or transfer to higher level of care

3. Airway management
4. Acute dehydration
5. Blunt head trauma
6. Diabetic ketoacidosis
7. Fever in infants less than three months of age
8. Long bone fractures
9. Medication safety
10. Seizures
11. Sepsis
12. Respiratory distress (e.g., asthma, bronchiolitis, croup, foreign body, aspiration pneumonia)
13. Facility-specific issues as identified by the PdLN and/or physician
14. Prevention of unnecessary tests and procedures per the “Choosing Wisely® Initiatives”

D. Maintain written QI plan, trending and analysis reports, agenda, minutes, and attendance rosters to be readily available to the EMS Agency for the review process.

V. Ancillary Services

A. Respiratory Care Practitioners (RCP)

1. At least one RCP shall be in-house twenty-four hours per day to respond to the ED.

2. All RCPs shall be a current PALS provider or instructor.

3. The hospital shall have a mechanism to track and monitor PALS certifications for RCP.

B. Radiology

1. The radiology department shall have pediatric-specific policies and procedures pertaining to imaging studies of children.

2. Qualified specialist in radiology must be on-call and promptly available twenty-four hours per day.

3. Radiology technician must be in-house twenty-four hours per day, with a back-up technician on-call and promptly available.

4. CT scan technician must be on-call and promptly available.

5. Ultrasound technician or designated operator must be on-call and promptly available.

C. Laboratory

1. Laboratory service shall have pediatric-specific policies and procedures pertaining to laboratory studies of children, including, but not limited to, obtaining samples, and micro technique for small or limited sample sizes.

2. Technician must be in-house twenty-four hours per day, with a back-up

technician on-call and promptly available.

VI. Policies and Procedures

Policies and procedures pertaining to the emergency care of children shall include, but are not limited to, the following, and multiple required elements may be incorporated into one policy – e.g., “Care of the Pediatric patient in the ED”:

A. Triage:

1. Vital signs recorded at triage for infants and children, to include age-appropriate measurement of temperature, heart rate, respiratory rate, and pain scale.

2. Blood pressure and pulse oximetry monitoring shall be available for children of all ages. Optimally, blood pressure and pulse oximetry should be assessed on all children. Exceptions must be addressed in policy and monitored.

B. Pediatric patient safety in the ED (e.g., environment of care)

C. Immunization assessment and management of the under immunized patient

D. Reporting of all aspects of the mandated reporting of child maltreatment (suspected child abuse, neglect, and sexual assault) to include:

1. An immediate verbal telephone report to Child Protection Hotline (CPH) and/or law enforcement if the child is in danger

2. Completion of the written or online Suspected Child Abuse Report (SCAR) #8572 report to Department of Children and Family Services (DCFS) within 36 hours

3. Documentation of the case number or referral number and tracking number in the medical record

4. Social Service (during business hours) or Registered Nurse (afterhours/weekends) to review the final patient disposition with the physician on-duty to assure the mandated reporting and medical record documentation is complete, and the coordination of care per CPH is communicated for a safe disposition of the child (family, caregiver or law enforcement)

5. Checklist to assure all forms, notifications, and documentation are completed with physician notification and appropriate documentation

6. Monthly QI reviews by Social Services and ED to assure the appropriate recognition of and reporting processes of child maltreatment cases

E. Include in the above policy the coordination of care with a Sexual Assault Response Team (SART) Center for an acute suspected sexual assault patient/victim requiring a forensic evidentiary examination or appropriate referral to include:

1. Patient to receive a medical screening examination and any necessary stabilization treatment

2. ED nurse or physician to notify the law enforcement agency in the city where the crime occurred

    a. Once law enforcement officer arrives and authorizes a forensic evidentiary examination

    b. The officer will contact the forensic nurse

    c. Obtain the officer's identification (department and badge number) for documentation

    d. The forensic nurse and advocates are on-call and must be notified directly by law enforcement

    e. If the ED has any questions, they may contact the forensic nurse for consult or for clarification

    f. Obtain the SART Center's address and the arranged time, that the officer and patient will meet the forensic nurse

    g. Prior to the patient's disposition to the SART Center, patient must be medically cleared and all emergency medical conditions stabilized. The patient should be discharged from the ED

3. Provide specific discharge instructions and required documentation to include:

    a. Plan of care

    b. Patient destination to include the SART Center address

    c. Transported/accompanied by law enforcement or permit the patient to be transported by family or caregiver

4. Develop a checklist to assure all forms, notifications and documentation are completed with physician notification and appropriate documentation for a safe disposition

F. Pediatric assessment and reassessment, including identification of abnormal vital signs according to the age of the patient, and physician notification when abnormal values are obtained

G. Pain assessment, treatment, and reassessment, utilizing developmentally appropriate pain scales (include a description of the tools used for infant and child)

H. Consent and assent for emergency treatment (including situations in which a parent/legal guardian is not immediately available)

I. Do Not Resuscitate (DNR) orders/Advanced Health Care Directives (AHCD)

J. Death of the child in the ED and care of the grieving family

K. Care and safety for the pediatric patient with mental and/or behavioral health

emergencies

L. Physical and chemical restraint of patients

M. Procedural sedation

N. Reducing radiation exposure for pediatric patients

O. Safe surrender of newborns

P. Daily verification of proper location and functioning of equipment and supplies for the pediatric crash cart, and a content listing of items in each drawer

Q. Family Centered Care, including:

1. Supporting appropriate family presence during all aspects of care to include invasive procedures and resuscitation

2. Education of the patient, family, and regular caregivers

3. Discharge planning and instructions

4. Culturally and linguistically appropriate services

R. Communication with patient's medical home or primary provider based on illness and severity (e.g., aftercare instructions, x-ray results, and laboratory studies as appropriate)

S. Transfer from the ED to another facility

T. A surge plan for back-up personnel in the ED

U. Disaster preparedness addressing the following pediatric issues:

1. Minimizing parent-child separation, and methods for reuniting separated children with their families

2. Pediatric surge capacity for both injured and non-injured children

3. Medical and mental health therapies, as well as social services, for children in the event of a disaster

4. Disaster drills that include a pediatric mass casualty incident at least once every two years

5. Decontamination

V. Medication safety addressing the following pediatric issues:

1. All pediatric weights shall be recorded in kilograms:

a. Children shall be weighed in kilograms, with the exception of children who require emergency stabilization, and the weight shall be recorded in a prominent place on the medical record such as with the vital signs

b. For children who cannot be safely weighed, a standard method for estimating weight in kilograms shall be used (e.g., a length-based resuscitation tape)

c. Scales used to weigh children must be configured to display weights in kilograms only

d. Electronic medical records shall allow for weight entries in kilograms only

2. Medication orders should be written clearly, in milligrams per kilogram, and should specify the total dosage – not to exceed the safe maximum dosage

3. Processes for safe medication storage, prescribing, and delivery should be established and should include the use of pre-calculated dosing guidelines for children of all ages

4. Involve the patient and /or family in the medication safety process to ensure accurate patient identification and provide education as to the rationale for the medication

VII. Interfacility Transfer

A written Interfacility Consultation and Transfer Agreement for tertiary or specialty care shall be established, which shall include, at a minimum, the following:

A. A plan for subspecialty consultation (telephone, or real-time telemedicine) twenty-four hours per day

B. Identification of transferring and receiving hospitals' responsibilities in accordance with Emergency Medical Treatment and Active Labor Act (EMTALA)

C. A process for selecting the appropriately staffed transport service to match the patient's acuity level

VIII. Equipment, Supplies, and Medications

A. Pediatric equipment, supplies, and medications shall be easily accessible, labeled, and logically organized – a mobile pediatric crash cart shall be utilized.

B. Staff shall be able to identify the locations of all items. A locator chart of the locations of all items (e.g., a locator grid identifying the required equipment and supplies) shall be maintained.

C. The following are the required EDAP equipment, supplies, and medications:

1. General Equipment

a. Weight scale measuring only in kilograms for both infants and children

b. Standardized length-base resuscitation tape (most recent edition) or other standardized method to estimate pediatric weights in kilograms

c. Pediatric drug dosage reference material with dosages calculated in milligrams per kilogram – either posted, or readily available

d. Developmentally appropriate pain scale assessment tools for infants and children

e. Blood and IV fluid warmer (Rapid infuser)

f. Warming and cooling system with appropriate disposable blankets

2. Monitoring Equipment

a. Blood pressure cuffs in the following sizes:

i. Neonatal
ii. Infant
iii. Child
iv. Adult arm
v. Adult thigh

b. Vascular Doppler device (handheld)

c. ECG monitor/defibrillator:

i. ECG electrodes in pediatric and adult sizes
ii. Defibrillator paddles in pediatric and adult sizes, and/or;
iii. Hands-free defibrillation device
iv. External pacing capability
v. Multifunction pads in pediatric and adult sizes

d. Thermometer with hypothermia capability

3. Airway Management

a. Bag-Valve-Mask (BVM) device with self-inflating bag in the following sizes:

i. Infant (minimum 450ml)
ii. Child
iii. Adult

b. BVM clear masks in the following sizes:

i. Neonate
ii. Infant
iii. Child
iv. Adult

c. Laryngoscope handle:

i. Pediatric
ii. Adult

d. Laryngoscope Blades:

i. Macintosh/curved: 2, 3
ii. Miller/straight: 0, 1, 2, 3

e. Endotracheal Tubes in the following sizes:

i. Uncuffed: mm 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5
ii. Cuffed: mm 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0

f. Stylets for endotracheal tubes:

i. Pediatric
ii. Adult

g. Magill Forceps:

i. Pediatric
ii. Adult

h. Continuous end-tidal CO2 monitoring device for pediatric and adult patients (preferred). If not available, colorimetric CO2 detector may be utilized.

i. Pulse oximeter unit with sensors in the following sizes:

i. Infant
ii. Pediatric
iii. Adult

j. Nasopharyngeal Airways in the following sizes:

12, 14, 18, 20, 22, 24, 26, 30 Fr

k. Oropharyngeal Airways in the following sizes:

i. Neonatal: 00 / 40 mm
ii. Infant: 0 / 50 mm
iii. Child: 1 / 60 mm
iv. Small child: 2 / 70 mm
v. Small adult: 3 / 80 mm
vi. Medium adult: 4 / 90 mm
vii. Large adult: 5 / 100 mm

l. Clear oxygen masks in the following sizes:

i. Infant
ii. Child
iii. Adult

m. Non-rebreather masks in the following sizes:

i. Infant
ii. Child
iii. Adult

n. Nasal cannulas in the following sizes:

i. Infant
ii. Child
iii. Adult

o. Suction catheters in the following sizes:

6, 8, 10, 12 Fr

p. Yankauer suction tips

q. Feeding tubes in the following sizes:

5, 8 Fr

r. Nasogastric Tubes in the following sizes:

5, 8, 10, 12, 14, 16, 18 Fr

s. Laryngeal Mask Airways (LMA) in the following sizes:

1, 1.5, 2, 2.5, 3, 4, 5

t. Cricothyrotomy Catheter set (pediatric)

u. Tracheostomy trays: **Requirement for PMC's. Optional for EDAP's**

i. Pediatric
ii. Adult

v. Tracheostomy Tubes: **Requirement for PMC's. Optional for EDAP's**

i. Neonatal: size mm 2.0, 2.5, 3.0, 3.5, 4.0, 4.5
ii. Pediatric: size mm 3.0, 3.5, 4.0, 5.0, 5.5, 6.0

4. Vascular Access Equipment

a. Arm boards in the following sizes:

i. Infant
ii. Child
iii. Adult

b. IV volume rate control administration sets with calibrated chambers

c. IV catheters in the following sizes:

16, 18, 20, 22, 24 gauge

d. 3-way stopcocks

e. Device or needle to achieve intraosseous (IO) vascular access, to include needles in the appropriate sizes for pediatric and adult patients

f. IV solutions, to include the following in 250ml and/or 500ml bags:

i. 0.9 NS
ii. D5.45NS
iii. D5NS
iv. D10W

5. Fracture Management Devices

a. Splinting supplies for long bone fractures

b. Spinal motion restriction devices in the following sizes:

i. Infant
ii. Child
iii. Adult

c. Spinal board with the appropriate straps

6. Specialized Trays or Kits

a. Newborn delivery kit to include:

i. Bulb syringe
ii. Umbilical clamps
iii. Towels
iv. Scissors

b. Newborn initial resuscitation equipment should be readily available, including:

i. Meconium aspirator
ii. Radiant warmer
iii. BVM device with self-inflating bag and clear mask for newborns

c. Umbilical Vein Catheters, or 5.0 Fr feeding tube

d. Central Line Trays in the following sizes:
Requirement for PMC's. **Optional for EDAP's.**

i. 4.0 Fr
ii. 5.5 Fr
iii. 7.0 Fr

e. Thoracostomy tray:

i. Pediatric

ii. Adult

f. Chest drainage system

g. Chest tubes in the following sizes: (At least one in each size range)

(10 – 12) (16 – 24) (28 – 40) Fr – **Requirement for EDAP's**
8, 12, 16, 20, 24, 28 Fr – **Required for PMC's**

h. Lumbar Puncture trays and spinal needles:

i. 22 g, 3 inch
ii. 22-25 g, 1½ inch

i. Urinary catheterization sets and urinary (indwelling) catheters in the following sizes:

5, 8, 10, 12, 14, 16 Fr

7. Pediatric-Specific Resuscitation

a. Immediately available drug calculation resources

b. The following medications must be immediately available:

i. Adenosine
ii. Albuterol
iii. Amiodarone
iv. Atropine
v. Atrovent
vi. Calcium chloride
vii. Dobutamine
viii. Dopamine
ix. Epinephrine 0.1mg/mL **(IV administration**)
x. Epinephrine 1mg/mL (**IM administration**)
xi. Epinephrine for inhalation
xii. Lidocaine
xiii. Mannitol or hypertonic saline
xiv. Naloxone
xv. Procainamide
xvi. Sodium Bicarbonate 4.2% (or a process to obtain the drug in an emergency situation)
xvii. Sodium Bicarbonate 8.4%

CROSS REFERENCE:

Prehospital Care Policy Manual

Ref. No. 312, Pediatric Liaison Nurse
Ref. No. 318, Pediatric Medical Centers
Ref. No. 506, Trauma Triage
Ref. No. 508, Sexual Assault Patient Destination
Ref. No. 508.1, SART Center Roster

Ref. No. 510, Pediatric Patient Destination
Ref. No. 620, EMS Quality Improvement Program
Ref. No. 621, Notification of Personnel Change
Ref. No. 621.1, Notification of Personnel Change Form
EMS Agency Pediatric Advisory Committee Bylaws
EMS Agency SART Standards
California Clinical Forensic Medical Training Center, California Sexual Assault Response Team (SART) Manual

ACKNOWLEDGEMENTS

The EMS Agency EDAP Standards were first developed by the Committee on Pediatric Emergency Medicine (COPEM), which is made up of representatives from the following organizations: Los Angeles Pediatric Society, Pediatric Liaison Nurses of Los Angeles County, California Chapter of the American College of Emergency Physicians (ACEP), National Emergency Medical Services for Children (EMSC) Resource Alliance, American Academy of Pediatrics (AAP)-California Chapter 2, Emergency Nurses Association (ENA), American College of Surgeons (ACS), and the EMS Agency.

The EDAP Standards have since been revised, endorsed by The Hospital Association of Southern California, and now meet or exceed the guidelines established by the Emergency Medical Services Authority (EMSA) #182: Administration, Personnel, and Policy for the Care of Pediatric Patients in the Emergency Department, and the 2009 Joint Policy Statement: Guidelines for Care of Children in the Emergency Department which was ratified by the AAP, ACEP, and the ENA.

ATTACHMENT 2

CONTRACT DISCREPANCY REPORT

TO:

FROM:

DATES: **Prepared:** _____

Returned by Contractor: _____

Action Completed: _____

DISCREPANCY PROBLEMS: _____

_____

_____

_____ _____

Signature of County Representative Date

CONTRACTOR RESPONSE (Cause and Corrective Action): _____

_____

_____

_____ _____

Signature of Contractor Representative Date

COUNTY EVALUATION OF CONTRACTOR RESPONSE: _____

_____

_____

_____ _____

Signature of Contractor Representative Date

COUNTY ACTIONS: _____

_____

_____

CONTRACTOR NOTIFIED OF ACTION:

County Representative's Signature and Date _____

Contractor Representative's Signature and Date _____

ATTACHMENT 3

CURRENT TEMIS HOSPITAL HARDWARE AND SOFTWARE SPECIFICATIONS

Minimum Workstation Specification

- Intel® Core i7 Processor – 940 or better
- Microsoft Windows 10 64-bit
- 8 GB of RAM
- 2 GB of Available Disk Space
- Display Adapter and Monitor Capable of Displaying 1024 X 768
- 1 Gbps NIC Adapter or faster
- Mouse
- Keyboard
- LA Base Software
- Internet Explorer 11 or Chrome 33 or higher
- High-speed internet connection for each work station

- Remote support from WebEx is utilized for remote desktop support. If this does not comply with your institution's IT policy, we request network access via a VPN with desktop access via an industry standard solution.

- IT staff should have FTP access for downloading and uploading of large files (minimum 5 megabits) related to product updates and technical support.

- For sites wishing to use SQL Server Express, this software will need to be installed by the customer prior to the installation of TEMIS applications.

- TEMIS software vendor should have direct access to the server console to facilitate troubleshooting directly.

ATTACHMENT 4

COMMUNICATIONS MANAGEMENT COMMITTEE (Ad Hoc)

1. PURPOSE: The Communications Management Committee ("CMC") is organized to provide technical and administrative assistance in the design, maintenance, and operation of the PCS to the PCS Manager.

2. ORGANIZATION: The CMC shall be composed of the following representatives or their designees:

   A. PCS Manager, appointed by the Director of the Department of Health Services;

   B. Chief Deputy Director, Internal Services Department;

   C. Executive Director, Hospital Association of Southern California;

   D. Consultant, nominated by the EMSC;

   E. Representative, nominated by the Los Angeles County Ambulance Association;

   F. Representative, nominated by the Los Angeles County Chapter of the Southern California Fire Chiefs Association.

   G. Representative, nominated by the Base Hospital Advisory Committee.

   Failure of the listed non-County agencies to appoint representatives to the CMC shall not invalidate the formation of the CMC. Alternative arrangements which fulfill the purposes of this committee may also be utilized with the approval of the local EMS Agency.

3. RESPONSIBILITIES:

   A. Assess current operations of PCS;

   B. Identify current and on-going problems;

   C. Develop solutions and schedules for resolving problems;

   D. Report status to participants of PCS on a regular basis; and

   E. Bring major problems to the attention of the directors of the local EMS Agency and the Internal Services Department.

4. MEETINGS: The CMC shall meet on an "as needed" basis as determined by the PCS Manager.

ATTACHMENT 5

BASE HOSPITAL FORM

Log # Sequence # ☐ Pg2

GEN INFO

Date |_|_|_|_|_|_|_|_| Provider Code |_|_|_|

Time |_|_|_|_| Unit _____

Location _____ |_|_|

Pt.# ___ of ___ Sex ☐ M ☐ F ☐ N

Age _____ ☐ Yrs ☐ Mos ☐ Days ☐ Wks ☐ Hrs ☐ Est.

Weight _____ ☐ Kg ☐ Lbs

Peds Weight Color Code:

☐ Too Tall

Hospital Code: |_|_|_|

☐ Phone ☐ 9-1-1 Call

☐ Radio ☐ 9-1-1 RE-Triage

☐ VMED28 ☐ FT

ASSESSMENT

PROVIDER IMPRESSION |_|_|_|_|_|_|_|_|_|_| LEVEL OF DISTRESS ☐None ☐MID ☐Moderate ☐Severe

CHIEF COMPLAINT CODES |_|_|_|_|_|_|_|

mLAPSS

Met: ☐ Y ☐ N

Last Known Well

Date: _____

Time: _____

Protocol: _____

O/P

O

R

S

T

LAMS Score: _____

Medical Hx:

Medications:

☐ NKA Allergies:

DNR/AHCD/POLST? ☐ Y ☐ N ☐ Unk

PRIOR to BASE

MEDS:
☐ ADE _____
☐ ALB _____
☐ ASA _____
☐ EPI _____
☐ PEN _____
☐ MID _____
☐ NAR _____
☐ NTG _____
☐ OND _____
☐ Morphine _____
☐ GLU/GLP _____
☐ D10 _____

TXS:
☐ BMV ☐ CPAP
☐ ETT ☐ King
☐ NMR
☐ GLucometer
☐ DEFibrillatedX ___
☐ CAR ☐ TCP
☐ AED-Analyzed
☐ AED-Defibrillated
☐ Needle THoracost.
☐ Tourniquet(TK)
☐ OTher:

PHYSICAL

LOC ☐ ALERT ☐ Ox3
☐ Disoriented
☐ Combative
☐ NoT Alert
☐ NonMal for Pt
☐ No Response

PUPILS ☐ PERL
☐ Unequal
☐ PInpoint
☐ Fixed/Dilated
☐ Cataracts
☐ Sluggish

RESPIRATION ☐ CLEAR ☐ NORMAL rate/effort
TIDAL VOLUME: ☐ N ☐ + ☐ -
☐ Wheezes ☐ Labored ☐ Apnea
☐ Rales ☐ Unequal ☐ Snoring
☐ RHonchi ☐ JVD
☐ STridor ☐ Accessory Muscle Use

Capnography# _____
Waveform? ☐ Y ☐ N
ADV AIRWAY
BS after ETT/King? ☐ Y ☐ N
ETCO2: ☐ + ☐ -

SKIN ☐ NML
☐ Pale ☐ Hot
☐ Cool/Cold
☐ Diaphoretic
☐ Cyanotic
☐ Flushed

☐ IUP: ____ wks
☐ Suspected Drugs/ETOH

GCS
Eye _____ Verbal _____ Motor _____
TOTAL GCS: Repeat GCS (if applicable):

Glucometer
#1: _____ #2: _____
Glucometer Ordered? ☐ Y ☐ N

Cap Refill:
☐ NoRmal
☐ DElayed

ECG

Initial Rhythm: |_|_|_|

12-Lead ECG @ ____:____

EMS Interpretation:
☐ NormaL ☐ ABnormal ☐ STEMI

Software Interpretation:
☐ NormaL ☐ ABnormal ☐ STEMI

Artifact? ☐ Y ☐ N

Wavy Baseline? ☐ Y ☐ N

Paced Rhythm? ☐ Y ☐ N

VITALS/TXS

O2 @ _____ lpm Titrated? ☐ Y ☐ N via: ☐ NC ☐ Mask ☐ BMV ☐ BioW by ☐ EXisting Trach ☐ ETT ☐ King ☐ CPAP

IV: ☐ SL ☐ FC _____ cc ☐ TKO ☐ WO ☐ Not Ordered ☐ IV Unable ☐ Refused ☐ IO ☐ ProcXisting IV

TransCutaneous Pacing @ mA: _____ Rate: _____ Capture? ☐ Y ☐ N Needle THoracostomy? ☐ Y ☐ N

Spinal Motion Restriction? ☐ Y ☐ N CMS Intact: ☐ Before ☐ After SMR Refused? ☐ Y ☐ N ☐ Tourniquet (TK)

TIME	B/P	PULSE	RR	O2 SAT	PAIN	CO2 #	ECG	DRUG/DEFIB	SEDs paid 48hrs? ☐Y ☐N	DOSE	ROUTE	RESULT
								☐REFUSED				
								☐PRN				
								☐PRN				
								☐PRN				

ARREST

Witnessed by:
☐ Citizen ☐ EMS ☐ None

CPR by:
☐ Citizen ☐ EMS ☐ None

Arrest to CPR (in minutes) _____

Rtn of Pulse (ROSC)? ☐ Y ☐ N

Rtn of Pulse (ROSC) @ ____:____

Resus D/C @ ____:____

Resus D/C Rhythm |_|_|_|

Total Min. EMS CPR: _____

TRAUMA

☐ No Apparent Injury
☐ BUrns/Elec. Shock
☐ Critical Burn
☐ SBP <80(<70 if <1 yr)
☐ RR<10/>29(<20/<1yr)
☐ Susp. Pelvic FX
☐ Spinal Cord Injury
☐ Inpatient Trauma
☐ Uncontrolled Bleeding

B P
☐ ☐ Trauma Arrest
☐ ☐ Head
☐ GCS≤14
☐ ☐ Face/Mouth
☐ ☐ Neck
☐ ☐ Back
☐ ☐ Chest
☐ Flail Chest
☐ ☐ Tension Pneumo

B P
☐ ☐ Abdomen
☐ Diffuse Abd. Tenderness
☐ ☐ Genitals
☐ ☐ Buttocks
☐ ☐ Extremities
☐ EXtrem. above knee/elbow
☐ FRactures ≥2 long bones
☐ ☐ Amputation above wrist/ankle
☐ ☐ Neur/Vasc/Mangled
☐ ☐ Minor Lacerations

MECHANISM

PROTECTIVE DEVICES: ☐ HeLmet ☐ Seat Belt ☐ Air Bag ☐ Car Seat/Booster

☐ Enclosed Vehicle
☐ EJected
☐ EXtricated@ _____
☐ Pass. Space Intr. ☐ >12" ☐ >18"
☐ Survived Fatal Accident
☐ Impact >20mph Unenclosed
☐ Ped/Bike: Runover/Thrown/>20mph
☐ Ped/Bike <20mph
☐ Motorcycle/Moped
☐ TAser
☐ SPorts/Rec
☐ ASsault
☐ STabbing
☐ GSW
☐ ANimal Bite
☐ CRush
☐ Telemetry Data
☐ Special Consid.
☐ AntiCoagulants
☐ FAll ☐ >15ft(>10ft Peds)
☐ Self-Inflict'd/Accid.
☐ Self-Inflict'd/Intent.
☐ Electrical Shock
☐ Thermal Burn
☐ Hazmat Exposure
☐ Work-Related
☐ UNknown
☐ OTher:

MOIs: |_|_|

TRANSPORT

CODE all options. CHECK actual destination:	CODE	ETA
☐ MAR		
☐ EDAP (age ≤14)		
☐ TC		
☐ PTC (trauma, age ≤14)		
☐ PMC (medical, age ≤14)		
☐ STEMI Receiving Center		
☐ PrimAry Stroke Center		
☐ Comprehensive StroKe Center		
☐ PeriNatal (≥20wks pregnancy)		
☐ SART		
☐ Other		
Time Clear		
Time Receiving Hospital Notified		
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ Not Required
☐ Required/Criteria Met
☐ Guidelines Met

PT TRANSPORTED VIA:
☐ ALS ☐ BLS ☐ Other
☐ Helicopter - ETA: _____
☐ No Transport

DESTINATION RATIONALE:

☐ ED Saturation ☐ Internal Disaster ☐ CT Diversion ☐ IFT
SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ Cardiac Arrest (X)
☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center
☐ SC Not AccessibLe ☐ JudGment (Prov/AmBase)
☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway
☐ Requested by: ☐ Other:

REASON FOR NO TRANSPORT:

☐ AMA ☐ DOA ☐ Unwarranted ☐ T.O.R. ☐ Other
☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObservAtion
☐ OR ☐ Cath Lab ☐ INterventional Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |_|_|_| (Hosp code) ☐ Other: _____
ED Diagnosis:

COMMENTS:

MICN: |_|_|_|_|_|

Physician: |_|_|_|_|_|_|

Patient Name/Number:

HS2340 (4-19) BASE HOSPITAL

ATTACHMENT 6

BASE HOSPITAL FORM
(Page 2)

Log # _____ Seq. # _____

Date | | | | | | Hospital Code | | |

Time	B/P	P	R	Drugs / EKG / Treatments	Dose	Results

Additional Comments:

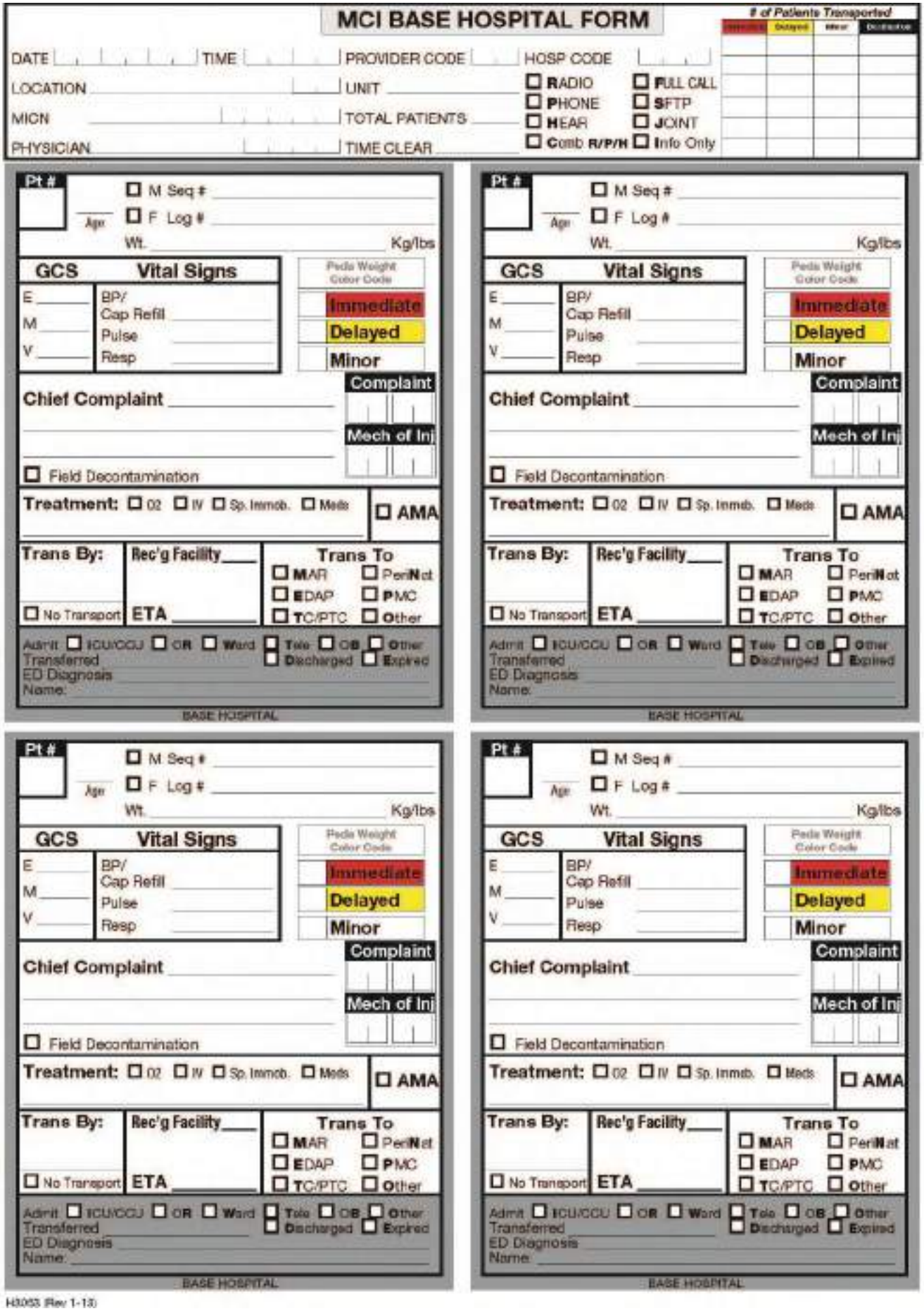
SIGN	MICN/Cert. #	Physician	Patient Name/Number

H2354 76B15H2

BASE HOSPITAL

(Must accompany Page 1)

ATTACHMENT 7



MCI BASE HOSPITAL FORM

of Patients Transported

DATE ____ TIME ____ PROVIDER CODE ____ HOSP CODE ____

LOCATION ____ UNIT ____

MICN ____ TOTAL PATIENTS ____

PHYSICIAN ____ TIME CLEAR ____

☐ RADIO ☐ PHONE ☐ HEAR ☐ Comb R/P/H

☐ FULL CALL ☐ SFTP ☐ JOINT ☐ Info Only

Pt #

Age

☐ M Seq # ____

☐ F Log # ____

Wt. ____ Kg/lbs

GCS

E ____

M ____

V ____

Vital Signs

BP/

Cap Refill ____

Pulse ____

Resp ____

Peds Weight Color Code

Immediate

Delayed

Minor

Chief Complaint ____

Complaint

Mech of Inj

☐ Field Decontamination

Treatment: ☐ O2 ☐ IV ☐ Sp. Immob. ☐ Meds

☐ AMA

Trans By:

☐ No Transport

Rec'g Facility ____

ETA ____

Trans To

☐ MAR ☐ PeriNat

☐ EDAP ☐ PMC

☐ TC/PTC ☐ Other

Admit ☐ ICU/CCU ☐ OR ☐ Ward ☐ Tele ☐ OB ☐ Other

Transferred ☐ Discharged ☐ Expired

ED Diagnosis

Name:

BASE HOSPITAL

Pt #

Age

☐ M Seq # ____

☐ F Log # ____

Wt. ____ Kg/lbs

GCS

E ____

M ____

V ____

Vital Signs

BP/

Cap Refill ____

Pulse ____

Resp ____

Peds Weight Color Code

Immediate

Delayed

Minor

Chief Complaint ____

Complaint

Mech of Inj

☐ Field Decontamination

Treatment: ☐ O2 ☐ IV ☐ Sp. Immob. ☐ Meds

☐ AMA

Trans By:

☐ No Transport

Rec'g Facility ____

ETA ____

Trans To

☐ MAR ☐ PeriNat

☐ EDAP ☐ PMC

☐ TC/PTC ☐ Other

Admit ☐ ICU/CCU ☐ OR ☐ Ward ☐ Tele ☐ OB ☐ Other

Transferred ☐ Discharged ☐ Expired

ED Diagnosis

Name:

BASE HOSPITAL

Pt #

Age

☐ M Seq # ____

☐ F Log # ____

Wt. ____ Kg/lbs

GCS

E ____

M ____

V ____

Vital Signs

BP/

Cap Refill ____

Pulse ____

Resp ____

Peds Weight Color Code

Immediate

Delayed

Minor

Chief Complaint ____

Complaint

Mech of Inj

☐ Field Decontamination

Treatment: ☐ O2 ☐ IV ☐ Sp. Immob. ☐ Meds

☐ AMA

Trans By:

☐ No Transport

Rec'g Facility ____

ETA ____

Trans To

☐ MAR ☐ PeriNat

☐ EDAP ☐ PMC

☐ TC/PTC ☐ Other

Admit ☐ ICU/CCU ☐ OR ☐ Ward ☐ Tele ☐ OB ☐ Other

Transferred ☐ Discharged ☐ Expired

ED Diagnosis

Name:

BASE HOSPITAL

Pt #

Age

☐ M Seq # ____

☐ F Log # ____

Wt. ____ Kg/lbs

GCS

E ____

M ____

V ____

Vital Signs

BP/

Cap Refill ____

Pulse ____

Resp ____

Peds Weight Color Code

Immediate

Delayed

Minor

Chief Complaint ____

Complaint

Mech of Inj

☐ Field Decontamination

Treatment: ☐ O2 ☐ IV ☐ Sp. Immob. ☐ Meds

☐ AMA

Trans By:

☐ No Transport

Rec'g Facility ____

ETA ____

Trans To

☐ MAR ☐ PeriNat

☐ EDAP ☐ PMC

☐ TC/PTC ☐ Other

Admit ☐ ICU/CCU ☐ OR ☐ Ward ☐ Tele ☐ OB ☐ Other

Transferred ☐ Discharged ☐ Expired

ED Diagnosis

Name:

BASE HOSPITAL

H3053 (Rev 1-13)

ATTACHMENT 8

Base Hospital Documentation Manual

Los Angeles County

Emergency Medical Services Agency

REVISED:
July 2018

LANCET TECHNOLOGY
Innovative Data Solutions

TABLE OF CONTENTS

Base Hospital Documentation Manual 1
COMMON NULL VALUES 5
GEN INFO SECTION 6
LOG # 7
NOTIFICATION ONLY? 8
MCI PATIENT? 9
SEQUENCE NUMBER 10
PG 2 11
DATE 12
TIME 13
LOCATION 14
PROVIDER CODE 15
PROVIDER UNIT 17
PT. # __ OF __ 18
AGE 19
AGE UNITS 20
SEX 21
WEIGHT 22
WEIGHT UNITS 23
PEDS WEIGHT COLOR CODE 24
HOSPITAL CODE 25
COMMUNICATION TYPE 26
CALL TYPE 27
ASSESSMENT SECTION 28
PROVIDER IMPRESSION 29
CHIEF COMPLAINT CODES 30
LEVEL OF DISTRESS 34
mLAPSS MET 35
LAST KNOWN WELL DATE 36
LAST KNOWN WELL TIME 37
LAMS SCORE 38
PROTOCOL (Prior to EMS Update 2018 Training) 39
PROTOCOL (After EMS Update 2018 Training) 40
O/P,Q,R,S,T 42

MEDICAL HX 43
MEDICATIONS 44
ALLERGIES 45
DNR/AHCD/POLST? 46
PRIOR TO BASE MEDS 47
PRIOR TO BASE TXS 48
PHYSICAL SECTION 49
LOC 50
IUP_ WKS 51
SUSPECTED DRUGS/ETOH 52
EYE 53
VERBAL 54
MOTOR 55
TOTAL GCS 56
PUPILS 57
RESPIRATION 58
ADV AIRWAY 59
SKIN 60
GLUCOMETER 61
GLUCOMETER ORDERED? 62
ECG/ARREST 63
12 LEAD ECG @ 65
SOFTWARE INTERPRETATION 66
☐ NORMAL ☐ ABNORMAL ☐ STEMI 66
EMS INTERPRETATION 67
☐ NORMAL ☐ ABNORMAL ☐ STEMI 67
ARTIFACT? 68
WAVY BASELINE? 69
PACED RHYTHM? 70
WITNESSED BY: 71
CPR BY: 72
ARREST TO CPR 73
RTN OF PULSE (ROSC)? 74
RTN OF PULSE (ROSC) @ 75
RESUS D/C TIME 76

RESUS D/C RHYTHM 77
TOTAL MIN. EMS CPR: 78
VITALS & TXS SECTION 79
O2 @ ___ LPM 80
TITRATED? 81
VIA: 82
IV: 83
TRANSCUTANEOUS PACING @ mA: 84
RATE: 85
CAPTURE? 86
NEEDLE THORACOSTOMY 87
SPINAL MOTION RESTRICTION? 88
CMS INTACT: 89
SMR REFUSED 90
TOURNIQUET 91
TIME 92
B/P 93
PULSE 94
RR 95
O2 SAT 96
PAIN 97
CO2 # 98
ECG 99
DRUG/DEFIB 100
SEDs IN PAST 48 HRS 101
DOSE 102
ROUTE 103
TX/RESULTS 104
TRAUMA SECTION 105
TRAUMA 106
MECHANISM OF INJURY 108
TRANSPORT SECTION 111
CODE ALL OPTIONS 112
CHECK ACTUAL DESTINATION 114
ETA 116
CHECK ONE 117

DESTINATION RATIONALE 118
PT TRANSPORTED VIA: 120
REASON FOR NO TRANSPORT 121
TIME CLEAR 122
TIME RECEIVING HOSPITAL NOTIFIED 123
NAME OF PERSON NOTIFIED: 124
TRANSPORT SCENARIOS 125
DISPO SECTION 135
IF BASE IS RECEIVING HOSPITAL 136
COMMENTS 137
MICN/PHYSICIAN 138
PATIENT NAME/NUMBER 139
APPENDIX 140
REQUIRED DATA FIELDS FOR ALL BASE HOSPITAL CONTACTS 141
REQUIRED DATA FIELDS FOR ALL SFTP CALLS (Prior to EMS UPDATE 2018 Training) 143
REQUIRED DATA FIELDS FOR ALL NOTIFICATION CALLS (After EMS UPDATE 2018 Training) 145

COMMON NULL VALUES

Definition

These values are to be used with each of the data elements described in this document which have been defined to accept the Null Values

Field Values

- F6: Not Documented
- F7: Not Applicable

Additional Information

- For any collection of data to be of value and reliably represent intended information, a strong commitment must be made to ensure that data collected are complete and accurate.
- Not Documented: This null value code applies if the documentation being referenced has nothing recorded in a specific field
- Not Applicable: This null value code applies if the data field referenced does not apply to the patient (e.g., “Reason for No Transport” if patient was transported)

GEN INFO SECTION

LOG

Definition

Number assigned by the hospital to each base contact or notification call that coincides with its numbered entry on a base contact or notification call log

Additional Information

- **Required** field for all base hospital contacts and notification calls
- Format is unique to each individual hospital

Uses

- Unique patient identifier
- Assists in locating the coinciding audio file

Data Source Hierarchy

- Base Hospital Log
- Base Hospital Form
- Notification Form
- Notification Log

NOTIFICATION ONLY?

Definition

Field indicating whether or not record being entered into TEMIS was a notification call

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Field is autofilled with “N” unless changed by user to “Y”

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Notification Form
- Notification Log
- EMS Report Form
- Audio records

MCI PATIENT?

Definition

Field indicating whether or not incident involved three or more patients

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Field is autofilled with “N” unless changed by user to “Y”

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

SEQUENCE NUMBER

Definition

Unique, alphanumeric EMS record number provided by the paramedic, and found pre-printed at the top right corner of EMS report form hard copies. Electronically assigned to ePCRs from approved providers

Additional Information

- **Required** field for all base hospital contacts and notification calls: electronic data entry cannot begin without this number
- Consists of two letters and six digits on pre-printed EMS Report Forms; or two letters, ten digits if obtained from an approved ePCR provider. Neither format should contain spaces.
- If sequence number is missing or incorrectly documented, every effort must be taken by the base hospital to obtain it – either by reviewing the audio recording, or by contacting the appropriate provider agency directly. Only after all efforts to obtain the actual sequence number have been exhausted may a request be made of the EMS Agency for assistance, or as a last resort, a 'dummy' sequence number, in a **timely** fashion.
- A fictitious sequence number **should not** be generated for any reason.

Uses

- Unique patient identifier
- Essential link between other EMS Agency databases

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- Audio records
- Fire Station logs
- Notification Form
- Notification Log
- EMS Agency

PG 2

Definition

Checkbox indicating that a Base Hospital Form supplemental page was used

Uses

- Use when space is needed for additional Drugs, ECGs, Treatments, and/or Comments

Data Source Hierarchy

- Base Hospital Form Page 2
- Base Hospital Form

DATE

Definition

Date of base hospital contact or notification call

Field Values

- Collected as MMDDYYYY

Additional Information

- **Required** field for all base hospital contacts and notification calls
- Excluding midnight crossover from New Year's Eve to New Year's Day, the last two digits of the date must match the first two numeric digits in a 12-digit sequence number

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Notification Form
- Notification Log

TIME

Definition

Time of day that base hospital contact or notification was initiated

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts and notification calls

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Notification Form
- Notification Log

LOCATION

Definition

Two-letter code indicating where the incident occurred

Field Values

AI	Airport	**OF**	Office
AM	Ambulance	**PA**	Park
BE	Beach	**PL**	Parking Lot
CL	Cliff/Canyon	**PO**	Pool
CO	Commercial Establishment	**PV**	Public Venue/Event
DC	Dialysis Center	**RA**	Recreation Area
DO	Doctor's Office/Clinic	**RE**	Restaurant
FA	Farm	**RI**	Residential Institution
FR	Freeway	**RL**	Religious Building
FS	Fire Station	**RS**	Retail Store
GY	Gym	**RT**	Railroad Track
HO	Home	**SC**	School
IN	Industrial	**ST**	Street
JA	Jail	**UC**	Urgent Care
MB	Military Base	**WI**	Wilderness Area
MC	Hospital/Medical Center	**OT**	Other
NH	Nursing Home		

Additional Information

- **Required** field for all base hospital contacts
- Location codes are listed on the back of pages 1 and 4 of the Base Hospital Form
- Additional details can be written on the adjacent line: e.g., the name of the facility or business, or any other useful information

Uses

- Allows for data sorting and tracking by incident location
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

PROVIDER CODE

Definition

Two-letter code for the EMS provider primarily responsible for the patient's prehospital care

Field Values

PUBLIC PROVIDERS			
AF	Arcadia Fire	**LV**	La Verne Fire
AH	Alhambra Fire	**MB**	Manhattan Beach Fire
AV	Avalon Fire	**MF**	Monrovia Fire
BA	Burbank Airport Fire	**MO**	Montebello Fire
BF	Burbank Fire	**MP**	Monterey Park Fire
BH	Beverly Hills Fire	**OT**	Other Provider
CB	LA County Beaches	**PF**	Pasadena Fire
CC	Culver City Fire	**RB**	Redondo Beach Fire
CF	LA County Fire	**SA**	San Marino Fire
CG	US Coast Guard	**SG**	San Gabriel Fire
CI	LA City Fire	**SI**	Sierra Madre Fire
CM	Compton Fire	**SM**	Santa Monica Fire
CS	LA County Sheriff	**SP**	South Pasadena Fire
DF	Downey Fire	**SS**	Santa Fe Springs Fire
ES	El Segundo Fire	**TF**	Torrance Fire
FS	U.S. Forest Service	**UF**	Upland Fire
GL	Glendale Fire	**VE**	Ventura County Fire
LB	Long Beach Fire	**VF**	Vernon Fire
LH	La Habra Heights Fire	**WC**	West Covina Fire
PRIVATE PROVIDERS			
AA	American Professional Ambulance Corp.	**LY**	Lynch EMS Ambulance
AB	Ambulife Ambulance, Inc.	**MI**	MedResponse, Inc.
AN	Antelope Ambulance Service	**MR**	MedReach Ambulance
AR	American Medical Response	**MT**	MedCoast Ambulance
AT	All Town Ambulance, LLC	**MY**	Mercy Air
AU	AmbuServe Ambulance	**PE**	Premier Medical Transport
AW	AMWest Ambulance	**PN**	PRN Ambulance, Inc.
AZ	Ambulnz Health, Inc.	**RE**	REACH Air Medical Service
CA	CARE Ambulance	**RR**	Rescue Services (Medic-1)
CL	CAL-MED Ambulance	**RY**	Royalty Ambulance
EA	Emergency Ambulance	**SC**	Schaefer Ambulance
EX	Explorer 1 Ambulance & Medical Services	**SO**	Southern California Ambulance
FC	First Care Ambulance	**SY**	Symons Ambulance
FM	Firstmed Ambulance Services, Inc.	**TR**	Trinity Ambulance
GC	Gentle Care Transport	**VA**	Viewpoint Ambulance, Inc.
GU	Guardian Ambulance Service	**WE**	Westcoast Ambulance
LE	Lifeline Ambulance	**WM**	West Med/McCormick Ambulance Service
LT	Liberty Ambulance		

Additional Information

- **Required** field for all base hospital contacts and notification calls
- Refers to the EMS provider establishing base contact or providing notification

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- Notification Form
- Notification Log
- Audio records

PROVIDER UNIT

Definition

Alphanumeric apparatus code consisting of type of vehicle + numeric vehicle identifier for the paramedic unit establishing base contact or providing notification

Field Values

- AB: Private Ambulance
- AT: Assessment Truck
- AE: Assessment Engine
- BK: Bike
- BT: Boat
- CT: Cart
- HE: Helicopter
- PE: Paramedic Engine
- PT: Paramedic Truck
- SQ: Squad
- RA: Rescue

Additional Information

- **Required** field for all base hospital contacts and notification calls
- This is a free-text field – the values above reflect those commonly used by EMS providers

Uses

- System evaluation and monitoring

Data Hierarchy

- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- Notification Form
- Notification Log
- Audio records

PT. # __ OF __

Definition

Number identifying the patient amongst the total number of patients involved in an incident

Additional Information

- If there is only one patient write “Pt.# 1 of 1”
- If there are two patients, and the patient is identified by the paramedics as the second patient, write “Pt.# 2 of 2”

Uses

- Assists with patient identification and tracking
- Identifies multiple-patient incidents
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Base Hospital Log
- Audio records

AGE

Definition

Numeric value for the age (actual or best approximation) of the patient

Field Values

- Enter the numeric age value

Additional Information

- **Required** field for all base hospital contacts and notification calls
- Must also indicate unit of age
- If the age is estimated, mark the “Est.” checkbox

Uses

- Allows for data sorting and tracking by age
- Assists with patient identification
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Base Hospital Log
- Notification Form
- Notification Log
- Audio records

AGE UNITS

Definition

Checkboxes indicating units of measurement used to report the age of the patient

Field Values

- **Y**rs: Years – used for patients 2 years old or older
- **M**os: Months – used for patients 1 month to 23 months old
- **W**ks: Weeks – used for patients whose age is reported in weeks instead of months
- **D**ays: Days – used for patients 1 to 29 days old
- **H**rs: Hours – used for patients who are newborn and up to 23 hours old

Additional Information

- **Required** field for all base hospital contacts and notification calls
- If the unit of age is estimated, mark the “Est.” checkbox

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Base Hospital Log
- Notification Form
- Notification Log
- Audio records

SEX

Definition

Checkbox indicating the gender of the patient

Field Values

- **M**: Male
- **F**: Female

Additional Information

- **Required** field for all base hospital contacts and notification calls
- Patients who are undergoing or have undergone a hormonal and/or surgical sex reassignment should be coded using their stated preference
- Patients unable to state their preference should be coded according to paramedic observation/judgment

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Base Hospital Log
- Notification Form
- Notification Log
- Audio records

WEIGHT

Definition

Numeric value of the weight of the patient

Field Values

- Up to three-digit numeric field

Additional Information

- **Required** field for all pediatric patients and all base hospital contacts with adult patients for whom medications are ordered
- Must also indicate a unit of weight
- For pediatric patients, document the measured weight in kilograms obtained from the length-based pediatric resuscitation tape, if applicable
- If the pediatric patient is taller than the length-based pediatric resuscitation tape, mark the "Too Tall" checkbox, and obtain weight in estimated kilograms

Uses

- Assists with determination of appropriate treatment
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

WEIGHT UNITS

Definition

Checkboxes indicating units of measurement used to report patient's weight

Field Values

- **K**g: Kilograms
- **L**bs: Pounds

Additional Information

- **Required** field for all pediatric patients and for all base hospital contacts with adult patients for whom medications are ordered
- For pediatric patients, document the measured weight in kilograms obtained from the length-based pediatric resuscitation tape, if applicable
- If the pediatric patient is taller than the length-based pediatric resuscitation tape, mark the "Too Tall" checkbox, and obtain weight in estimated kilograms

Uses

- Assists with determination of appropriate treatment
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

PEDS WEIGHT COLOR CODE

Definition

Color that corresponds with the length of an infant or child as measured on a length-based pediatric resuscitation tape

Field Values

- Grey: **3**, **4**, or **5** kg (newborn infants)
- P**I**nk: 6-7 kg (~3 -6 mos)
- **R**ed: 8-9 kg (~7-10 mos)
- P**U**rple: 10-11 kg (~12-18 mos)
- **Y**ellow: 12-14 kg (~19-35 mos)
- **W**hite: 15-18 kg (~3-4 yrs)
- **B**lue: 19-22 kg (~5-6 yrs)
- **O**range: 24-28 kg (~7-9 yrs)
- Gr**E**en: 30-36 kg, or about 80 lbs (~10-12 yrs)
- **T**oo Tall: patient is longer than tape

Additional Information

- **Required** field for all pediatric patients
- Document the measured weight in kilograms obtained from the length-based pediatric resuscitation tape, if applicable
- If the pediatric patient is taller than the length-based pediatric resuscitation tape, mark the "Too Tall" checkbox, and obtain weight in estimated kilograms

Uses

- Assists with determination of appropriate treatment
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

HOSPITAL CODE

Definition

Three-letter code for the base hospital contacted

Field Values

AMH	Methodist Hospital of Southern California	**NRH**	Dignity Health - Northridge Hospital Medical Center
AVH	Antelope Valley Hospital	**PVC**	Pomona Valley Hospital Medical Center
CAL	Dignity Health - California Hospital Medical Center	**PIH**	PIH Health Hospital- Whittier
CSM	Cedars-Sinai Medical Center	**QVH**	Citrus Valley M.C - Queen of the Valley Campus
GWT	Adventist Health - Glendale	**SFM**	St. Francis Medical Center
HCH	Providence Holy Cross Medical Center	**SJS**	Providence Saint Joseph Medical Center
HGH	LAC Harbor - UCLA Medical Center	**SMM**	Dignity Health - Saint Mary Medical Center
HMH	Huntington Hospital	**TOR**	Torrance Memorial Medical Center
HMN	Henry Mayo Newhall Hospital	**UCL**	Ronald Reagan UCLA Medical Center
LCM	Providence Little Co. of Mary Torrance	**USC**	LAC+USC Medical Center
LBM	Long Beach Memorial Medical Center		

Additional Information

- **Required** field for all base hospital contacts
- Codes are also listed on the back of pages 1 and 4 of the Base Hospital Form

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log

COMMUNICATION TYPE

Definition

Checkbox indicating the device used by the paramedic to establish base hospital contact

Field Values

- **R**adio: Radio
- **P**hone: Telephone
- **V**MED28: formerly known as Hospital Emergency Administrative Radio (HEAR)

Additional Information

- **Required** field for all base hospital contacts

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form

CALL TYPE

Definition

Checkboxes indicating the level of EMS encounter

Field Values

- **F**ull Call: Paramedics establish base contact for online medical direction based upon a complete patient report (includes Against Medical Advice calls and calls downgraded from ALS to BLS)
- **S**FTP: Paramedics working for an authorized SFTP provider agency assess, treat, and transport patients according to existing protocols. Only limited patient and destination information is exchanged with the base hospital – no medical direction is given
- **J**oint Run: Paramedics initially utilize existing protocols, but then establish base contact when the patient requires treatment beyond what is covered by protocol or when additional medical direction or consultation is needed. A full patient report is given and medical direction is provided by the base hospital.
- **I**nfo Only: Base hospital contact is established for the purpose of documenting information only when base hospital orders are not possible or practical (i.e., patient elopes prior to establishment of base contact, or patient arrives at the receiving facility before base contact was possible)
- **M**TP (Medical Treatment Protocol): Paramedics assess, treat, and transport patients according to existing treatment protocols. Patient and destination information is exchanged with the base hospital – no medical direction is given.
- IF**T** (Interfacility Transfer): Patient is being transferred via ALS from one acute care facility to another

Additional Information

- **Required** field for all base hospital contacts
- An AMA call is considered to be a Full Call – not Info Only
- If a call is an IFT and a protocol was utilized, check the IFT box as the protocol number will be documented elsewhere and can be used to identify SFTP/MTP calls

Uses

- System evaluation and monitoring
- Establishes system participants' roles and responsibilities

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

ASSESSMENT SECTION

PROVIDER IMPRESSION

Definition

Four-letter code(s) representing the provider's impression of the patient's presentation

Field Values

ABOP	Abdominal Pain/Problems	**ELCT**	Electrocution	**PREG**	Pregnancy Complications
AGDE	Agitated Delirium	**ENTP**	ENT/Dental Emergencies	**LABR**	Pregnancy/Labor
CHOK	Airway Obstruction/Choking	**NOBL**	Epistaxis	**RARF**	Respiratory Arrest/Failure
ETOH	Alcohol Intoxication	**EXNT**	Extremity Pain/Swelling – Non-Traumatic	**SOBB**	Resp. Distress/Bronchospasm
ALRX	Allergic Reaction	**EYEP**	Eye Problem – Unspecified	**RDOT**	Resp. Distress/Other
ALOC	ALOC – Not Hypoglycemia or Seizure	**FEVR**	Fever	**CHFF**	Resp. Distress/Pulmonary Edema/CHF
ANPH	Anaphylaxis	**GUDO**	Genitourinary Disorder – Unspecified	**SEAC**	Seizure – Active
PSYC	Behavioral/Psychiatric Crisis	**DCON**	HazMat Exposure	**SEPI**	Seizure – Postictal
BPNT	Body Pain – Non Traumatic	**HPNT**	Headache – Non-Traumatic	**SEPS**	Sepsis
BRUE	BRUE	**HYPR**	Hyperglycemia	**SHOK**	Shock
BURN	Burns	**HYTN**	Hypertension	**SMOK**	Smoke Inhalation
COMO	Carbon Monoxide	**HEAT**	Hyperthermia	**STNG**	Stings/Venomous Bites
CANT	Cardiac Arrest– Non-Traumatic	**HYPO**	Hypoglycemia	**STRK**	Stroke/CVA/TIA
DYSR	Cardiac Dysrhythmia	**HOTN**	Hypotension	**DRWN**	Submersion/Drowning
CPNC	Chest Pain – Not Cardiac	**COLD**	Hypothermia/Cold Injury	**SYNC**	Syncope/Near Syncope
CPMI	Chest Pain – STEMI	**INHL**	Inhalation Injury	**CABT**	Traumatic Arrest – Blunt
CPSC	Chest Pain – Suspected Cardiac	**LOGI**	Lower GI Bleeding	**CAPT**	Traumatic Arrest – Penetrating
BRTH	Childbirth (Mother)	**FAIL**	Medical Device Malfunction – Fail	**TRMA**	Traumatic Injury
COFL	Cold/Flu Symptoms	**NAVM**	Nausea/Vomiting	**UPGI**	Upper GI Bleeding
DRHA	Diarrhea	**BABY**	Newborn	**VABL**	Vaginal Bleeding
DIZZ	Dizziness/Vertigo	**NOMC**	No Medical Complaint	**WEAK**	Weakness – General
DEAD	DOA – Obvious Death	**ODPO**	Overdose/Poisoning/Ingestion		
DYRX	Dystonic Reaction	**PALP**	Palpitations		

Additional Information

- **Required** field for all base hospital contacts and notification calls
- First copy of Provider Impression cannot be a null value
- Do not enter more than one copy of the same Provider Impression code
- Provider Impression codes are found on the back of pages 1 and 4 of the Base Hospital Form

Uses

- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Base Hospital Log
- Audio records
- Notification Form
- Notification Log

CHIEF COMPLAINT CODES

Definition

Two-letter code(s) representing the patient's most significant medical or trauma complaints

Field Values – Trauma Codes

- **N**o **A**pparent Injury (**NA**): No complaint, or signs or symptoms of injury following a traumatic event
- **BU**rns/Elec. Shock (**BU**): Thermal or chemical burn, or electric shock
- **C**ritical **B**urn (**CB**): Patients ≥ 15 years of age with 2nd (partial thickness) and 3rd (full thickness) degree burns involving ≥ 20% Total Body Surface Area (TBSA) **OR** patients ≤ 14 years of age with 2nd and 3rd degree burns involving 10% TBSA
- SBP <**90** (<70 if under 1y) (**90**): Systolic blood pressure less than 90mmHg in a patient greater than one year of age (or systolic blood pressure less than 70mmHg in a patient less than one year of age) following a traumatic event
- **RR** <10/>29 (<20 if <1y) (**RR**): A sustained respiratory rate greater than 29 breaths/minute, or respiratory rate of less than 10 breaths/minute (or less than 20 breaths/minute in a patient less than one year of age), following a traumatic event
- **S**usp. Pelvic F**X** (**SX**): Suspected pelvic fracture, excluding isolated hip fractures from a ground level fall
- **S**pinal **C**ord Injury (**SC**): Suspected spinal cord injury, or presence of weakness/paralysis/parasthesia following a traumatic event
- **I**npatient **T**rauma (**IT**): Interfacility transfer (IFT) of an admitted, injured patient from one facility to an inpatient bed at another facility, excluding ER to ER transfers
- **T**rauma Arrest (**BT** or **PT**): Cessation of cardiac output and effective circulation due to blunt or penetrating force
- **H**ead (**BH** or **PH**): Injury to the head or skull in the area from above the eyebrows to behind the ears, due to blunt or penetrating force. This code can also be applied in association with facial injuries when it is likely that the brain is involved
- GCS ≤**14** (**14**): Blunt force head injury associated with a Glasgow Coma Scale score of less than or equal to 14
- **F**ace/Mouth (**BF** or **PF**): Injury to the anterior aspect of the face, mouth, or skull, from and including the eyebrows, down to and including the angle of the jaw and the ears, due to blunt or penetrating force
- **N**eck (**BN** or **PN**): Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to blunt or penetrating force
- **B**ack (**BB** or **PB**): Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to blunt or penetrating force
- **C**hest (**BC** or **PC**): Injury to the anterior chest in the area between the clavicle and the xyphoid process, bordered on either side by the posterior axillary line, due to blunt or penetrating force
- **F**lail **C**hest (**FC**): Blunt force injury to the chest wall resulting in an unstable chest wall, characterized by paradoxical chest wall movement with respirations
- Tension **P**neum (**BP** or **PP**): Air enters the pleural space due to blunt or penetrating force, and creates pressure on chest organs. Signs and symptoms can include: SOB, tachypnea, decreased or absent lung sounds on one side, shock, neck vein distention, and/or tracheal deviation
- **A**bdomen (**BA** or **PA**): Injury to any of the abdominal quadrants, flanks, or pelvis due to blunt or penetrating force

- **D**iffuse Abd. Tender. (**BD**): Blunt force injury to the abdomen resulting in tenderness in two or more quadrants
- **G**enitals (**BG** or **PG**): Injury to the external reproductive structures due to blunt or penetrating force
- Buttoc**K**s (**BK** or **PK**): Injury to the buttocks due to blunt or penetrating force
- **E**xtremities (**BE** or **PE**): Injury or pain to the shoulders, arms, hands, legs, or feet due to blunt or penetrating force
- E**X**trem. above knee/elbow (**PX**): Penetrating force injury to an extremity, proximal to (above) the knee or elbow
- F**R**actures ≥ 2 long bones (**BR**): Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur)
- Amputat**I**on above wrist/ankle (**BI** or **PI**): Amputation proximal to (above) the wrist or ankle due to blunt or penetrating force
- Neur/**V**asc/Mangled (**BV** or **PV**): Injury to an extremity with neurological and/or vascular compromise, or that is crushed, degloved, or mangled due to blunt or penetrating force
- Minor **L**acerations (**BL** or **PL**): Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to blunt or penetrating force

Field Values – Medical Codes

- **A**bd/**P**elvic Pain (**AP**): Pain or discomfort in the abdomen or pelvic region not associated with trauma
- **A**gitated **D**elirium (**AD**): Acute onset of extreme agitation and combative or bizarre behavior that may be accompanied by paranoid delusions, hallucinations, aggression with unusual increase in human strength, and hyperthermia
- **A**llergic **R**eaction (**AR**): Acute onset of rash, hives, itching, redness of the skin, runny nose, facial and/or airway swelling, wheezing, shortness of breath, and/or abdominal pain in apparent reaction to ingestion or contact with a substance.
- **A**ltered **L**OC (**AL**): Any state of arousal other than normal, such as confusion, lethargy, combativeness, coma, etc., not associated with trauma
- **A**pneic **E**pisode (**AE**): Episode of cessation of respiration for a brief or prolonged period of time
- B**EH**avioral (**EH**): Abnormal behavior of apparent mental or emotional origin
- Bleeding **O**ther **S**ite (**OS**): Bleeding from a site not elsewhere listed that is not associated with trauma (e.g. dialysis shunt)
- Brief **R**esolved **U**nexplained Event (**RU**): An event occurring in an infant <1 year of age when the observer reports a sudden, brief, and now resolved episode of ≥1 of the following: cyanosis or pallor, absent, decreased, or irregular breathing, marked change in tone (hyper – or hypotonia), and altered level of responsiveness
- **C**ardiac **A**rrest (**CA**): Sudden cessation of cardiac output and effective circulation not associated with trauma
- **C**hest **P**ain (**CP**): Pain in the anterior chest occurring anywhere from the clavicles to the lower costal margins not associated with trauma
- **CH**oking/Airway Obstruction (**CH**): Acute onset of apnea, choking and/or difficulty breathing due to apparent partial or complete obstruction of the airway
- **C**ough/**C**ongestion (**CC**): Cough and/or congestion in the chest, nasal passages, or throat
- **D**evice (Medical) **C**omplaint (**DC**): Any complaint associated with a patient's existing medical device (e.g. G-tube, AICD, ventilator, etc.)
- **DI**zzy (**DI**): The patient complains of sensation of spinning or feeling off-balance. If associated with complaint of weakness, code both complaints

- **DO**A (**DO**): Patient is determined to be dead upon arrival of EMS, as per the Prehospital Care Manual
- **DY**srhythmia (**DY**): Cardiac monitor indicates an abnormal cardiac rhythm (SVT, VT, etc.)
- **FE**ver (**FE**): Patient exhibits or complains of an elevated body temperature
- **F**oreign **B**ody (**FB**): Patient complains of a foreign body anywhere in the body
- **GI** Bleed (**GI**): Signs or symptoms of gastrointestinal bleeding such as vomiting blood, coffee-ground emesis, melena, rectal bleeding, etc.
- **H**ead **P**ain (**HP**): Headache or any other type of head pain not associated with trauma
- **HY**poglycemia (**HY**): Patient is symptomatic and has a measured blood glucose level that is below normal
- **I**npatient **M**edical (**IM**): Interfacility transfer (IFT) of an admitted, ill (not injured) patient from one facility to an inpatient bed at another facility
- **LA**bor (**LA**): Patient is greater than 20 weeks pregnant, and experiencing signs or symptoms of labor such as uterine contractions, vaginal bleeding, spontaneous rupture of membranes, crowning, etc.
- **L**ocal **N**euro Signs (**LN**): Weakness, numbness, or paralysis of a body part or region – including slurred speech, facial droop, and/or expressive aphasia
- **N**ausea/**V**omiting (**NV**): Patient is vomiting, or complains of nausea and/or vomiting
- **N**ear **D**rowning (**ND**): Submersion causing water inhalation, unconsciousness, or death not associated with trauma
- **N**eck/**B**ack Pain (**NB**): Pain in any area from base of skull and the shoulders to the buttocks not associated with trauma
- **N**e**W**born (**NW**): Newborn infant delivered out of the hospital setting
- **N**o Medical **C**omplaint (**NC**): No complaint, or signs or symptoms of illness in a patient not involved in a traumatic event
- **NO**sebleed (**NO**): Bleeding from the nose, not associated with trauma
- **OB**stetrics (**OB**): Any complaints, signs, or symptoms which may be related to a known pregnancy (e.g., bleeding, abdominal pain/cramping, high blood pressure, edema, convulsions, severe headaches)
- **O**ther **P**ain (**OP**): Complaint of pain at a site not listed, and which is not associated with trauma (e.g. toothache, ear pain, etc.)
- **O**ver**D**ose (**OD**): Ingestion of or contact with a drug or other substance in quantities greater than recommended or generally practiced
- **P**alpitation**S** (**PS**): Sensation that the heartbeat is irregular or fast
- **PO**isoning (**PO**): Ingestion of or contact with a toxic substance
- **R**espiratory **A**rrest (**RA**): Sudden cessation of breathing not associated with trauma
- **SE**izure (**SE**): Convulsions or involuntary body movements or gaze (not associated with trauma), or signs, symptoms, or history of recent seizure
- **S**hortness of **B**reath (**SB**): Sensation of not being able to catch one's breath, and/or signs or symptoms of difficulty breathing such as gasping, wheezing, rapid respiratory rate, cyanosis, retractions, use of accessory muscles, etc.
- **SY**ncope (**SY**): Transient loss of consciousness, including sensation of "near syncope" when other associated symptoms such as weakness/dizziness do not apply
- **VA**ginal Bleeding (**VA**): Abnormal vaginal bleeding
- **WE**ak (**WE**): Patient complains of feeling weak, or exhibits signs or symptoms of decreased strength and/or muscle tone
- **OT**her (**OT**): Signs or symptoms not listed above, that are not associated with trauma

Additional Information

- **Required** field for all base hospital contacts
- First copy of Chief Complaint cannot be a null value
- Do not enter more than one copy of the same chief complaint
- If the patient has multiple complaints, enter in order of significance
- Two-letter codes for trauma can be derived from the bolded, capitalized letters in the Trauma area of the Base Hospital Form
- Medical complaint codes are found on the back of pages 1 and 4 of the Base Hospital Form
- Medical complaints should not be documented with trauma complaints, unless it is suspected that a medical complaint preceded/caused the injury, or vice versa (e.g., chest pain/dizziness that caused an MVA, or seizure activity following a blow to the head.) Do not document a medical complaint such as “HP” (head pain) if the pain is due to a gunshot wound to the head – instead use only the trauma code of “PH.”

Uses

- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Base Hospital Log
- Audio records

LEVEL OF DISTRESS

Definition

Checkboxes indicating paramedics' impression of the level of discomfort or severity of illness of the patient, based on assessment of signs, symptoms, and complaints

Field Values

- **N**one: The patient appears well and has no acute signs or symptoms related to the incident. Advanced life support techniques and transportation may not be necessary
- Mil**D**: Indicates that the patient does not have a life-threatening problem. Advanced life support techniques and transportation may not be necessary
- **M**oderate: Patient may have a life-threatening problem, or the degree of patient discomfort is high. Advanced life support techniques, base hospital contact, and patient transportation are usually necessary
- **S**evere: Refers to a life-threatening condition. Advanced life support techniques, base hospital contact, and patient transportation are generally necessary

Additional Information

- **Required** field for all base hospital contacts

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

mLAPSS MET

Definition

Checkboxes indicating whether or not patient met all Modified Los Angeles Prehospital Stroke Screen (mLAPSS) criteria as defined in Reference 521 – Stroke Patient Destination

Field Values

- **Y**: Yes, patient met all mLAPSS criteria
- **N**: No, patient did not meet all mLAPSS criteria

Additional Information

- mLAPSS criteria include:
    - No history of seizures or epilepsy
    - Age ≥ 40
    - At baseline, patient is not wheelchair bound or bedridden
    - Blood glucose value between 60 and 400 mg/dL
    - Obvious asymmetry or unilateral weakness is observed in one or more of the following:
        - Facial Smile/Grimace
        - Grip
        - Arm Strength
- **Required** field for all base hospital contacts with a chief complaint of “LN”, a provider impression code of “STRK”, or a destination of Primary Stroke Center, “PSC”, or Comprehensive Stroke Center, “CSC”
- If mLAPSS performed, blood glucose value must also be documented
- Patients who meet mLAPSS criteria should also have a LAMS performed and be transported, at a minimum, to the nearest available PSC

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Stroke Center Log
- Audio records

LAST KNOWN WELL DATE

Definition

Date when the patient was last known to be well, symptom-free, or at baseline or usual state of health

Field Values

- Collected as MMDDYYYY

Additional Information

- **Required** field for all base hospital contacts with a “Y” value for “mLAPSS Met” or with a destination of “PSC” or “CSC” for suspected stroke
- If unknown, enter “Not Applicable” (F7)

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Stroke Center Log
- Audio records

LAST KNOWN WELL TIME

Definition

Time of day when the patient was last known to be well, symptom-free, or at baseline or usual state of health

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts with a “Y” value for “mLAPSS Met” or with a destination of “PSC” or “CSC” for suspected stroke
- If unknown, enter “Not Applicable” (F7)

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Stroke Center Log
- Audio records

LAMS SCORE

Definition

Patient's total score for the Los Angeles Motor Scale (LAMS)

Field Values

- Numeric value range from 0 to 5

Additional Information

- LAMS includes 3 components:
  - Facial Droop
    - Absent=0
    - Present=1
  - Arm Drift
    - Absent=0
    - Drifts Down=1
    - Falls Rapidly=2
  - Grip Strength
    - Normal=0
    - Weak Grip=1
    - No Grip=2
- **Required** field for all base hospital contacts with a "Y" value for "mLAPSS Met"
- Patients with a LAMS score of < 4 should be transported to the nearest available PSC
- Patients with a LAMS score of ≥ 4 should be transported to the nearest available CSC

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Stroke Center Log
- Audio records

PROTOCOL (Prior to EMS Update 2018 Training)

Definition

Four-digit numeric code of the Standing Field Treatment Protocol (SFTP) utilized by approved SFTP providers

Field Values

General Advanced Life Support			
1202	General ALS		
Dysrhythmias			
1210	Non-Traumatic Cardiac Arrest (Adult)		
Medical			
1243	Altered Level of Consciousness	**1249**	Respiratory Distress
1244	Chest Pain	**1250**	Seizure (Adult)
1247	Overdose/Poisoning (Suspected)	**1251**	Stroke/Acute Neurological Deficits
1248	Pain Management	**1252**	Syncope
Pediatrics/Childbirth			
1261	Emergency Childbirth - Mother	**1264**	Pediatric Seizure
1262	Emergency Childbirth - Newborn		
Trauma			
1271	Burns	**1277**	Traumatic Arrest
1275	General Trauma		

Additional Information

- **Required** field for all SFTP and Joint call types
- More than one protocol can be used
- Do not enter more than one copy of the same protocol number
- Protocol identified must match the patient's chief complaint

Uses

- Allows for data sorting and tracking by protocol
- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

PROTOCOL (After EMS Update 2018 Training)

Definition

Four- or five-digit code of the Medical Treatment Protocol (MTP) utilized by the providers

Field Values

1201	Assessment		
General Medical			
1202	General Medical	**1202-P**	General Medical (Pediatric)
1203	Diabetic Emergencies	**1203-P**	Diabetic Emergencies (Pediatric)
1204	Fever/Sepsis	**1204-P**	Fever/Sepsis (Pediatric)
1205	GI/GU Emergencies	**1205-P**	GI/GU Emergencies (Pediatric)
1206	Medical Device Malfunction	**1206-P**	Medical Device Malfunction (Pediatric)
1207	Shock/Hypotension	**1207-P**	Shock/Hypotension (Pediatric)
Behavioral			
1208	Agitated Delirium	**1208-P**	Agitated Delirium (Pediatric)
1209	Behavioral/Psychiatric Crisis	**1209-P**	Behavioral/Psychiatric Crisis (Pediatric)
Cardiovascular/Chest Pain			
1210	Cardiac Arrest	**1210-P**	Cardiac Arrest (Pediatric)
1211	Cardiac Chest Pain		
1212	Cardiac Dysrhythmia-Bradycardia	**1212-P**	Cardiac Dysrhythmia-Bradycardia (Pediatric)
1213	Cardiac Dysrhythmia-Tachycardia	**1213-P**	Cardiac Dysrhythmia-Tachycardia (Pediatric)
1214	Pulmonary Edema/CHF		
Childbirth/Pregnancy			
1215	Childbirth (Mother)	**1215-P**	Childbirth (Mother) (Pediatric)
		1216-P	Newborn/Neonatal Resuscitation (Pediatric)
1217	Pregnancy Complication	**1217-P**	Pregnancy Complication (Pediatric)
1218	Pregnancy/Labor	**1218-P**	Pregnancy/Labor (Pediatric)
Environmental			
1219	Allergy	**1219-P**	Allergy (Pediatric)
1220	Burns	**1220-P**	Burns (Pediatric)
1221	Electrocution	**1221-P**	Electrocution (Pediatric)
1222	Hyperthermia (Environmental)	**1222-P**	Hyperthermia (Environmental) (Pediatric)
1223	Hypothermia/Cold Injury	**1223-P**	Hypothermia/Cold Injury (Pediatric)
1224	Stings/Venomous Bites	**1224-P**	Stings/Venomous Bites (Pediatric)
1225	Submersion	**1225-P**	Submersion (Pediatric)
ENT Emergencies			
1226	ENT/Dental Emergencies	**1226-P**	ENT/Dental Emergencies (Pediatric)
1228	Eye Problem	**1228-P**	Eye Problem (Pediatric)
Neurology			
1229	ALOC	**1229-P**	ALOC (Pediatric)
1230	Dizziness/Vertigo	**1230-P**	Dizziness/Vertigo (Pediatric)
1231	Seizure	**1231-P**	Seizure (Pediatric)
1232	Stroke/CVA/TIA	**1232-P**	Stroke/CVA/TIA (Pediatric)
1233	Syncope/Near Syncope	**1233-P**	Syncope/Near Syncope (Pediatric)
Respiratory			
1234	Airway Obstruction	**1234-P**	Airway Obstruction (Pediatric)
		1235-P	BRUE (Pediatric)
1236	Inhalation Injury	**1236-P**	Inhalation Injury (Pediatric)
1237	Respiratory Distress	**1237-P**	Respiratory Distress (Pediatric)
Toxicology			
1238	Carbon Monoxide Exposure	**1238-P**	Carbon Monoxide Exposure (Pediatric)
1239	Dystonic Reaction	**1239-P**	Dystonic Reaction (Pediatric)
1240	HazMat	**1240-P**	HazMat (Pediatric)
1241	Overdose/Poisoning/Ingestion	**1241-P**	Overdose/Poisoning/Ingestion (Pediatric)

Trauma			
1242	Crush Injury/Syndrome	**1242-P**	Crush Injury/Syndrome (Pediatric)
1243	Traumatic Arrest	**1243-P**	Traumatic Arrest (Pediatric)
1244	Traumatic Injury	**1244-P**	Traumatic Injury (Pediatric)

Additional Information

- **Required** field for all base hospital contacts and notification calls
- More than one protocol can be used
- Do not enter more than one copy of the same protocol number
- Protocol identified must correlate to the provider impression

Uses

- Allows for data sorting and tracking by protocol
- Assists with determination of appropriate treatment
- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Notification Form
- Notification Log
- Audio Records

O/P,Q,R,S,T

Definition

Acronym used as a tool to assess and document the following symptom attributes:

- **O/P**: Onset/Provocation
- **Q**: Quality
- **R**: Region/Radiation/Relief
- **S**: Severity
- **T**: Time

Field Values

- Free text

Uses

- Prompts thorough assessment and documentation of patient's symptoms
- Assists with determination of appropriate treatment and transport

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

MEDICAL HX

Definition

Space to indicate previous medical problem(s) experienced by the patient, if applicable

Field Values

- Free text

Uses

- Prompts thorough assessment and documentation of patient's symptoms
- Assists with determination of appropriate treatment and transport

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

MEDICATIONS

Definition

Space to indicate medications currently being taken by the patient, if applicable

Field Values

- Free text

Additional Information

- Indicate patient compliance, if applicable
- Include nonprescription drugs and herbal supplements

Uses

- Assists with determination of appropriate treatment and transport

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

ALLERGIES

Definition

Checkbox and space to indicate patient history of adverse reactions or allergies to medications or other substances, if applicable

Field Values

- Free text, or
- NKA: No known allergies checkbox

Additional Information

- If the patient has no known allergies, mark the “NKA” box
- Allergies to non-medication items may be listed if they are related to the current problem or potential treatments (e.g., adhesive tape, or latex)

Uses

- Patient safety

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

DNR/AHCD/POLST?

Definition

Checkbox indicating presence of a valid DNR, Advance Healthcare Directive (AHCD), or Physician Order for Life Sustaining Treatment (POLST) form for the patient

Field Values

- **Y**: Yes
- **N**: No
- **U**: Unknown

Additional Information

- EMS personnel need not validate authenticity of document provided – should provide base hospital with the type of document and its contents

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- DNR/AHCD/POLST
- Audio Records

PRIOR TO BASE MEDS

Definition

Checkboxes and spaces indicating medications and dosages administered prior to base contact, if applicable

Field Values

ADE	Adenosine	**NAR**	Narcan
ALB	Nebulized Albuterol	**NTG**	Nitroglycerin
ASA	Aspirin	**OND**	Ondansetron
EPI	Epinephrine	**Morphine**	Morphine Sulfate
FEN	Fentanyl	**GLU/GLP**	Glucagon/Glucose Paste
MID	Midazolam	**D50/25/10**	D50W/25W/D10W

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

PRIOR TO BASE TXS

Definition

Checkboxes indicating treatments rendered prior to base contact, if applicable

Field Values

BMV	Bag-Mask Ventilation	**CAR**	Cardioversion
CPAP	Continuous Positive Airway Pressure	**TC**P	Transcutaneous Pacing
ETT	Endotracheal Tube Intubation	**A**ED- **A**nalyzed	AED Analyzed Rhythm
King	King Airway	**A**ED- **D**efibrillated	AED Defibrillated Patient
SMR	Spinal Motion Restriction	Needle **TH**oracost.	Needle Thoracostomy
GLucometer	Glucometer Reading	Tourniquet (**TK**)	Tourniquet
DEFibrillated X	Number of defibrillation attempts	**OT**her	Other Treatment Not Listed

Additional Information

- Checked Glucometer checkbox should be accompanied by the reading obtained
- Checked Defibrillated checkbox should be accompanied by the number of times defibrillation performed

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

PHYSICAL SECTION

LOC

Definition

Checkboxes indicating the patient's initial level of consciousness

Field Values

- **A**lert: Patient is awake and responsive to the environment
- **O** X 3: Patient is oriented to person, time, and place
- **D**isoriented: Patient is not oriented to person, time, and/or place
- **C**ombative: Patient is physically resistant to interaction with on-scene personnel
- No**T** Alert: Patient is awake, but is drowsy or lethargic – may include intoxicated patients
- Nor**M**al for Patient: Patient's behavior, although not typical of most patients, is reported by family, caregivers, etc., to be the same as it was before the incident (e.g., patients who suffer from mental illness, dementia, developmental delays, etc.). Can also be used for infants and children who are age appropriate
- No **R**esponse: Patient is unresponsive to verbal and painful stimuli

Additional Information

- **Required** field for all base hospital contacts
- Mark all that apply

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

IUP_ WKS

Definition

Checkbox and space indicating the number of weeks of intrauterine pregnancy, if applicable

Additional Information

- Patients may only be able to provide the number of months, not weeks, of their pregnancy – in this case, pregnancies reported of greater than 4½ months can be assumed to be greater than 20 weeks
- Patients injured while at least 20 weeks pregnant meet trauma triage special considerations for transport to a trauma center

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

SUSPECTED DRUGS/ETOH

Definition

Checkbox indicating that the situation, patient behavior, or statements made by the patient, family members or bystanders cause the paramedics to suspect that chief complaint may be related to alcohol and/or drug use

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

EYE

Definition

Checkboxes indicating the Glasgow Coma Scale numerical value that corresponds to the patient's initial eye opening response to stimuli

Field Values

- **4**: Spontaneous – opens eyes spontaneously, no stimuli required
- **3**: To Verbal – opens eyes only when spoken to or asked
- **2**: To Pain – opens eyes only in response to noxious stimuli such as sternal rub or nail bed pressure
- **1**: None – patient does not open eyes in response to noxious stimuli

Additional Information

- **Required** field for all base hospital contacts
- GCS eye opening values are the same for adult and pediatric patients

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

VERBAL

Definition

Checkboxes indicating the Glasgow Coma Scale numerical value that corresponds to the patient's initial verbal response to stimuli

Field Values – Adult and Verbal Pediatric Patients

- **5**: Oriented x 3 – patient is oriented to person, time, and place
- **4**: Confused – patient may respond to questions coherently, but is disoriented or confused
- **3**: Inappropriate – random words or speech unrelated to questions or conversation
- **2**: Incomprehensible – makes incoherent sounds or moans only
- **1**: None – patient has no verbal response to noxious stimuli

Field Values – Infants and Toddlers

- **5**: Smiles and tracks objects, speech appropriate for age
- **4**: Cries but consolable, or confused
- **3**: Inconsistently consolable, or random words
- **2**: Moaning, incoherent sounds only
- **1**: No verbal response to noxious stimuli

Additional Information

- **Required** field for all base hospital contacts

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

MOTOR

Definition

Checkboxes indicating the Glasgow Coma Scale numerical value that corresponds to the patient's initial motor response to stimuli

Field Values

- **6**: Obedient – obeys verbal commands / spontaneous purposeful movement
- **5**: Purposeful – purposeful movement is made in response to noxious stimuli (e.g., attempts to push away or grab source of stimuli
- **4**: Withdrawal – withdraws body part from source of noxious stimuli
- **3**: Flexion –extremities move towards body core in response to noxious stimuli (decorticate posturing)
- **2**: Extension – extremities move away from body core in response to noxious stimuli (decerebrate posturing)
- **1**: None – patient has no motor response to noxious stimuli

Additional Information

- **Required** field for all base hospital contacts
- GCS motor values are the same for adult and pediatric patients

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TOTAL GCS

Definition

Sum of the initial three numerical values documented for each element of the Glasgow Coma Scale.

Field Values

- One- or two-digit numeric value between 3 and 15

Additional Information

- Maximum total score is 15, which is considered normal. Minimum score possible is 3, which may indicate severe or fatal brain injury
    - 3 to 8 may indicate severe brain injury
    - 9 to 13 may indicate moderate brain injury
    - 14 or 15 may indicate mild or no brain injury
- Space is provided for documentation of a repeat GCS, if applicable

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

PUPILS

Definition

Checkboxes indicating findings from assessment of the patient's initial pupillary response to light

Field Values

- **P**ERL: Pupils are equal in size and react to light
- **U**nequal: Pupils are unequal in size
- **F**ixed/Dilated: Pupils are dilated and do not react to light
- **C**ataracts: Cataracts in one or both eyes interfere with pupil exam
- **S**luggish: Pupils react to light slower than normal

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

RESPIRATION

Definition

Checkboxes indicating findings from initial assessment of the patient's respiratory system

Field Values

- **C**lear: No abnormal sounds are heard on auscultation
- **N**ormal rate/effort: Breathing appears effortless and rate is within normal limits for patient
- Tidal Volume:
  - **N**: Normal depth of inspiration is observed
  - **+**: Increased depth of inspiration is observed
  - **-**: Decreased depth of inspiration is observed
- **W**heezes: Coarse, whistling sound heard on auscultation, associated with inspiration and/or expiration
- **R**ales: Rattling or crackling noises heard on auscultation, associated with inspiration
- R**H**onchi: Coarse, rattling or snoring sound heard on auscultation, associated with inspiration and/or expiration
- S**T**ridor: High-pitched, audible wheezing sound associated with inspiration and/or expiration
- **L**abored: Breathing appears to be difficult or requires extra effort
- **U**nequal: Chest rise or breath sounds diminished on one side
- **J**VD: Distended jugular veins are observed in the supine patient
- Accessory **M**uscle Use: Patient is using additional muscles to assist with difficulty breathing, such as those of the neck, shoulders, or abdomen
- **A**pnea: Patient is not breathing or stops breathing for periods of time
- **S**noring: Prolonged snorting sound/soft palate vibration that is audible during inspiration
- Capnography #: The initial numerical CO_2 measurement from the capnometer
- Waveform: Indicates whether or not a waveform is observed on the capnography tracing:
  - **Y**es
  - **N**o

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

ADV AIRWAY

Definition

Checkboxes indicating initial assessment of findings after placement of an advanced airway, if applicable

Field Values

- BS after ETT/King: Mark appropriate box to indicate whether or not breath sounds are auscultated after placement of an endotracheal tube or King LTs-D
  - **Y**es
  - **N**o
- $ETCO_2$: Mark appropriate box to indicate presence or absence of CO_2 detected after placement of an endotracheal tube or King LTs-D:
  - **+**: present
  - **–**: absent

Additional Information

- **Required** field for all base hospital contacts with advanced airway placement in the field

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

SKIN

Definition

Checkboxes indicating findings from assessment of the patient's initial skin signs

Field Values

- **N**ML: All aspects of skin assessment are normal (color, temperature, moisture, and appearance)
- **P**ale: Skin appears abnormally pale, ashen, or gray
- Coo**L**/Cold: Skin feels cool or cold to touch
- **D**iaphoretic: Skin is sweaty or moist to touch
- **C**yanotic: Skin or lips appear blue
- **F**lushed: Skin appears red
- **H**ot: Skin feels warmer than normal or hot to touch
- Cap Refill No**R**mal: Capillary refill is less than or equal to 2 seconds
- Cap Refill D**E**layed: Capillary refill is greater than 2 seconds

Additional Information

- Capillary refill must be completed for all pediatric patients without a documented systolic blood pressure

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

GLUCOMETER

Definition

Numeric value of the patient's blood glucose measurement, if applicable

Field Values

- Up to three-digit numeric value
- #1: The initial blood glucose level
- #2: The second blood glucose level, if applicable

Additional Information

- **Required** field for all base hospital contacts if mLAPSS is performed **OR** if Protocol 1251 is utilized (prior to EMS Update 2018 training) **OR** Protocol 1232 is utilized (after EMS Update 2018 training).
- If equipment used yields an alpha reading indicating blood sugar is "LOW," enter the number "1"
- If equipment used yields an alpha reading indicating blood sugar is "HIGH," enter the number "999"

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

GLUCOMETER ORDERED?

Definition

Checkboxes indicating whether or not a glucometer was ordered by the base hospital, if applicable

Field Values

- **Y**: Yes
- **N**: No

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

ECG/ARREST

INITIAL RHYTHM

Definition

Two- or three-letter code indicating patient's initial cardiac rhythm from the cardiac monitor

Field Values

1HB	1st Degree Heart Block	**PEA**	Pulseless Electrical Activity
2HB	2nd Degree Heart Block	**PM**	Pacemaker Rhythm
3HB	3rd Degree Heart Block	**PST**	Paroxysmal Supraventricular Tachycardia
AFI	Atrial Fibrillation	**PVC**	Premature Ventricular Contraction
AFL	Atrial Flutter	**SA**	Sinus Arrhythmia
AGO	Agonal Rhythm	**SB**	Sinus Bradycardia
ASY	Asystole	**SR**	Sinus Rhythm
AVR	Accelerated Ventricular Rhythm	**ST**	Sinus Tachycardia
IV	Idioventricular Rhythm	**SVT**	Supraventricular Tachycardia
JR	Junctional Rhythm	**VF**	Ventricular Fibrillation
PAC	Premature Atrial Contraction	**VT**	Ventricular Tachycardia
PAT	Paroxysmal Atrial Tachycardia		

Additional Information

- **Required** field for all base hospital contacts where patients are reported to be placed on a cardiac monitor
- ECG codes are also found on the back of pages 1 and 4 of the Base Hospital Form
- Additional cardiac rhythm information can be documented in the Assessment section

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ECG strip
- Audio Records

12 LEAD ECG @

Definition

Time of day that a 12-lead ECG was performed, if applicable

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts where either the software or EMS interpretation of the 12 lead ECG indicates STEMI
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, enter the 12-lead time from the STEMI ECG in this field

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ECG strip
- SRC Log
- Audio records

SOFTWARE INTERPRETATION
☐ NORMAL ☐ ABNORMAL ☐ STEMI

Definition

Checkboxes indicating the software's interpretation of 12-lead ECG, if applicable

Field Values

- **N**orma**L**: Electronic interpretation indicates ECG is normal
- **AB**normal: Electronic interpretation indicates ECG is abnormal
- STE**MI**: Electronic interpretation indicates an ST-Elevation Myocardial Infarction, or manufacturer's equivalent

Additional Information

- **Required** field for all base hospital contacts where a 12-lead ECG is performed
- If electronic interpretation indicates an ST-Elevation Myocardial Infarction (or manufacturer's equivalent) the patient should be transported to the nearest available STEMI Receiving Center (SRC)
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, enter STEMI (two-letter code **MI**) in this field

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ECG strip
- SRC Log
- Audio records

EMS INTERPRETATION
☐ NORMAL ☐ ABNORMAL ☐ STEMI

Definition

Checkboxes indicating EMS personnel's interpretation of 12-lead ECG, if applicable

Field Values

- **N**orma**L**: EMS personnel interpretation indicates ECG is normal
- **AB**normal: EMS personnel interpretation indicates ECG is abnormal
- STE**MI**: EMS personnel interpretation indicates an ST-Elevation Myocardial Infarction

Additional Information

- **Required** field for all base hospital contacts where a 12-lead ECG is performed
- If EMS personnel interpretation indicates an ST-Elevation Myocardial Infarction the patient should be transported to the nearest available STEMI Receiving Center (SRC)
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, enter STEMI (two-letter code **MI**) in this field

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ECG strip
- SRC Log
- Audio records

ARTIFACT?

Definition

Checkbox indicating whether or not artifact is observed on 12-lead ECG tracing

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for all base hospital contacts where either the software or EMS interpretation of the 12 lead ECG indicates STEMI
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, indicate whether artifact is present on the STEMI ECG in this field
- Electronic artifact interferes with accurate ECG interpretation, and may indicate need to repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ECG strip
- Audio records

WAVY BASELINE?

Definition

Checkbox indicating whether or not baseline of 12-lead ECG tracing moves with respiration

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for all base hospital contacts where either the software or EMS interpretation of the 12 lead ECG indicates STEMI
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, indicate whether wavy baseline is present on the STEMI ECG in this field
- Wavy baseline can interfere with accurate ECG interpretation, and may indicate need to reposition leads and repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ECG strip
- Audio Records

PACED RHYTHM?

Definition

Checkbox indicating whether or not 12-lead ECG or electronic interpretation indicates presence of a pacemaker-generated rhythm

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for all base hospital contacts where either the software or EMS interpretation of the 12 lead ECG indicates STEMI
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, indicate whether a paced rhythm is present on the STEMI ECG in this field
- Pacemakers can interfere with accurate ECG interpretation and must be reported

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ECG strip
- Audio Records

WITNESSED BY:

Definition

Checkbox indicating witnesses to a patient's collapse due to cardiac arrest, if applicable

Field Values

- **C**itizen: Witnessed by a non-EMS person (e.g., law enforcement or nursing home personnel, bystanders, family, etc.)
- **E**MS: Witnessed by EMS personnel
- **N**one: Not witnessed

Additional Information

- **Required** field for all base hospital contacts with a chief complaint of "CA" (cardiac arrest) or provider impression of "CANT" (cardiac arrest – non-traumatic)

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

CPR BY:

Definition

Checkbox indicating by whom CPR was performed on a patient in cardiac arrest, if applicable

Field Values

- **C**itizen: CPR was initiated by a non-EMS person (e.g., law enforcement or nursing home personnel, bystanders, family, etc.)
- **E**MS: CPR was initiated by EMS upon arrival
- **N**one: No CPR was initiated

Additional Information

- **Required** field for all base hospital contacts with a chief complaint of “CA” (cardiac arrest) or provider impression of “CANT” (cardiac arrest – non-traumatic)

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

ARREST TO CPR

Definition

Estimated time, in minutes, from the time of arrest to the time of initiation of CPR, if applicable

Field Values

- Collected as minutes

Additional Information

- **Required** field for all base hospital contacts with a witnessed, non-traumatic cardiac arrest/collapse
- If the arrest was unwitnessed, field will be entered as “Not Applicable” (F7 key) in TEMIS
- If arrest was witnessed, but minutes from arrest to CPR is not provided, field will be entered as “Not Documented” (F6 key) in TEMIS

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

RTN OF PULSE (ROSC)?

Definition

Checkbox indicating whether or not return of spontaneous circulation (ROSC) – or 'sustained restoration of a spontaneous, perfusing rhythm that results in a palpable pulse, breathing (more than occasional gasp), coughing, movement, and/or a measureable blood pressure following cardiac arrest' – occurred, if applicable

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for all base contacts patients with a chief complaint of "CA" (cardiac arrest) or provider impression of "CANT" (cardiac arrest – non-traumatic)
- Document even if the pulses are lost prior to arrival at the receiving facility
- Non-traumatic cardiac arrest patients with ROSC in the field should be transported to the nearest available STEMI Receiving Center (SRC)
- Patients in traumatic arrest should be transported according to trauma destination policies

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

RTN OF PULSE (ROSC) @

Definition

Time of day when return of spontaneous circulation (ROSC) occurs, if applicable

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for base hospital contacts with ROSC in the field
- Document even if the pulses are lost prior to arrival at the receiving facility
- Patients with ROSC in the field should be transported to the nearest available STEMI Receiving Center (SRC)
- If patient has a DNR/AHCD, field will be entered as “Not Applicable” (F7 key) in TEMIS

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

RESUS D/C TIME

Definition

Time of day when resuscitative measures were terminated or patient was pronounced dead by the base hospital, if applicable

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts where resuscitative measures were discontinued in the field

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

RESUS D/C RHYTHM

Definition

Two- or three-letter code identifying the cardiac rhythm reported when resuscitative measures were terminated or patient was pronounced dead by the base hospital, if applicable

Field Values

AGO	Agonal	**PEA**	Pulseless Electrical Activity
ASY	Asystole	**VF**	Ventricular Fibrillation
IV	Idioventricular Rhythm		

Additional Information

- **Required** field for all base hospital contacts where resuscitative measures were discontinued in the field
- PEA is not a defined rhythm, but rather a finding that may be present at time of pronouncement where electrical activity and/or rhythm seen on the cardiac monitor does not produce a palpable pulse or auscultatable heartbeat

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TOTAL MIN. EMS CPR:

Definition

Time in minutes from the initiation of CPR by EMS personnel, to the time when resuscitative measures were terminated or patient was pronounced dead by the base hospital, if applicable

Field Values

- Collected in minutes
- Up to two-digit numeric field

Additional Information

- **Required** field for all base hospital contacts where resuscitative measures were discontinued in the field

Uses

- Assists with determination of appropriate treatment and transport
- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

VITALS & TXS SECTION

O2 @ ___ LPM

Definition

Numeric value of the number of liters per minute of oxygen delivered to the patient, if applicable

Field Values

- One- or two-digit numeric value between 2 and 15

Additional Information

- The oxygen delivery device used must also be indicated

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TITRATED?

Definition

Checkbox indicating that the number of liters per minute of oxygen ordered by the base was given in a range, to be adjusted to desired effect, if applicable

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- The oxygen delivery device used must also be indicated

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

VIA:

Definition

Checkboxes indicating the type of device used to deliver oxygen to the patient, if applicable

Field Values

- **N**C: Nasal Cannula
- **M**ask: Oxygen mask
- **B**MV: Bag-Mask Ventilation
- Blo**W** By: Oxygen delivery device is used to “blow” oxygen towards patient’s face
- E**X**isting Trach.: Patient is being oxygenated/ventilated via an existing tracheostomy tube
- **E**TT: Endotracheal Tube
- **K**ing: King LTS-D (laryngeal tube suction device)
- **C**PAP: Continuous Positive Airway Pressure

Additional Information

- The number of liters per minute of oxygen delivered must also be indicated

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

IV:

Definition

Checkboxes indicating whether or not IV access was ordered for the patient, and type

Field Values

- **S**L: Saline Lock device
- **F**C: Fluid challenge –specified amount of IV fluid is ordered to be given over a specified amount of time. In the space provided, enter the number of cc's of IV fluid ordered
- **T**KO: To keep open – minimum drip rate necessary to keep line patent
- **W**O: Wide open – maximum drip rate possible (clamp wide open)
- **N**ot Ordered: No IV ordered
- **I**V Unable: Paramedics were not able to successfully establish an IV
- **R**efused: Patient refused to allow paramedics to establish IV access
- I**O**: Intraosseous device
- Pree**X**isting IV: Upon arrival of EMS personnel, the patient already had IV access established (by a clinic, urgent care, doctor's office, etc.)

Additional Information

- **Required** field for all base hospital contacts

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TRANSCUTANEOUS PACING @ mA:

Definition

Numeric value of the electrical current strength in milliamps (mA) required to achieve capture (as evidenced by a palpable pulse that corresponds with rhythm observed on cardiac monitor) during transcutaneous pacing, if applicable

Field Values

- Up to three-digit numeric value

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

RATE:

Definition

Numeric value of the rate of capture during transcutaneous pacing (as evidenced by a palpable pulse that corresponds with rhythm observed on cardiac monitor), if applicable

Field Values

- Up to three-digit numeric value

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

CAPTURE?

Definition

Checkbox indicating whether or not mechanical capture (as evidenced by a palpable pulse that corresponds with rhythm observed on cardiac monitor) was achieved during transcutaneous pacing, if applicable

Field Values

- **Y**: Yes
- **N**: No

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

NEEDLE THORACOSTOMY

Definition

Checkbox indicating whether or not a needle thoracostomy was ordered, if applicable

Field Values

- Y: Yes
- N: No

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

SPINAL MOTION RESTRICTION?

Definition

Checkbox indicating whether or not the patient was placed in spinal motion restriction

Field Values

- Y: Yes
- N: No

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

CMS INTACT:

Definition

Checkboxes indicating whether patient's circulation, motor function, and sensation (CMS) were intact before and after spinal motion restriction, if applicable

Field Values

- **I**ntact **B**efore: CMS intact in all extremities prior to spinal immobilization
- **I**ntact **A**fter: CMS intact in all extremities after spinal immobilization

Additional Information

- CMS should always be assessed before and after spinal immobilization

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

SMR REFUSED

Definition

Checkboxes indicating that spinal motion restriction was refused by the patient, if applicable

Field Values

- Y: Yes
- N: No

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TOURNIQUET

Definition

Checkbox indicating that a device for stopping the flow of blood through a vein or artery was applied for bleeding control in the prehospital setting, if applicable

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TIME

Definition

Time of day that corresponds to the adjacent vital signs, ECG, and treatments fields

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- May write “PTC” if event occurred prior to base contact – will be entered as “Not Documented” (F6 key) in TEMIS
- Time on radio console should only be used if vital signs are repeated during the course of the base contact. Time base contact was initiated should not be used as the time for vital signs obtained prior to base contact

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

B/P

Definition

Numeric values of the patient's systolic and/or diastolic blood pressure

Field Values

- Up to three-digit numeric value
- Documented as numeric systolic value / numeric diastolic value

Additional Information

- If the blood pressure is palpated, write "P" for the diastolic value – will be entered as "Not Documented" (F6 key) in TEMIS

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

PULSE

Definition

Numeric value of the patient's palpated pulse rate

Field Values

- Up to three-digit numeric value

Additional Information

- Measured in beats palpated per minute
- If cardiac monitor shows a rhythm that does not produce signs of perfusion, rate is documented as "0"

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

RR

Definition

Numeric values of the patient's initial, unassisted respiratory rate

Field Values

- Up to three-digit numeric value

Additional Information

- Measured in breaths per minute
- If patient requires mechanical assistance, then unassisted rate is documented only, not the assisted rate

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

O2 SAT

Definition

Numeric value of the patient's percent oxygen saturation in the prehospital setting

Field Values

- Up to three-digit percentage from 0 to 100

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

PAIN

Definition

Numeric value indicating the patient's subjective pain level

Field Values

- Up to two-digit value from 0 to 10

Additional Information

- Pain level should be assessed whenever trauma or pain is the chief complaint, a mechanism of injury exists, and before and after administration of pain medication

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

CO2

Definition

Numeric value indicating the concentration of carbon dioxide measured by the capnometer, if applicable

Field Values

- Up to three-digit value

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

ECG

Definition

Two- or three-letter code indicating the patient's subsequent rhythm(s) on cardiac monitor, if applicable

Field Values

1HB	1st Degree Heart Block	**PEA**	Pulseless Electrical Activity
2HB	2nd Degree Heart Block	**PM**	Pacemaker Rhythm
3HB	3rd Degree Heart Block	**PST**	Paroxysmal Supraventricular Tachycardia
AFI	Atrial Fibrillation	**PVC**	Premature Ventricular Contraction
AFL	Atrial Flutter	**SA**	Sinus Arrhythmia
AGO	Agonal Rhythm	**SB**	Sinus Bradycardia
ASY	Asystole	**SR**	Sinus Rhythm
AVR	Accelerated Ventricular Rhythm	**ST**	Sinus Tachycardia
IV	Idioventricular Rhythm	**SVT**	Supraventricular Tachycardia
JR	Junctional Rhythm	**VF**	Ventricular Fibrillation
PAC	Premature Atrial Contraction	**VT**	Ventricular Tachycardia
PAT	Paroxysmal Atrial Tachycardia		

Additional Information

- Cardiac rhythm should be assessed and documented here any time a change is noted, or after any cardiac-related treatments

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ECG strip
- Audio Records

DRUG/DEFIB

Definition

Space for documenting defibrillation/cardioversion and medication codes ordered by the base hospital

Field Values

ADE	Adenosine	**DEF**	Defibrillation
ALB	Nebulized Albuterol	**DOP**	Dopamine
AMI	Amiodarone	**EPI**	Epinephrine
ASA	Aspirin	**P-EPI**	Push-dose Epinephrine
ATR	Atropine	**FEN**	Fentanyl
BEN	Benadryl	**GLP**	Glucose Paste
BIC	Sodium Bicarbonate	**GLU**	Glucagon
CAL	Calcium Chloride	**MID**	Midazolam
CAR	Cardioversion	**Morphine**	Morphine Sulfate
D10	D10W	**NAR**	Narcan
D25	D25W	**NTG**	Nitroglycerin
D50	D50W	**OND**	Ondansetron

Additional Information

- **Required** field for all base hospital contacts in which medications are ordered
- Each drug/defibrillation ordered should be written on a separate line so that dose and results can be clearly documented
- Mark the “Refused” box if the patient refused medication administration
- Mark the “PRN” box if the medication and/or defibrillation are ordered as PRN

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio records

SEDs IN PAST 48 HRS

Definition

Checkboxes indicating whether or not patient has used sexually enhancing drugs (SED) within the past 48 hours

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Use of SEDs must be assessed prior to ordering nitroglycerin for any patient

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

DOSE

Definition

Space for alphanumeric value of joules of defibrillation/cardioversion and/or dose of medication ordered by the base hospital

Field Values

- Free text

Additional Information

- Include dose and unit of measurement: e.g., “1mg” or “300J”

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

ROUTE

Definition

Two-letter code indicating the route of medication administration ordered by the base hospital, if applicable

Field Values

- **IV**: Intravenous
- **IO**: Intraosseous
- **SQ**: Subcutaneous
- **IM**: Intramuscular
- **PO**: By Mouth (per os) / oral disintegrating tablets (ODT)
- **IN**: Intranasal/Inhalation (e.g, HHN)
- **SL**: Sublingual

Additional Information

- Drug route codes are listed on the back of pages 1 and 4 of the Base Hospital Form

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TX/RESULTS

Definition

Space for brief documentation of results of medications given or treatments rendered

Field Values

- "**-**": Deteriorated
- "**+**": Improved
- "**N**": No Change

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TRAUMA SECTION

TRAUMA

Definition

Checkboxes indicating the nature and location of the patient's injury, if applicable

Field Values

- **N**o **A**pparent Injury (**NA**): No complaint, or signs or symptoms of injury following a traumatic event
- **BU**rns/Elec. Shock (**BU**): Thermal or chemical burn, or electric shock
- **C**ritical **B**urn (**CB**): Patients ≥ 15 years of age with 2nd (partial thickness) and 3rd (full thickness) degree burns involving ≥ 20% Total Body Surface Area (TBSA) **OR** patients ≤ 14 years of age with 2nd and 3rd degree burns involving ≥10% TBSA
- SBP <**90** (<70 if under 1y) (**90**): Systolic blood pressure less than 90mmHg in a patient greater than one year of age (or systolic blood pressure less than 70mmHg in a patient less than one year of age) following a traumatic event
- **RR** <10/>29 (<20 if <1y) (**RR**): A sustained respiratory rate greater than 29 breaths/minute, or respiratory rate of less than 10 breaths/minute (or less than 20 breaths/minute in a patient less than one year of age), following a traumatic event
- **S**usp. Pelvic F**X** (**SX**): Suspected pelvic fracture, excluding isolated hip fractures from a ground level fall
- **S**pinal **C**ord Injury (**SC**): Suspected spinal cord injury, or presence of weakness/paralysis/parasthesia following a traumatic event
- **I**npatient **T**rauma (**IT**): Interfacility transfer (IFT) of an admitted, injured patient from one facility to an inpatient bed at another facility, excluding ER to ER transfers
- **T**rauma Arrest (**BT** or **PT**): Cessation of cardiac output and effective circulation due to blunt or penetrating force
- **H**ead (**BH** or **PH**): Injury to the head or skull in the area from above the eyebrows to behind the ears, due to blunt or penetrating force. This code can also be applied in association with facial injuries when it is likely that the brain is involved
- GCS ≤**14** (**14**): Blunt force head injury associated with a Glasgow Coma Scale score of less than or equal to 14
- **F**ace/mouth (**BF** or **PF**): Injury to the anterior aspect of the face, mouth, or skull, from and including the eyebrows, down to and including the angle of the jaw and the ears, due to blunt or penetrating force
- **N**eck (**BN** or **PN**): Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to blunt or penetrating force
- **B**ack (**BB** or **PB**): Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to blunt or penetrating force
- **C**hest (**BC** or **PC**): Injury to the anterior chest in the area between the clavicle and the xyphoid process, bordered on either side by the posterior axillary line, due to blunt or penetrating force
- **F**lail **C**hest (**FC**): Blunt force injury to the chest wall resulting in an unstable chest wall, characterized by paradoxical chest wall movement with respirations
- Tension **P**neum (**BP** or **PP**): Air enters the pleural space due to blunt or penetrating force, and creates pressure on chest organs. Signs and symptoms can include: SOB, tachypnea, decreased or absent lung sounds on one side, shock, neck vein distention, and/or tracheal deviation
- **A**bdomen (**BA** or **PA**): Injury to any of the abdominal quadrants, flanks, or pelvis due to blunt or penetrating force

- **D**iffuse Abd. Tender. (**BD**): Blunt force injury to the abdomen resulting in tenderness in two or more quadrants
- **G**enitals (**BG** or **PG**): Injury to the external reproductive structures due to blunt or penetrating force
- Buttoc**K**s (**BK** or **PK**): Injury to the buttocks due to blunt or penetrating force
- **E**xtremities (**BE** or **PE**): Injury or pain to the shoulders, arms, hands, legs, or feet due to blunt or penetrating force
- E**X**tr ↑ knee/elbow (**PX**): Penetrating force injury to an extremity, proximal to (above) the knee or elbow
- F**R**actures ≥ 2 long bones (**BR**): Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur.
- Amputat**I**on ↑ wrist/ankle (**BI** or **PI**): Amputation proximal to (above) the wrist or ankle due to blunt or penetrating force
- Neur/**V**asc/Mangled (**BV** or **PV**): Injury to an extremity with neurological and/or vascular compromise, or that is crushed, degloved, or mangled due to blunt or penetrating force
- Minor **L**acerations (**BL** or **PL**): Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to blunt or penetrating force

Additional Information

- **Required** field for all base hospital contacts where patient is reported to be injured or a mechanism of injury is present
- Check all that apply - if the patient has multiple complaints, enter Chief Complaints in order of significance
- Codes beginning with “B” or “P” indicate Blunt or Penetrating injury, respectively
- Two-letter codes can be derived from the bolded, capitalized letters of the trauma descriptions – trauma codes should be listed in order of significance in the “Chief Complaint Code” fields
- Patients with injuries documented must also have a mechanism of injury documented – and vice versa
- Medical complaints should not be documented with trauma complaints, unless it is suspected that a medical complaint preceded/caused the injury, or vice versa (e.g., chest pain/dizziness that caused an MVA, or seizure activity following a blow to the head.) Do not document a medical complaint such as “HP” (head pain) if the pain is due to a gunshot wound to the head – instead use only the trauma code of “PH.”
- Penetrating injuries may be inflicted by dull objects travelling at high velocity (e.g., bullets), sharp objects with a low velocity, or from a slashing or puncturing force
- Blunt injuries occur from a forces that do not typically penetrate the skin (e.g., baseball bat) though lacerations may be caused by the tearing/crushing force of a blunt object or broken bones
- Injury descriptions listed in **red** meet trauma triage criteria for transport to the nearest available trauma center

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

MECHANISM OF INJURY

Definition

Checkboxes indicating how the patient was injured

Field Values

- Protective Devices – **H**e**L**met (**HL**): The patient riding on an unenclosed motorized vehicle/bicycle was wearing a helmet at the time of impact
- Protective Devices – **S**eat **B**elt (**SB**): Patient was wearing a seat belt at the time of impact
- Protective Devices – **A**ir**B**ag (**AB**): Airbag deployed at the time of impact and directly protected the patient
- Protective Devices – **C**ar **S**eat/Booster (**CS**): The patient was riding in a car seat or booster at the time of impact
- **E**nclosed **V**eh. (**EV**): Patient involved in collision while in an enclosed vehicle, such as a an automobile, bus, or other enclosed motorized vehicle
- **Ej**ected (**EJ**): Patient was fully or partially thrown from a vehicle, including convertibles and trucks. Does **NOT** include motorcycles
- **EX**tricated @ (**EX**): Time of day that the patient was removed from the vehicle when use of a pneumatic tool was required
- **P**assenger **S**pace Intrusion (**PS**): Intrusion of greater than 12 inches into an occupied passenger space of a motor vehicle, or greater than 18 inches into an unoccupied passenger space – check this box if amount of intrusion is not known or not specified by paramedics
- **12**: Intrusion of greater than 12 inches into an occupied passenger space of a motor vehicle – check this box when amount of intrusion is specified by paramedics
- **18** : Intrusion of greater than 18 inches into an unoccupied passenger space – check this box when amount of intrusion is specified by paramedics
- **S**urvived **F**atal Accident (**SF**): The patient survived a collision where another person **in the same vehicle** was fatally injured
- Impact > **20**mph Unenclosed (**20**): An unenclosed transport crash (e.g., skateboard, bicycle, horse, etc.) with an estimated impact greater than 20mph
- Ped/Bike: **R**unover/**T**hrown/>20mph (**RT**): Pedestrian, bicyclist, or motorcyclist struck by an automobile and is thrown, run over, or has an estimated impact of greater than 20mph
- **P**ed/**B**ike < 20mph (**PB**): Pedestrian, bicyclist, or motorcyclist struck by a motorized vehicle, who is NOT thrown or run over, at an estimated impact of less than 20 mph
- **M**otorcycle/**M**oped (**MM**): The patient was riding on a motorcycle or moped at the time of impact
- **SP**orts/Rec (**SP**): Any injury that occurs during a sporting or recreational athletic activity, such as aerobics, football, jogging, etc.
- **AS**sault (**AS**): Patient was physically assaulted (kicked, punched, strangled, etc.) by means other than stabbing or shooting
- **ST**abbing (**ST**): A sharp or piercing instrument (e.g. knife, broken glass, ice pick, etc.) caused an injury which penetrated the skin
- **GS**W (**GS**): Gunshot Wound - injury was caused by discharge of a gun (accidental or intentional)
- **AN**imal Bite (**AN**): The teeth of a human, reptile, dog, cat, or other animal inflicted an injury, whether or not the skin was punctured. Insect bites and bee stings are not considered animal bites, and should be coded as “Other”

- **CR**ush (**CR**): Injury sustained as the result of external pressure being placed on body parts between two opposing forces
- **T**elemetry **D**ata (**TD**): Vehicle telemetry data is encountered that is consistent with high risk of serious injury
- **S**pecial **C**onsid. (**SC**): Injured patients that meet Special Considerations due to age greater than 55 years, pregnancy > 20 weeks, age greater than 65 years with a systolic BP of less than 110mmHg, or patients in blunt traumatic full arrest who, based on a paramedic's thorough patient assessment, believes transport is indicated
- **A**nti**C**oagulants (**AC**): Injured patient is on anticoagulant medication other than aspirin (excludes minor extremity injury)
- **FA**ll (**FA**): Any injury resulting from a fall from any height
- >**15** ft. (>10 ft. Peds) (**15**): A vertical, uninterrupted fall of greater than 15 feet for an adult or greater than 10 feet or 3 times the height of the child for a pediatric patient. This mechanism is a subcategory of "Fall." This does not include falling down stairs or rolling down a sloping cliff.
- **S**elf-Inflict'd/**A**ccid. (**SA**): The injury appears to have been accidentally caused by the patient
- **S**elf-Inflict'd/**I**ntent. (**SI**): The injury appears to have been intentionally caused by the patient
- **E**lectrical **S**hock (**ES**): Passage of an electrical current through body tissue as a result of contact with an electrical source
- **T**hermal **B**urn (**TB**): Burn caused by heat
- **H**azmat **E**xposure (**HE**): The patient was exposed to toxic or poisonous agents, such as liquids, gases, powders, foams, or radioactive material
- **W**ork- **R**elated (**WR**): Injury occurred while patient was working, and may be covered by Worker's Compensation
- **UN**known (**UN**): The cause or mechanism of injury is unknown
- **OT**her (**OT**): A cause of injury that does not fall into any of the existing categories

Additional Information

- **Required** field for all base hospital contacts where patient is reported to be injured or a mechanism of injury is present
- Check all that apply
- Two-letter codes can be derived from the bolded, capitalized letters of the mechanisms of injury (MOI) – MOIs should be listed in order of significance in the MOI code fields
- Patients with a mechanism of injury documented must also have a trauma code documented – and vice versa
- Mechanisms of injury listed in **red** meet trauma triage criteria for transport to the nearest available trauma center
- Mechanisms of injury listed in **blue** meet trauma guidelines for transport to the nearest available trauma center - strong consideration should be given to a trauma center destination
- Do not enter more than one copy of the same mechanism of injury
- Cannot have a MOI that is only Anticoagulants (AC) or Special Considerations (SC), an additional mechanism of injury must be entered

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TRANSPORT SECTION

CODE ALL OPTIONS

Definition

Three-letter code for each of the potential patient destination facilities

Field Values

LOS ANGELES COUNTY 9-1-1 RECEIVING			
ACH	Alhambra Hospital Medical Center	LBC	Community Hospital of Long Beach
AHM	Catalina Island Medical Center	LBM	Long Beach Memorial Medical Center
AMH	Methodist Hospital of Southern California	LCH	Palmdale Regional Medical Center
AVH	Antelope Valley Hospital	LCM	Providence Little Co. of Mary Hospital Torrance
BEV	Beverly Hospital	MCP	Mission Community Hospital
BMC	Southern California Hospital at Culver City	MHG	Memorial Hospital of Gardena
CAL	Dignity Health - California Hospital Medical Center	MID	Olympia Medical Center
CHH	Children's Hospital Los Angeles	MLK	Martin Luther King Jr. Community Hospital
CHP	Community Hospital of Huntington Park	MPH	Monterey Park Hospital
CNT	Centinela Hospital Medical Center	NOR	LA Community Hospital at Norwalk
CPM	Coast Plaza Doctors Hospital	NRH	Dignity Health - Northridge Hospital Medical Center
CSM	Cedars-Sinai Medical Center	OVM	LAC Olive View Medical Center
DCH	PIH Health Hospital - Downey	PAC	Pacifica Hospital of the Valley
DFM	Marina Del Rey Hospital	PIH	PIH Health Hospital- Whittier
DHL	Lakewood Regional Medical Center	PLB	College Medical Center
ELA	East Los Angeles Doctors Hospital	PVC	Pomona Valley Hospital Medical Center
ENH	Encino Hospital Medical Center	QOA	Hollywood Presbyterian Medical Center
FPH	Foothill Presbyterian Hospital	QVH	Citrus Valley M.C. - Queen of the Valley Campus
GAR	Garfield Medical Center	SDC	San Dimas Community Hospital
GEM	Greater El Monte Community Hospital	SFM	St. Francis Medical Center
GMH	Dignity Health - Glendale Memorial Hospital and Health Center	SGC	San Gabriel Valley Medical Center
GSH	Good Samaritan Hospital	SJH	Providence Saint John's Health Center
GWT	Adventist Health - Glendale	SJS	Providence Saint Joseph Medical Center
HCH	Providence Holy Cross Medical Center	SMH	UCLA Medical Center, Santa Monica
HEV	Glendora Community Hospital	SMM	Dignity Health - St. Mary Medical Center
HGH	LAC Harbor-UCLA Medical Center	SOC	Sherman Oaks Hospital
HMH	Huntington Hospital	SPP	Providence Little Co. of Mary San Pedro
HMN	Henry Mayo Newhall Hospital	SVH	Saint Vincent Medical Center
HWH	West Hills Hospital & Medical Center	TOR	Torrance Memorial Medical Center
ICH	Citrus Valley M.C. - Intercommunity Campus	TRM	Providence Tarzana Medical Center
KFA	Kaiser Foundation Hospital- Baldwin Park	UCL	Ronald Reagan UCLA Medical Center
KFB	Kaiser Permanente Downey Med Ctr	USC	LAC+USC Medical Center
KFH	Kaiser Permanente South Bay Med Ctr	VHH	USC Verdugo Hills Hospital
KFL	Kaiser Permanente Los Angeles Med Ctr	VPH	Valley Presbyterian Hospital
KFO	Kaiser Permanente Woodland Hills M.C.	WHH	Whittier Hospital Medical Center
KFP	Kaiser Permanente Panorama City M.C.	WMH	Adventist Health - White Memorial
KFW	Kaiser Permanente West LA Med Ctr		

ORANGE COUNTY 9-1-1 RECEIVING			
ANH	Anaheim Regional Medical Center	LPI	La Palma Intercommunity Hospital
CHO	Children's Hospital of Orange County	PLH	Placentia Linda Hospital
FHP	Fountain Valley Regional Hospital and Medical Center	SJD	St. Jude Medical Center
KHA	Kaiser Foundation Hospital- Anaheim	UCI	UCI Medical Center
KFI	Kaiser Permanente Irvine Medical Center	WMC	Western Medical Center Santa Ana
LAG	Los Alamitos Medical Center		
SAN BERNARDINO COUNTY 9-1-1 RECEIVING			
ARM	Arrowhead Regional Medical Center	KFN	Kaiser Foundation Hospital- Ontario
CHI	Chino Valley Medical Center	LLU	Loma Linda University Medical Center
DHM	Montclair Hospital Medical Center	SAC	San Antonio Community Hospital
KFF	Kaiser Foundation Hospital- Fontana		
OTHER COUNTY 9-1-1 RECEIVING			
LRR	Los Robles Hospital & Med Ctr (Ventura)	SJO	St. John's Regional Medical Center (Ventura)
SIM	Simi Valley Hospital (Ventura)	RCC	Ridgecrest Regional Hospital (Kern)
NON-BASIC HOSPITALS			
LBV	Long Beach VA	WVA	Wadsworth VA Medical Center

Additional Information

- **Required** field for all base hospital contacts
- A three-letter code for MAR must be documented for all patients, regardless of age
- A three-letter code for EDAP must be documented for all pediatric patients of less than or equal to 14 years of age

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

CHECK ACTUAL DESTINATION

Definition

Checkboxes indicating actual destination of patient

Field Values

- **M**AR: Most Accessible Receiving facility (licensed basic emergency department) that can be reached in the shortest amount of time. Depending on traffic and geography, this may not necessarily be the closest facility. Must be documented for all patients regardless of actual destination
- **E**DAP: Most accessible Emergency Department Approved for Pediatrics approved to receive patients of less than or equal to 14 years of age. Must be documented for all pediatric patients regardless of actual destination
- **T**C: Most accessible Trauma Center approved to receive critically injured patients. Must be documented for all adult patients that meet criteria, guidelines, or special considerations for transport to a TC, regardless of actual destination
- PT**C**: Most accessible Pediatric Trauma Center approved to receive critically injured pediatric patients of less than or equal to 14 years of age. Must be documented for all pediatric patients that meet criteria, guidelines, or special considerations for transport to a PTC, regardless of actual destination
- **P**MC: Most accessible Pediatric Medical Center approved to receive critically ill pediatric patients of less than or equal to 14 years of age. Must be documented for all pediatric patients that meet guidelines for transport to a PMC, regardless of actual destination
- **S**TEMI Receiving Center: Most accessible ST-Elevation Myocardial Infarction (STEMI) Receiving Center approved to receive patients with a suspected STEMI, or who have Return of Spontaneous Circulation (ROSC) following a non-traumatic cardiac arrest. Must be documented for all patients who meet criteria for transport to a SRC, regardless of actual destination
- Prim**A**ry Stroke Center: Most accessible Primary Stroke Center approved to receive suspected stroke patients or patients with a positive mLAPSS exam. Must be documented for all patients who meet guidelines for transport to a PSC, regardless of actual destination
- Comprehensive Stro**K**e Center: Most accessible Comprehensive Stroke Center approved to receive patients with a positive mLAPSS exam and a LAMS score ≥ 4
- Peri**N**atal: Most accessible Perinatal Center approved to receive patients greater than or equal to 20 weeks pregnant. Must be documented for all patients who meet guidelines for transport to a Perinatal Center
- SA**R**T: Most accessible Sexual Assault Response Team facility approved to receive actual or suspected victims of sexual assault/abuse. Must be documented for patients who meet guidelines for transport to a SART Center
- **O**ther: Licensed basic emergency department that may also appropriately receive the patient in addition to those listed above. Most frequently used when the closest facility is inaccessible (e.g., is requesting diversion.) The reason for using “Other” as a destination must be documented in the “Destination Rationale” section

Additional Information

- **Required** field for all base hospital contacts where patients are transported by EMS personnel
- Check only the actual patient destination
- If more than one specialty center option applies, choose the option most applicable to the patient's presentation (e.g., pregnant pediatric patients, or sexually assaulted trauma patients)

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

ETA

Definition

Estimated time of arrival (ETA) for each of the possible destinations documented

Field Values

- Collected as minutes

Additional Information

- ETA must be provided for each possible destination

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio records

CHECK ONE

Definition

Checkboxes indicating whether or not a specialty center destination was indicated for the patient

Field Values

- **S**pecialty Center **N**ot Required: Patient does not meet guidelines or criteria for transport to a specialty center
- **S**pecialty Center **R**equired/Criteria Met: Patient meets criteria or requirements for transport to a specialty center
- **S**pecialty Center **G**uidelines Met: Patient meets guidelines for transport to a specialty center

Additional Information

- **Required** field for all base hospital contacts
- Check one box only
- If more than one specialty center option applies, choose the option most applicable to the patient's presentation
- If patient meeting requirements, criteria, or guidelines is not transported to specialty center, must indicate reason in the "Destination Rationale" section

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio records

DESTINATION RATIONALE

Definition

Checkboxes indicating the reason that the patient was transported to a facility other than the most accessible receiving facility or specialty center, if applicable

Field Values

- **E**D Saturation: Most accessible receiving facility or EDAP has requested diversion due to emergency department saturation
- Internal **D**isaster: Most accessible receiving facility or specialty center is closed due to internal disaster such as fire, flood, etc.
- **C**T Diversion: CT scanner at the most accessible receiving facility or specialty center is non-functioning
- I**F**T: Patient is being transferred from one facility to another
- SC Diversion **T**C/PTC: Most accessible TC/PTC is closed due to encumberment of the trauma team or OR
- SC Diversion **P**MC: Most accessible PMC is closed due to lack of critical equipment
- SC Diversion STE**M**I: Most accessible SRC is closed due to Cath lab encumberment or malfunction
- SC Diversion Cardiac Arrest (**X**): Injured patient meeting trauma criteria is in blunt traumatic cardiac arrest (BT), and is transported to the MAR rather than the most accessible TC/PTC
- SC Diversion Prim**A**ry Stroke Center: Most accessible primary stroke center is closed when there is no means (CT scan or MRI) to perform diagnostic brain imaging
- SC Diversion Comprehensive Stro**K**e Center: Most accessible comprehensive stroke center is closed due to stroke resource encumberment or critical equipment/interventional radiology room unavailability
- SC Not Accessib**L**e: Specialty center not accessible due to transport time constraints or geography
- Jud**G**ment (Provider/Base): Patient does not meet specialty center criteria, requirements, or guidelines, but is transported to a specialty center based on Base or the Provider judgment; or, meets, but is not transported to a specialty center
- Shared Am**B**ulance: The patient does not meet specialty center criteria, requirements, or guidelines, but is transported to SC because they are sharing an ambulance with a patient who does meet SC criteria/guidelines/requirements
- Minimal In**J**uries: Patient meets trauma criteria or guidelines but is determined to have only minimal injuries which do not warrant transport to a specialty center
- **U**nmanageable Airway: Patient meets specialty center criteria, requirements, or guidelines, but airway cannot be adequately managed due to injury or illness, and patient's life may be jeopardized by transport to any facility but the closest
- **R**equested By: Patient is transported to a facility other than the most accessible receiving facility or specialty center by request from the patient, a family member, patient's private medical doctor (PMD), or other authorized person
- **O**ther: Patient is transported a facility other than the most accessible receiving facility or specialty center for any reason other than those listed above (use space below to briefly document reason)

Additional Information

- **Required** field for all base hospital contacts where the patient is transported to “Other,” (not the closest receiving facility or specialty center)

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio records

PT TRANSPORTED VIA:

Definition

Checkboxes indicating the type of transport unit used

Field Values

- **A**LS: An Advanced Life Support Transport unit in which patient was accompanied by at least one paramedic
- **B**LS: Basic Life Support Transport unit in which patient was accompanied by EMTs only
- **O**ther: Type of transport not listed above
- **H**elicopter ETA: Helicopter transport requested – indicate ETA of helicopter to scene
- **N**o Transport: Patient was not transported (must indicate reason for no transport in the "Reason for No Transport" field)

Additional Information

- **Required** field for all base hospital contacts

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

REASON FOR NO TRANSPORT

Definition

Checkboxes indicating reason why patient was not transported, if applicable

Field Values

- **A**MA: Patient refuses transport
- **D**OA: Patient is determined to be dead on arrival as per Prehospital Care Manual
- **U**nwarranted: Patient's condition does not require transportation to a hospital
- **T**.O.R.: Resuscitative measures are terminated by EMS personnel
- **P**ronounced by: Enter the name of the physician who pronounced the patient dead, if applicable
- **O**ther: Mark this box if the patient was not transported due a reason not listed above

Additional Information

- **Required** field for all base hospital contacts where the patient is not transported

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

TIME CLEAR

Definition

The time of day that paramedic contact with the base hospital ends

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts
- Use one timepiece throughout call to ensure accurate time intervals

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form

TIME RECEIVING HOSPITAL NOTIFIED

Definition

The time of day that the receiving hospital was notified of an arriving patient

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts where the patient is transported to a receiving facility other than the base hospital
- Use one timepiece throughout call to ensure accurate time intervals

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form

NAME OF PERSON NOTIFIED:

Definition

Space to document the name of the person at the receiving facility notified of an arriving patient

Field Values

- Free text

Additional Information

- Not necessary if base hospital is the receiving facility
- Document whatever name is given – e.g., “Mary” or “Dr. Jones”

Uses

- Provides documentation of communication

Data Source Hierarchy

- Base Hospital Form
- Audio records

TRANSPORT SCENARIOS

Specialty Care Center Not Required

70 y/o female, short of breath x 2 hours, speaking in full sentences, in mild/moderate distress:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☒ **M**AR	PIH	7
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | | |	
Time Receiving Hospital Notified	| | | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☒ **N**ot Required
☐ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Cardiac Arrest (**X**)
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- Indicate the actual destination by checking MAR
- Check Specialty Center: Not Required (SOB as described meets no specialty center criteria or guidelines as per Reference No. 502)
- Destination Rationale is left blank, as there is no deviation from destination principles

Pediatric: EDAP Required

2 y/o male, febrile, witnessed tonic/clonic seizure. No signs of trauma, GCS is improving:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	LCM	5
☒ **E**DAP (age ≤14)	LCM	5
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | | |	
Time Receiving Hospital Notified	| | | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☒ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Cardiac Arrest (**X**)
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and EDAP
- Indicate the actual destination by checking EDAP
- Check Specialty Center: Required/Criteria Met (EDAP specialty center is required for patients 14yrs of age or younger, as per Reference No. 510)
- Destination Rationale is left blank, as there is no deviation from destination principles

Pediatric: PTC Criteria

5 y/o female, fell from a second story window, GCS 4-6-5. CC = BB, PI=TRMA, MOIs = FA and 15:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ **M**AR	KFL	4
	☐ **E**DAP (age ≤14)	UCL	7
	☐ **T**C	|__|__|	
	☒ PT**C** (trauma, age ≤14)	UCL	7
	☐ **P**MC (medical, age ≤14)	|__|__|	
	☐ **S**TEMI Receiving Center	|__|__|	
	☐ Prim**A**ry Stroke Center	|__|__|	
	☐ Comprehensive Stro**K**e Center	|__|__|	
	☐ Peri**N**atal (≥20wks pregnancy)	|__|__|	
	☐ SA**R**T	|__|__|	
	☐ **O**ther	|__|__|	
	Time Clear	|__|__|__|	
	Time Receiving Hospital Notified	|__|__|__|	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☐ **N**ot Required ☒ **R**equired/Criteria Met ☐ **G**uidelines Met	☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Cardiac Arrest (**X**) ☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center ☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway ☐ **R**equested by: ☐ **O**ther:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ **A**LS ☐ **B**LS ☐ **O**ther ☐ **H**elicopter-ETA: ____ ☐ **N**o Transport	☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther ☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR, EDAP, and PTC
- Indicate the actual destination by checking PTC
- Check Specialty Center: Required/Criteria Met (MOI=15 is a criteria for transport to a PTC as per Reference No. 506)
- Destination Rationale is left blank, as there is no deviation from destination principles

Pediatric: PTC Guideline

7 y/o female, auto vs bicycle at less than 5mph, wearing a helmet. CC = BE, PI=TRMA, MOIs = PB and HL:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ **M**AR	HEV	2
	☒ **E**DAP (age ≤14)	AMH	8
	☐ **T**C	|__|__|	
	☐ PT**C** (trauma, age ≤14)	USC	20
	☐ **P**MC (medical, age ≤14)	|__|__|	
	☐ **S**TEMI Receiving Center	|__|__|	
	☐ Prim**A**ry Stroke Center	|__|__|	
	☐ Comprehensive Stro**K**e Center	|__|__|	
	☐ Peri**N**atal (≥20wks pregnancy)	|__|__|	
	☐ SA**R**T	|__|__|	
	☐ **O**ther	|__|__|	
	Time Clear	|__|__|__|	
	Time Receiving Hospital Notified	|__|__|__|	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☐ **N**ot Required ☐ **R**equired/Criteria Met ☒ **G**uidelines Met	☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Cardiac Arrest (**X**) ☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center ☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance ☒ Minimal In**J**uries ☐ **U**nmanageable Airway ☐ **R**equested by: ☐ **O**ther:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ **A**LS ☐ **B**LS ☐ **O**ther ☐ **H**elicopter-ETA: ____ ☐ **N**o Transport	☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther ☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR, EDAP, and PTC
- Indicate the actual destination by checking EDAP
- Check Specialty Center: Guidelines Met (Auto vs Ped/Bike at less than 20mph [PB] is a guideline for transport to a PTC as per Reference No. 506.) If more than one specialty center option applies, choose the option most applicable to the patient's presentation.
- Check Destination Rationale: Minimal Injuries, as this is the reason patient was not transported to the PTC

Pediatric: PMC Guideline

4 y/o male, witnessed tonic/clonic seizure. No signs of trauma, but GCS is not improving:

TRANSPORT

CODE all options, CHECK actual destination:	CODE	ETA
☐ **M**AR	SJS	8
☐ **E**DAP (age ≤14)	SJS	8
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☒ **P**MC (medical, age ≤14)	CHH	15
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☐ **R**equired/Criteria Met
☒ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Cardiac Arrest (**X**)
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR, EDAP, and PMC
- Indicate the actual destination by checking PMC
- Check Specialty Center: Guidelines Met (persistent altered mental status is a guideline for transport to a PMC, as per Reference No. 510)
- Destination Rationale is left blank, as there is no deviation from destination principles

Perinatal: Specialty Center Guidelines Met

24 y/o female, 22 weeks pregnant with abdominal cramping x 2 hours. No signs of trauma:

TRANSPORT

CODE all options, CHECK actual destination:	CODE	ETA
☐ **M**AR	ENH	5
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☒ Peri**N**atal (≥20wks pregnancy)	NRH	15
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☐ **R**equired/Criteria Met
☒ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Cardiac Arrest (**X**)
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and Perinatal Center
- Indicate the actual destination by checking Perinatal Center
- Check Specialty Center: Guidelines Met (patients who are at least 20 weeks pregnant and who appear to have a pregnancy related complaint or complication is a guideline for transport to a Perinatal, as per Reference No. 511)
- Destination Rationale is left blank, as there is no deviation from destination principles

PSC: Specialty Center Guidelines Met

50 y/o male, L facial droop x 1 hr, positive mLAPSS exam, LAMS Score = 2:

TRANSPORT

CODE all options, CHECK actual destination:	CODE	ETA
☐ MAR	HGH	5
☐ EDAP (age ≤14)		
☐ TC		
☐ PTC (trauma, age ≤14)		
☐ PMC (medical, age ≤14)		
☐ STEMI Receiving Center		
☒ PrimAry Stroke Center	TOR	12
☐ Comprehensive StroKe Center		
☐ PeriNatal (≥20wks pregnancy)		
☐ SART		
☐ Other		
Time Clear		
Time Receiving Hospital Notified		
Name of Person Notified:		

CHECK ONE:

Specialty Center:
- ☐ Not Required
- ☐ Required/Criteria Met
- ☒ Guidelines Met

PT TRANSPORTED VIA:

☒ ALS ☐ BLS ☐ Other
☐ Helicopter-ETA: ____
☐ No Transport

DESTINATION RATIONALE:

☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT
SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ Cardiac Arrest (X)
☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center
☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)*
☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway
☐ Requested by: ☐ Other:

REASON FOR NO TRANSPORT:

☐ AMA ☐ DOA ☐ Unwarranted ☐ Other
☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |__|__|__| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and PSC
- Indicate the actual destination by checking PSC
- Check Specialty Center: Guidelines Met (positive mLAPSS exam & a LAMS score of 3 or less meets guidelines for transport to a PSC as per Reference No. 521)
- Destination Rationale is left blank, as there is no deviation from destination principles

CSC: Specialty Center Guidelines Met

62 y/o female, R arm drift and no R grip strength x 3 hours, positive mLAPSS exam, LAMS Score = 4:

TRANSPORT

CODE all options, CHECK actual destination:	CODE	ETA
☐ MAR	QOA	6
☐ EDAP (age ≤14)		
☐ TC		
☐ PTC (trauma, age ≤14)		
☐ PMC (medical, age ≤14)		
☐ STEMI Receiving Center		
☐ PrimAry Stroke Center	QOA	6
☒ Comprehensive StroKe Center	KFL	9
☐ PeriNatal (≥20wks pregnancy)		
☐ SART		
☐ Other		
Time Clear		
Time Receiving Hospital Notified		
Name of Person Notified:		

CHECK ONE:

Specialty Center:
- ☐ Not Required
- ☐ Required/Criteria Met
- ☒ Guidelines Met

PT TRANSPORTED VIA:

☒ ALS ☐ BLS ☐ Other
☐ Helicopter-ETA: ____
☐ No Transport

DESTINATION RATIONALE:

☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT
SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ Cardiac Arrest (X)
☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center
☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)*
☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway
☐ Requested by: ☐ Other:

REASON FOR NO TRANSPORT:

☐ AMA ☐ DOA ☐ Unwarranted ☐ Other
☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |__|__|__| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR, PSC, and CSC
- Indicate the actual destination by checking CSC
- Check Specialty Center: Guidelines Met (positive mLAPSS exam & a LAMS Score of 4 or greater meets guidelines for transport to a CSC as per Reference No. 521)
- Destination Rationale is left blank, as there is no deviation from destination principles

Specialty Center Judgment

66 y/o male, crushing chest pain and SOB for 15min, Abnormal ECG, hx of MI, DM, HTN. MICN directs transport to SRC due to high suspicion of MI:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ **M**AR	CNT	5
	☐ **E**DAP (age ≤14)	| |	
	☐ **T**C	| |	
	☐ PT**C** (trauma, age ≤14)	| |	
	☐ **P**MC (medical, age ≤14)	| |	
	☒ **S**TEMI Receiving Center	UCL	15
	☐ Prim**A**ry Stroke Center	| |	
	☐ Comprehensive Stro**K**e Center	| |	
	☐ Peri**N**atal (≥20wks pregnancy)	| |	
	☐ SA**R**T	| |	
	☐ **O**ther	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:

Specialty Center:
☒ **N**ot Required
☐ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Cardiac Arrest (**X**)
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☒ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and SRC
- Indicate the actual destination by checking SRC
- Check Specialty Center Not Required
- Check Destination Rationale: Judgment

9-1-1 Interfacility Transfer

66 y/o male presented by private auto to a non-SRC facility, c/o crushing chest pain and SOB for 15min, ECG in ED shows STEMI. 9-1-1 is activated for rapid transport to closest SRC:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ **M**AR	CNT	0
	☐ **E**DAP (age ≤14)	| |	
	☐ **T**C	| |	
	☐ PT**C** (trauma, age ≤14)	| |	
	☐ **P**MC (medical, age ≤14)	| |	
	☒ **S**TEMI Receiving Center	UCL	15
	☐ Prim**A**ry Stroke Center	| |	
	☐ Comprehensive Stro**K**e Center	| |	
	☐ Peri**N**atal (≥20wks pregnancy)	| |	
	☐ SA**R**T	| |	
	☐ **O**ther	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☒ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Cardiac Arrest (**X**)
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- *(Run Type at top right of form is IFT)*
- Enter hospital codes for the closest MAR and SRC
- Indicate the actual destination by checking SRC
- Destination Rationale is left blank, as there is no deviation from destination principles

ED Saturation

55 y/o female, c/o abdominal pain x 3 days. The closest facility has requested diversion due to ED saturation:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ **M**AR	NRH	5
	☐ **E**DAP (age ≤14)	| |	
	☐ **T**C	| |	
	☐ PT**C** (trauma, age ≤14)	| |	
	☐ **P**MC (medical, age ≤14)	| |	
	☐ **S**TEMI Receiving Center	| |	
	☐ Prim**A**ry Stroke Center	| |	
	☐ Comprehensive Stro**K**e Center	| |	
	☐ Peri**N**atal (≥20wks pregnancy)	| |	
	☐ SA**R**T	| |	
	☒ **O**ther	MCP	12
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:

Specialty Center:
☒ **N**ot Required
☐ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☒ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ **I**FT
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Cardiac Arrest (**X**)
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- Indicate the actual destination by checking Other, and enter the hospital code for the actual destination
- Check Specialty Center: Not Required (AP as described meets no specialty center criteria or guidelines as per Reference No. 502)
- Destination Rationale is ED Saturation, as patient did not go to the MAR due to diversion request for ED Saturation

Specialty Center Diversion

17 y/o male, single stab wound to LUQ, CC = PA, PI=TRMA, MOI = ST. Most accessible trauma center has requested trauma diversion:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ **M**AR	MHG	8
	☐ **E**DAP (age ≤14)	| |	
	☐ **T**C	SFM	10
	☐ PT**C** (trauma, age ≤14)	| |	
	☐ **P**MC (medical, age ≤14)	| |	
	☐ **S**TEMI Receiving Center	| |	
	☐ Prim**A**ry Stroke Center	| |	
	☐ Comprehensive Stro**K**e Center	| |	
	☐ Peri**N**atal (≥20wks pregnancy)	| |	
	☐ SA**R**T	| |	
	☒ **O**ther	HGH	15
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☒ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ **I**FT
SC diversion: ☒ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Cardiac Arrest (**X**)
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and TC
- Indicate the actual destination by checking Other, and enter the hospital code for the actual destination
- Check Specialty Center: Required/Criteria Met (PA is a criteria for transport to a TC as per Reference No. 506)
- Destination Rationale is SC Diversion: TC/PTC, as patient was not transported to closest TC due to diversion request

Conducted Electrical Weapon (CEW, aka Taser®)

34 y/o male, status post deployment of a conducted electrical weapon (CEW, trade name Taser®) dart to chest, minor laceration to chest, no other trauma or associated signs or symptoms. CC = PL, PI=TRMA, MOI = OT:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☒ **M**AR	PLB	3
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	LBM	5
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☒ **N**ot Required
☐ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☐ **A**LS ☒ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Cardiac Arrest (**X**)
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and TC
- Indicate the actual destination by checking MAR
- Check Specialty Center: Not Required (PL is not a criteria or guideline for transport to a TC as per Reference No. 506)
- Destination Rationale is left blank, as there is no deviation from destination principles

Minimal Injuries

17 y/o male, status post leg struck by car in parking lot, minor abrasion to foot, no deformity, no other trauma or associated signs or symptoms. CC = BE, PI=TRMA, MOI = PB:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☒ **M**AR	BMC	3
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	UCL	15
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☐ **R**equired/Criteria Met
☒ **G**uidelines Met

PT TRANSPORTED VIA:

☐ **A**LS ☒ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Cardiac Arrest (**X**)
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☒ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |_|_|_| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and TC
- Indicate the actual destination by checking MAR
- Check Specialty Center: Guidelines Met (PB is a guideline for transport to a TC as per Reference No. 506)
- Destination Rationale is Minimal Injuries, as patient was not transported to the closest TC, due to minimal injuries

Shared Ambulance

8 y/o male, restrained rear passenger in a moderate speed MVA. Pt. c/o LLE pain only, no deformity noted. CC = BE, PI=TRMA, MOIs = EV, SB. Patient's mother was unrestrained driver and meets trauma criteria:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	DCH	3
☐ **E**DAP (age ≤14)	DCH	3
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	LBM	20
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☒ **O**ther	SFM	8
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☒ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Cardiac Arrest (**X**)
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☒ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR, EDAP, and PTC
- Indicate the child's actual destination by checking Other (patient not transported to MAR, EDAP, or PTC) and enter the hospital code for the actual destination
- Check Specialty Center: Required/Criteria Met (EDAP, PMC or PTC is required for all pediatric patients)
- Destination Rationale is Shared Ambulance, as patient was transported to Other

Patient Request

82 y/o male, c/o cough and fever x 3 days, vital signs stable. Pt. is a Kaiser member and is requesting transport to Kaiser – which is accessible but not the MAR:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	DCH	3
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☒ **O**ther	KFB	6
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☒ **N**ot Required
☐ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Cardiac Arrest (**X**)
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☒ **R**equested by: *Patient* ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- Indicate the actual destination by checking Other, and enter the hospital code for the actual destination
- Check Specialty Center: Not Required (CC and FE, as described meet no specialty center criteria or guidelines as per Reference No. 502)
- Destination Rationale is Requested by: Patient, as patient did not go to the MAR due to patient request

AMA

36 y/o female, history of diabetes, status post altered mental status resolved with paramedic administration of D50 for blood glucose of 40. GCS now 4-6-5, no complaints, vital signs stable. The patient has decided she does not want to be transported to the hospital and wishes to sign out against the medical advice of the paramedics and MICN:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	AMH	3
☐ **E**DAP (age ≤14)	|__|	
☐ **T**C	|__|	
☐ PT**C** (trauma, age ≤14)	|__|	
☐ **P**MC (medical, age ≤14)	|__|	
☐ **S**TEMI Receiving Center	|__|	
☐ Prim**A**ry Stroke Center	|__|	
☐ Comprehensive Stro**K**e Center	|__|	
☐ Peri**N**atal (≥20wks pregnancy)	|__|	
☐ SA**R**T	|__|	
☐ **O**ther	|__|	
Time Clear	|___|	
Time Receiving Hospital Notified	|___|	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☒ **N**ot Required
☐ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☐ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter-ETA: ____
☒ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Cardiac Arrest (**X**)
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☒ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- No actual destination is indicated, as patient is not transported
- Check Specialty Center Not Required (adult with status post medical ALOC does not meet Specialty Center criteria or guidelines)
- Destination Rationale is left blank, as there is no destination
- Reason for No Transport is AMA

Hyperbaric Chamber

25 y/o male, status post scuba diving accident, GCS 2-1-4, no signs of trauma, helicopter transport 5 minutes away:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	AHM	3
☐ **E**DAP (age ≤14)	|__|	
☐ **T**C	|__|	
☐ PT**C** (trauma, age ≤14)	|__|	
☐ **P**MC (medical, age ≤14)	|__|	
☐ **S**TEMI Receiving Center	|__|	
☐ Prim**A**ry Stroke Center	|__|	
☐ Comprehensive Stro**K**e Center	|__|	
☐ Peri**N**atal (≥20wks pregnancy)	|__|	
☐ SA**R**T	|__|	
☒ **O**ther	USC	25
Time Clear	|___|	
Time Receiving Hospital Notified	|___|	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☒ **N**ot Required
☐ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☐ **A**LS ☐ **B**LS ☐ **O**ther
☒ **H**elicopter-ETA: 5
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Cardiac Arrest (**X**)
☐ Prim**A**ry Stroke Center ☐ Comprehensive Stro**K**e Center
☐ SC Not Accessib**L**e ☐ Jud**G**ment *(Provider/Base)*
☐ Shared Am**B**ulance ☐ Minimal In**J**uries ☐ **U**nmanageable Airway
☐ **R**equested by: ☒ **O**ther: HBC

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown ☐ **I**CU ☐ Obser**V**ation
☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- Indicate the actual destination by checking Other, and enter the hospital code for the actual destination
- Check Specialty Center Not Required (an unconscious patient status post scuba diving accident shall go immediately to a MAC-listed hyperbaric chamber, as per Reference No. 518)
- Destination Rationale is Other: HBC (hyperbaric chamber)

DISPO SECTION

IF BASE IS RECEIVING HOSPITAL

Definition

Checkboxes indicating the emergency department disposition of patients transported to the base hospital

Field Values

- **D**ischarged: Patient was discharged home from the emergency department
- **W**ard: Patient was admitted to a medical/surgical ward
- **S**tepdown: Patient was admitted to a Direct Observation Unit (DOU), Stepdown Unit, or Telemetry Unit
- **I**CU: Patient was admitted to an Intensive Care Unit or Cardiac Care Unit
- Obser**V**ation: Observation unit (provides < 24 hour stays)
- O**R**: Patient was transferred directly from the emergency department to the operating room
- **C**ath Lab: Patient was transferred directly from the emergency department to the Cardiac Catheterization Lab
- I**N**terventional Radiology: Patient was transferred directly from the emergency department to Interventional Radiology for embolization, angiography, etc.
- **E**xpired in ED: Patient died in the emergency department
- O**B**: Patient was admitted to an obstetrics department
- **T**ransferred to: Patient was transferred directly from the emergency department to another healthcare facility – document the name of the facility or the three-letter hospital code in the space provided
- **O**ther: Patient disposition other than those listed above – document disposition on the line provided
- ED Diagnosis: Emergency department diagnosis as documented by a physician – is entered into TEMIS as an ICD-10 code

Additional Information

- **Required** field for all patients for whom the base hospital contacted or notified is the receiving facility
- May be completed at a later time by personnel other than the MICN/MD initially contacted or notified

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Notification Form
- Notification Log
- ED Records
- Other hospital records

COMMENTS

Definition

Space provided for documentation of any additional information

Field Values

- Free text

Additional Information

- Base Hospital Form Page 2 can be utilized if additional space is needed for documentation

Uses

- Additional documentation, if needed

Data Source Hierarchy

- Base Hospital Form

MICN/PHYSICIAN

Definition

Signature and certification/identification number of the MICN and/or Base physician contacted

Field Values

- Free text

Additional Information

- **Required** field for all base hospital contacts
- First initial and last name is sufficient for signature
- If **both** a MICN and a physician handle the call, or if a physician is consulted during the run, both names and numbers are documented
- Physician #s are created by each base hospital and are not assigned by Lancet Technology or the EMS Agency

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log

PATIENT NAME/NUMBER

Definition

Patient's name/hospital medical record number

Field Values

- Free text

Additional Information

- May be completed at a later time by personnel other than the MICN/MD initially contacted

Uses

- Patient identification
- Link between other databases

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ED Records
- Other hospital records

APPENDIX

REQUIRED DATA FIELDS FOR ALL BASE HOSPITAL CONTACTS

Gen Info:

- Log and Sequence #
- Date and Time of Call
- Provider Code and Unit #
- Age, Age Units, and Sex of Patient
- Pediatric Weight (in kilograms, from length-based tape)
- Pediatric Weight Color Code
- Hospital Code of base handling the run
- Communication and Call Type
- Location

Assessment:

- Provider Impression
- Chief Complaint
- Severity of Distress

Physical:

- LOC/GCS
- mLAPSS (if CC=LN, PI=STRK, or actual destination =PSC or CSC for suspected stroke)
- Last Known Well Date/Time (if mLAPSS met = Y, or if patient was transported to a PSC or CSC for suspected stroke)
- LAMS Score (if mLAPSS met=Y)
- Adv Airway (if advanced airway placed): BS after ETT/King, and CO_2 Detection, if applicable

ECG/Arrest:

- Initial Rhythm (for all patients placed on a cardiac monitor or on whom a 12-lead is performed)
- Interpretation (for all patients on whom a 12-lead is performed)
- For all 12-lead ECGs with an interpretation of “STEMI”
    - 12-lead time
    - Artifact?
    - Wavy Baseline?
    - Paced Rhythm?
- For all patients with a chief complaint of “CA” or provider impression of “CANT”
    - Initial Rhythm
    - Witnessed by
    - CPR by
    - Arrest to CPR (if arrest is witnessed)
    - Rtn of Pulse (ROSC)?
    - Rtn of Pulse (ROSC) @ (if patient has return of pulses)
    - Resus D/C Rhythm (if resuscitative measures are discontinued or patient is pronounced)
    - Total Min. EMS CPR (if resuscitative measures are discontinued or patient is pronounced)
    - Resuscitation D/C’d @ (if resuscitative measures are discontinued or patient is pronounced)

Vitals/TXs:

- Intravenous Access
- Medications ordered (name) and PRN, if applicable

Trauma:

- Trauma Complaint
- Mechanism of Injury
    - Includes PSI, 12” or 18” if applicable

Transport:

- Destination options (MAR, TC, etc.)
- Actual transport destination (if patient was transported)
- Check One
- Pt Transported Via
- Destination Rationale (if applicable)
- Reason For No Transport (if patient was not transported)

Dispo:

- Time Clear
- Time Receiving Hospital Notified (for all patients transported to a receiving facility other than the base hospital)
- ED Diagnosis (if the base is the receiving facility)
- Patient Disposition (if the base is the receiving facility)

Signature:

- MICN # (if MICN handled the call)
- Physician # (if the physician handled the call or was consulted by the MICN)

REQUIRED DATA FIELDS FOR ALL SFTP CALLS (Prior to EMS UPDATE 2018 Training)

Gen Info:

- Log and Sequence #
- Date and Time of Call
- Provider Code and Unit Number
- Age, Age Units, and Sex
- Pediatric Weight (in kilograms, from length-based tape) and Color Code
- Hospital Code of base handling run
- Communication and Call Type
- Location

Assessment:

- Provider Impression
- Chief Complaint
- Severity of Distress
- Protocol Used

Physical:

- GCS (for Protocol 1243)
- mLAPSS, Last Known Well Date/Time, LAMS Score (for Protocol 1251)

ECG/Arrest (for Protocol 1244)

- Initial Rhythm and Interpretation
- For all 12-lead ECGs with an interpretation of “STEMI”
    - 12-lead time
    - Artifact?
    - Wavy Baseline?
    - Paced Rhythm?
- ROSC? and ROSC@ (for Protocol 1210, if applicable)

Vitals/TXs:

- Glucometer (for Protocol 1251)

Trauma:

- Trauma Complaint
- Mechanism of Injury
- If patient was transported to a trauma center for criteria/guidelines/judgment:
    - Complete vital signs
    - GCS

Transport:

- Actual Transport Destination (if patient was transported)
- Check One
- Pt Transported Via
- Destination Rationale (if applicable)
- Reason For No Transport (if patient was not transported)

Dispo:

- Time Clear
- Time Receiving Hospital Notified (for all patients transported to a receiving facility other than the base hospital)
- ED Diagnosis (if the base is the receiving facility)
- Patient Disposition (if the base is the receiving facility)

Signature

- MICN # (if the MICN handled the call)
- Physician # (if the physician handled the call or was consulted by the MICN)

REQUIRED DATA FIELDS FOR ALL NOTIFICATION CALLS
(After EMS UPDATE 2018 Training)

Gen Info:

- Log and Sequence #
- Date and Time of Call
- Provider Code and Unit #
- Age, Age Units, and Sex of Patient

Assessment:

- Provider Impression

Dispo:

- ED Diagnosis
- Patient Disposition

BASE HOSPITAL COMMUNICATIONS EQUIPMENT

I. BASE HOSPITAL LEGACY COMMUNICATIONS EQUIPMENT

A. The following list describes the minimum equipment requirements involved in the Hospital's portion of the Emergency Medical Services Communications System (EMSCS).

1. MED 1-8 RADIO STATIONS

a. Radio Equipment

i. 2 each – Transceiver, 4-channel, transmitter output adjustable between 20-45 watts, with CTCSS and “AND” squelch

ii. 2 Duplexer

iii. 2 each – Antenna, Omni-directional, vertically polarized, typically 5.0 dB gain

iv. 2 each – Hardware Kit, Antenna Mounting

v. 2 each – Coaxial cable, (5/8 hardline type) low-lost at UHF, including connection, etc. (maximum length – approx. 100ft)

2. Radio Transmitter Power – Power output of each MED 1-8 transmitter shall be adjusted for 20 watts to appear at the base of the antenna.

B. MED 9 RADIO STATION

1. Radio Equipment

a. 1 each – Transceiver, Single-Channel, transmitter output adjustable between 20-45 watts, with CTCSS and “AND” squelch

b. 1 each – Duplexer

c. 1 each – Coaxial cables (5/8 hardline type) low-loss at UHF, including connectors, etc. (maximum length – approx. 100ft)

d. 1 each Antenna, Omni-directional, vertically polarized, typically 5.0 dB gain

e. 1 lot Hardware Kit, Antenna Mounting

2. Radio Transmitter Power

   Power output on the MED 9 transmitter shall be adjusted for 20 watts to appear at base of antenna.

C. The Contractor shall maintain its base hospital legacy communications equipment until such time the radio portions of the EMCS is sufficiently transitioned to LARICS. This transition is anticipated to be completed in 2022.

II. LARICS Compatible Base Hospital Communications Equipment

The transition from the legacy system to LARICS will involve the following:

A. The County will identify Trauma Centers to serve as regional paramedic radio equipped base hospitals based on geographic location and system reliability.

B. These Trauma Centers shall serve as the regional back-up paramedic communications in the event of cellular communication failure.

C. These Trauma Centers will be subsidized by the County through the Trauma Center Services Agreement.

REMOTE BASE STATION RADIO SITES

	REMOTE POINT	ASSIGNMENT	FROM	BASE HOSPITAL	SOURCE	SUBSCRIBER	ACTIVE
1	BLACK JACK, DEACON PEAK, TOWER PEAK	MED 1-4	LOMITA SHERIFF	TORRANCE MEMORIAL MEDICAL CENTER	LEASED LINE	LEASED LINE TORRANCE MEMORIAL MEDICAL CENTER	YES
2	RIO HONDO MICROWAVE	MED 1-4	SAN DIMAS SHERIFF	POMONA VALLEY HOSPITAL MEDICAL CENTER	LACO MICROWAVE	LEASED LINE POMONA VALLEY HOSPITAL MEDICAL CENTER	YES
		MED 5-8	SAN DIMAS SHERIFF	POMONA VALLEY HOSPITAL MEDICAL CENTER	LACO MICROWAVE	LEASED LINE POMONA VALLEY HOSPITAL MEDICAL CENTER	YES
		MED 9	SAN DIMAS SHERIFF	POMONA VALLEY HOSPITAL MEDICAL CENTER	LACO MICROWAVE	LEASED LINE POMONA VALLEY HOSPITAL MEDICAL CENTER	
3	THE COUNTRY	MED 5-8	POINT	POMONA VALLEY HOSPITAL MEDICAL CENTER	LEASED LINE	LEASED LINE	YES
4	HAUSER PEAK	MED9 #970 MED 7a		HENRY MAYO NEWHALL			
5	OAT MOUNTAIN	MED 4a MED 5A		HENRY MAYO NEWHALL			
6	BALD MOUNTAIN	MED 4A #810		HENRY MAYO NEWHALL			
7	VERDUGO HILLS HOSPITAL	MED2A #92		HUNTINGTON MEMORIAL			
8	PASADENA CITY COLLEGE	MED 9v, MED 5v		HUNTINGTON MEMORIAL			
9	BEACH CITIES, HARBOR MASTER	MED 9 #860 MED-1Dv		LITTLE COMPANY OF MARY			

	REMOTE POINT	ASSIGNMENT	FROM	BASE HOSPITAL	SOURCE	SUBSCRIBER	ACTIVE
10	BLACKJACK MOUNTAIN	MED 6D #160		LITTLE COMPANY OF MARY			
11	LITTLE COMPANY OF MARY - SAN PEDRO	MED 9#190 MED 4E MED 8E		LITTLE COMPANY OF MARY			
12	SAN PEDRO HILL	MED 9#960 MED 8E		LITTLE COMPANY OF MARY			
13	VAN NUYS COURT	MED 8A		NORTHRIDGE HOSPITAL MEDICAL CENTER			
14	DIAMOND BAR	MED5A #250 OR #680		POMONA VALLEY HOSPITAL MEDICAL CENTER			
15	JOHNSTONE	MED 5A #250		POMONA VALLEY HOSPITAL MEDICAL CENTER			
16	LONG BEACH COMMUNITY HOSPITAL	MED 7Ev		ST MARY MEDICAL CENTER			
17	LAKEWOOD REGIONAL	MED 7Ev		ST MARY MEDICAL CENTER			
18	SIGNAL HILL	MED 7Ev		ST MARY MEDICAL CENTER			
19	HOLLYWOOD PRESBYTERIAN	MED 9 #750 MED 7C #750		LAC+USC MEDICAL CENTER			

COMMUNICATIONS EQUIPMENT MAINTENANCE STANDARDS

I. Radio station room, antenna structure and control lines

A. Radio Station Room

1. Radio equipment shelter (with sufficient space to install three (3) radio stations). Not required if the Hospital has suitable existing facility to house radio station equipment on roof or top floor of Hospital's tallest building.

2. One (1) each Power Distribution Panel (wired to hospital's emergency A.C. power as well as commercial power)

3. Five (5) each A.C. Power Outlets near radio stations and connected to Item No. 2 above

One (1) lot - Hardware Kit, Antenna Mounting

B. Antenna Structure

One (1) each Tower, antenna, up to sixty (60) ft. or other structure suitable for antenna mounting (installed near radio station room)

C. Radio Control Lines

At least four (4) sets of 4 wire circuits - one (1) set per transceiver and one (1) spare set must be installed by hospital from terminal block(s) in the radio station room termination points close to the control consoles.

D. Control Consoles and Paramedic Telephones

1. Location in the Emergency Department

2. Console Equipment

a. One (1) each - Hospital Coordination Console (HCC) per Specification No. 1928, or other suitable tone/remote control console with DTMF decoder

b. Two (2) each - Medical Communications Console per Revised. Specification No. 1927

Above items (a and b) can be a single equipment instead of two (2), if provision is made for control of both MED 1-8 transceivers from the single console. Provision must also be made for connection of both paramedic emergency telephones to the single console. The Console must provide means to log all traffic via radio channels and telephone calls to the console. The recording medium must be of archival quality. It is recommended that, unless space considerations for the consoles are the Hospital's primary concern, two MCTC's be installed.

E. Power Outlets

At least eight (8) A.C. power outlets shall be provided. Outlets must be connected to Hospital's emergency power system as well as commercial power.

F. Paramedic Emergency Telephones

Two (2) telephones with telephone lines shall be dedicated for paramedic/hospital communications.

G. Maintenance and Trouble Call Reporting

1. Purpose: To provide preventive and ongoing maintenance and/or repair for PCS Equipment.

2. Responsibilities of Hospital:

a. Provide the local EMS Agency with evidence of twenty-four (24) hours per day, seven (7) days per week maintenance and repair service for radio and system equipment.

b. Report problems to the Internal Services Department.

c. Perform or cause to be performed the following preventive maintenance:

(1) Quarterly:

Systems check to include:

a. console functions and operation;

b. Transmit and receive test of all frequencies.

c. Clean and service base hospital recording system.

(2) Annually:

a. FCC frequency and deviation test for all radios;

b. Visual inspection of the antenna structures;

c. Solicit report from assigned field provider units about any chronic communication problems to include but not be limited to field equipment, dead space, radio failure and co-channel interference, and submit a written report to the local EMS Agency about such problems.

LOS ANGELES COUNTY EMS AGENCY

BASE HOSPITAL RADIO CHANNEL ASSIGNMENTS / PARAMEDIC TELEPHONE NUMBERS

BASE HOSPITAL	HAILING CHANNEL	SITES	BASE TRANSMIT PRIMARY	BASE RECEIVE PRIMARY	BASE TRANSMIT SECONDARY	BASE RECEIVE SECONDARY	TELEPHONE LANDLINE
Antelope Valley Hospital (AVH)	#760 on 9A	local	463.150 A	468.150 A	463.025 A	468.025 A	(661) 723-7169
		Hauser	463.150 A	468.150 A	463.025 A	468.025 A	
California Hospital Medical Center (CAL)	#62 on 9A	local	463.100 C	468.100 C	463.025 C	468.025 C	(213) 765-9519
	#37 on 9A	MLK	463.175 D	468.175 D	463.150 D	468.150 D	
Cedars-Sinai Medical Center (CSM)	#94 on 9A	local	463.000 B	468.000 B	463.125 B	468.125 B	(310) 657-0662 (310) 657-0663
Glendale Adventist Medical Center (GWT)	#17 on 9A	local	463.125 C	468.125 C			(818) 247-1532 (818) 247-1533
Harbor/UCLA Medical Center (HGH)	#64 on 9A	local	463.075 D	468.075 D	463.150 D	468.150 D	(310) 328-1800
		Baldwin Hills	463.050 B	468.050 B	463.150 B	468.150 B	(310) 328-1801
		Gardena	462.975 A	467.975 A			
Henry Mayo Newhall Memorial Hospital (HMN)	#81 on 9A #81 on 4A	local	463.075 A	468.075 A	463.100 A	468.100 A	(805) 255-2730
		Bald Mtn	463.075 A	468.075 A			(805) 259-2731
		Oat Mtn	463.075 A	468.075 A	463.100 A	468.100 A	(805) 259-3061
Providence Holy Cross Medical Center (HCH)	#42 on 9A	local	463.125 A	468.125 A	463.025 A	468.025 A	(818) 361-7341 (818) 361-7342
Huntington Memorial Hospital (HMH)	#92 on 9A	local	463.100 F	468.100 F	463.050 F	468.050 F	(626) 397-8026
	#92 on 2A	Verdugo Hills Hosp	463.025 A	468.025 A			(626) 397-8027
	9A	PCC	463.100 F	468.100 F			(626) 397-8028
LAC/USC Medical Center (USC)	#28 on 9A	local	463.075 C	468.075 C	463.125 C	468.125 C	(323) 441-7222
	#75 on 7C	Vermont	463.050 C	468.050 C	463.150 C	468.150 C	
Providence Little Company of Mary Hospital (LCM)	#16 on 9A	local	463.125 D	468.125 D	463.025 D	468.025 D	(310) 540-7180
	9A #86 1D	Beach Cities Hosp	463.000 D	468.000 D			~~(310) 540-1009~~
	#16 on 6D	Blackjack	463.125 D	468.125 D			(310) 316-8576
	#19 on 9A	S. P. Peninsula Hosp	463.175 E	468.175 E	463.075 E	468.075 E	(310) 316-8436
	#96 on 9A	S. Pedro Hill	463.175 E	468.175 E			

LOS ANGELES COUNTY EMS AGENCY

BASE HOSPITAL RADIO CHANNEL ASSIGNMENTS / PARAMEDIC TELEPHONE NUMBERS

BASE HOSPITAL	HAILING CHANNEL	SITES	BASE TRANSMIT PRIMARY	BASE RECEIVE PRIMARY	BASE TRANSMIT SECONDARY	BASE RECEIVE SECONDARY	TELEPHONE LANDLINE
Long Beach Memorial Medical Center (LBM)	#60 on 9A #61 on 9A	local Rio Hondo	463.100 D 463.125 F	468.100 D 468.125 F	463.025 D 463.000 F	468.025 D 468.000 F	(562) 933-1400 (562) 427-1176
Methodist Hospital of Southern California (AMH)	#49 on 9A	local	463.175 F	468.175 F	463.050 F	468.050 F	(626) 445-4481 (626) 445-4417 (626) 445-6470
Northridge Hospital Medical Center (NRH)	#29 on 9A	local	463.000 A	468.000 A	463.175 A	468.175 A	(818) 885-9888
		Van Nuys	463.175 A	468.175 A			(818) 885-9889
Pomona Valley Hospital Medical Center (PVC)	#25 on 9A	local	463.150 F	468.150 F	463.025 F	468.025 F	(909) 623-6561
	#25 on 5A	Johnstone	463.100 A	468.100 A			(909) 623-6562
	#25 or #68 on 5A	Diamond Bar	463.100 A	468.100 A			
Presbyterian Intercommunity Hospital (PIH)	#84 on 9A	local	463.050 E	468.050 E	463.175 E	468.175 E	(310) 945-6539 (310) 945-6530
Citrus Valley Medical Center-Queen of the Valley Campus (QOA)	#18 on 9A	local	463.075 F	468.075 F			(626) 338-1183 (626) 338-1184
St. Francis Medical Center (SFM)	#53 on 9A	local	463.000 E	468.000 E	463.175 E	468.175 E	(310) 603-2511
		Downey Hosp	463.025 E	468.025 E			(310) 603-2511 (310) 603-2511
Providence St. Joseph Medical Center (SJS)	#35 on 9A	local	463.100 A	468.100 A	463.050 A	468.050 A	(818) 841-3644 (818) 841-3673
St. Mary Medical Center (SMM)	#35 on 7E, #35 on 9A	local	463.150 E	468.150 E	463.075 E	468.075 E	(562) 432-0517
	#35 on 7E	LB Com. Hosp.	463.150 E	468.150 E			(562) 435-2833
	#35 on 7E	Lakewood Reg Hosp	463.150 E	468.150 E			
	#35 on 7E	Reservoir Hill	463.150 E	468.150 E			
Torrance Memorial Medical Center (TOR)	#79 on 9A	local	462.975 D	467.975 D	463.050 A	468.050 A	(310) 530-7631
	#79 on 3A	Blackjack	463.050 A	468.050 A			
Ronald Reagan UCLA Medical Center (UCL)							(310) 208-5387

PARAMEDIC COMMUNICATIONS SYSTEM TROUBLE CONTROL PROCEDURES

1. The Paramedic Communications System

   A. The paramedic communications system, as it exists now, consists of the following items requiring Internal Services Department (ISD) maintenance.

      LAC+USC Medical Center, Harbor-UCLA Medical Center: each of the two (2) County hospitals has three (3) base stations, MED 1-4, MED 5-8, MED 9, two (2) hot line telephones for incoming paramedic calls; one (1) VMED28 (formerly H.E.A.R.) radio, sometimes used by paramedics.

   B. The non-County hospital or its consultant is responsible for maintenance of leased lines between the hospital and the base station location or the entry to the County microwave system unless noted. ISD involvement on leased lines is to provide access to County sites and work with the TELCO concerned as necessary to resolve the problem. When the Service Provider/Consultant determines that the fault is at the County site or equipment past their control, the fault will be reported to the Dispatcher (See Exhibit D.1).

2. Maintenance Control: Maintenance control revolves on the County ISD Dispatcher, who will act as the single point of contact between the entity requesting repair or maintenance and the maintenance personnel. After normal business hours, the Dispatcher may be reached at Emergency after hours (562) 922-0611 or Dispatch (562) 401-9349. Maintenance itself will be accomplished by personnel of the Microwave Maintenance Division, Radio Field Services, Antelope Valley Shop, and may require the involvement of third party Maintenance Service or other disciplines within ISD. Maintenance personnel may call the person requesting the repair for clarification of information provided by the Dispatcher, or if joint effort is required, to arrange for the parties to meet or communicate.

   A. Routine Procedures – County Hospitals: The following procedures are guidelines to be used for controlling and resolving trouble reports:

      (1) The Dispatcher will be notified of a problem by either hospital personnel or maintenance shop personnel.

      (2) The Dispatcher requires the following information:

         (a) description of the problem;

         (b) classification of the problem: e.g., phone line, microwave circuit, console, logging recorder or radio;

         (c) caller's name;

         (d) caller's telephone number;

(e) the address and room number where the problem exists; and

(f) if the problem was reported outside normal working hours, or late in the business day, ask whether or not work may be delayed until the next normal business day. (Normal County maintenance working days are from 7:30 A.M. to 4:00 P.M., Monday through Friday.)

(3) The Dispatcher will assign a number to the trouble call.

(4) The Dispatcher will log the call and prepare a trouble ticket by entering the trouble number and will time stamp the trouble ticket.

(5) The Dispatcher will notify the appropriate maintenance personnel immediately, providing the trouble number and available details. When it cannot be determined which shop may be responsible for non-County hospital problems, the Field Services shop will be notified. During regular working hours, trouble calls will be provided to the maintenance shop concerned. When the shop is closed or after normal working hours, appropriate maintenance personnel will be called at their homes, unless it has been determined by the calling party that work may be held in abeyance until the next regular business day.

(6) The Dispatcher will log the time and to whom the call was given on the daily log.

(7) The Dispatcher will time stamp the trouble ticket and write the name of the person who took the call in the maintenance shop.

(8) When repair has been completed, the technician will contact the person who reported the problem and ask them to test the system. If that person informs the technician that the problem has been cleared, the technician will notify the Dispatcher of that fact.

(9) When the Dispatcher is notified that the trouble has been resolved, the dispatcher will so note on the log along with who reported the trouble resolved.

(10) The Dispatcher will then time stamp the trouble ticket.

(11) The Dispatcher will call the person reporting the trouble to confirm that the trouble has been cleared.

(12) If maintenance has determined that the problem at a County hospital is a leased line problem, this shall be reported to the Dispatcher with circuit information. The Dispatcher will take action with the appropriate TELCO.

(13) When TELCO reports the problem has been cleared, the Dispatcher will so notify the person making the trouble report.

B. Non-County Hospitals: The following procedures are guidelines to be used for controlling and resolving trouble reports:

(1) The Dispatcher will be notified of a problem by either a consultant or if at a hospital, hospital personnel or maintenance shop personnel, as designated by their agreement with the consultant.

(2) The ISD Dispatcher requires the following information:

(a) description of the problem;

(b) classification of the problem: e.g., definitely a remote County site problem, no radio control, noisy receiver;

(c) caller's name;

(d) caller's telephone number;

(e) the address and room number where the problem exists; and

(f) if the problem was reported outside normal working hours, or if late in the business day, ask whether or not work may be delayed until the next normal business day.

(3) The Dispatcher will assign a number to the trouble call.

(4) The Dispatcher will log the call and prepare a trouble ticket by entering the trouble number and will time stamp the trouble ticket.

(5) The Dispatcher will notify the appropriate maintenance personnel immediately, providing the trouble number and available details. When it cannot be determined which shop may be responsible for non-County hospital problems, the Field Services shop will be notified. During regular working hours, trouble calls will be provided to the maintenance shop concerned. When the shop is closed or after normal working hours, appropriate maintenance personnel will be called at their homes, unless it has been determined by the calling party that work may be held in abeyance until the next regular business day. In such case, the call will be made to the shop at 7:30 A.M. on the next business day.

(6) The Dispatcher will log the time and to whom the call was given, on the daily log.

(7) The Dispatcher will time stamp the trouble ticket and write the name of the person who took the call in the maintenance shop.

(8) When repair has been completed, the technician will contact the person who reported the problem and ask them to test the system. If that person informs the technician that the problem has been cleared, the technician will notify the Dispatcher of that fact.

(9) When the Dispatcher is notified that the trouble has been resolved, the Dispatcher will so note on the log along with who reported the trouble resolved.

(10) The Dispatcher will then time stamp the trouble ticket.

(11) The Dispatcher will call the person reporting the trouble to confirm that the trouble has been cleared.

(12) If maintenance has determined that the problem is a leased line problem, this shall be reported to the Dispatcher (with circuit information). The Dispatcher will so inform the person reporting the problem and request that the person report back.

(13) If the private agency calls back indicating that the trouble was a leased line problem, and that it has been cleared, the Dispatcher will note that on the trouble ticket, time stamp it and close it.

(14) If the private agency calls back indicating that the trouble is not a leased line problem, the Dispatcher will reopen the trouble ticket and reinitiate the maintenance procedure. See Paragraph 2 above.

Escalation Procedure

C. Dispatch Actions: In the event that the trouble has not been cleared up by 3:00 P.M., on normal business days, the Dispatcher shall do the following:

(1) Call the appropriate maintenance shop for a follow-up report on the trouble.

(2) If the trouble will be carried over to the next business day, note that fact, the time and the name of the supervisor authorizing the carry over on the trouble ticket. These tickets will be placed in the carry-over slot.

(3) If work will continue until resolution of the problem, note the name of the technician assigned on the trouble ticket. These tickets will be passed on to each succeeding shift until closed out.

(4) If work in progress has not been resolved by 7:30 A.M. the next working day, the appropriate maintenance shop will be called requesting new completion times on these trouble calls.

(5) After logging the time, name of shop contact and status of actions taken, call the person reporting the trouble and provide a status

report.

D. Escalation:

(1) After 24 hours have elapsed with no report of problem resolution, the Dispatcher will call the section head of the maintenance shop involved and report that fact. This information, the section head's response and the time will be logged and entered on the trouble ticket. The person reporting the problem will be called and apprised of the status of work on their problem.

(2) After 48 hours have elapsed with no report of problem resolution, the Dispatcher will call the maintenance Division Chief concerned, requesting problem resolution. The person reporting the trouble and the Department of Health Services, EMS Division, will be called and given the status of actions taken, including the fact that the problem has escalated to the Division Chief. The DHS representative will be given the name and telephone number of the Division Chief.

(3) After 72 hours have elapsed with report of problem resolution, the Dispatcher will call the Branch Manager notifying them of the problem and the fact that 72 hours have elapsed since the problem was first reported. This information will be logged by the Dispatcher. The person reporting the problem and the Department of Health Services, EMS Division, will be called and given the status if action taken, including the fact that the problem has been escalated to the Branch Manager. When the Division Chief or Branch Manager provides the Dispatcher with the status of the delayed repair action, the Dispatcher will note the status, who called, and the time in the log and will inform the person reporting the problem and DHS of the status of actions.

ISD TELEPHONE NUMBERS FOR MAINTENANCE SUPPORT

ISD DISPATCH 24/7 (562) 401-9349

ATTACHMENT 14

PROCEDURE FOR NON-COMPLIANCE WITH DATA COLLECTION REQUIREMENTS

Month	Action 1	Audit Result	Action 2
1st	Contractor starts Base Hospital Form submission and electronic data entry of paramedic base hospital contacts occurring in the 1st month.		
2nd	Contractor starts Base Hospital Form submission and electronic data entry of paramedic base hospital contacts occurring in the 2nd month.		
3rd	EMS Agency reviews Contractor's 1st month data compliance	Contractor does not meet 90% compliance in: 1. Submitting Base Hospital Forms within sixty (60) calendar days of incident, or 2. Submitting required data under County's automated data collection system within forty-five (45) calendar days following an incident, or 3. Submitting accurate and valid data on all mandatory data fields.	EMS Agency notifies Contractor's Prehospital Care Coordinator, via email or telephone, of audit results, requests corrective action plan and assists in determining solutions.
4th	EMS Agency reviews Contractor's 2nd month data compliance	No significant improvement Significant Improvement	EMS Agency sends a written notice to Contractor notifying of audit results and continued non-compliance. Monitor
5th	EMS Agency reviews Contractor's 3rd month data compliance	No significant improvement Significant Improvement	EMS Agency notifies Contractor's Prehospital Care Coordinator in writing of audit results and request to submit within 15 calendar days a plan to correct deficiency. Monitor
6th	EMS Agency reviews Contractor's 4th month data compliance	No significant improvement Significant improvement	Within 15 days of County's receipt of Contractor's plan, the County will provide Contractor a written approval or request additional modifications to Contractor's plan. Monitor

Month	Action 1	Audit Result	Action 2
7th	EMS Agency reviews Contractor's 5th month data compliance	No significant improvement Significant improvement	County will notify Contractor CEO in writing of continued non-compliance and advise that a penalty will be assessed if compliance is not improved. Monitor
8th	EMS Agency reviews Contractor's 6th month data compliance	No significant improvement Improvement based on approved corrective action plan	County will assess $2,600 penalty for non-compliance Monitor
9th	EMS Agency reviews Contractor's 7th month data compliance	No significant improvement Improvement based on approved corrective action plan	Still non-compliant Monitor
10th	EMS Agency reviews Contractor's 8th month data compliance	No significant improvement Improvement based on approved corrective action plan	Still non-compliant Monitor
11th	EMS Agency reviews Contractor's 9th month data compliance	No significant improvement Improvement based on approved corrective action plan	County will assess additional $1,300 penalty for non-compliance Monitor
12th	EMS Agency reviews Contractor's 10th month data compliance	No significant improvement Improvement based on approved corrective action plan	Still non-compliant Monitor
13th	EMS Agency reviews Contractor's 11th month data compliance	No significant improvement Improvement based on approved corrective action plan	Still non-compliant Monitor
14th	EMS Agency reviews Contractors 12th month data compliance	No significant improvement Improvement based on approved corrective action plan	County will assess additional $1,300 penalty for non-compliance Monitor two additional months of data. If two additional months of data show that Contractor remains non-compliant, Contractor will be evaluated for agreement termination.

INTENTIONALLY OMITTED

INTENTIONALLY OMITTED

EXHIBIT D

CONTRACTOR'S EEO CERTIFICATION

Pasadena Hospital Association, Ltd
Contractor Name

100 W. California Blvd, Pasadena, CA 91105
Address

95-1644036
Internal Revenue Service Employer Identification Number

GENERAL CERTIFICATION

In accordance with Section 4.32.010 of the Code of the County of Los Angeles, the contractor, supplier, or vendor certifies and agrees that all persons employed by such firm, its affiliates, subsidiaries, or holding companies are and will be treated equally by the firm without regard to or because of race, religion, ancestry, national origin, or sex and in compliance with all anti-discrimination laws of the United States of America and the State of California

CONTRACTOR'S SPECIFIC CERTIFICATIONS

1.	The Contractor has a written policy statement prohibiting discrimination in all phases of employment.	Yes ☒	No ☐
2.	The Contractor periodically conducts a self analysis or utilization analysis of its work force.	Yes ☒	No ☐
3.	The Contractor has a system for determining if its employment practices are discriminatory against protected groups.	Yes ☒	No ☐
4.	Where problem areas are identified in employment practices, the Contractor has a system for taking reasonable corrective action, to include establishment of goals or timetables	Yes ☒	No ☐

Steven Mah, Chief Financial Officer
Authorized Official's Printed Name and Title

REDACTED
Authorized Official's Signature

6/30/19
Date

EXHIBIT E

COUNTY'S ADMINISTRATION

MASTER AGREEMENT NO. H-708207

FACILITY MASTER AGREEMENT PROJECT DIRECTOR (MAPD):

Name: Richard Tadeo

Title: Assistant Director

Address: 10100 Pioneer Blvd., Suite 200
Santa Fe Springs, CA 90670

Telephone: (562) 378-1610

Facsimile: (562) 941-5835

E-Mail Address: rtadeo@dhs.lacounty.gov

FACILITY PROJECT DIRECTOR:

Name: Christine Clare

Title: Chief, Hospital Programs

Address: 10100 Pioneer Blvd., Suite 200
Santa Fe Springs, CA 90670

Telephone: (562) 378-1661

Facsimile: (562) 946-6701

E-Mail Address: cclare@dhs.lacounty.gov

FACILITY PROJECT MANAGER:

Name: Lorrie Perez

Title: Base Coordinator

Address: 10100 Pioneer Blvd., Suite 200
Santa Fe Springs, CA 90670

Telephone: (562) 378-1655

Facsimile: (562) 946-6701

E-Mail Address: LLPerez@dhs.lacounty.gov

EXHIBIT F

CONTRACTOR'S ADMINISTRATION

Pasadena Hospital Association, ltd
CONTRACTOR'S NAME

MASTER AGREEMENT NO. H-708207

CONTRACTOR'S PROJECT DIRECTOR: Name: Jenny Van Slyke
Title: Prehospital Care Coordinator
Address: 100 W. California Blvd.
Pasadena, CA 91105
Telephone: 626-397-8482
Facsimile: 626-397-2981
E-Mail Address: jenny.vanslyke@huntingtonhospital.com

CONTRACTOR'S AUTHORIZED OFFICIAL(S)
Name: Karen Knudsen
Title: Emergency Department Manager
Address: 100 W. California Blvd.
Pasadena, CA 91105
Telephone: 626-397-3872
Facsimile: 626-397-9281
E-Mail Address: Karen.Knudsen@huntingtonhospital.com

Name: Alisan Birnie
Title: Clinical Director, ED/Trauma/CCU/DOU/DMC
Address: 100 W. California Blvd
Pasadena, CA 91105
Telephone: 626-397-5105
Facsimile: 626-397-9281
E-Mail Address: alisan.birnie@huntingtonhospital.com

Notices to Contractor shall be sent to the following address:

Name: Dr. Lori Morgan, MD, MBA
Title: President and CEO
Address: 100 W. California Blvd
Pasadena, CA 91105
Telephone: 626-397-5555
Facsimile: 626-397-2995
E-Mail Address: lori.morgan@huntingtonhospital.com

FORMS REQUIRED AT THE TIME OF MASTER AGREEMENT EXECUTION

G1 CONTRACTOR ACKNOWLEDGEMENT AND CONFIDENTIALITY AGREEMENT

EXHIBIT G1

(Note: This certification is to be executed and returned to County with Contractor's Master Agreement.)

Contractor Name Pasadena Hospital Association, Ltd

County Master Agreement No. H-706207

GENERAL INFORMATION:

The Contractor referenced above has entered into a Master Agreement with the County of Los Angeles to provide certain services to the County. The County requires the Corporation to sign this Contractor Acknowledgement and Confidentiality Agreement.

CONTRACTOR ACKNOWLEDGEMENT:

Contractor understands and agrees that the Contractor employees, consultants, Outsourced Vendors and independent contractors (Contractor's Staff) that will provide services in the above referenced agreement are Contractor's sole responsibility. Contractor understands and agrees that Contractor's Staff must rely exclusively upon Contractor for payment of salary and any and all other benefits payable by virtue of Contractor's Staff's performance of work under the above-referenced Master Agreement.

Contractor understands and agrees that Contractor's Staff are not employees of the County of Los Angeles for any purpose whatsoever and that Contractor's Staff do not have and will not acquire any rights or benefits of any kind from the County of Los Angeles by virtue of performance of work under the above-referenced Master Agreement. Contractor understands and agrees that Contractor's Staff will not acquire any rights or benefits from the County of Los Angeles pursuant to any agreement between any person or entity and the County of Los Angeles.

CONFIDENTIALITY AGREEMENT:

Contractor and Contractor's Staff may be involved with work pertaining to services provided by the County of Los Angeles and, if so, Contractor and Contractor's Staff may have access to confidential data and information pertaining to persons and/or entities receiving services from the County. In addition, Contractor and Contractor's Staff may also have access to proprietary information supplied by other vendors doing business with the County of Los Angeles. The County has a legal obligation to protect all such confidential data and information in its possession, especially data and information concerning health, criminal, and welfare recipient records. Contractor and Contractor's Staff understand that if they are involved in County work, the County must ensure that Contractor and Contractor's Staff, will protect the confidentiality of such data and information. Consequently, Contractor must sign this Confidentiality Agreement as a condition of work to be provided by Contractor's Staff for the County.

Contractor and Contractor's Staff hereby agrees that they will not divulge to any unauthorized person any data or information obtained while performing work pursuant to the above-referenced Master Agreement between Contractor and the County of Los Angeles. Contractor and Contractor's Staff agree to forward all requests for the release of any data or information received to County's Project Manager.

Contractor and Contractor's Staff agree to keep confidential all health, criminal, and welfare recipient records and all data and information pertaining to persons and/or entities receiving services from the County, design concepts, algorithms, programs, formats, documentation, Contractor proprietary information and all other original materials produced, created, or provided to Contractor and Contractor's Staff under the above-referenced Master Agreement. Contractor and Contractor's Staff agree to protect these confidential materials against disclosure to other than Contractor or County employees who have a need to know the information. Contractor and Contractor's Staff agree that if proprietary information supplied by other County vendors is provided during this employment, Contractor and Contractor's Staff shall keep such information confidential.

Contractor and Contractor's Staff agree to report any and all violations of this agreement by Contractor and Contractor's Staff and/or by any other person of whom Contractor and Contractor's Staff become aware.

Contractor and Contractor's Staff acknowledge that violation of this agreement may subject Contractor and Contractor's Staff to civil and/or criminal action and that the County of Los Angeles may seek all possible legal redress.

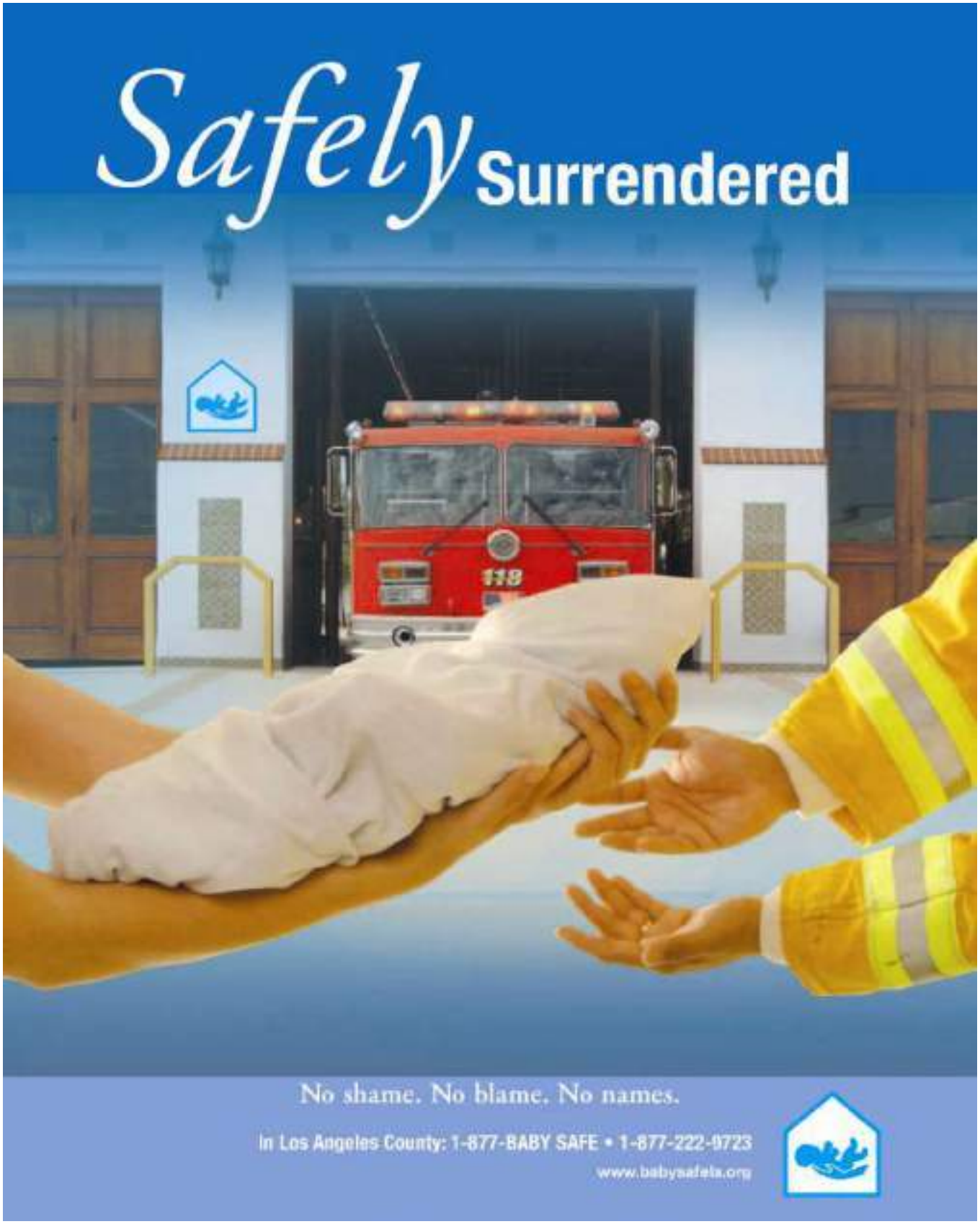
SIGNATURE: REDACTED

PRINTED NAME: Steven Mar

POSITION: Chief Financial Officer

DATE: 6/30/19

INTENTIONALLY OMITTED


Safely Surrendered
No shame. No blame. No names.
In Los Angeles County: 1-877-BABY SAFE • 1-877-222-9723
www.babysafela.org

Safely Surrendered Baby Law

In Los Angeles County: 1 877 BABY SAFE 1 877 222 9723
www.babysafela.org

What is the Safely Surrendered Baby Law?

California's Safely Surrendered Baby Law allows parents or other persons, with lawful custody, which means anyone to whom the parent has given permission to confidentially surrender a baby. As long as the baby is three days (72 hours) of age or younger and has not been abused or neglected, the baby may be surrendered without fear of arrest or prosecution.

How does it work?

A distressed parent who is unable or unwilling to care for a baby can legally, confidentially, and safely surrender a baby within three days (72 hours) of birth. The baby must be handed to an employee at a hospital or fire station in Los Angeles County. As long as the baby shows no sign of abuse or neglect, no name or other information is required. In case the parent changes his or her mind at a later date and wants the baby back, staff will use bracelets to help reconnect them to each other. One bracelet will be placed on the baby, and a matching bracelet will be given to the parent or other surrendering adult.

What if a parent wants the baby back?

Parents who change their minds can begin the process of reclaiming their baby within 14 days. These parents should call the Los Angeles County Department of Children and Family Services at **1-800-540-4000**.

Can only a parent bring in the baby?

No. While in most cases a parent will bring in the baby, the Law allows other people to bring in the baby if they have lawful custody.

Does the parent or surrendering adult have to call before bringing in the baby?

No. A parent or surrendering adult can bring in a baby anytime, 24 hours a day, 7 days a week, as long as the parent or surrendering adult surrenders the baby to someone who works at the hospital or fire station.

Does the parent or surrendering adult have to tell anything to the people taking the baby?

No. However, hospital or fire station personnel will ask the surrendering party to fill out a questionnaire designed to gather important medical history information, which is very useful in caring for the baby. The questionnaire includes a stamped return envelope and can be sent in at a later time.

What happens to the baby?

The baby will be examined and given medical treatment. Upon release from the hospital, social workers immediately place the baby in a safe and loving home and begin the adoption process.

What happens to the parent or surrendering adult?

Once the parent or surrendering adult surrenders the baby to hospital or fire station personnel, they may leave at any time.

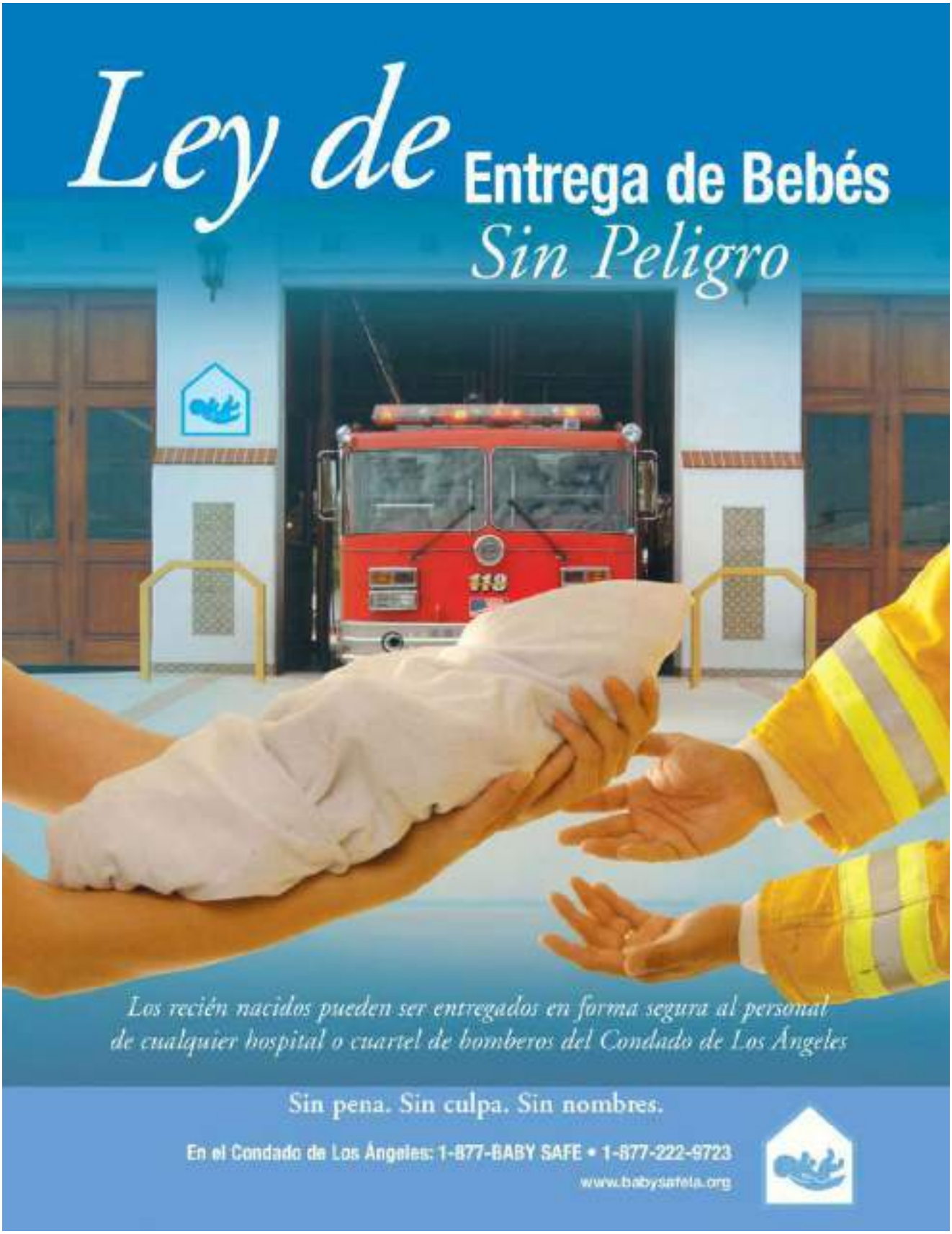
Why is California doing this?

The purpose of the **Safely Surrendered Baby Law** is to protect babies from being abandoned, hurt or killed by their parents. You may have heard tragic stories of babies left in dumpsters or public bathrooms. Their parents may have been under severe emotional distress. The mothers may have hidden their pregnancies, fearful of what would happen if their families found out. Because they were afraid and had no one or nowhere to turn for help, they abandoned their babies. Abandoning a baby is illegal and places the baby in extreme danger. Too often, it results in the baby's death. The **Safely Surrendered Baby Law** prevents this tragedy from ever happening again in California.

A baby's story



Early in the morning on April 9, 2005, a healthy baby boy was safely surrendered to nurses at Harbor-UCLA Medical Center. The woman who brought the baby to the hospital identified herself as the baby's aunt and stated the baby's mother had asked her to bring the baby to the hospital on her behalf. The aunt was given a bracelet with a number matching the anklet placed on the baby; this would provide some identification in the event the mother changed her mind about surrendering the baby and wished to reclaim the baby in the 14-day period allowed by the Law. The aunt was also provided with a medical questionnaire and told she would have the mother complete and mail back in the stamped return envelope provided. The baby was examined by medical staff and pronounced healthy and full-term. He was placed with a loving family that had been approved to adopt him by the Department of Children and Family Services.


Ley de Entrega de Bebés Sin Peligro
Los recién nacidos pueden ser entregados en forma segura al personal de cualquier hospital o cuartel de bomberos del Condado de Los Ángeles
Sin pena. Sin culpa. Sin nombres.
En el Condado de Los Angeles: 1-877-BABY SAFE • 1-877-222-9723
www.babysafela.org

Ley de Entrega de Bebés *Sin Peligro*

En el Condado de Los Ángeles: 1-877-BABY SAFE • 1-877-222-9723
www.babysafela.org

¿Qué es la Ley de Entrega de Bebés sin Peligro?

La Ley de Entrega de Bebés sin Peligro de California permite la entrega confidencial de un recién nacido por parte de sus padres u otras personas con custodia legal, es decir cualquier persona a quien los padres le hayan dado permiso. Siempre que el bebé tenga tres días (72 horas) de vida o menos, y no haya sufrido abuso ni negligencia, pueden entregar al recién nacido sin temer de ser arrestados o procesados.

Cada recién nacido se merece la oportunidad de tener una vida saludable. Si alguien que usted conoce está pensando en abandonar a un recién nacido, infórmele que tiene otras opciones. Hasta tres días (72 horas) después del nacimiento, se puede entregar un recién nacido al personal de cualquier hospital o cuartel de bomberos del condado de Los Angeles.

¿Cómo funciona?

El padre/madre con dificultades que no puede o no quiere cuidar de su recién nacido puede entregarlo en forma legal, confidencial y segura dentro de los tres días (72 horas) del nacimiento. El bebé debe ser entregado a un empleado de cualquier hospital o cuartel de bomberos del Condado de Los Ángeles. Siempre que el bebé no presente signos de abuso o negligencia, no será necesario suministrar nombres ni información alguna. Si el padre/madre cambia de opinión posteriormente y desea recuperar a su bebé, los trabajadores utilizarán brazaletes para poder vincularlos. El bebé llevará un brazalete y el padre/madre o el adulto que lo entregue recibirá un brazalete igual.

¿Qué pasa si el padre/madre desea recuperar a su bebé?

Los padres que cambien de opinión pueden comenzar el proceso de reclamar a su recién nacido dentro de los 14 días. Estos padres deberán llamar al Departamento de Servicios para Niños y Familias (Department of Children and Family Services) del Condado de Los Ángeles al 1-800-540-4000.

¿Sólo los padres podrán llevar al recién nacido?

No. Si bien en la mayoría de los casos son los padres los que llevan al bebé, la ley permite que otras personas lo hagan *si tienen custodia legal.*

¿Los padres o el adulto que entrega al bebé deben llamar antes de llevar al bebé?

No. El padre/madre o adulto puede llevar al bebé en cualquier momento, las 24 horas del día, los 7 días de la semana, siempre y cuando entreguen a su bebé a un empleado del hospital o cuartel de bomberos.

¿Es necesario que el padre/madre o adulto diga algo a las personas que reciben al bebé?

No. Sin embargo, el personal del hospital o cuartel de bomberos le pedirá a la persona que entregue al bebé que llene un cuestionario con la finalidad de recabar antecedentes médicos importantes, que resultan de gran utilidad para cuidar bien del bebé. El cuestionario incluye un sobre con el sello postal pagado para enviarlo en otro momento.

¿Qué pasará con el bebé?

El bebé será examinado y le brindarán atención médica. Cuando le den el alta del hospital, los trabajadores sociales inmediatamente ubicarán al bebé en un hogar seguro donde estará bien atendido, y se comenzará el proceso de adopción.

¿Qué pasará con el padre/madre o adulto que entregue al bebé?

Una vez que los padres o adulto hayan entregado al bebé al personal del hospital o cuartel de bomberos, pueden irse en cualquier momento.

¿Por qué se está haciendo esto en California? ?

La finalidad de la **Ley de Entrega de Bebés sin Peligro** es proteger a los bebés para que no sean abandonados, lastimados o muertos por sus padres. Usted probablemente haya escuchado historias trágicas sobre bebés abandonados en basureros o en baños públicos. Los padres de esos bebés probablemente hayan estado pasando por dificultades emocionales graves. Las madres pueden haber ocultado su embarazo, por temor a lo que pasaría si sus familias se enteraran. Abandonaron a sus bebés porque tenían miedo y no tenían nadie a quien pedir ayuda. El abandono de un recién nacido es ilegal y pone al bebé en una situación de peligro extremo. Muy a menudo el abandono provoca la muerte del bebé. La **Ley de Entrega de Bebés sin Peligro** impide que vuelva a suceder esta tragedia en California.

Historia de un bebé



A la mañana temprano del día 9 de abril de 2005, se entregó un recién nacido saludable a las enfermeras del Harbor-UCLA Medical Center. La mujer que llevó el recién nacido al hospital se dio a conocer como la tía del bebé, y dijo que la madre le había pedido que llevara al bebé al hospital en su nombre. Le entregaron a la tía un brazalete con un número que coincidía con la pulsera del bebé; esto serviría como identificación en caso de que la madre cambiara de opinión con respecto a la entrega del bebé y decidiera recuperarlo dentro del período de 14 días que permite esta ley. También le dieron a la tía un cuestionario médico, y ella dijo que la madre lo llenaría y lo enviaría de vuelta dentro del sobre con franqueo pagado que le habían dado. El personal médico examinó al bebé y se determinó que estaba saludable y a término. El bebé fue ubicado con una buena familia que ya había sido aprobada para adoptarlo por el Departamento de Servicios para Niños y Familias.

MASTER AGREEMENT FOR SPECIALTY CARE CENTER DESIGNATIONS

Amendment No. 1

THIS AMENDMENT is made and entered into this ___ day of _____, 20__,

By and between — COUNTY OF LOS ANGELES (hereafter "County").

And — PASADENA HOSPITAL ASSOCIATION, LTD. DBA HUNTINGTON HOSPITAL (hereafter "Contractor")

Business Address:

100 West California Boulevard
Pasadena, CA 91105

WHEREAS, reference is made to that certain document entitled "Specialty Care Center Designations Agreement," dated _____, and further identified as Agreement No.: _____, and any amendments and any other modifications thereto (all hereafter referred to as "Master Agreement"); and

WHEREAS, on June 11, 2019 the Board of Supervisors delegated authority to the Director of Health Services, or designee, to, among other delegations, execute amendments to the Master Agreement to add additional Specialty Care Center Designations; and

WHEREAS, it is the intent of the parties hereto to amend the Master Agreement to add a Specialty Care Center Designation, Hospital Preparedness Program, update certain terms and conditions, and to provide for other changes set forth herein; and

WHEREAS, the Agreement, Sub-paragraph 8.1 - Amendments provides that such changes may be made in the form of an Amendment which is formally approved and executed by the parties; and

WHEREAS, the Contractor warrants that it continues to possess the competence, expertise and personnel necessary to provide services consistent with the requirements of this Agreement and consistent with the professional standard of care for these services.

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

1. This Amendment shall be effective upon execution.

2. The Master Agreement is hereby incorporated by reference, and all of its terms and conditions, including capitalized terms defined herein, shall be given full force and effect as if fully set forth herein.

3. The Master Agreement, Paragraph 2.0-Definitions, is deleted in its entirety and replaced to read as follows:

"2.0 DEFINITIONS

2.1 **Contractor:** The sole proprietor, partnership, corporation, or public hospital or healthcare center that has entered into this Master Agreement with the County to obtain a Specialty Care Center Designation and comply with the respective designation's requirements, standards, protocols, perform or execute any performance requirements, and/or other tasks specified in the respective Specialty Care Center Designation in Exhibit A.

2.3 **Contractor's Project Manager:** The individual designated by Contractor, a healthcare facility or hospital, to administer the Master Agreement operations after the Master Agreement award.

2.4 **Day(s):** Calendar day(s) unless otherwise specified.

2.5 **DHS:** Los Angeles County Department of Health Services

2.6 **Director:** Los Angeles County Director of Health Services (acting, interim or permanent) or authorized designee.

2.7 **County's Project Director:** Person designated by County with authority for County on contractual or administrative matters relating to this Master Agreement that cannot be resolved by the County's Project Manager.

2.8 **County's Project Manager:** Person designated by County's Project Director to manage the operations under this Master Agreement

2.9 **County's Project Monitor:** Person with responsibility to oversee the day to day activities of this Master Agreement. Responsibility for inspections of any and all tasks, deliverables,

goods, services and other work provided by the healthcare facility or hospital.

2.10 **Fiscal Year:** The twelve (12) month period beginning July 1st and ending the following June 30th.

2.11 **Master Agreement:** This Agreement , including all Exhibits and Amendments thereto, as may be made from time to time, executed between County and Contractor, a healthcare facility or hospital. It sets forth the terms and conditions for the issuance and performance of the Specialty Care Center Designation in Exhibit A."

3. The Master Agreement, Paragraph **3.0-SPECIALTY CARE CENTER DESIGNATIONS,** Sub-paragraph 3.2 is deleted in its entirety and replaced to read as follows:

"3.2 If Contractor provides any tasks, deliverables, goods, services, or other work, other than as specified in this Master Agreement, the same shall be deemed to be a gratuitous effort on the part of the Contractor, and Contractor shall have no claim whatsoever against the County under this Master Agreement."

4. The Master Agreement, Paragraph **7.0 – ADMINISTRATION OF AGREEMENT-CONTRACTOR,** Sub-paragraph **7.6 – Confidentiality** is deleted in its entirety and replaced to read as follows:

"**7.6 Confidentiality**

7.6.1 Contractor shall maintain the confidentiality of all records and information, including, but not limited to, billings, the County records, and patient records, in accordance with all applicable Federal, State and local laws, rules, regulations, ordinances, directives, guidelines, policies and procedures relating to confidentiality, including, without limitation, County policies, of which Contractor has been provided concerning information technology security and the protection of confidential records and information.

7.6.2 Contractor shall indemnify, defend, and hold harmless County, its Special Districts, elected and appointed officers, employees, and agents, from and against any and all claims, demands, damages, defense costs and legal fines asserted by third parties from any material breach by Contractor, its officers, employees, agents, or subcontractors, to comply with this Sub-paragraph

7.6, as determined by County in its sole judgment. Any legal defense pursuant to Contractor's indemnification obligations under this Sub-paragraph 7.6 shall be conducted by Contractor and performed by counsel selected by Contractor and approved by County. Notwithstanding the preceding sentence, the County shall have the right to participate in any such defense at its sole cost and expense, except that in the event Contractor fails to provide the County with a full and adequate defense, as determined by County in its sole judgment, the County shall be entitled to retain its own counsel, including, without limitation, County Counsel, and reimbursement from Contractor for all such costs and expenses incurred by County in doing so. Contractor shall not have the right to enter into any settlement, agree to any injunction, or make any admission, in each case, on behalf of the County without the County's prior written approval.

7.6.3 Contractor shall inform all of its officers, employees, agents and subcontractors providing services hereunder of the confidentiality provisions of this Master Agreement.

7.6.4 Contractor shall sign and adhere to the provisions of Exhibit G1 - Contractor Acknowledgement and Confidentiality Agreement."

5. The Master Agreement, Paragraph **8.0-STANDARD TERMS AND CONDITIONS**, Paragraph 8.1.2 is deleted in its entirety and replaced to read as follows:

"8.1.2 The County's Board of Supervisors or Chief Executive Officer or designee may require the addition and/or change of certain terms and conditions in the Master Agreement during the term of this Master Agreement. The County reserves the right to add and/or change such provisions as required by the County's Board of Supervisors or Chief Executive Officer or designee. To implement such changes, an Amendment to the Master Agreement shall be prepared and executed by Contractor and by Director or his/her designee. Any such amendment will be effective only if accepted by the Contractor by signing such amendment. County or Contractor may terminate this agreement for convenience at any time as pursuant to Sub-paragraph 8.50."

6. The Master Agreement, Paragraph **8.0-STANDARD TERMS AND CONDITIONS**, Sub-paragraph **8.7 - COMPLIANCE WITH APPLICABLE LAWS, RULES, AND REGULATIONS**, is deleted in its entirety and replaced to read as follows:

8.7 COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

8.7.1 In the performance of this Master Agreement, Contractor shall comply with all applicable Federal, State and local laws, regulations, ordinances, and the standards of a Centers for Medicare and Medicaid Services (CMS) approved accrediting body (i.e., The Joint Commission)by which Contractor is accredited as well as the standards set for in California Code of Regulations, Title 22, Division 5. All provisions required thereby to be included in this Master Agreement are incorporated herein by reference.

8.7.2 Contractor and County shall indemnify, defend, and hold harmless each party, its officers, employees, and agents, from and against any and all claims, demands, damages, defense costs and legal fines, arising from any material breach, connected with, or related to any failure by Contractor, its officers, employees, agents, or subcontractors, to comply with any such laws, rules, regulations, ordinances, or standards. Any legal defense pursuant to Contractor's indemnification obligations under this Sub-paragraph 8.7 shall be conducted by Contractor and performed by counsel selected by Contractor and approved by the County. Notwithstanding the preceding sentence, County shall have the right to participate in any such defense at its sole cost and expense, except that in the event Contractor fails to provide County with a full and adequate defense as determined by the County in its sole judgement, the County shall be entitled to retain its own counsel, including, without limitation, County Counsel, and reimbursement from Contractor for all such costs and expenses incurred by County in doing so. Contractor shall not have the right to enter into any settlement, agree to any injunction or other equitable relief, or make any admission, in each case, on behalf of County without County's prior written approval."

7. The Master Agreement, Paragraph **8.0-STANDARD TERMS AND CONDITIONS**, Sub-paragraph 8.29.1 - **Evidence of Coverage and Notice to County**, is deleted in its entirety and replaced to read as follows:

"8.29.1 **Evidence of Coverage and Notice to County**

- Certificate(s) of insurance coverage (Certificate) or other evidence of coverage satisfactory to County, and a copy of an Additional Insured endorsement confirming County and its Agents (defined below) has been given Insured status under the Contractor's General Liability policy, shall be delivered to

County at the e-mail address shown below and provided prior to commencing services under this Agreement.

- Renewal Certificates shall be provided to County prior to the Contractor's policy expiration dates. The County reserves the right to obtain complete, certified copies of any required Contractor and/or Sub-Contractor insurance policies at any time.
- Certificates shall identify all Required Insurance coverage types and limits specified herein, reference this Agreement by name or number, and be signed by an authorized representative of the insurer(s). The insured party named on the Certificate shall match the name of the Contractor identified as the contracting party in this Agreement. Certificates shall provide the full name of each insurer providing coverage, its NAIC (National Association of Insurance Commissioners) identification number if applicable, , the amounts of any policy deductibles or self-insured retentions exceeding fifty thousand ($50,000.00) dollars, and list any County required endorsement forms.
- Neither the County's failure to obtain, nor the County's receipt of, or failure to object to a non-complying insurance certificate or endorsement, or any other insurance documentation or information provided by the Contractor, its insurance broker(s) and/or insurer(s), shall be construed as a waiver of any of the Required Insurance provisions.

Certificates and copies of any required endorsements shall be e-mailed to:

emsinsurance@dhs.lacounty.gov

The Contractor also shall promptly report to County any injury or property damage accident or incident, including any injury to a Contractor employee occurring on County property, and any loss, disappearance, destruction, misuse, or theft of County property, monies or securities entrusted to the Contractor. The Contractor also shall promptly notify County of any third party claim or suit filed against the Contractor or any of its Sub-Contractors which arises from or relates to this Agreement, and could result in the filing of a claim or lawsuit against the Contractor and/or County."

8. The Master Agreement, Exhibit A - Specialty Care Center Designation Agreements, is deleted in its entirety and replaced by Exhibit A-1, Specialty Care Center Designation Exhibit for Paramedic Base Hospital, attached hereto and incorporated herein by reference. All references to Exhibit A in the Agreement shall hereafter be replaced by Exhibit A-1.

8. The Master Agreement is modified to add Exhibit A-2, Specialty Care Center Designation Exhibit for Hospital Preparedness Program Participant, attached hereto and incorporated herein by reference.

9. Except for the changes set forth hereinabove, Master Agreement shall not be changed in any respect by this Amendment

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

/

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be executed by the County's Director of Health Services, or authorized designee, and Contractor has caused this Amendment to be executed on its behalf by its duly authorized officer(s), on the day, month, and year first above written.

COUNTY OF LOS ANGELES

By: _____ for
Christina R. Ghaly, M.D.
Director of Health Services

CONTRACTOR

PASADENA HOSPITAL ASSOCIATION,LTD.
DBA HUNTINGTON HOSPITAL

By: REDACTED
Signature

Laci J. Morgan, MD, MBA
Printed Name

President and CEO
Title

APPROVED AS TO FORM:
MARY C. WICKHAM
County Counsel

By_____
Brian T. Chu, Deputy County Counsel

EXHIBIT A-1

SPECIALTY CARE CENTER DESIGNATION EXHIBIT
FOR
PARAMEDIC BASE HOSPITAL

SECTION	TITLE	PAGE

1.0 PURPOSE 1
2.0 SCOPE OF AGREEMENT 1
3.0 GENERAL REQUIREMENTS 1
4.0 TERM OF SPECIALTY CARE CENTER DESIGNATION 2
5.0 ANNUAL FEES 2
6.0 ADDITION AND/OR DELETION OF FACILITIES, SPECIFIC TASKS AND/OR WORK HOURS 2
7.0 QUALITY CONTROL 3
8.0 QUALITY ASSURANCE PLAN 3
9.0 DEFINITIONS 4
10.0 RESPONSIBILITIES 4
10.1 Personnel 4
10.2 Furnished Items 4
10.3 Policies and Procedures 4
10.4 Interim System Re-Configuration 5
10.5 System Configuration 5
10.6 Data Management 5
10.7 Staff Designation 7
10.8 Assignment of ALS Units 7
10.9 Paramedic Communication System Management 7
10.10 Responsibilities of County through ISD 8
10.11 Agreement Compliance 8
10.12 Project Manager 9
10.13 Personnel 9
10.14 Uniforms/Identification Badges 9
10.15 Materials and Equipment 9
10.16 Contractor's Office 9
10.17 Standards and Protocols 9
10.18 Data Collection 10
10.19 Program Monitoring 12
10.20 Communication between Base Hospital and Receiving Hospital 13
10.21 Reimbursement for ALS Direction 13
10.22 Base Hospital Assignment of ALS units 13
10.23 Continuing Education (CE) Provider Program 13
10.24 Hospital Minutes/Attendance Rosters/Newsletters and Other Communication Related Materials 14
10.25 Base Hospital Medical Director 15
10.26 Base Hospital Physicians 15
10.27 Mobile Intensive Care Nurses (MICNs) 16
10.28 Prehospital Care Coordinator (PCC) 16
10.29 EMS Agency Notification of Hiring/Termination of MICNs 17
10.30 Quality Improvement (QI) 17
10.31 Paramedic Communication System (PCS) 18
11.0 HOURS/DAY OF WORK 19

12.0 WORK SCHEDULES 19
13.0 UNSCHEDULED WORK 19
14.0 PROCEDURE FOR NON-COMPLIANCE AND PENALTIES 19

LISTING OF ATTACHMENTS

ATTACHMENT	ATTACHMENT NAME
1	PREHOSPITAL CARE POLICY REFERENCE NO. 316, EMERGENCY DEPARTMENT APPROVED FOR PEDIATRICS (EDAP) STANDARDS
2	CONTRACT DISCREPANCY REPORT
3	CURRENT TEMIS HOSPITAL HARDWARE AND SOFTWARE SPECIFICATIONS
4	COMMUNICATIONS MANAGEMENT COMMITTEE (Ad Hoc)
5	BASE HOSPITAL FORM
6	BASE HOSPITAL FORM (PAGE 2)
7	MCI BASE HOSPITAL FORM
8	BASE HOSPITAL DOCUMENTATION MANUAL
9	BASE HOSPITAL COMMUNICATIONS EQUIPTMENT
10	REMOSTE BASE STATION RADIO SITES
11	CURRENT TEMIS HOSPITAL HARDWARE AND SOFTWARE SPECIFICATIONS
12	BASE HOSPITAL CHANNEL ASSIGNMENT/PARAMEDIC TELEPHONE NUMBERS
13	PARAMEDIC COMMUNICATIONS SYSTEM TROUBLE CONTROL PROCEDURES
14	PROCEDURE FOR NON-COMPLIANCE WITH DATA COLLECTION REQUIREME

SPECIALTY CARE CENTER DESIGNATION EXHIBIT: PARAMEDIC BASE HOSPITAL

1.0 PURPOSE

Pursuant to the Emergency Medical Services System and Prehospital Emergency Medical Care Personnel Act ("Act") (Health and Safety Code, Sections 1797, et seq.) the Emergency Medical Services (EMS) Agency serves as the lead Agency for coordination of the emergency medical services system in the County of Los Angeles (County). In this role, the EMS Agency awards Paramedic Base Hospital designations to qualified general acute hospitals to support the County's Advanced Life Support (ALS) programs. Title 22 of the California Code of Regulations, requires a paramedic base hospital to provide immediate medical direction to paramedic personnel via direct two-way voice communication with field units assigned to the hospital. Each Paramedic Base Hospital in the County pays the EMS Agency an annual fee to offset County's costs for data collection, monitoring, and evaluation of Advanced Life Support (ALS) programs.

2.0 SCOPE OF AGREEMENT

The basis of this Master Agreement is the desire and intention of the parties to cooperate in the operation of each party's component of the paramedic delivery system, consistent with each party's other health services activities and fiscal requirements and the duties and responsibilities of the County. Its purposes are to establish, in a manner reflective of that cooperation, the specific duties and responsibilities of the parties with respect to the matters addressed herein and to provide mechanisms and procedures for: (a) resolution of disputes, (b) communications regarding the operation of the system, (c) consideration of future development of the system in response to change in circumstances, (d) interaction with other system participants, and (e) quality improvement.

3.0 GENERAL REQUIREMENTS

3.1 Contractor must be licensed by the California Department of Public Health as a general acute care hospital.

3.2 Contractor must be accredited by the Joint Commission or other accrediting body deemed acceptable by the Centers for Medicare and Medicaid Services (CMS).

3.3 Contractor must have a special permit for Basic or Comprehensive Emergency Medical Service pursuant to the provisions of Title 22, Division 5, California Code of Regulations.

3.4 Contractor must meet or exceed standards for Emergency Departments Approved for Pediatrics (Attachment 1).

3.5 Contractor must subscribe and have access to ReddiNet® and VMED28 communication systems.

3.6 Contractor administration, medical staff and emergency room staff shall meet the requirements under applicable State regulations and the EMS Agency's policies and procedures for the provision of services under this Master Agreement.

4.0 TERM OF SPECIALTY CARE CENTER DESIGNATION

4.1 The term of this Designation shall be five (5) years or less commencing after execution by the Director as authorized by the County's Board of Supervisors, and shall terminate on June 30, 2024, unless sooner terminated or extended, in whole or in part, as provided in the Master Agreement, Sub-paragraph 8.1, Amendments.

4.2 The County shall have the sole option to extend this Designation term commensurate with the five (5) additional one-year extension options exercised under Sub-paragraph 4.1 of the Master Agreement, through June 30, 2029 (hereafter "Optional Term") for a maximum total Master Agreement term of ten (10) years. Such option and extension shall renew automatically, unless sooner terminated or extended, in whole or in part, as provided in the Master Agreement, Sub-paragraph 4.4.

5.0 ANNUAL FEES

5.1 Contractor shall pay annual fees to provide ongoing financial support to County for data collection, monitoring, and evaluation of the ALS programs, all of which benefit Contractor in the provision of base hospital services. Contractor understands that its fees offset a portion of the County's costs.

5.2 The annual fees payable to County by Contractor under this Master Agreement shall be Twelve Thousand Five Hundred and Thirtyfive Dollars ($12,535), which shall be prorated if the beginning year is less than twelve months. These fees may be increased in future FYs based upon a review of the actual costs under this Agreement.

5.3 For any Contractor that is a designated Trauma Center, the base hospital fee is waived.

6.0 ADDITION AND/OR DELETION OF FACILITIES, SPECIFIC TASKS AND/OR WORK HOURS

6.1 The EMS Agency may elect to restructure the prehospital care system as it deems necessary in accordance with paragraph 7.4 and 7.5 of this Sub-Exhibit PBH, Specialty Care Center Designation Exhibit.

6.2 All changes must be made in accordance with sub-paragraph 8.1 Amendments of the Master Agreement.

7.0 QUALITY CONTROL

The Contractor shall establish and utilize a comprehensive Quality Control Plan to assure it complies with the general requirements, terms, and conditions in this Master Agreement throughout the term. Upon request, the Plan shall be submitted to the County Contract Project Monitor for review. The plan shall include, but may not be limited to the following:

7.1 Method of monitoring to ensure that Master Agreement requirements are being met.

7.2 A record of all inspections conducted by Contractor, any corrective action taken, the time a problem was first identified, a clear description of the problem, and the time elapsed between identification and completed corrective action, shall be provided to the County upon request.

8.0 QUALITY ASSURANCE PLAN

The County will evaluate Contractor's performance under this Master Agreement using the quality assurance procedures as defined in the Master Agreement, Paragraph 8, Standard Terms and Conditions, Sub-paragraph 8.15, County's Quality Assurance Plan.

8.1 Monthly Meetings

Intentionally Omitted

8.2 Contract Discrepancy Report (Attachment 2)

8.2.1. Verbal notification of a Master Agreement discrepancy will be made to the Agreement Project Monitor as soon as possible whenever a Master Agreement discrepancy is identified. The problem shall be resolved within a time period mutually agreed upon by the County and Contractor.

8.2.2. The County Agreement Project Monitor will determine whether a formal Contract Discrepancy Report shall be issued. Upon receipt of this document, Contractor is required to respond in writing to the County Agreement Project Monitor within thirty (30) workdays, acknowledging the reported discrepancies or presenting contrary evidence. A plan for correction of all deficiencies identified in the Contract Discrepancy Report shall be submitted to the County Agreement Project Monitor within thirty (30) workdays.

8.3 County Observations

In addition to departmental contracting staff, other County personnel may observe performance, activities, and review documents relevant to this Master Agreement at any time during normal business hours. However, these personnel may not unreasonably interfere with Contractor's performance.

9.0 DEFINITIONS

Intentionally Omitted

10.0 RESPONSIBILITIES

The County's and Contractor's responsibilities are as follows:

COUNTY

10.1 Personnel

The County will administer the Master Agreement according to Master Agreement, Paragraph 6.0, Administration of Agreement - County. Specific duties will include:

10.1.1. Monitoring Contractor's performance in the daily operation of this Agreement.

10.1.2. Providing direction to Contractor in areas relating to policy, information and procedural requirements.

10.1.3. Preparing Amendments in accordance with the Master Agreement, Paragraph 8.0, Standard Terms and Conditions, Sub-paragraph 8.1 Amendments.

10.2 Furnished Items

Intentionally Omitted

10.3 Policies and Procedures

10.3.1 Establish policies and procedures consistent with State and County laws, regulations, and standards to assure medical control of ALS personnel.

10.3.2 Review and revise policies every three years or as needed.

10.3.3 Make available to Contractor upon execution of this Master Agreement all protocols and policies which the EMS Agency currently considers to be applicable to participants in the ALS system as posted on the EMS Agency's website

10.4 Interim System Re-Configuration

EMS Agency may, on an interim basis, restructure the prehospital care system as it deems necessary, including reassignment of ALS Units to or from Contractor as the primary directing base hospital, in those instances when a designated base hospital gives notice that it is withdrawing from the system or when a designated base hospital is suspended or terminated from the prehospital care system. In the event that an interim restructuring occurs, Contractor, if affected by the restructuring, shall be given the immediate opportunity to provide written and oral statements to Director regarding the restructuring to the EMS Agency and shall be provided with the "due process" procedures specified in Paragraph 9.1, Due Process of the Agreement. Nothing herein, however, is intended to prevent implementation by Director on an emergency basis of such changes as he/she may find measurably necessary to preserve the integrity of the prehospital care system and to protect the health and safety of County residents.

10.5 System Configuration

Director shall notify Contractor of proposals for substantial operational or structural changes in the components of the ALS system or in the overall operation or configuration of such system. This shall include, but not be limited to, increasing or decreasing the number of base hospitals in the event that a restructuring of the prehospital care system is deemed necessary. In the event the number of base hospitals is increased or decreased, and unless otherwise agreed upon by the parties, written notice shall be given to Contractor at least one-hundred and twenty (120) calendar days prior to the effective date of any resulting substantial operational or structural changes to the EMS Agency. If the need for Contractor to serve as a base hospital can no longer be substantiated, or if Contractor is adversely affected by the addition of a new base hospital, Contractor, upon request, shall be provided with "due process" as specified in Paragraph 9.8, Due Process of the Agreement.

10.6 Data Management

10.6.1 DHS, after consultation with and advice from the Emergency Medical Services Commission ("EMSC") Data Advisory Committee, as defined by the EMS Commission bylaws, if duly constituted, shall continue maintenance of a comprehensive Base Hospital Documentation Manual.

The DHS base hospital data collection system includes:

1. A base hospital documentation manual.

2. A minimum of eight (8) hours Trauma and Emergency Medicine Information System ("TEMIS") basic software training, up to twenty-four (24) hours of intermediate/advanced training for all necessary persons identified by Contractor, and additional training as agreed upon by County, to enable Contractor personnel to perform data entry, database maintenance, and basic report generation functions.

3. A nonexclusive, nontransferable license to Contractor to use TEMIS software and documentation and any software updates for as long as County maintains its software license contract with TEMIS software vendor, or until this Master Agreement is terminated as set forth herein. Such license also includes the right to copy TEMIS software, data, and documentation for back-up or archive purposes, but such license further gives Contractor no right to sell, lease, sublease, donate, assign, distribute, or otherwise transfer any right in TEMIS software, data, or documentation to any other person or entity.

4 Software meeting specifications shown in Attachment 3, CURRENT TEMIS HOSPITAL HARDWARE AND SOFTWARE SPECIFICATIONS, attached hereto and incorporated herein by reference, for the purpose of base hospital data entry and/or data manipulation. In the event that this Master Agreement is terminated for any reason, DHS shall promptly remove all TEMIS software provided by County/County's TEMIS-related contractor and Contractor shall return to County all TEMIS data and documentation (and all copies thereof made by Contractor hereunder) provided by County to Contractor.

10.6.2 DHS, on behalf of County, in the event of errors in software, shall use reasonable efforts to promptly rectify the software. Whenever possible, DHS shall correct a problem in twenty-four (24) hours or less (excluding Saturday, Sunday, and Holidays). County shall have no such obligation if the problem(s) is (are) a direct or indirect result of software modifications, made without the prior written approval from Director.

10.6.3 The foregoing are the only warranties of any kind, either expressed or implied, that are made by County, and County disclaims all other warranties including, but not limited to, the implied warranties of fitness for a particular purpose. In no event shall County be liable for any direct, indirect incidental, or consequential damages of any nature whatsoever (including, without limitation, damages for loss of business profits, business interruption, loss of information, and the like), arising out of the use or inability to use the software (including without limitation any claim

of patent infringement or other similar claim), even if County has been advised of the possibility of such damages.

10.6.4 County does not warrant that operation of the software will be uninterrupted or error-free or that all errors will be corrected.

10.6.5 County does not assume and shall have no liability under this Master Agreement for failure to repair or replace defective software, the related data or documentation due directly or indirectly to causes beyond the control of, and without the fault or negligence of County, including, but not limited to, acts of God, acts of public enemy, acts of the United States, any state, or other political subdivision, fires, floods, epidemics, quarantine, restrictions, strikes, freight embargoes, or similar or other conditions beyond the control of County.

10.7 Staff Designation

Director shall designate staff within the EMS Agency to review, monitor, communicate and coordinate matters affecting the EMS delivery system under the jurisdiction of the EMS Agency. EMS staff shall periodically attend Contractor's continuing education programs, field care audits, and meetings related to the EMS system and shall perform contract compliance reviews as specified in this Master Agreement.

10.8 Assignment of ALS Units

After consultation with Contractor and provider agencies, Director shall assign designated ALS units to operate under Contractor's primary control as base hospital. These assignments may be changed from time to time by Director after consultation with Contractor. Director shall take into consideration the receiving hospital for the majority of patients handled by the ALS unit being assigned, whether the ALS unit being assigned is primarily a 9-1-1 response unit or private interfacility transport unit, and the provider agency's desire to affiliate with a particular base hospital.

10.9 Paramedic Communication System Management

10.9.1 Designate one individual within DHS as the PCS manager to provide administration and direction of the PCS.

10.9.2 Utilize County's Internal Services Department ("ISD") for ongoing design, installation, maintenance, and technical consultation.

10.9.3 Assign Contractor frequencies and private line ("PL") tones in consultation with ISD.

10.9.4 Notify Contractor of any proposals for operational or structural changes in the components of the PCS. No non-emergent substantial operational or structural change in the components of the PCS will be made without prior notification of Contractor, and until Contractor, if it wishes, has appropriately exhausted administrative due process remedies under the Agreement.

10.9.5 Promulgate PCS communications operations procedures and maintenance standards in cooperation with ISD prior to the execution of this Agreement. Any changes made during the term of this Agreement shall be reviewed and approved by the Communications Management Committee, described in Attachment 4, attached hereto and incorporated herein by reference.

10.9.6 Notify the Hospital Association of Southern California ("HASC") of any proposals for changes in policies and procedures.

10.10 Responsibilities of County through ISD

10.10.1 Assume ongoing responsibility for the design, development, timely implementation, and technical integrity of the PCS. To the extent feasible, ISD shall consult with the DHS PCS Manager and solicit input in the areas of design development, implementation, and technical integrity of the PCS.

10.10.2 Maintain and repair County-owned equipment.

10.10.3 Prepare PCS communications operating procedures and maintenance standards in cooperation with the EMS Agency.

10.11 Agreement Compliance

Should DHS, as determined by Contractor, fail to comply with any provision set forth hereunder as a DHS responsibility or obligation, Contractor may do any or all of the following in addition to other rights which Contractor may have hereunder or at law.

1) Send Director a written statement itemizing the areas of concern and request or specify a plan for remedial action.

2) Send Director a written itemized listing of the area(s) of concern and notification of intent to terminate Master Agreement.

3) Institute the review procedures outlined in Paragraph 9.1, Due Process of the Master Agreement.

CONTRACTOR

10.12 Project Manager

10.12.1. Contractor shall provide a full-time Project Manager or designated alternate.

10.12.2. Project Manager shall act as a central point of contact with the County.

10.12.3 Project Manager/alternate shall have full authority to act for Contractor on all matters relating to the daily operation of the Master Agreement. Project Manager/ alternate shall be able to effectively communicate, in English, both orally and in writing.

10.13 Personnel

Intentionally Omitted

10.14 Uniforms/Identification Badges

Intentionally Omitted

10.15 Materials and Equipment

The purchase of all materials/equipment to provide the needed services is the responsibility of the Contractor. Contractor shall use materials and equipment that are safe for the environment and safe for use by the employee

10.16 Contractor's Office

Intentionally Omitted

10.17 Standards and Protocols

Contractor shall implement and monitor the policies and procedures of the EMS Agency related to the services performed by Contractor under this Master Agreement.

10.18 Data Collection

Contractor shall complete and submit the following documents to Director, the completion and submission of which shall be according to DHS procedure and formats previously provided to Contractor:

1) Base Hospital Form: The MICN or emergency department physician, or both, shall complete at least one current EMS Agency approved and provided Base Hospital Form for every contact involving a patient where on-line medical direction is given. Samples of the EMS Agency approved Base Hospital Form are attached as Attachment 5, (Base Hospital Form), Attachment 6 (Page 2), Attachment 7 (MCI Form), attached hereto and incorporated herein by reference. Contractor shall submit the Base Hospital Form within sixty (60) calendar days of the incident. Upon approval of Director, Contractor may discontinue transmittal of a "hard copy" of the form when Director determines that the computer data Base Hospital Form information which is transmitted to the EMS Agency is of high quality and timely, and reflects all documentation. Base Hospital Form should be completed in accordance with the current Base Hospital Documentation Manual (Attachment 8) as posted on the EMS Agency's website.

2) Receiving Hospital Outcome Data: Contractor shall complete emergency department outcome data for all patients delivered to its emergency department via the County's 9-1-1 system. Contractor personnel shall submit the appropriate information as defined in Attachment 10, attached hereto and incorporated herein by reference, to the EMS Agency. Upon approval of Director, Contractor may discontinue collection of ED diagnosis and patient disposition on the Base Hospital Form when the Director determines alternative methods (i.e., via contractor's EMR) for submission of outcome data is of high quality and timely.

3) Required Data Elements: Contractor shall enter data elements as defined in Attachment 8 for all patients where Contractor provided base hospital medical direction into TEMIS.

4) In the event the EMS Agency determines that existing forms, logs, and documents should be modified or that additional data should be collected from Contractor, said modification or request for additional data must first be reviewed by the EMSC Data Advisory Committee, if constituted. The EMS Agency shall estimate the cost impact on Contractor of the proposed modification or request for additional data, and, if a dispute concerning same arises, the matter may be submitted to the EMSC for arbitration in accordance with County Code Section 3.20.070.

5) Contractor shall submit required data under County's automated data collection system to the EMS Agency via EMS Agency defined media within

forty-five (45) calendar days following an "incident". Data format must meet specifications defined by the EMS Agency. Should County remove all or any portion of TEMIS software required to submit Contractor's data to County via County defined media, or fail to correct any software errors that prevent Contractor from being able to perform data entry, Contractor's obligation to submit data electronically shall cease, until County has reinstalled the necessary software or corrected the software errors.

6) Contractor shall utilize TEMIS application programs and provide hardware which meets the requirements listed under TEMIS Hospital Hardware and Software Specifications described in Attachment 3. Contractor shall in no way modify the structure or function of the software as set forth in the Master Agreement without the prior written approval of Director. The software provided shall be used exclusively for the purposes intended herein and shall be maintained by Contractor in a secure location.

7) Contractor shall provide all supplies necessary for the ongoing use of their equipment (e.g., printer cartridges, printer paper, compact discs, DVDs, flash drives, etc.)

8) Contractor shall seek telephone assistance from County's Project Manager or their designee, whenever TEMIS operation failure occurs, to obtain County TEMIS maintenance services as described herein.

9) Contractor shall assign qualified back-up personnel, excluding PCC, to enter data into TEMIS, as reasonably appropriate for Contractor to meet Contractor's data collection responsibilities described herein. Furthermore, Contractor shall permit adequate time for complete training of such personnel. Arrangements for training of new or replacement Contractor personnel shall be the primary responsibility of Contractor.

10) All software application modules, all modifications, enhancements, and revisions thereto, and all materials, documents, software programs and documentation, written training documentation and aids, and other items provided by County or its agents, are "proprietary" or "confidential". Contractor shall use reasonable means to ensure that these confidential data system products are safeguarded and held in confidence. Such means shall include, but not be limited to, disclosing confidential County data system products only to employees with a need to know of such confidential County data system products in order for Contractor to exercise its rights and perform its obligation as a base hospital; and not reproducing, adapting, modifying, disassembling, decompiling, reverse engineering, distributing, or disclosing any confidential County data system products except as expressly permitted hereunder. Copies of software, application modules, and data may be made for the sole purpose of backup only.

11) Contractor shall indemnify, hold harmless, and defend County from and against any and all liability, damages, costs, and expenses, including, but not limited to, defense costs and attorneys' fees, for or by reason of any actual or alleged infringement of any United States patent, copyright, or any actual or alleged trade secret disclosure, arising from or related to the misuse of the software license by Contractor or Contractor personnel.

10.19 Program Monitoring

10.19.1. Contractor extends to Director, or his or her designee and to authorized representatives of the State, the right to review and monitor Contractor's programs and procedures with respect to this Master Agreement, and to inspect its facilities for contractual compliance with State and EMS Agency policies and regulations.

10.19.2. Inspections by DHS staff shall be conducted during County's normal business hours and only after Director has given Contractor at least three (3) working days prior written notice thereof. In computing the three (3) working days, a Saturday, Sunday, or legal holiday shall not be included. Entry and exit conferences shall be held with Contractor's Administrator or his or her designee. Said notice need not be given where Director determines that the health and welfare of patients may be jeopardized by waiting the three days period.

10.19.3. 10.20.2 Program Review: At minimum, audits shall be conducted every three (3) years to ensure compliance with State and EMS Agency policies and regulations. Contractor shall be given no less than thirty (30) calendar days notice in advance of said review. Contractor and its staff shall fully cooperate with County representatives. In the conduct of such audit and review, Contractor shall allow such representatives access to all reports, audio recordings, medical records, and other reports pertaining to this Master Agreement, and shall allow photocopies to be made of these documents, utilizing Contractor's photocopier.

10.19.4. An exit conference shall be held following the performance of such an on-site compliance review by Director and results of the compliance review shall be discussed with Contractor's Administrator or his or her authorized designee prior to the generation of any final written report or action by Director or other DHS representatives based on such review. The exit conference shall be held on site prior to the departure of the reviewers and Contractor shall be provided with an oral list of preliminary findings at the exit conference. A written report of the program review shall be prepared and provided to Contractor. Contractor shall permit periodic unscheduled site visits by EMS Agency representatives for monitoring ED diversion status, continuing education programs and prehospital care meetings.

10.20 Communication between Base Hospital and Receiving Hospital

Contractor shall communicate all appropriate ALS patient management information to the receiving hospital to which a patient is directed as result of on-line medical direction. Such notification shall be by telephone or ReddiNet and conveyed by a physician or MICN familiar with the treatment given, as soon as the patient destination is determined, or as soon as is practically possible.

10.21 Reimbursement for ALS Direction

Nothing in this Agreement shall prohibit Contractor from seeking reimbursement, contributions or other payments from municipalities, paramedic provider agencies, or receiving hospitals to defray costs associated with providing ALS services, including supply and resupply of ALS units. Except as expressly noted, nothing herein, however, requires reimbursement or other payment from municipalities, paramedic provider agencies, or receiving hospitals to defray such Contractor costs.

10.22 Base Hospital Assignment of ALS units

Except as otherwise noted herein, the number of ALS units assigned to Contractor on a primary basis shall be based upon the receiving hospital for the majority of patients handled by the ALS Units being assigned; whether a Base Hospital within the geographic area can reasonably accept an/any additional unit/s; whether the ALS Unit being assigned is primarily a 9-1-1 response unit or private interfacility transport unit, and the provider agency's desire to affiliate with a particular base hospital. Subject to Paragraph 9.1, Due Process of the Agreement, nothing herein, however, shall be deemed to restrict Director and County's Board of Supervisors in the exercise of their authority under applicable laws and regulations to designate additional base hospitals for the geographic area served by Contractor hereunder.

10.23 Continuing Education (CE) Provider Program

10.23.1. Contractor shall establish and maintain an EMS continuing education provider program in accordance with policies established by Director in the Prehospital Care and CE Manuals. Contractor shall provide a minimum of six (6) hours of field care audits and six (6) hours of instructor-based education per year. Contractor may require additional field care audits which exceed EMS Agency requirements for MICN certification, to maintain MICN sponsorship.

10.23.2. Contractor shall facilitate scheduling structured field observation for MICN certification.

10.23.3. In addition, Contractor shall provide special and mandatory training programs deemed necessary in writing by Director. A minimum of three (3) classes, per mandatory training program, shall be offered.

10.23.4 Contractor shall provide supervised clinical experience for paramedic interns in accordance with State and EMS Agency policies and procedures, upon request of a Los Angeles County approved training school that has a signed Clinical Affiliation Agreement with Contractor.

10.23.5. Contractor shall coordinate a prehospital orientation program for new base hospital physician and nursing staff to the prehospital program.

10.23.6. Contractor shall facilitate the education of new MICNs by providing instructor(s) to lecture, perform radio simulations, or assist as needed at any MICN Development Course to which Contractor sends MICN candidates.

10.23.7. To the extent Contractor is required to provide mandatory formal education programs over and above those set forth in subparagraphs (1) and (2) immediately above, Contractor may seek reimbursement, contributions, or other payment to defray its costs from municipalities, paramedic provider agencies, or receiving hospitals. However, nothing herein shall be deemed to require any such reimbursement, contribution, or payment.

10.23.8. Contractor shall forward the following to the EMS Agency:

1) Monthly continuing education schedules to the Office of Certification and Program Approvals prior to scheduled date of course.

2) Yearly summaries of EMS CE classes including the date, course title, instructor or non-instructor based, and number of EMS continuing education hours to the Office of Certification and Program Approvals by January 31 of the following year.

3) Course rosters or attendance verification for County mandated training programs to the Office of Certification and Program Approvals no later than fifteen (15) calendar days after the class concludes, but not to exceed established deadline of course.

10.24 Hospital Minutes/Attendance Rosters/Newsletters and Other Communication Related Materials

Contractor shall maintain records of communications with base hospital personnel which may be inclusive of, but not limited to, base hospital meetings, e-mail

communications, newsletters or other communication related materials. These records of communications shall be available to the EMS Agency during program review audits and shall be submitted to the EMS Agency upon request.

10.25 Base Hospital Medical Director

Contractor shall designate an emergency physician to direct and coordinate the medical aspects of field care and related activities of medical and emergency medical services personnel assigned to Contractor (including without limitation, the quality improvement program for the services provided here within), and to ensure compliance with policies, procedures, and protocols established by the EMS Agency. This physician, who shall have the title of "Base Hospital Medical Director", shall:

1) Be board certified in emergency medicine.

2) Be engaged in the field of emergency medicine as a full-time emergency physician, as defined by spending an average of at least ninety-six (96) hours per month in the practice of emergency medicine at Contractor's hospital, and have experience and knowledge of base hospital radio operations and EMS Agency policies and procedures. The number of prescribed hours may include administrative and or educational hours spent in meeting Base Hospital Medical Director responsibilities.

3) Comply with the provisions set forth in the Prehospital Care Manual.

4) Satisfactorily complete orientation to Contractor's prehospital care program.

5) Attend an EMS orientation course as provided by the EMS Agency within six (6) months of assuming Base Hospital Medical Director responsibilities.

6) Reimbursement for Medical Director: Nothing in this Agreement shall prohibit Contractor from seeking reimbursement, contributions, or other payment from municipalities, paramedic provider agencies, or receiving hospitals to defray Contractor's costs associated with providing ALS services, including the base hospital medical director's salary. However, nothing in this Agreement shall be deemed to require any such reimbursement, contribution, or other payment.

10.26 Base Hospital Physicians

Contractor shall have at least one (1) full-time emergency department physician on duty at all times. Such emergency department physician shall be responsible for prehospital management of patient care and patient destination. If a paramedic run is not handled directly by the base hospital physician, such physician shall be immediately available for consultation by an MICN directing a paramedic run. All of

Contractor's emergency department physicians participating in Contractor's activities as a base hospital shall

1) Satisfactorily complete Contractor's base hospital orientation program within thirty (30) days of assuming base physician responsibilities. Such a program shall include: prehospital treatment protocols, medical control guidelines and base hospital radio operations.

2) Be board certified or board eligible in emergency medicine as recognized by the American Board of Medical Specialties.

3) Comply with policies and procedures of the EMS Agency.

4) Be under the direction of the Base Hospital Medical Director.

10.27 Mobile Intensive Care Nurses (MICNs)

Contractor shall have at least one (1) MICN on duty at all times. MICNs shall:

1) Be currently certified as a MICN in Los Angeles County.

2) Be currently certified as an American Heart Association Advanced Cardiac Life Support provider or instructor.

3) Comply with policies and procedures of the EMS Agency

4) Be under the direction of the base hospital physician on duty.

5) Be employed by one of the following agencies approved to employ and utilize MICNs in Los Angeles County:

   a) Base Hospital

   b) EMS Agency

   c) Paramedic training program

   d) Paramedic provider agency

10.28 Prehospital Care Coordinator (PCC)

Contractor shall designate a dedicated MICN with experience and knowledge of base hospital radio operations and EMS Agency policies and regulations to serve as the Contractor's PCC and as a liaison to the EMS Agency, paramedic provider agencies, and the local receiving facilities. Under the direction of, and in conjunction

with the Contractor's Base Hospital Medical Director, the PCC shall assist in directing and coordinating the medical aspects of field care and related activities of medical and emergency medical services personnel assigned to Contractor and shall ensure compliance with policies, procedures, and protocols established by the EMS Agency. The PCC shall:

1) Be currently certified as an MICN in Los Angeles County.

2) Have experience in, and knowledge of, base hospital radio operations and EMS Agency policies, procedures, and protocols.

3) Be sufficiently available during normal County business hours to meet the responsibilities set forth in this subparagraph.

4) Comply with the provisions set forth in the Prehospital Care Manual.

5) Attend an EMS orientation course as provided for by the EMS Agency within six (6) months of assuming PCC responsibilities.

Nothing in this Agreement shall prohibit Contractor from seeking reimbursement, contributions, or other payment from municipalities, paramedic provider agencies, or receiving hospitals to defray Contractor's costs associated with providing ALS services, including the PCC's salary. Nothing, however, in this Agreement shall be deemed to require any such reimbursement, contributions, or other payments.

10.29 EMS Agency Notification of Hiring/Termination of MICNs

Contractor shall notify the EMS Agency's Office of Prehospital Certification within fifteen (15) working days of the hiring or termination of any MICN as well as failure of the MICN to meet established guidelines set by the EMS Agency in maintaining current certification.

Failure of a MICN to meet current certification requirements established by the EMS Agency and EMS Agency mandated courses shall result in immediate suspension of their MICN certification.

10.30 Quality Improvement (QI)

Contractor shall have a current prehospital care QI plan approved by the EMS Agency and ensure participation in the EMS Agency's systemwide QI program by designating a representative for the meetings.

Contractor shall have a process developed, with input from the base hospital medical director, base hospital physician, the PCC, MICNs, paramedics and Contractor administration to:

1) Identify important aspects of prehospital care issues.

2) Identify indicators for those important aspects.

3) Evaluate the prehospital care and service, including trends, to identify opportunities for improvement.

4) Take action to improve care and service, or to solve problems, and evaluate the effectiveness of those actions.

5) Contractor shall also participate in the EMS Agency's Quality Improvement Program, with records provided by Contractor in accordance with the terms of this Agreement

10.31 Paramedic Communication System (PCS)

10.31.1 Provide the specific PCS base hospital communications equipment listed in Attachment 9, attached hereto and incorporated herein by reference, meeting the operational requirements and standards as determined by the County through the Director of the ISD. Any changes in required communications equipment shall be mutually agreed upon between the parties. These changes shall be made in consultation with the EMS Agency's PCS manager

10.31.2 Acquire and maintain in effect throughout the term of this Master Agreement FCC licenses for such communications equipment in accordance with California Public Safety Radio Association ("CPSRA") procedures.

10.31.3 Operate, maintain, and repair Contractor-owned PCS equipment in accordance with standards promulgated hereunder

10.31.4 Obtain leased lines to current or new remote control stations or to a closer termination point on new or current stations or lines jointly determined by Contractor, Director, and ISD. If Contractor is afforded capability of remote control radio stations located at a County site or other remotely located site as shown in Attachment 10. If the remote radio stations are located at a non-County site and are owned by Contractor, then Contractor shall also pay for all costs associated with the maintenance and repair of such stations, and for all costs of the A.C. power required for operating the equipment.

10.31.5 Comply with the operating and maintenance standards for communications equipment as set forth in Attachment 11, attached hereto and incorporated herein by reference. Contractor further agrees to operate its PCS equipment in accordance with the transmitter power output and antenna specifications as shown in Attachment 9 .

10 31.6 Comply with channel assignments made by the EMS Agency for communication with paramedics Attachment 12.

10 31 7 Provide training of Contractor personnel assigned to Contractor's PCS operation on the use of communications equipment listed in Attachment 9.

10.31.8 Comply with Paramedic System Trouble Control Procedures established by the EMS Agency PCS manager listed in Attachment 13.

10.31.9 Have the capability of emergency maintenance and repair of PCS equipment, as well as periodic preventive maintenance, either by its own personnel or through a communications service company which has a service contract with Contractor and which has a demonstrated capability of providing the required services.

10.31.10 Nothing in this Agreement shall prohibit Contractor from seeking reimbursement, contributions, or other payment from municipalities, paramedic provider agencies, or receiving hospitals to defray Contractor's costs associated with providing ALS services However, nothing in this Master Agreement shall be deemed to require any such reimbursement, contributions, or payment.

11.0 HOURS/DAY OF WORK

Intentionally Omitted

12.0 WORK SCHEDULES

Intentionally Omitted

13.0 UNSCHEDULED WORK

Intentionally Omitted

14.0 PROCEDURE FOR NON-COMPLIANCE AND PENALTIES

Contractor's failure to meet data collection requirements for base hospital data elements shall be addressed by the County in accordance with Attachment 14, Procedure for Non-Compliance with Data Collection Requirements.

ATTACHMENT 1

PREHOSPITAL CARE POLICY REFERENCE NO. 316,
EMERGENCY DEPARTMENT APPROVED FOR PEDIATRICS (EDAP) STANDARDS

Exhibit 23-F

Social Program Agreement (Contract # CP-05-377)

EXECUTIVE OFFICE

BOARD OF SUPERVISORS
CELIA ZAVALA
EXECUTIVE OFFICER

COUNTY OF LOS ANGELES
EXECUTIVE OFFICE
BOARD OF SUPERVISORS

KENNETH HAHN HALL OF ADMINISTRATION
500 WEST TEMPLE STREET, ROOM 383
LOS ANGELES, CALIFORNIA 90012
(213) 974-1411 • www.bos.lacounty.gov

MEMBERS OF THE BOARD
HILDA L. SOLIS
MARK RIDLEY-THOMAS
SHEILA KUEHL
JANICE HAHN
KATHRYN BARGER

March 5, 2020

Jamie Brady-Smith
Huntington Hospital
100 W. California Blvd.
Pasadena, CA 91105

Dear Jamie Brady-Smith:

Enclosed for your review and signature is Social Program Agreement (Contract # CP-05-377). Fifth District Supervisor Kathryn Barger of the Los Angeles County Board of Supervisors has pledged financial assistance in the amount of $5,000 to Huntington Hospital.

In order to process the agreement, we require the following documentation to be completed and signed by an authorized representative of the organization with a wet signature:

- **Social Program Agreement**
- **W-9 form**

Please do not make any corrections or use whiteout on the Agreement. All corrections must be submitted in writing to the e-mail address listed below. Corrections made to the Agreement without first obtaining authorization could invalidate the Agreement and require a new Agreement to be executed. **Please mail the signed Agreement and W-9 form within 10 business days** to:

Susanna Ponciano
Board of Supervisors
500 West Temple Street, Ste. 383
Los Angeles, CA 90012

Please note, upon termination of the agreement, a Final Report, Expenditure Summary Spreadsheet, and supporting documentation detailing the actual expenditures must be submitted to the Executive Office of the Board of Supervisors within 60 days of the termination of this Agreement. All funding must be spent within the designated contract period, expenditures dated outside of the contract period will not be accepted and may result in forfeiture of the funds. If you have any questions, please contact me at (213) 974-2253 or email me at SPonciano@bos.lacounty.gov.

Very truly yours,

Susanna Ponciano
for
HANNA CHERU
Administrative Deputy

HC:sp

c: Anna Mouradian, Chief Deputy, Fifth District

SOCIAL PROGRAM AGREEMENT
Contract No. CP-05-377
Fiscal Year 2019-20

Name of Organization:	Huntington Hospital "Contractor"		
Address:	100 W. California Blvd., Pasadena, CA 91105		
Website (if applicable)	www.fabfoodandwine.com		
Contractor's Project Director:	Jamie Brady-Smith	**Telephone No.:**	(626) 397-3241

Status of Organization: Profit [ ] Non Profit [x]

Description of Organization: The mission of the Huntington Hospital is to provide excellent health care and compassionate service to each person by bringing together outstanding physicians, caring nurses, professional staff, and advanced technologies.

Description of Program/Project: The funds will be used by the Huntington Hospital to assist with the hospital's Trauma Center, which is the largest trauma center in the San Gabriel Valley. The Huntington Hospital Trauma Center is the largest Emergency Department and only Level II Trauma Center in the San Gabriel Valley. Over 70,000 patients seek emergency care every year, the majority of whom suffer medical problems or injuries requiring swift and effective treatment. The department's vital services are available 24 hours a day, 365 days a year. The funds will assist with the various costs expended by the hospital in order to keep the hospital running for the community

Proposed Social Need to be Satisfied: Health and social service initiatives and programs

Contract Period:	10/2019-06/30/2020	**Grant Amount:**	$5,000

Total Proposed Expenditures:

1) Personnel Costs:	0	**2) Non-Personnel Costs:**	$5,000

County Department:	Board of Supervisors, Fifth District		
County Contact Person:	Sunny Nemer	**Telephone No:**	(626) 356-5407

Contractor verifies that:

- I have the power to execute this contract.
- I have read the attached Terms and Conditions and agree thereto.
- Financial and program records will be maintained for 3 years.
- A Final Report and supporting documentation on the results and expenditures of this project will be made within 60 days from the expiration or termination of this Agreement, to the Executive Office.
- These funds will be used for the program specified above and will only be spent within the Contract Period. All unused funds will be returned at the end of the Contract Period.

REDACTED

Contractor Signature — Title: Senior VP Philanthropy & Public Relations — Date: 3-10-20

Jane Haderlein — jane.haderlein@huntington.hospital.com

Contractor Printed Name — Contractor E-mail Address

COUNTY OF LOS ANGELES
Pursuant to Government Code Sections 23005, and 26227, and an adopted Resolution by the Board of Supervisors:

By _____
SACHI A. HAMAI
Chief Executive Officer

By _____
ARLENE BARRERA
Acting Auditor-Controller

APPROVED AS TO FORM:

MARY C. WICKHAM
County Counsel

By REDACTED
DEPUTY

By _____
CELIA ZAVALA
Executive Officer, Board of Supervisors

SOCIAL PROGRAM AGREEMENT
TERMS AND CONDITIONS

1. **COMPENSATION**
The COUNTY shall compensate the CONTRACTOR payable upon execution of the Social Program Agreement ("Agreement").

2. **INDEPENDENT CONTRACTOR**
The CONTRACTOR shall perform all services included in this Agreement in an independent capacity and neither CONTRACTOR nor CONTRACTOR'S employees shall be considered as employees of the COUNTY. This Agreement is by and between the CONTRACTOR and the COUNTY and is not intended, and shall not be construed to create the relationship of agent, servant, employee, partnership, joint venture, or association, between the COUNTY and the CONTRACTOR.

3. **ENTIRE AGREEMENT**
This document constitutes the entire Agreement between the COUNTY and the CONTRACTOR for services to be performed.

4. **ASSIGNMENTS AND SUBCONTRACTS**
The CONTRACTOR may enter into subcontracts for performance of portions of this Agreement only upon receipt of prior written consent of the County Department Director or his/her designee. All appropriate provisions and requirements of this Agreement shall apply to the sub-agreement. The CONTRACTOR shall be held responsible by the COUNTY for performance of any sub-contractor.

5. **INDEMNIFICATION**
CONTRACTOR agrees to indemnify, defend and hold harmless the COUNTY, their agents, officers and employees from and against any and all liability, expense, including defense costs and legal fees, and claims for damages of any nature whatsoever, including, but not limited to bodily injury, death, personal injury, or property damage arising from or connected with CONTRACTOR'S operations or services hereunder, including any workers' compensation suits, Federal Fair Labor Standards Act wage and hour law violations, liability, or expense, arising from or connected with services performed by or on behalf of CONTRACTOR by any person pursuant to this Agreement.

6. **INSURANCE**
Without limiting CONTRACTORS indemnification of COUNTY, the CONTRACTOR shall provide and maintain at its own expense insurance coverage satisfying the requirements specified in this Agreement. Such insurance shall be provided by insurer(s) satisfactory to the COUNTY'S Risk Manager and evidence of such programs satisfactory to the COUNTY shall be delivered to County Contact Person on or before the effective date of this Agreement. These minimum insurance coverage terms, types and limits also are in addition to and separate from any other any other contractual obligation imposed upon the Contractor pursuant to this Agreement. All such insurance, except for Workers' Compensation, shall be primary to and not contributing with any other insurance or self-insurance coverage maintained by County and shall name the County of Los Angeles as an additional insured. Neither the COUNTY'S failure to obtain, nor the COUNTY'S receipt of, or failure to object to a non-complying insurance certificate or endorsement, or any other insurance documentation or information provided by the CONTRACTOR its insurance broker(s) and/or insurer(s), shall be construed as a waiver of any of the insurance coverage requirements. CONTRACTOR shall insure the following insurance coverage as it applies to this Agreement:

A. **Commercial General:**
Providing scope of coverage equivalent to ISO policy form CG 00 01, with limits of not less than $1 million per occurrence.

C. **Workers' Compensation:**
Insurance in an amount and form to meet all applicable requirements of the Labor Code of the State of California, and which specifically covers all persons providing services by or on behalf of CONTRACTOR and all risks to such persons under this Agreement, and including Employers' Liability coverage with a $1 million per limit.

D. **Crime Insurance:**
A comprehensive blanket crime insurance policy with each insuring agreement in an amount not less than $25,000, insuring against loss of money, securities, or other property affected to hereunder which may result from:

(1) Dishonesty or fraudulent acts of officers, directors, or employees of CONTRACTOR, or
(2) Disappearance, destruction or wrongful abstraction inside or outside the premises or CONTRACTOR, while in the care, custody or control of the CONTRACTOR, or
(3) Sustained through forgery or direction to pay a certain sum in money.

E. **Sexual Misconduct Liability:**
If, under the terms of this Agreement, CONTRACTOR's program or project involves care or supervision of children, seniors, and/or other vulnerable persons, CONTRACTOR shall provide insurance covering actual or alleged claims for sexual misconduct and/or molestation with limits of not less than two million ($2,000,000) per claim and two million ($2,000,000) aggregate, and claims for negligent employment, investigation, supervision, training or retention of, or failure to report to proper authorities, a person(s) who committed any act of abuse, molestation, harassment, misdreatment or maltreatment of a sexual nature.

F. **Professional Liability – Errors and Omissions:**
If, under the terms of this agreement, CONTRACTOR's program or project involves provision of medical, legal, accounting, architectural, engineering, interpreting, programming, or consulting services, CONTRACTOR shall provide Professional Liability Insurance covering CONTRACTOR's professional liability arising from or related to this Agreement, with limits of not less than $1 million per claim and two ($2) million aggregate. Further, CONTRACTOR understands and agrees it shall maintain such coverage for a period of not less than three (3) years following this Agreement's expiration, termination or cancellation.

7. **RECORDS RETENTION AND INSPECTION**
Within thirty (30) days of COUNTY's written request, CONTRACTOR shall allow COUNTY access to financial and program records during regular business hours at any place CONTRACTOR keeps those records.

8. **CONFLICT OF INTEREST**
CONTRACTOR covenants that neither the CONTRACTOR nor any of it agents, officers, its employees, or sub-contractors who presently exercise any function or responsibility in connection with the program has personal interest, direct or indirect, in the Agreement, except to the extent he may receive compensation for his or her performance pursuant to this Agreement.

CONTRACTOR, its agents, officers, employees, and sub-contractors shall comply with all applicable Federal, State and County laws and regulations governing conflict of interest.

9. **ASSURANCES**
The CONTRACTOR gives and certifies with respect to the programs that it will comply with all applicable COUNTY, state, and federal laws and regulations, including, but not limited to Federal OMB Circulars A-102, A-110, A-122, and A-133 as they apply to the CONTRACTOR.

The CONTRACTOR further assures that:

A. **Authority:**
It possesses legal authority to execute the proposed program, that a resolution, motion, or similar action has been fully adopted or passed, as an official act of the CONTRACTOR'S governing body, authorizing receipt of the funds, and directing and designating the authorized representative(s) of the CONTRACTOR to act in connection with the program specified and to provide such additional information as may be required by the COUNTY.

B. **Civil Rights:**
CONTRACTOR shall abide by the provisions of the Title VI and VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. Sections 2000e (17), (P.L. 88-353), and applicable Federal and State laws, rules and regulations prohibiting discrimination under any program activity or employment for which CONTRACTOR received funding under this Agreement. Any subcontracts awarded by CONTRACTOR shall contain this provision.

C. **Prohibited Actions:**
CONTRACTOR agrees not to engage in or permit any religious proselytizing or political propagandizing in connection with the performance of this Agreement. The CONTRACTOR agrees to comply with the provision of the Federal Hatch Act (5 U.S.C. Section 1501 et

seq.), as amended, and with Section 818 (a) of Subtitle B of Title VI of Pub. L. 97-35, which limits political activity of certain State and local employees, and with 31 U.S.C. Section 1352, and with Section 319 (a)(1) of Title III of Pub. L 101-121 (which prohibits use of Federal funds to influence the award of Federal contracts or grants.

D. OSHA/CAL-OSHA Compliance:
CONTRACTOR shall comply with the provisions of the Occupational Safety and Health Act of 1970 (29 U.S.C. 651 et seq.) and the California Occupational Safety and Health Act (Cal.Labor Code §6300).

10. SUSPENSION AND TERMINATIONS
The CONTRACTOR agrees to suspend program operations for a period not to exceed sixty (60) working days effective immediately upon written notice of suspension from the County Project Director. This provision will be applied if, in the judgment of the County Project Director, circumstances exist which could result in illegal or inappropriate expenditures of program funds. Either party may terminate this agreement or any part hereof by giving fifteen (15) days notice to the other.

The County Department Director or his/her designee may terminate this Agreement immediately by written notice to the CONTRACTOR upon CONTRACTOR'S failure to comply with the provisions of this Agreement. It is also understood and agreed, however, that should the COUNTY determine that CONTRACTOR'S failure to perform relates to only part of the services CONTRACTOR is performing, the COUNTY, in its sole discretion, may elect to terminate only that part of the Agreement which shall in no way void or invalidate the rest of this Agreement. In the event of termination of all or part of this Agreement, COUNTY shall pay to CONTRACTOR for all allowable budgeted costs actually incurred by CONTRACTOR prior to the effective date of such termination less payments paid by COUNTY for such services.

If this Agreement is terminated, CONTRACTOR shall within five (5) days of receipt of notice of termination from COUNTY, notify all other parties who are subcontractees of the CONTRACTOR of such termination.

Payment shall be made upon the filing with the COUNTY, by CONTRACTOR, of a voucher(s) evidencing the time expended and the cost incurred. Said vouchers must be filed with the COUNTY thirty (30) days of date of said termination.

11. FAIR LABOR
CONTRACTOR agrees to indemnify, defend, and hold harmless the COUNTY, its agents, officers and employees from any and all liability including, but not limited to, wages, overtime pay liquidated damages, penalties, court costs, and attorneys' fees arising under any wage and hour law violation including, but not limited to, Federal Fair Labor Standards Act for services performed by the CONTRACTOR'S employees for which the COUNTY may be found jointly or solely liable.

12. CITIZENSHIP
CONTRACTOR warrants that it fully complies with all laws regarding employment of aliens and others, and that all its employees performing services hereunder meet citizenship or alien status requirements contained in Federal statutes and regulations. CONTRACTOR shall indemnify, defend and hold harmless, the COUNTY, its officers and employees from employer sanctions and any other liability which may be assessed against the CONTRACTOR or COUNTY, or both, in connection with any alleged violation of Federal statutes or regulations pertaining to the eligibility for employment of persons performing services under this agreement.

13. COUNTY LOBBYISTS
CONTRACTOR and each COUNTY lobbyist or COUNTY lobbying firm as defined in Los Angeles County Code Section 2.160.010, retained by CONTRACTOR, shall fully comply with the County Lobbyist Ordinance, Los Angeles County Code chapter 2.160. Failure on the part of CONTRACTOR or any COUNTY lobbyist or COUNTY lobbying firm retained by CONTRACTOR to fully comply with the County Lobbyist Ordinance shall constitute a material breach of this Agreement upon which COUNTY may immediately terminate or suspend this Agreement.

14. USE OF RECYCLED PAPER
Consistent with the Board of Supervisors' policy to reduce the amount of solid waste deposited at County landfills, CONTRACTOR agrees to use recycled-content paper to the maximum extent possible on the Project.

15. NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT
As applicable, CONTRACTOR shall notify its employees, and shall require each subcontractor to notify its employees, that they may be eligible for the Federal Earned Income Credit under the Federal income tax laws. Such notice shall be provided in accordance with the requirements set forth in Internal Revenue Service Notice 1015.

16. CONSIDERATION OF GAIN PROGRAM PARTICIPANTS FOR EMPLOYMENT
As applicable, should CONTRACTOR require additional or replacement personnel after the effective date of this Agreement, CONTRACTOR shall give consideration for any such employment openings to participants in the COUNTY'S Department of Public Social Services' Greater Avenues for Independence (GAIN) Program who meet the CONTRACTOR'S minimum qualifications for the open position. The COUNTY will refer GAIN participants by job category to the CONTRACTOR.

17. CONTRACTOR'S ACKNOWLEDGMENT OF COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM
As required by the COUNTY's Child Support Compliance Program (County Code Chapter 2.200) and without limiting the CONTRACTOR's duty under this Agreement to comply with all applicable provisions of law, the CONTRACTOR warrants that it is now in compliance and shall during the term of this Agreement maintain in compliance with employment and wage reporting requirements as required by the Federal Social Security Act (42 USC Section 653a) and California Unemployment Insurance Code Section 1088.5, and shall implement all lawfully served Wage and Earnings Withholding Orders or Child Support Services Department Notices of Wage and Earnings Assignment for Child, Family or Spousal Support, pursuant to Code of Civil Procedure Section 706.031 and Family Code Section 5246(b).

18. CONTRACTOR'S ACKNOWLEDGMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW
The CONTRACTOR shall notify and provide to its employees, and shall require each subcontractor to notify and provide to its employees, a fact sheet regarding the Safely Surrendered Baby Law, its implementation in Los Angeles County, and where and how to safely surrender a baby. The fact sheet is available on the Internet at www.babysafela.org for printing purposes.

19. TERMINATION FOR DEFAULT
Services performed under this Agreement may be terminated immediately in whole or in part by COUNTY by providing to CONTRACTOR a written Notice of Default if 1) CONTRACTOR fails to perform the services within the time specified in this Agreement or any extensions approved by COUNTY, 2) CONTRACTOR fails to perform any other covenant or condition of this Agreement, or 3) CONTRACTOR fails to make progress so as to endanger its performance under this Agreement.

In its sole discretion, COUNTY may include in the Notice of Default a period of time for CONTRACTOR to cure the Default(s).

Without limitation of any additional rights or remedies to which it may be entitled, if COUNTY terminates all or part of the services because of CONTRACTOR'S Default, COUNTY, in its sole discretion, may procure replacement services, as determined by COUNTY at its sole discretion.

20. TERMINATION FOR IMPROPER CONSIDERATION
County may, by written notice to CONTRACTOR, immediately terminate the right of CONTRACTOR to proceed under this Agreement if it is found that consideration, in any form, was offered or given by CONTRACTOR, either directly or through an intermediary, to any County officer, employee or agent with the intent of securing the Agreement or securing favorable treatment with respect to the award, amendment or extension of the Agreement or the making of any determinations with respect to the CONTRACTOR's performance pursuant to the Agreement. In the event of such termination, COUNTY shall be entitled to pursue the same remedies against CONTRACTOR as it could pursue in the event of default by the CONTRACTOR. CONTRACTOR shall immediately report any attempt by a County officer or employee to solicit such improper consideration. The report shall be made either to the County manager charged with the supervision of the employee or to the County Auditor-Controller's Employee Fraud Hotline at (800) 544-6861. Among other items, such improper consideration may take the form of cash,

discounts, service, the provision of travel or entertainment, or tangible gifts.

21. **FINAL REPORT**
CONTRACTOR shall complete and submit a report to the Executive Office of the County of Los Angeles Board of Supervisors ("Final Report") under penalty of perjury to identify the goals, objectives and specific activities stated in the Agreement, and to certify that the contract satisfied the social needs of the County. Further, the Final Report shall identify the actual expenses incurred and state the amount unused in order to be returned to the COUNTY. CONTRACTOR shall provide receipts and/or a budget to specify how funds were expended.

22. **FACSIMILE REPRESENTATIONS**
The COUNTY and the CONTRACTOR hereby agree to regard facsimile representations of original signatures of authorized officers of each party, when appearing in appropriate places and received via communications facilities, as legally sufficient evidence that such original signatures have been affixed to this Agreement, such that the parties need not follow up facsimile transmissions of such documents with subsequent (non-facsimile) transmission of "original" versions of such documents.

23. **NOTICES**
Notices will be sent to the CONTRACTOR addressed as follows:

Huntington Hospital
100 W. California Blvd.
Pasadena, CA 91105

Jamie Brady-Smith (626) 397-3241
(Contact Person) (Telephone Number)

Huntington Hospital
(Contractor's Name)

Notices, performance and fiscal reports shall be sent to the COUNTY as follows:

Board of Supervisors
County of Los Angeles
500 W. Temple Street, Room 383
Los Angeles, CA 90012

Attention: SUSANNA PONCIANO, FISCAL SERVICES

March 5, 2020

Exhibit 23-G

Contract No. 23,340 for COVID-19 Pandemic

CONTRACT NO. 23,340

THIS CONTRACT is made between the CITY OF PASADENA ("City"), a municipal corporation, PASADENA CENTER OPERATING COMPANY, a non-profit public benefit corporation ("PCOC"), and PASADENA HOSPITAL ASSOCIATION, LTD., d/b/a Huntington Memorial Hospital, a California corporation with headquarters at 100 West California Blvd., Pasadena, California 91105 ("Contractor").

WHEREAS, international, national, state, and local health and governmental authorities are responding to an outbreak of respiratory disease caused by a novel coronarius named " SARS-Co V-2," and the disease it causes has been named "coronavirus disease 2019," abbreviated COVID-19, ("COVID-19");

WHEREAS, on since March 4, 2020, the City of Pasadena and its officials have declared, ratified, and issued a local health emergency, a local emergency, and health orders, all in response to the COVID-19 pandemic;

WHEREAS, on March 4, 2020, the Governor of the State of California declared a state of emergency to make additional resources available, formalize emergency actions already underway across multiple state agencies and departments, and help the state prepare for broader spread of COVID-19;

WHEREAS, on March 13, 2020, the President of the United States of America declared a national emergency and announced that the federal government would make emergency funding available to assist state and local

governments in preventing the spread of and addressing the effects of COVID-19;

WHEREAS, Contractor reports that, even with limiting elective surgeries as informed by guidance from various health authorities, its existing medical facilities at its principal place of business are reasonably forecasted to become overloaded in the near future and may not be able to accommodate needs to respond to the COVID-19 pandemic;

WHEREAS, the City and PCOC desire to make available to Contractor certain space at the City-owned Pasadena Center to operate an Alternative Care Site (the "ACS") where Contractor intends to provide hospital and medical services associated with the COVID-19 pandemic.

The City, PCOC, and Contractor agree as follows.

1.0 CITY, PCOC, AND CONTRACTOR RELATIONSHIP.

1.1 City agrees to provide Contractor the exclusive right to use certain space at the Pasadena Center, as described in Exhibit "A," to establish an ACS and to perform the services as hereinafter set forth as authorized by the City Council on April 6, 2020, for the purposes of assisting the City in carrying out efforts to prevent the spread of the novel coronavirus (COVID-19), as further set forth in the declaration of local health emergency, ratified by the City Council on March 9, 2020, health orders issued by the Health Officer on March 19 and 22, 2020, and the declaration of local emergency, ratified by the City Council on March 17, 2020 (and its supplements).

1.2 The term of this Contract shall be for the pendency of the Contractor's operation of an ACS at the Pasadena Center. The ACS is presently scheduled to provide approximately 250 beds to treat COVID-19 patients and patients suspected to be COVID-19 positive who are accepted by Contractor for hospital admission. The purpose of the ACS is to treate COVID-19 patients at a location other than at Contractor's principal place of business, when overloaded and unable to accommodate needs to respond to the COVID-19 pandemic. The Pasadena Center is owned by the City, and is operated by PCOC. The City and PCOC shall not charge Contractor a fee for the use of the Pasadena Center.

2.0 SCOPE OF SERVICES.

2.1 Contractor shall perform all work necessary to complete the services described in Exhibit "A."

2.2 All services shall be performed to the satisfaction of City.

2.3 All services shall be performed according to applicable state and federal requirements, including, but not limited to, CDC requirements, in place during the term of this Contract. Contractor shall seek to operate the ACS pursuant to Contractor's state hospital license and Medicare and Medi-Cal provider agreements and third party payor agreements.

3.0 PERSONNEL.

3.1 Contractor represents that it employs and/or contracts with all personnel as required and reasonably available to perform the services under this Contract.

3.2 Contractor may contract for services, equipment, and supplies as necessary for operation of the ACS at the Pasadena Center.

3.3 Contractor, and all personnel engaged in the work, shall be fully qualified and authorized or permitted under then-current and applicable federal, state, and/or local legal requirements to perform the services called for in this Contract.

4.0 TIME OF PERFORMANCE.

4.1 Contractor shall commence its services (occupying the ACS) immediately upon receipt of a Notice to Proceed from the City, and shall complete its occupation no later than 15 days following the date that Contractor discharges the last patient from the ACS.

4.2 The time for performing the services may only be extended in writing by City, and only upon a showing of good cause, in the City's sole discretion.

4.3 Notwithstanding the foregoing, Contractor's obligations under this Contract shall not begin until it obtains any necessary assurances and

approvals to operate the ACS and to be reimbursed for hospital services provided there.

5.0 COMPENSATION AND FEES

5.1 This is a zero-dollar contract. The City shall provide Contractor the use of certain space at the Pasadena Center at no cost for use as an ACS to increase the availability of hospital services within the City, which assists the City in carrying out efforts to prevent the spread of COVID-19.

6.0 PAYMENT BY THIRD PARTIES TO CONTRACTOR.

6.1 Contractor shall submit bills to and collect from the applicable health insurance or health plan payor (including, but no limited to, Medicare and Medi-Cal, private health insurance companies or employer-sponsored health plans) reimbursement and payment for items and services provided by Contractor to patients at the ACS. Any revenue received by Contractor as a result of these efforts will be the sole property of Contractor.

7.0 CHANGE ORDERS. [intentionally omitted]

8.0 CITY'S RESPONSIBILITY. City shall cooperate with Contractor as may be reasonably necessary for Contractor to perform its services; and will give any required access, approvals, or decisions as promptly as practicable so as to avoid unreasonable delay in the provision of Contractor's services.

9.0 GENERAL TERMS AND CONDITIONS.

9.1 INDEPENDENT CONTRACTOR.

9.1.1 It is understood that in the performance of the services herein provided for, Contractor shall be, and is, an independent contractor, and is not an agent or employee of City and shall furnish such services in its own manner and method except as required by this Contract. Further, Contractor has and shall retain the right to exercise full control over the employment, direction, supervision, compensation and discharge of all persons employed by Contractor in the performance of the services in operating the ACS. Contractor shall be solely responsible for, and shall indemnify, defend and save City and PCOC harmless from all matters relating to the payment of its employees, including compliance with social security, withholding and all other wages, salaries, benefits, taxes, exactions, and regulations of any nature whatsoever.

9.1.2 Contractor acknowledges that Contractor and any subcontractors, agents or employees employed by Contractor shall not, under any circumstances, be considered employees of the City or PCOC, and that they shall not be entitled to any of the benefits or rights afforded employees of City or PCOC, including, but not limited to, sick leave, vacation leave, holiday pay, Public Employees Retirement System benefits, or health, life, dental, long-term disability or workers' compensation insurance benefits.

9.2 CONTRACTOR NOT AGENT. Except as the City may authorize in writing, Contractor and its subcontractors shall have no authority, express or implied, to act on behalf of or bind the other parties in any capacity whatsoever as agents or otherwise.

9.3 OWNERSHIP OF WORK. [intentionally omitted]

9.4 CORRECTION OF WORK. Contractor shall promptly correct any defective, inaccurate or incomplete tasks, deliverables, goods, services and other work for which Contractor is responsible, without additional cost to the City. The performance or acceptance of services furnished by Contractor shall not relieve the Contractor from the obligation to correct subsequently discovered defects, inaccuracies or incompleteness.

9.5 WAIVER. Neither party's waiver of any term, condition, breach or default of this Contract shall not be considered to be a waiver of any other term, condition, default or breach, nor of a subsequent breach of the one waived.

9.6 SUCCESSORS. This Contract shall inure to the benefit of, and shall be binding upon, the parties hereto and their respective heirs, successors and/or assigns.

9.7 NO ASSIGNMENT. Contractor shall not assign or transfer this Contract or any rights hereunder without the prior written consent of the City and approval by the City Attorney, which may be withheld in the City's sole discretion. Any unauthorized assignment or transfer shall be null and void and shall

constitute a material breach by the Contractor of its obligations under this Contract. No assignment shall release the original parties or otherwise constitute a novation.

9.8 COMPLIANCE WITH LAWS. Contractor shall comply with all Federal, State, County and City laws, ordinances, rules and regulations, which are, as amended, waived, and/or suspended from time to time, incorporated herein and applicable to the performance hereof, including but without limitation the federally-required and/or recommended additional provisions in Exhibit "C," attached hereto, the Pasadena Center's Facility Policies and Procedures, as may be amended from time to time, and CDC requirements.

9.9 INTERPRETATION.

9.9.1 Applicable Law. This Contract, and the rights and duties of the parties hereunder (both procedural and substantive), shall be governed by and construed according to the laws of the State of California.

9.9.2 Entire Agreement. This Contract, including any Exhibits attached hereto, constitutes the entire agreement and understanding between the parties regarding its subject matter and supersedes all prior or contemporaneous negotiations, representations, understandings, correspondence, documentation and agreements (written or oral).

9.9.3 Written Amendment. This Contract may only be changed by written amendment signed by Contractor and the City Manager or other authorized representative of the City, subject to any requisite authorization

by the City Council, with the exception of revisions to Exhibit "D," which describes the temporary space of the ACS, with revisions to be made as described in the scope of work, Exhibit "A." Any oral representations or modifications concerning this Contract shall be of no force or effect.

9.9.4 Severability. If any provision in this Contract is held by any court of competent jurisdiction to be invalid, illegal, void, or unenforceable, such portion shall be deemed severed from this Contract, and the remaining provisions shall nevertheless continue in full force and effect as fully as though such invalid, illegal, or unenforceable portion had never been part of this Contract.

9.9.5 Order of Precedence. In case of conflict between the terms of this Contract and the terms contained in any document attached as an Exhibit or otherwise incorporated by reference, the terms of this Contract shall strictly prevail.

9.9.6 Choice of Forum. The parties hereby agree that this Contract is to be enforced in accordance with the laws of the State of California, is entered into and/or is performed in the City of Pasadena and that all claims or controversies arising out of or related to performance under this Contract shall be submitted to and resolved in a forum within the County of Los Angeles at a place to be determined by the rules of the forum.

9.9.7 Duplicate Originals. There shall be two (2) fully signed copies of this Contract, each of which shall be deemed an original.

9.10 ATTORNEY'S FEES. Except as otherwise provided herein, if any action at law or in equity is brought to enforce or interpret the terms of this Contract, each party shall be responsible for their own attorney's fees, costs and necessary disbursements.

9.11 TIME OF ESSENCE. Time is strictly of the essence with respect to provisions under this Contract and each and every covenant, term and provision hereof.

9.12 AUTHORITY OF CONTRACTOR. The Contractor hereby represents and warrants to the City that the Contractor has the right, power, legal capacity and authority to enter into and perform its obligations under this Contract, and its execution of this Contract has been duly authorized.

9.13 ARBITRATION OF DISPUTES. Any dispute for under $25,000 arising out of or relating to the negotiation, construction, performance, non-performance, breach or any other aspect of this Contract, shall be settled by binding arbitration in accordance with the Commercial Rules of the American Arbitration Association at Los Angeles, California and judgment upon the award rendered by the Arbitrators may be entered in any court having jurisdiction thereof. The City does not waive its right to object to the timeliness or sufficiency of any claim filed or required to be filed against the City and reserves the right to conduct full discovery.

9.14 INDEMNITY.

9.14.1 Contractor agrees to indemnify, hold harmless and defend (even if the allegations are false, fraudulent or groundless), to the maximum extent permitted by law, PCOC and its Board of Directors, the City, its City Council and each member thereof, and their officers, employees, commission members and representatives, from any and all liability, loss, suits, claims, damages, costs, judgments and expenses (including attorney's fees and costs of litigation) which in whole or in part result from, or arise out of, or are claimed to result from or to arise out of:

A. any activity on or use of PCOC's or City's premises or facilities or any performance under this Contract; or

B. any acts, errors or omissions (including, without limitation, professional negligence) of Contractor, its employees, representatives, subcontractors, or agents in connection with the performance of this Contract.

9.14.2 This agreement to indemnify includes, but is not limited to, personal injury (including death at any time) and property or other damage (including, but without limitation, contract or tort or patent, copyright, trade secret or trademark infringement) sustained by any person or persons (including, but not limited to, companies, or corporations, Contractor and its employees or agents, and members of the general public). The sole negligence or willful misconduct of PCOC, the City, their employees or agents other than

Contractor or Contractor's subcontractors are excluded from this indemnity agreement.

9.15 RELEASE. Contractor agrees to release and covenants not to sue PCOC, its Board of Directors, the City, its City Council and each member thereof, and their officers, employees, commission members and representatives for any damage or injury (including death) to itself, its officers, employees, agents and independent contractors damaged or claiming to be damaged from any performance under this Contract.

9.16 INSURANCE. Contractor shall, at its own expense, procure and maintain policies of insurance of the types and in the amounts set forth in Exhibit "B," attached hereto.

9.17 NOTICES.

Any notice or demand to be given by one party to the other shall be given in writing and by personal delivery or prepaid first-class, registered or certified mail, addressed as follows. Notice simply to the City of Pasadena or any other City department is not adequate notice.

If to the City:	Bryan Frieders, Interim Fire Chief Pasadena Fire Department 215 N. Marengo Avenue, #195 Pasadena, CA 91101
If to the Contractor:	Terence Ou, Director of Compliance Huntington Memorial Hospital 100 West California Blvd. Pasadena, CA 91105

Any such notice shall be deemed to have been given upon delivery, if personally delivered, or, if mailed, upon receipt or upon expiration of three (3) business days from the date of posting, whichever is earlier. Either party may change the address at which it desires to receive notice upon giving written notice of such request to the other party.

9.18 TERMINATION FOR CONVENIENCE (Without Cause). Either Party may terminate this Contract in whole or in part at any time, for any cause or without cause, upon fifteen (15) calendar days' written notice to the other Party, excepting that Contractor may continue to operate the ACS for such period as is necessary to transfer or discharge all then-current patients and to complete closure of the ACS operations in a manner compliant with applicable law.

10.0 ADDITIONAL ASSURANCES

10.1 EQUAL EMPLOYMENT OPPORTUNITY PRACTICES.

Contractor agrees to comply with Section 4.08.035 of the City's Competitive Bidding and Purchasing Ordinance of the Pasadena Municipal Code, the rules and regulations promulgated thereunder, and the California Fair Employment and Housing Act (Government Code section 12900 et seq.) in relation to the operation of the ACS and to this end:

10.1.1 Contractor certifies and represents that, during the performance of this Contract, the Contractor and any other parties with whom it may subcontract shall adhere to equal opportunity employment practices to assure that applicants and employees are treated equally and are not

discriminated against because of their race, religion, color, national origin, ancestry, disability, sex, age, medical condition, marital status. Contractor further certifies that it will not maintain any segregated facilities.

10.1.2 Contractor shall, in all solicitations or advertisements for applicants for employment placed by or on behalf of this Contract, state that it is an "Equal Opportunity Employer" or that all qualified applicants will receive consideration for employment without regard to their race, religious creed, color, national origin, ancestry, disability, sex, age, medical condition or marital status.

10.1.3 Contractor shall, if requested to do so by the City, certify that it has not, in the performance of this Contract, discriminated against applicants or employees because of their race, religious creed, color, national origin, ancestry, disability, sex, age, medical condition or marital status.

10.1.4 If requested to do so by the City, Contractor shall provide the City with access to copies of all of its records pertaining or relating to its employment practices, except to the extent such records or portions of such records are confidential or privileged under state or federal law.

10.1.5 Contractor agrees to recruit Pasadena residents initially and to give them preference, if all other factors are equal, for any new positions which result from the performance of this Contract and which are performed within the City, unless prohibited by applicable federal or state laws or regulations.

10.1.6 Nothing contained in this Contract shall be construed in any manner so as to require or permit any act which is prohibited by law.

10.1.7 The Contractor shall include the provisions set forth in paragraphs numbered 10.1.1 through 10.1.6 of subsection 10.1 of this Contract, inclusive, in each of its subcontracts.

10.2 PASADENA BUSINESS LICENSE. Contractor shall obtain, and pay any and all costs associated therewith, any Pasadena Business License which may be required by the Pasadena Municipal Code.

10.3 MAINTENANCE AND INSPECTION OF RECORDS.

10.3.1 Contractor shall maintain the confidentiality of all protected health and medical information in accordance with all applicable State and Federal law, including without limitation the Health Insurance Portability and Accountability Act ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH") and the California Confidentiality of Medical Information Act ("CMIA"). Except as permitted by law, including, but not limited to, compliance with the Access to Records provision in Exhibit "C," Contractor shall not disclose or otherwise provide the City with access to any personal, medical or other protected information.

10.3.2 Contractor shall maintain and preserve all such records for its operation of the ACS for a period of at least 3 years after termination of the Contract. Contractor shall maintain all such records in the City of Pasadena. If not, the Contractor shall, upon request, promptly deliver the

records to the City of Pasadena or reimburse the City for all reasonable and extra costs incurred in conducting the audit at a location other than the City of Pasadena, including, but not limited to, such additional (out of the City) expenses for personnel, salaries, private auditors, travel, lodging, meals and overhead.

10.4 CONFLICT. Contractor hereby represents, warrants and certifies that no member, officer or employee of the Contractor is a director, officer or employee of the City of Pasadena, or a member of any of its boards, commissions or committees, except to the extent permitted by law.

11.0 TAXPAYER PROTECTION AMENDMENT.

Under the provisions of the City of Pasadena Taxpayer Protection Amendment of 2000 ("Taxpayer Protection Act"), the Contractor/Organization will be considered a "recipient of a public benefit." The full provisions of the Taxpayer Protection Act are set forth in Pasadena City Charter, Article XVII. Under the Taxpayer Protection Act, City public officials who approve this Contract/transaction are prohibited from receiving specified gifts, campaign contributions or employment from Contractor/Organization for a specified time. As well, if this Contract is to be approved by the City Council, Councilmembers or candidates for Council are prohibited from receiving campaign contributions during the time this Contract is being negotiated. This prohibition extends to individuals and entities that are specified and identified in the Taxpayer Protection Act and includes Contractor/Organization and its trustees, directors, partners, corporate officers and those with more than a 10% equity, participation, or

revenue interest in Contractor/Organization. Contractor/Organization understands and agrees that: (A) Contractor/Organization is aware of the Taxpayer Protection Act; (B) Contractor/Organization will complete and return the forms provided by the City in order to identify all of the recipients of a public benefit specified in the Taxpayer Protection Act; and (C) Contractor/Organization will not make any prohibited gift, campaign contribution or offer of employment to any public official who negotiated and/or approved this Contract/transaction.

IN WITNESS WHEREOF, the parties hereto have caused this Contract to be executed by their duly authorized representatives as of the date set forth below.

DATED:

CITY OF PASADENA

By: REDACTED

Steve Mermell
City Manager

ATTEST: REDACTED

Mark Jomsky, CMC
City Clerk

DATED:

PASADENA CENTER OPERATING COMPANY

By: _____

Michael Ross
Chief Executive Officer

DATED:

PASADENA HOSPITAL ASSOCIATION, LTD. d/b/a HUNTINGTON MEM. HOSPITAL

REDACTED

Lori J. Morgan
President and CEO

APPROVED AS TO FORM:

REDACTED

Javan N. Rad
Chief Assistant City Attorney

REVIEWED:

REDACTED

Erika Estrada
Purchasing Administrator

JNR/drc
4/11/2020
0000160892C031

IN WITNESS WHEREOF, the parties hereto have caused this Contract to be executed by their duly authorized representatives as of the date set forth below.

DATED:

CITY OF PASADENA

By: REDACTED

Steve Mermell
City Manager

ATTEST:

Mark Jomsky, CMC
City Clerk

DATED:

PASADENA CENTER OPERATING COMPANY

By: REDACTED

Michael Ross
Chief Executive Officer

DATED:

PASADENA HOSPITAL ASSOCIATION, LTD. d/b/a HUNTINGTON MEM. HOSPITAL

By: REDACTED

Lorl J. Morgan
President and CEO

APPROVED AS TO FORM:

Javan N. Rad
Chief Assistant City Attorney

REVIEWED:

REDACTED

Erika Estrada
Purchasing Administrator

JNR/drc
4/11/2020
0000160892C031

IN WITNESS WHEREOF, the parties hereto have caused this Contract to be executed by their duly authorized representatives as of the date set forth below.

DATED:

CITY OF PASADENA

By: REDACTED

Steve Mermell
City Manager

ATTEST:

REDACTED

Mark Jomsky, CMC
City Clerk

DATED:

PASADENA CENTER OPERATING COMPANY

By:_____

Michael Ross
Chief Executive Officer

DATED:

PASADENA HOSPITAL ASSOCIATION, LTD. d/b/a HUNTINGTON MEM. HOSPITAL

By: REDACTED

Lori J. Morgan
President and CEO

APPROVED AS TO FORM:

_____

Javan N. Rad
Chief Assistant City Attorney

REVIEWED:

_____

Erika Estrada
Purchasing Administrator

JNR/drc
4/11/2020
0000160892C031

EXHIBIT A

Scope of Work

Contractor will operate an alternative care site ("ACS") at a specified location at the Pasadena Center to treat patients who have either tested positive for COVID-19 or are suspected to be positive for COVID-19. The ACS will operate as an additional location under Contractor's existing hospital license, Medicare and Medi-Cal provider agreements, and third party payor agreements.

The parties presently plan for the ACS to be constructed in a temporary space in two adjoining ballroom spaces in the Exhibit Hall at the Pasadena Center. The temporary space, as described in Exhibit "D," may be changed, adjusted, and/or modified by the City, in its sole discretion, from time to time, and Exhibit "D" may be revised to reflect the then-current space, without the need for a formal amendment to this Contract.

The City shall reconfigure and/or build out temporary space for the ACS at the Pasadena Center, by providing, at the City's sole expense, the labor, material, supplies, and services (collectively "Materials") necessary to set up the ACS. As of the date of this Contract, the City anticipates such Materials to be provided by Redrock Entertainment Services, LLC ("Redrock"). Contractor shall be permitted to use the Materials in its operation of the ACS at no cost to Contractor. Contractor shall cooperate with Redrock or an equivalent vendor of the City's choosing to ensure that the Materials are appropriate for the operation of the ACS in accordance with applicable building, licensing, and certification requirements then-applicable to the ACS.

Contractor has the sole right and responsibility to operate the ACS and, notwithstanding any other provision of this Contract, Contractor has the right to overall control and governance over the provision of its services at the ACS. Contractor shall operate the ACS in accordance with standards and/or guidance approved by HHS/CDC and must be implemented in a manner that incorporates social distancing measures, to the greatest extent feasible. Contractor shall provide City with a copy of Contractor's disaster plan that it has activated under applicable law and emergency waivers. Notwithstanding the foregoing, Contractor shall provide the City with daily patient census reports.

To the extent feasible, Contractor will stock the ACS with the medical equipment, medical supplies, medication/drugs, devices, and linens/laundry necessary to treat patients at the ACS. The type and amount of these supplies will be based on Contractor's experience as a hospital operator and as needed and available to provide hospital services at the ACS. The City shall be responsible for providing dietary and food service for ACS patients and staff.

PCOC provides exclusive services for, among other things, telecommunications, electrical/utilities, house sound system, and rigging. All other suppliers, such as general service contractors, must obtain approval by PCOC prior to commencing work at the Pasadena Center. Contractor shall use all PCOC furnished exclusive services and personnel in place during the term the ACS is operated. PCOC reserves the right to approve all other vendors and services prior to Contractor's occupation of the ACS, based on compliance with PCOC indemnity requirements.

Contractor shall comply with PCOC's Facility Policies & Procedures (also known as the Policies & Procedures Guidebook), a current copy of which is available online at http://www.pasadenacenter.com. The space occupied by the ACS, including the keys thereto, shall at all times be under the control of PCOC's duly authorized representative. Contractor shall at its own expense place any necessary personnel at entrances or exits, with the exception of the City and/or PCOC providing security for the venue.

The City will provide all other supplies and services necessary to build out and maintain the ACS, including, but not limited to, water, utilities, traffic management, cleaning/janitorial services for all areas away from the bed areas, including, but not limited to, restrooms, common areas, floors, hallways, eating areas, kitchen and storage facilities, and security.

Contractor will be solely responsible for obtaining payment and/or reimbursement from patients, insurers, and others, for hospital services and treatment provided at the ACS under this Contract.

Contractor and City will cooperate with each other in seeking reimbursement from government authorities (or others) for the costs incurred in the performance of, and in relation to, this Contract.

EXHIBIT B

Insurance Requirements

Contractor shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder and the results of that work by Contractor, its agents, representatives, employees or subcontractors. The cost of such insurance shall be borne by Contractor.

MINIMUM SCOPE AND LIMIT OF INSURANCE

Coverage shall be at least as broad as:

1. Commercial General Liability (CGL): Insurance Services Office (ISO) Form CG 00 01 covering CGL on an "occurrence" basis, including products and completed operations, property damage, bodily injury and personal & advertising injury with limits no less than $2,000,000 per occurrence. If a general aggregate limit applies, the general aggregate limit shall be twice the required occurrence limit. The policy shall include broad form contractual liability coverage.
2. Automobile Liability: ISO Form Number CA 0001 covering, Code 1 (any auto), or if Consultant has no owned autos, Code 8 (hired) and 9 (non- owned), with limit no less than $1,000,000 per accident for bodily injury and property damage.
3. Workers' Compensation insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than $1,000,000 per accident for bodily injury or disease.
4. Professional Liability (Medical Malpractice) insurance with limit no less than $5,000,000 per occurrence or claim, $10,000,000 in the annual aggregate.

Contractor should check with Contractor's insurance advisors to verify compliance and determine if additional coverage or limits may be needed to adequately insure Contractor's obligations under this agreement. These are the minimum required and do not in any way represent or imply that such coverage is sufficient to adequately cover Contractor's liability under this agreement. These insurance requirements shall not in any way relieve Contractor of liability in excess of such coverage, nor shall it preclude City and/or Pasadena Center Operating Company (PCOC) from taking such other actions as are available to it/them under any other provisions of this agreement or law. These insurance requirements shall not in any way act to reduce coverage that is broader or includes higher limits than those required. If Contractor maintains broader coverage and/or higher limits than the minimums shown above, City and PCOC require and shall be entitled to the broader coverage and/or the higher limits

maintained by Contractor. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage required, which are applicable to any given loss, shall be available to City and PCOC.

The insurance to be provided by Contractor under this agreement shall not include any endorsement limiting coverage available to City and/or PCOC that is otherwise required herein; and any policy or endorsement language that (i) negates coverage to City and/or PCOC for City's and/or PCOC's own negligence; (ii) limits the duty to defend City and/or PCOC under the policy; (iii) provides coverage to City and/or PCOC only if Contractor is negligent, or (iv) permits the recovery of defense costs from any additional insured. The insurance provided under this agreement shall not contain any restrictions or limitations which are inconsistent with City's and/or PCOC's rights under this agreement.

Other Insurance Provisions
The insurance policies are to contain, or be endorsed to contain, the following provisions:

Additional Insured Status
The Pasadena Center Operating Company, its Board of Directors, and City of Pasadena, its City Council, their officers, officials, employees, agents, and volunteers are to be covered as additional insureds on the CGL policy with respect to liability arising out of work or operations performed by or on behalf of Contractor including materials, parts, or equipment furnished in connection with such work or operations. General liability additional insured coverage shall be provided in the form of an endorsement to Contractor's insurance at least as broad as ISO Form CG 20 10 11 85 (ongoing operations) and CG 20 37 (completed operations).

Severability of Interests (Cross-Liability).
A severability of interest provision must apply for all the additional insureds, ensuring that Contractor's insurance shall apply separately to each insured against whom a claim is made or suit is brought, except with respect to the insurer's limits of liability.

Primary Coverage
For any claims related to this contract, Contractor's insurance coverage shall be primary insurance coverage at least as broad as ISO CG 20 01 04 13 as respects PCOC, its Board of Directors, and City, its City Council, their officers, officials, employees, agents, and volunteers. Any insurance or self-insurance maintained by PCOC, its Board of Directors, and City, its City Council, their officers, officials, employees, agents, or volunteers shall be excess of Contractor's insurance and shall not contribute with it.

Notice of Cancellation/Change in Coverage
Each insurance policy required above shall state that coverage shall not be suspended, voided, canceled reduced in coverage or in limits, non-renewed, or materially changed except after thirty (30) days' prior written notice has been given to City and PCOC, except that ten (10) days' prior written notice shall apply in the event of cancellation for non-payment of premium. Prior written notice shall be sent to City and PCOC pursuant to the Notices provisions of this agreement.

Waiver of Subrogation
Contractor hereby grants to City and PCOC a waiver of any right to subrogation which any insurer of Contractor may acquire against City and/or PCOC by virtue of the payment of any loss under such insurance. Contractor agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not City or PCOC has received a waiver of subrogation endorsement from the insurer.

Self-Insured Retentions
Self-insured retentions must be declared to and approved by City and PCOC. City and PCOC may require Contractor to purchase coverage with a lower retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention.

Acceptability of Insurers
Insurance is to be placed with insurers authorized to conduct business in the state of California with a current A.M. Best's rating of no less than A:VII.

Claims Made Policies
If the Professional Liability (Medical Malpractice) policy provides coverage on a claims-made basis:

1. The Retroactive Date must be shown and must be before the date of the contract or the beginning of contract work.
2. Insurance must be maintained and evidence of insurance must be provided for at least five (5) years after completion of the contract of work.
3. If the policy is canceled or non-renewed, and not replaced with another claims-made policy form with a Retroactive Date prior to the contract effective date, Contractor must purchase "extended reporting" coverage for a minimum of five (5) years after completion of contract work.

Certificate Holder
Certificate Holder on each insurance certificate shall be addressed pursuant to the Notices provisions of this agreement.

JNR/drc
4/11/2020
0000160892C031

Verification of Coverage
Contractor shall furnish City and PCOC with original certificates and amendatory endorsements or copies of the applicable policy language effecting coverage required by this clause. A statement on an insurance certificate will not be accepted in lieu of the actual endorsements required herein. Each insurance certificate shall include specifically identify this agreement. All certificates and endorsements are to be received and approved by City and PCOC before work commences. However, failure to obtain the required documents prior to the work beginning shall not waive Contractor's obligation to provide them. City and PCOC reserve the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications at any time.

Subcontractors
Contractor shall require and verify that all subcontractors maintain insurance meeting all the requirements stated herein, and Contractor shall ensure that City and PCOC are additional insureds on insurance required from subcontractors.

Failure to Maintain Insurance Coverage
If Contractor, for any reason, fails to maintain insurance coverage which is required pursuant to this contract, the same shall be deemed a material breach of contract. City and PCOC, at their sole option, may terminate this contract and obtain damages from Contractor resulting from said breach. Alternatively, City and PCOC may purchase such coverage (but have no special obligation to do so), and without further notice to Contractor, the City and PCOC may deduct from sums due to Contractor any premium costs advanced by City and PCOC for such insurance.

Special Risks or Circumstances
City and PCOC reserve the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

EXHIBIT C

Additional Provisions

To the extent City and/or Contractor apply for and receive Federal assistance provided by FEMA as a result of this Contract, this Contract is subject to the requirements set forth in 2 CFR Part 200, including Section 200.326 and 2 CFR Part 200, Appendix II, and any additional guidance or rulemaking that may be issued by the federal government with regard to FEMA financial assistance under emergency or exigent circumstances for COVID-19, and such provisions are hereby incorporated by reference.

Equal Employment Opportunity

During the performance of this contract, the contractor agrees as follows:

(1) The contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, gender identity, or national origin. The contractor will take affirmative action to ensure that applicants are employed, and that employees are treated during employment without regard to their race, color, religion, sex, sexual orientation, gender identity, or national origin. Such action shall include, but not be limited to the following:

> Employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided setting forth the provisions of this nondiscrimination clause.

(2) The contractor will, in all solicitations or advertisements for employees placed by or on behalf of the contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, or national origin.

(3) The contractor will not discharge or in any other manner discriminate against any employee or applicant for employment because such employee or applicant has inquired about, discussed, or disclosed the compensation of the employee or applicant or another employee or applicant. This provision shall not apply to instances in which an employee who has access to the compensation information of other employees or applicants as a part of such employee's essential job functions discloses the compensation of such other employees or applicants to individuals who do not otherwise have access to such information, unless such disclosure is in response to a formal complaint or charge, in furtherance of an investigation, proceeding, hearing, or action, including an

investigation conducted by the employer, or is consistent with the contractor's legal duty to furnish information.

(4) The contractor will send to each labor union or representative of workers with which he has a collective bargaining agreement or other contract or understanding, a notice to be provided advising the said labor union or workers' representatives of the contractor's commitments under this section, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

(5) The contractor will comply with all provisions of Executive Order 11246 of September 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

(6) The contractor will furnish all information and reports required by Executive Order 11246 of September 24, 1965, and by rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to his books, records, and accounts by the administering agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

(7) In the event of the contractor's noncompliance with the nondiscrimination clauses of this contract or with any of the said rules, regulations, or orders, this contract may be canceled, terminated, or suspended in whole or in part and the contractor may be declared ineligible for further Government contracts or federally assisted construction contracts in accordance with procedures authorized in Executive Order 11246 of September 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order 11246 of September 24, 1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

(8) The contractor will include the portion of the sentence immediately preceding paragraph (1) and the provisions of paragraphs (1) through (8) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to section 204 of Executive Order 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. The contractor will take such action with respect to any subcontract or purchase order as the administering agency may direct as a means of enforcing such provisions, including sanctions for noncompliance:

Provided, however, that in the event a contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the administering agency, the contractor may request the United States to enter into such litigation to protect the interests of the United States.

The applicant further agrees that it will be bound by the above equal opportunity clause with respect to its own employment practices when it participates in federally assisted construction work: Provided, That if the applicant so participating is a State or local government, the above equal opportunity clause is not applicable to any agency, instrumentality or subdivision of such government which does not participate in work on or under the contract.

The applicant agrees that it will assist and cooperate actively with the administering agency and the Secretary of Labor in obtaining the compliance of contractors and subcontractors with the equal opportunity clause and the rules, regulations, and relevant orders of the Secretary of Labor, that it will furnish the administering agency and the Secretary of Labor such information as they may require for the supervision of such compliance, and that it will otherwise assist the administering agency in the discharge of the agency's primary responsibility for securing compliance.

The applicant further agrees that it will refrain from entering into any contract or contract modification subject to Executive Order 11246 of September 24, 1965, with a contractor debarred from, or who has not demonstrated eligibility for, Government contracts and federally assisted construction contracts pursuant to the Executive Order and will carry out such sanctions and penalties for violation of the equal opportunity clause as may be imposed upon contractors and subcontractors by the administering agency or the Secretary of Labor pursuant to Part II, Subpart D of the Executive Order. In addition, the applicant agrees that if it fails or refuses to comply with these undertakings, the administering agency may take any or all of the following actions: Cancel, terminate, or suspend in whole or in part this grant (contract, loan, insurance, guarantee); refrain from extending any further assistance to the applicant under the program with respect to which the failure or refund occurred until satisfactory assurance of future compliance has been received from such applicant; and refer the case to the Department of Justice for appropriate legal proceedings.

Suspension and Debarment

(1) This contract is a covered transaction for purposes of 2 C.F.R, pt. 180 and 2 C.F.R. pt. 3000. As such, the contractor is required to verify that none of the contractor's principals (defined at 2 C.F.R. § 180.995) or its affiliates (defined at 2 C.F.R. § 180.905) are excluded (defined at 2 C.F.R § 180.940) or disqualified (defined at 2 C.F.R. § 180.935).

(2) The contractor must comply with 2 C.F.R. pt. 180, subpart C and2 C.F.R. pt. 3000, subpart C, and must include a requirement to comply with these regulations in any lower tier covered transaction it enters into.

(3) This certification is a material representation of fact relied upon by the City of Pasadena. If it is later determined that the contractor did not comply with 2

C.F.R. pt. 180, subpart C and 2 C.F.R. pt. 3000, subpart C, in addition to remedies available to the City of Pasadena, the Federal Government may pursue available remedies, including but not limited to suspension and/or debarment.

(4) The bidder or proposer agrees to comply with the requirements of2 C.F.R. pt. 180, subpart C and 2 C.F.R. pt. 3000, subpart C while this offer is valid and throughout the period of any contract that may arise from this offer. The bidder or proposer further agrees to include a provision requiring such compliance in its lower tier covered transactions.

Byrd Anti-Lobbying Amendment, 31 U.S.C. § 1352 (as amended)

Contractors who apply or bid for an award of $100,000 or more shall file the required certification. Each tier certifies to the tier above that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, officer or employee of Congress, or an employee of a Member of Congress in connection with obtaining any Federal contract, grant, or any other award covered by 31 U.S C. § 1352. Each tier shall also disclose any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier to tier up to the recipient who in turn will forward the certification(s) to the awarding agency.

Procurement of Recovered Materials

i. In the performance of this contract, the Contractor shall make maximum use of products containing recovered materials that are EPA-designated items unless the product cannot be acquired—

1. Competitively within a timeframe providing for compliance with the contract performance schedule;
2. Meeting contract performance requirements; or
3. At a reasonable price.

Ii. Information about this requirement, along with the list of EPA- designated items, is available at EPA's Comprehensive Procurement Guidelines web site, https://www.epa.gov/smm/comprehensive-procurement-guideline-cpg-program.

iii. The Contractor also agrees to comply with all other applicable requirements of Section 6002 of the Solid Waste Disposal Act."

Access to Records

The following access to records requirements apply to this contract:

(1) The Contractor agrees to provide the City of Pasadena, the FEMA Administrator, the Comptroller General of the United States, or any of their authorized representatives access to any books, documents, papers, and records of the Contractor which are directly pertinent to this contract for the purposes of making audits, examinations, excerpts, and transcriptions.

(2) The Contractor agrees to permit any of the foregoing parties to reproduce by any means whatsoever or to copy excerpts and transcriptions as reasonably needed.

(3) The Contractor agrees to provide the FEMA Administrator or his authorized representatives access to construction or other work sites pertaining to the work being completed under the contract.

(4) In compliance with the Disaster Recovery Act of 2018, the City of Pasadena and the Contractor acknowledge and agree that no language in this contract is intended to prohibit audits or internal reviews by the FEMA Administrator or the Comptroller General of the United States.

DHS Seal, Logo, and Flags

The contractor shall not use the DHS seal(s), logos, crests, or reproductions of flags or likenesses of DHS agency officials without specific FEMA pre-approval.

Program Fraud and False or Fraudulent Statements or Related Acts

The Contractor acknowledges that 31 U.S.C. Chap. 38 (Administrative Remedies for False Claims and Statements) applies to the Contractor's actions pertaining to this contract.

EXHIBIT D

Temporary Space for Contractor's Exclusive Use for the ACS
[as of April 11, 2020]



JNR/drc
4/11/2020
0000160892C031

#24

Title 11, California Code of Regulations, § 999.5(d)(5)(J)

Description of compliance with the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, as amended by the California Hospital Facilities Seismic Safety Act, for each health facility that is the subject of the affiliation

1. Attached to this Section 999.5(d)(5)(J) as **Exhibit 24-A** is a chart detailing all PHA buildings subject to the Seismic Safety Act, including their Structural Performance Category and OSHPD Non-structural Performance Category ratings.

2. Attached to this Section 999.5(d)(5)(J) as **Exhibit 24-B** are copies of correspondence from OSHPD compliance reports for the last five years.

Exhibit 24-A

PHA Buildings Subject to the Seismic Safety Act

County Code	Facility Nbr	Facility Name	City	Building Nbr	Building Name	Building Status	SPC Rating *	2007 Hazus Score (%)	2010 Hazus Score (%)	OSHPD NPC Rating *
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-02000	East Tower (3 story)	In Service	3			2
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-02001	West Tower	In Service	5			4
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-02002	La Vina Building	In Service	3			2
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-02003	Della Martin Center - Psychiatric B	Acute Psych Only	N/A			N/A
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-02004	Energy Plant	In Service	5			4
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-02005	Chiller Building	In Service	4			4
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-02008	Cooling Towers	Not a Building Structure	N/A			N/A

* 2s, 3s, 4s and 5s indicate SPC/NPC rating self-reported by the hospital and not verified by OSHPD
* 1s is a temporary rating assigned to seismically separate buildings created by retrofits
IND = HAZUS score cannot be determined as building is located on a fault and is equivalent to a HAZUS fail

SPC/NPC Ratings of Acute Care Hospital Buildings as of 6/18/2020

County Code	Facility Nbr	Facility Name	City	Building Nbr	Building Name	Building Status	SPC Rating *	2007 Hazus Score (%)	2010 Hazus Score (%)	OSHPD NPC Rating *
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-02010	Valentine Building - Structurally connected to BLD-02014	Not an Independent Building	N/A	8.24		N/A
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-02011	Wingate / Hahn Building	In Service	1	3.94		3
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-02012	Hahn Building - Structurally connected to BLD-02011	Not an Independent Building	N/A			N/A
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-02013	Service Building	In Service	1	7.15		2
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-02014	1938 Building	In Service	1		24.4	2
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-02015	1921 Building	In Service	1		14.36	2
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-02017	North Parking Structure - Structurally connected to BLD-02000	Not an Independent Building	N/A			N/A
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-02018	Electrical Switchgear Vault	In Service	4			4
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-03301	East Tower (7 story)	In Service	5			2
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-03302	East Tower Main Lobby	In Service	3			2
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-03303	New Boiler Building	In Service	5			4
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-05497	ED Addition	In Service	5			4
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-05498	Ambulance Canopy	In Service	5			4
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-05796	West Tower Tunnel	In Service	5			4
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-05955	South Campus Utility Tunnel	Tunnels	N/A			2
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-05956	East Tower Utility Tunnel	Tunnels	N/A			4
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-05957	ED Utility Tunnel	Tunnels	N/A			4
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-05970	East Tower Pedestrian Tunnel	Tunnels	4			4

* 2s, 3s, 4s and 5s indicate SPC/NPC rating self-reported by the hospital and not verified by OSHPD
* 1s is a temporary rating assigned to seismically separate buildings created by retrofits
IND = HAZUS score cannot be determined as building is located on a fault and is equivalent to a HAZUS fail

SPC/NPC Ratings of Acute Care Hospital Buildings as of 6/18/2020

County Code	Facility Nbr	Facility Name	City	Building Nbr	Building Name	Building Status	SPC Rating *	2007 Hazus Score (%)	2010 Hazus Score (%)	OSHPD NPC Rating *
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-05990	Bulk Oxygen Storage	Equipment Yard	N/A			4
19 - Los Angeles	11733	Huntington Memorial Hospital	Pasadena	BLD-06058	Bulk Oxygen	Equipment Yard	N/A			4

* 2s, 3s, 4s and 5s indicate SPC/NPC rating self-reported by the hospital and not verified by OSHPD
* 1s is a temporary rating assigned to seismically separate buildings created by retrofits
IND = HAZUS score cannot be determined as building is located on a fault and is equivalent to a HAZUS fail

Exhibit 24-B

OSHPD Compliance Reports

oshpd Office of Statewide Health Planning and Development

Facilities Development Division
400 R Street, Suite 200
Sacramento, California 95811-6213
(916) 440-8300
Fax (916) 324-9188
www.oshpd.ca.gov/fdd

June 16, 2014

Stephen Ralph
Administrator
Huntington Memorial Hospital
100 West California Blvd
Pasadena, CA 91105

RE: 2014-SB 499 Online Report Preparation
Huntington Memorial Hospital - 11733
100 W. California Blvd., Pasadena, CA 91105

Dear Mr. Stephen Ralph:

We are contacting you in preparation for the year 2014 SB 499 report that is required to be submitted to OSHPD no later than November 1, 2014. Due to operational constraints, OSHPD needs to update the building information for your facility prior to the start of making the forms electronically available for data input.

Our records show that your facility is comprised of the following general acute care hospital buildings and their corresponding OSHPD SPC ratings:

Building Number	Building Name	OSHPD SPC Rating
BLD-02000	East Tower (3 story)	3s
BLD-02001	West Tower	5s
BLD-02002	La Vina Building	3s
BLD-02004	Energy Plant	5s
BLD-02005	Chiller Building	4s
BLD-02008	Cooling Towers	4s
BLD-02011	Wingate / Hahn Building	1
BLD-02013	Service Building	1
BLD-02014	1938 Building	1
BLD-02015	1921 Building	1
BLD-02017	North Parking Structure	4s
BLD-02018	Electrical Switchgear Vault	4s
BLD-03301	East Tower (7 story)	5s
BLD-03302	East Tower Main Lobby	3s
BLD-03303	New Boiler Building	5s

Any updates and alterations to this building inventory for your facility must be submitted by close of business on July 24, 2014.

Where acute care services are being removed from a hospital building, see 2013 California Building Code (CBC), Volume 2, Section 3418A. For additional information you may refer to CAN 1-6-1.4.5.1.4. A project submittal is required to the appropriate review region of the Building Safety Section of OSHPD/FDD for review and plan approval. Such a project must be closed in compliance to be eligible for the processing of the request for building re-classification by the Seismic

Compliance Unit (SCU). The request for re-classification by the SCU must include the OSH-FD 121 application for each building.

For new buildings built since the year 2000 and not included in the list for your facility, a request to add the building to the building inventory must be submitted to the SCU. Such a request must include Form OSH-FD121, Evaluation self-declaration per 2013 California Administrative Code (CAC), Chapter 6, Section 2.0.1.2.1 and 11.01.2.2 and Matrix of Construction per 2013 CAC, Chapter 6, Section 1.3.4.6. The construction project for these buildings needs to be closed in compliance for SCU to assign SPC or NPC ratings.

For changes in Seismic Performance Compliance (SPC) category for any of buildings in your facility, verify that a re-classification request was submitted to SCU, close retrofit projects, if any, in compliance; and respond to remarks letters issued where applicable.

All of the above processes to add or reclassify a building take time, so it is imperative that the facility begin as soon as possible.

If you need further information regarding SB 499, you may visit our web site at http://www.oshpd.ca.gov or contact Brett Beekman at FDD-SB499@oshpd.ca.gov , or (213) 897-3264.

Sincerely

Brett Beekman
District Structural Engineer
Seismic Compliance Unit
OSHPD - FDD

cc: File
steve.ralph@huntingtonhospital.com
eugene.gutierrez@huntingtonhospital.com
eric.lanaria@huntingtonhospital.com
jim.noble@huntingtonhospital.com

OSHPD Office of Statewide Health Planning and Development

Facilities Development Division
400 R Street, Suite 200
Sacramento, California 95811-6213
(916) 440-8300
Fax (916) 324-9188
www.oshpd.ca.gov/fdd

July 22, 2015

Stephen Ralph
Administrator
Huntington Memorial Hospital
100 West California Blvd
Pasadena, CA 91105

RE: 2015-SB 499 Online Report Preparation
Huntington Memorial Hospital - 11733
100 W. California Blvd., Pasadena, CA 91105

Dear Mr. Stephen Ralph:

We are contacting you in preparation for the year 2015 SB 499 report that is required to be submitted to OSHPD no later than November 1, 2015. Due to operational constraints, OSHPD needs to update the building information for your facility prior to the start of making the forms electronically available for data input.

Our records show that your facility is comprised of the following general acute care hospital buildings and their corresponding OSHPD SPC ratings:

Building Number	Building Name	OSHPD SPC Rating
BLD-02000	East Tower (3 story)	3s
BLD-02001	West Tower	5
BLD-02002	La Vina Building	3s
BLD-02004	Energy Plant	5
BLD-02005	Chiller Building	4
BLD-02011	Wingate / Hahn Building	1
BLD-02013	Service Building	1
BLD-02014	1938 Building	1
BLD-02015	1921 Building	1
BLD-02017	North Parking Structure	4s
BLD-02018	Electrical Switchgear Vault	4
BLD-03301	East Tower (7 story)	5s
BLD-03302	East Tower Main Lobby	3s
BLD-03303	New Boiler Building	5
BLD-05796	West Tower Tunnel	5

Any updates and alterations to this building inventory for your facility must be submitted by close of business on August 20, 2015. Please also respond if you have no changes to your facilities building inventory.

Where acute care services are being removed from a hospital building, see 2013 California Building Code (CBC), Volume 2, Section 3418A. For additional information you may refer to CAN 1-6-1.4.5.1.4. A project submittal is required to the appropriate review region of the Building Safety Section of OSHPD/FDD for review and plan approval. Such a project

must be closed in compliance to be eligible for the processing of the request for building re-classification by the Seismic Compliance Unit (SCU). The request for re-classification to the SCU must include the OSH-FD 121 application for each building.

For new buildings built since the year 2000 and not included in the list for your facility, a request to add the building to the building inventory must be submitted to the SCU. Such a request must include Form OSH-FD121 (First 4 pages are sufficient), Evaluation self-declaration per 2013 California Administrative Code (CAC), Chapter 6, Section 2.0.1.2.1 and 11.01.2.2 and Matrix of Construction per 2013 CAC, Chapter 6, Section 1.3.4.6. The construction project for these buildings needs to be closed in compliance for SCU to assign SPC or NPC ratings.

For changes in Seismic Performance Compliance (SPC) category for any of buildings in your facility, verify that a re-classification request was submitted to SCU, close retrofit projects, if any, in compliance; and respond to remarks letters issued where applicable.

All of the above processes to add or reclassify a building take time, so it is imperative that the facility begin as soon as possible.

If you need further information regarding SB 499, you may visit our web site at http://www.oshpd.ca.gov or contact Brett Beekman at FDD-SB499@oshpd.ca.gov, or (213) 897-3264.

Sincerely

Brett Beekman
District Structural Engineer
Seismic Compliance Unit
OSHPD - FDD

cc: File
steve.ralph@huntingtonhospital.com
eugene.gutierrez@huntingtonhospital.com

OSHPD Office of Statewide Health Planning and Development

Facilities Development Division
400 R Street, Suite 200
Sacramento, California 95811-6213
(916) 440-8300
(916) 324-9188 Fax
www.oshpd.ca.gov/fdd

June 29, 2016

Stephen Ralph
Administrator
Huntington Memorial Hospital
100 West California Blvd
Pasadena, CA 91105

RE: 2016-SB 499 Online Report Preparation
Huntington Memorial Hospital - 11733
100 W. California Blvd., Pasadena, CA 91105

Dear Mr. Stephen Ralph:

We are contacting you in preparation for the year 2016 SB 499 report that is required to be submitted to OSHPD no later than November 1, 2016. Due to operational constraints, OSHPD needs to update the building information for your facility prior to the start of making the forms electronically available for data input.

Our records show that your facility is comprised of the following general acute care hospital buildings and their corresponding OSHPD SPC ratings:

Building Number	Building Name	OSHPD SPC Rating
BLD-02000	East Tower (3 story)	3
BLD-02001	West Tower	5
BLD-02002	La Vina Building	3
BLD-02004	Energy Plant	5
BLD-02005	Chiller Building	4
BLD-02011	Wingate / Hahn Building	1
BLD-02013	Service Building	1
BLD-02014	1938 Building	1
BLD-02015	1921 Building	1
BLD-02018	Electrical Switchgear Vault	4
BLD-03301	East Tower (7 story)	5
BLD-03302	East Tower Main Lobby	3
BLD-03303	New Boiler Building	5
BLD-05497	ED Addition	5
BLD-05498	Ambulance Canopy	5
BLD-05796	West Tower Tunnel	5
BLD-05955	South Campus Utility Tunnel	NA
BLD-05956	East Tower Utility Tunnel	NA
BLD-05957	ED Utility Tunnel	NA
BLD-05970	East Tower Pedestrian Tunnel	4

Any updates and alterations to this building inventory for your facility must be submitted by close of business on July 29, 2016. Even if there are no changes in the above list, please respond to confirm.

Where acute care services are being removed from a hospital building, see 2013 California Building Code (CBC), Volume 2, Section 3418A. For additional information you may refer to CAN 1-6-1.4.5.1.4. See http://www.oshpd.ca.gov/FDD/seismic_compliance/SB1953/Seismic_FAQs.html (Question 9 in the General Section) for the required documentation.

For new buildings built since the year 2000 and not included in the list for your facility, a request to add the building to the building inventory must be submitted to the SCU. See http://www.oshpd.ca.gov/FDD/seismic_compliance/SB1953/Seismic_FAQs.html (Question 8 in the General Section) for the required documentation.

For changes in Seismic Performance Compliance (SPC) category for any of buildings in your facility, verify that a re-classification request was submitted to SCU, close retrofit projects, if any, in compliance; and respond to remarks letters issued where applicable.

All of the above processes to add or reclassify a building take time, so it is imperative that the facility begin as soon as possible.

If you need further information regarding SB 499, you may visit our web site at http://www.oshpd.ca.gov or contact Brett Beekman at FDD-SB499@oshpd.ca.gov , or (213) 897-3264.

Sincerely

Brett W. Beekman, SE
Acting Supervisor HFR
South Los Angeles Region
Facility Development Division
t: 213.897.3264
f: 213.576.1306
e: Brett.Beekman@oshpd.ca.gov

cc: File
steve.ralph@huntingtonhospital.com
eugene.gutierrez@huntingtonhospital.com
eric.lanaria@huntingtonhospital.com
jim.noble@huntingtonhospital.com

OSHPD Office of Statewide Health Planning and Development

Facilities Development Division
2020 West El Camino Avenue,
Sacramento, California 95833
(916) 440-8300
Fax (916) 324-9188
www.oshpd.ca.gov/fdd

June 27, 2017

Stephen Ralph
Administrator
Huntington Memorial Hospital
100 West California Blvd
Pasadena, CA 91105

RE: 2016-SB 499 Online Report Preparation
Huntington Memorial Hospital - 11733
100 W. California Blvd., Pasadena, CA 91105

Dear Mr. Stephen Ralph:

We are contacting you in preparation for the year 2017 SB 499 report that is required to be submitted to OSHPD no later than November 1, 2017. Due to operational constraints, OSHPD needs to update the building information for your facility prior to the start of making the forms electronically available for data input.

Our records show that your facility is comprised of the following general acute care hospital buildings and their corresponding OSHPD Seismic Performance Category (SPC) ratings:

Building Number	Building Name	OSHPD SPC Rating
BLD-02000	East Tower (3 story)	3
BLD-02001	West Tower	5
BLD-02002	La Vina Building	3
BLD-02004	Energy Plant	5
BLD-02005	Chiller Building	4
BLD-02011	Wingate / Hahn Building	1
BLD-02013	Service Building	1
BLD-02014	1938 Building	1
BLD-02015	1921 Building	1
BLD-02018	Electrical Switchgear Vault	4
BLD-03301	East Tower (7 story)	5
BLD-03302	East Tower Main Lobby	3
BLD-03303	New Boiler Building	5
BLD-05497	ED Addition	5
BLD-05498	Ambulance Canopy	5
BLD-05796	West Tower Tunnel	5
BLD-05955	South Campus Utility Tunnel	NA

BLD-05956	East Tower Utility Tunnel	NA
BLD-05957	ED Utility Tunnel	NA
BLD-05970	East Tower Pedestrian Tunnel	4

Any updates and alterations to this building inventory for your facility must be submitted by close of business on July 28, 2017. Even if there are no changes in the above list, please respond to confirm.

Where acute care services are being removed from a hospital building, see 2016 California Building Code (CBC), Volume 2, Section 3418A. See http://www.oshpd.ca.gov/FDD/seismic_compliance/SB1953/Seismic_FAQs.html (Question 9 in the General Section) for the required documentation.

For new buildings built since the year 2000 and not included in the list for your facility, a request to add the building to the building inventory must be submitted to the Seismic Compliance Unit (SCU). See http://www.oshpd.ca.gov/FDD/seismic_compliance/SB1953/Seismic_FAQs.html (Question 8 in the General Section) for the required documentation.

For changes in SPC category for any of buildings in your facility, verify that a re-classification request was submitted to SCU, close retrofit projects, if any, in compliance; and respond to remarks letters issued where applicable.

All of the above processes to add or reclassify a building take time, so it is imperative that the facility begin as soon as possible.

If you need further information regarding SB 499, you may visit our web site at http://www.oshpd.ca.gov or contact me at FDD-SB499@oshpd.ca.gov, or (916) 440-8467.

Sincerely

Patrick Rodgers
Senior Structural Engineer
Seismic Compliance Unit
Facility Development Division
t: 916.440.8467

cc: File
steve.ralph@huntingtonhospital.com
eugene.gutierrez@huntingtonhospital.com
eric.lanaria@huntingtonhospital.com
jim.noble@huntingtonhospital.com

OSHPD Office of Statewide Health Planning and Development

Facilities Development Division
400 R Street, Suite 200
Sacramento, California 95811-6213
(916) 440-8300
(916) 324-9188 Fax
www.oshpd.ca.gov/fdd

July 3, 2018

Lori Morgan
Administrator
Huntington Memorial Hospital
100 West California Blvd
Pasadena, CA 91105

RE: 2018-SB 499 Online Report Preparation
Huntington Memorial Hospital - 11733
100 W. California Blvd., CA 91105

Dear Dr. Lori Morgan:

We are contacting you in preparation for the year 2018 SB 499 report that is required to be submitted to OSHPD no later than November 1, 2018. Due to operational constraints, OSHPD needs to update the building information for your facility prior to the start of making the forms electronically available for data input.

Our records show that your facility is comprised of the following general acute care hospital buildings and their corresponding OSHPD SPC ratings:

Building Number	Building Name	OSHPD SPC Rating
BLD-02000	East Tower (3 story)	3
BLD-02001	West Tower	5
BLD-02002	La Vina Building	3
BLD-02004	Energy Plant	5
BLD-02005	Chiller Building	4
BLD-02011	Wingate / Hahn Building	1
BLD-02013	Service Building	1
BLD-02014	1938 Building	1
BLD-02015	1921 Building	1
BLD-02018	Electrical Switchgear Vault	4
BLD-03301	East Tower (7 story)	5
BLD-03302	East Tower Main Lobby	3
BLD-03303	New Boiler Building	5
BLD-05497	ED Addition	5
BLD-05498	Ambulance Canopy	5
BLD-05796	West Tower Tunnel	5
BLD-05955	South Campus Utility Tunnel	-1
BLD-05956	East Tower Utility Tunnel	-1
BLD-05957	ED Utility Tunnel	-1
BLD-05970	East Tower Pedestrian Tunnel	4

Any updates and alterations to this building inventory for your facility must be submitted by close of business on August 14, 2018. Even if there are no changes in the above list, please respond to confirm.

Where acute care services are being removed from a hospital building, see 2016 California Building Code (CBC), Volume 2, Section 3418A. For additional information, you may refer to CAN 1-6-1.4.5.1.4. See http://www.oshpd.ca.gov/FDD/seismic_compliance/SB1953/Seismic_FAQs.html (Question 9 in the General Section) for the required documentation.

For new buildings built since the year 2000 and not included in the list for your facility, a request to add the building to the building inventory must be submitted to the SCU. See http://www.oshpd.ca.gov/FDD/seismic_compliance/SB1953/Seismic_FAQs.html (Question 8 in the General Section) for the required documentation.

For changes in Seismic Performance Compliance (SPC) category for any of buildings in your facility, verify that a re-classification request was submitted to SCU, close retrofit projects, if any, in compliance; and respond to remarks letters issued where applicable.

All of the above processes to add or reclassify a building take time, so it is imperative that the facility begin as soon as possible.

If you need further information regarding SB 499, you may visit our web site at http://www.oshpd.ca.gov or contact me at FDD-SB499@oshpd.ca.gov.

Sincerely

Patrick Rodgers
Senior Structural Engineer
Seismic Compliance Unit
Facility Development Division
t: 916.440.8467
f: 916.324.9188
e: patrick.rodgers@oshpd.ca.gov

cc: File

eugene.gutierrez@huntingtonhospital.com
alejandro.torres@huntingtonhospital.com

#25

Title 11, California Code of Regulations, § 999.5(d)(5)(K)

A description of each measure proposed by the applicant to mitigate or eliminate any significant adverse effect on the availability or accessibility of healthcare services to the affected communities by the transaction

The proposed Affiliation provides for Cedars-Sinai to become the sole member of PHA, meaning PHA will retain its assets, liabilities and employees, including contractual arrangements between PHA and physicians/medical groups that provide administrative, professional and coverage services. Accordingly, the parties do not anticipate that there will be any adverse effects on the availability or accessibility of healthcare in the affected community as a result of the proposed transaction. To the contrary, the parties anticipate that the Affiliation will strengthen PHA and its affiliates and thus benefit the community by improving the available services in the area and helping ensure the long-term viability of PHA and its affiliates. The members of the Cedars-Sinai Board of Directors nominated by PHA will help ensure that Cedars-Sinai continues to make high quality health care services available and accessible to the affected community.

In addition, under Section 13.14 of the Affiliation Agreement, Cedars-Sinai commits to PHA continuing important aspects of its healthcare operations as and for the periods determined by the California Attorney General, including the following:

- Huntington Hospital will continue as a licensed general acute care hospital, including to the extent that Huntington is able to meet the requirements of applicable accreditation agencies, maintaining each of the following with the same types and levels of services as currently provided:

  Level II Trauma Center
  Level III Neonatal Intensive Care Unit
  Comprehensive Stroke Center
  STEMI Receiving Center
  Advanced Cardiology and Cardiovascular Surgery Programs
  Advanced Robotic Surgery
  Orthopedic Service Line
  Oncology Service Line
  Neurology Service Line
  GME programs
  Senior Care Network
  Women's Health Services
  End of Life Services

- Huntington Hospital will continue to participate in the Medi-Cal and Medicare programs.

- Any future sale or change in control of Huntington Hospital will require the prior approval of the California Attorney General.

- Huntington Hospital will use commercially reasonable efforts to maintain Magnet Status with substantially the same types and levels of services as currently provided.

Title 11, California Code of Regulations, § 999.5(d)(6)

POSSIBLE EFFECT ON COMPETITION

#26

Title 11, California Code of Regulations, § 999.5(d)(6)(A)

If a Premerger Notification and Report Form is required to be submitted to the Federal Trade Commission under the Hart-Scott-Rodino Antitrust Improvement Act of 1976, a brief analysis of the possible effect of the transaction on each health facility that is subject to the transaction on competition and market share in any relevant product or geographic market

PHA operates in the greater Los Angeles health care market, which is competitive and highly fragmented. Under the U.S. Department of Justice and Federal Trade Commission's *Horizontal Merger Guidelines*, the agencies generally consider markets in which the Herfindahl-Hirschman Index ("HHI") is below 1,500 to be "unconcentrated." According to a recent study, *Consolidation in California's Health Care Market 2010-2016: Impact on Prices and ACA Premiums*, Nicolas C. Petris Center on Health Care Markets and Consumer Welfare School of Public Health, University of California, Berkeley, March 26, 2018 ("Report"), which provides HHI calculations for nineteen different rating areas of California, the area of Los Angeles – East, in which PHA is located, has the lowest HHI of all nineteen areas. According to the Report, the hospital HHI in Los Angeles – East is 656, which is well below 1,500.

There are 21 general acute care hospitals within a 10 mile radius of PHA, not counting any Kaiser facilities. Cedars-Sinai's closest hospital is located more than 17 miles from PHA and generally serves a different area, with very minimal service overlap.

Given the highly fragmented nature of the greater Los Angeles market, the large number of hospitals within just a short distance of PHA, and the very minimal overlap between PHA's and Cedars-Sinai's service areas, the proposed Affiliation will not have a significant impact on competition or market share in any relevant product or geographic market.

Additionally, there exists great potential for pro-competitive effects on the quality of care provided by PHA though care coordination and capital funding at Huntington Hospital. By reducing costs, the affiliated parties will be able to expand services and better compete with other local providers as well as with major medical center and health systems in the Los Angeles area. The Affiliation will permit the new system to expand both specialty and primary care services in order to allow patients to receive more services locally at competitive prices.

#27

Title 11, California Code of Regulations, § 999.5(d)(6)(B)

Copy of the Premerger Notification and Report Form as filed with the Federal Trade Commission pursuant to the Hart-Scott-Rodino Antitrust Improvement Act of 1976

The Hart-Scott-Rodino premerger notification and report will be submitted under separate cover as a confidential document in accordance with Section 999.5(c)(3).

Title 11, California Code of Regulations, § 999.5(d)(7)

OTHER PUBLIC INTEREST FACTORS

#28

Title 11, California Code of Regulations, § 999.5(d)(7)

Other Public Interest Factors

The parties believe that PHA's affiliation with Cedars-Sinai, another nonprofit healthcare system with a well-deserved reputation for excellence, the provision of effective healthcare services, and population health management, is in the best interest of the public. At a time when other hospitals are considering affiliations with for-profit counterparts, the affiliation with Cedars-Sinai will allow PHA to continue delivering critical services to the Pasadena community in partnership with a nonprofit organization that shares its values. The successful achievement of these goals are clearly exemplified by the recent affiliation between Cedars-Sinai and Torrance.

In addition, the Affiliation Agreement includes commitments for continued investment in Huntington Hospital in ways that will benefit the communities it serves and allow for a continued focus on quality patient care, excellence in its nursing and medical staffing, and the ongoing fulfillment of PHA's historic mission for the benefit of its physicians, employees and the communities of the San Gabriel Valley. The opportunities for collaboration and sharing of resources throughout the Cedars-Sinai's health system will also strengthen PHA's ability to serve its community and increase access to high-quality care throughout the region. The parties anticipate that the shared clinical expertise from affiliating with Cedars-Sinai's esteemed academic and research medical center, Cedars-Sinai Medical Center, will benefit PHA's patients, physicians and allied clinical staff.

In short, the parties expect the Affiliation to help maintain PHA's 128-year legacy and its connection to the communities it serves and to provide for an ongoing commitment to advancing PHA's existing mission and unique culture as a community institution.

Title 11, California Code of Regulations, § 999.5(d)(8)

BOARD RESOLUTION AUTHORIZING FILING OF NOTICE

#29

Title 11, California Code of Regulations, § 999.5(d)(8)

Resolution of the board of directors of the applicant authorizing the filing of the written notice and a statement by the chair of the board that the contents of the written notice are true, accurate and complete

1. Attached to this Section 999.5(d)(8) as **Exhibit 29-A** are the resolutions of the PHA Board that authorize the filing of this written notice.

2. Attached to this Section 999.5(d)(8) as **Exhibit 29-B** is a statement by the Chair of the PHA Board that the contents of this written notice are true, accurate and complete.

Exhibit 29-A

PHA Board Resolutions to Authorize Notice Filing

PASADENA HOSPITAL ASSOCIATION, LTD.

RESOLUTIONS OF THE BOARD OF DIRECTORS

July 14, 2020

WHEREAS, Pasadena Hospital Association, Ltd., doing business as Huntington Hospital (the "Corporation"), is a California nonprofit public benefit corporation that is recognized as exempt from federal income tax under Section 501(a) of the Internal Revenue Code of 1986 (as amended, the "Code") as an organization described in Section 501(c)(3) of the Code.

WHEREAS, the Corporation has been engaged in its charitable mission of delivering healthcare services to communities in Pasadena and the San Gabriel Valley for over 125 years, with the support of the Collis P. and Howard Huntington Memorial Hospital Trust (the "Trust").

WHEREAS, considering the importance of preserving and strengthening the quality and scope of services and the charity care and community benefits that the Corporation provides to the communities it serves and the propriety of identifying additional sources for the Corporation's current and anticipated capital needs, and in recognition of the long history of the Corporation and the hospital, the Board of Directors of the Corporation (the "Board"), with the advice of legal counsel to the Corporation, and after review and consideration of the duties of directors and management of the Corporation in connection with a potential transaction that could include a change of control of the Corporation, in late 2018 the Board authorized the formation of a committee (the "Rose Committee") to explore alternatives for the Corporation to consider.

WHEREAS, the Rose Committee engaged in a months-long process to explore alternatives, interviewed and selected Kaufman, Hall & Associates, LLC to assist the Rose Committee and undertook an evaluation of the priorities of the Corporation to assess the Corporation's alternatives, including mission, culture, clinical programs and services, physician alignment, ambulatory strategies, value-based care capabilities, IT resources, financial resources, and strategic alignment, as well as effects on the community governance of the Corporation and its relationship with the Trust.

WHEREAS, at the conclusion of this process in April 2019, the Rose Committee, with the guidance of Kaufman Hall, presented the findings of the Rose Committee to the Board and after deliberations the Board determined that it would be in the best interests of the Corporation and in furtherance of the charitable purposes it services to pursue a process designed to generate interest in an affiliation transaction in which the Corporation could join a health system that best meets the Corporation's priorities and authorized the reconstitution of the Rose Committee as the "Partnership Committee," adjusted the membership of the Partnership Committee to consist solely of directors, including directors who are also trustees of the Trust, and granted broad authority to the Partnership Committee, with the guidance and advice of Kaufman Hall and legal counsel for the Corporation, to explore strategic alternatives for the Corporation and the hospital, including the possibility of the Corporation becoming affiliated with a charitable health system with a

mission and values consistent with those of the Corporation (the "Potential Transaction"), and to report or make recommendations to the Board concerning the findings of the Partnership Committee.

WHEREAS, the Partnership Committee adopted and implemented protocols concerning compliance with California Health and Safety Code 1260.1, including prohibiting communications concerning the Potential Transaction to directors of the Corporation from members of management who may receive compensation from an acquiring party in a transaction with the Corporation.

WHEREAS, after April 2019, the Partnership Committee, with guidance and advice from its financial advisers and legal counsel, explored strategic alternatives for the Corporation, including identifying charitable health systems (the "Interested Parties") whose missions, values and operations provided a reasonable basis to believe that an affiliation with one of the systems could help the Corporation meet its objectives; entering into nondisclosure agreements with the Interested Parties; engaging in confidential discussions with the Interested Parties; soliciting and receiving nonbinding initial indications of interest from multiple Interested Parties; evaluating the initial indications for the Board; narrowing the field of Interested Parties based on their initial indications, after input and direction from the Board; two-way due diligence with the Interested Parties, including visiting each other's facilities; soliciting and receiving letters of intent from multiple Interested Parties; and negotiating the terms of the letters of intent with each Interested Party.

WHEREAS, at a meeting of the Board in February 2020 with no members of management participating, the Partnership Committee presented its qualitative assessment of each Interested Party based on campus tours and confidential meetings with directors and executives of each Interested Party measured against the criteria developed by the Rose Committee, but the Partnership Committee did not reach conclusions or make recommendations at that meeting, pending the outcome of negotiations concerning the letters of intent.

WHEREAS, after the February 2020 Board meeting, negotiations of the letters of intent continued, and one of the Interested Parties withdrew from the process.

WHEREAS, at a meeting of the Board duly held in March 2020 with no members of management participating, the Board, after presentations by the financial and legal advisers to the Corporation and due deliberation, determined that the Potential Transaction in which Cedars-Sinai Health System, a California nonprofit public benefit corporation that is recognized as exempt from federal income tax under Section 501(a) of the Code ("CSHS"), would become the sole member of the Corporation, commit to install a new electronic health record system, support the 9-year strategic capital plan of the Corporation and preserve key community healthcare programs, among other things, on substantially the terms in the letter of intent negotiated with CSHS and presented to the Board (collectively, the "Cedars Affiliation"), was in the best interests of the Corporation and in furtherance of its charitable purposes and authorized the Partnership Committee to negotiate agreements to implement the Cedars Affiliation.

WHEREAS, the letter of intent was signed by the Corporation and CSHS as of March 6, 2020, and a public announcement was issued on March 9, 2020.

WHEREAS, since March 2020, representatives of the Corporation have engaged in negotiations with representatives of CSHS, conducted due diligence of CSHS and its affiliates and facilitated due diligence of the Corporation and its affiliates by CSHS.

WHEREAS, the Board has received and reviewed substantially final versions of an affiliation agreement (the "Affiliation Agreement") between the Corporation and the Trust, on the one hand, and CSHS, on the other hand; amended and restated articles of incorporation of the Corporation (the "Amended Articles"); amended and restated bylaws of the Corporation (the "Amended Bylaws"); amended and restated bylaws of CSHS; a reimbursement agreement between Cedars-Sinai Medical Center, a California nonprofit public benefit corporation whose sole member is CSHS ("CSMC"), CSHS and the Trust, providing, among other things, for the Trust to remain obligated under the master indenture governing indebtedness of the Corporation, for CSHS and CSMC to cause the Trust to be released from its obligations under the master indenture within 3-7 years after the closing of the Cedars Affiliation and for CSMC to hold the Trust harmless from obligations under the master indenture; and the exhibits and schedules to these agreements and other documents and agreements to implement the Cedars Affiliation (collectively, and as they may be revised or amended in accordance with these resolutions, the "Transaction Documents").

WHEREAS, the Board has reviewed the Transaction Documents as they have been negotiated to date and summaries of the material terms of the Transaction Documents; the Board has had full opportunity to ask questions of the Partnership Committee and the financial and legal advisers to the Corporation and consider their responses; the Board has reviewed updates on the condition, financial and otherwise, of the Corporation and considered the viability of the Corporation and the hospital continuing on a standalone basis; and the Board engaged in deliberations regarding the strategic alternatives of the Corporation, including the possibilities of continuing on a standalone basis or proceeding with CSHS and the Cedars Affiliation.

NOW, THEREFORE, it is hereby resolved as follows:

APPROVAL OF CEDARS AFFILIATION

1. Based on the belief of the Board, after consultation and discussion with members of the Partnership Committee and advisers to the Corporation, consideration of the strategic alternatives of the Corporation, receipt and review of the documents described in these resolutions and due deliberation, that the Cedars Affiliation on substantially the terms described in the Affiliate Agreement and the Transaction Documents would further the charitable purposes of the Corporation and be in the best interests of the Corporation and the communities it serves, the Cedars Affiliation is hereby approved, ratified and confirmed in all respects.

2. The execution, delivery and performance by the Corporation of the Affiliation Agreement and each of the other Transaction Documents (as any such agreements or documents may be revised or amended in accordance with these resolutions) to which the Corporation is a party are hereby approved, ratified and confirmed in all respects.

AMENDMENT TO ARTICLES OF INCORPORATION

3. The amendments to Articles of Incorporation of the Corporation in substantially the form of the Amended Articles and the amendments reflected therein (as such amendments may be revised or amended in accordance with these resolutions) are hereby adopted and approved by the Board pursuant to California Corporations Code § 5812(a) and (b)(3) (it being recognized that, prior to the effectiveness of such amendments, the Corporation has no members and the existing Articles of Incorporation do not require approval by any person but the Board for an amendment to the Articles of Incorporation); *provided, however*, that implementation of such amendments (including their filing with the Secretary of State of the State of California) is subject to the satisfaction or waiver of all conditions to closing under the terms of the Affiliation Agreement.

AMENDMENT TO BYLAWS

4. The amendments to the Bylaws of the Corporation in substantially the form of the Amended Bylaws (as such amendments may be revised or amended in accordance with these resolutions) are hereby adopted and approved by the Board pursuant to California Corporations Code § 5150 (it being recognized that, prior to the effectiveness of such amendments, the Corporation has no members and the existing Articles of Incorporation and Bylaws do not require approval by any person but the Board for an amendment to the Bylaws); *provided, however*, that implementation of such amendments is subject to the satisfaction or waiver of all conditions to closing under the terms of the Affiliation Agreement and the contemporaneous implementation of the amendments to the Articles of Incorporation.

AUTHORIZED REPRESENTATIVES

5. The following individuals (the "Authorized Representatives"), or any one or more of them, will have the authority and discretion on behalf of the Corporation to negotiate, make or approve such changes to the Transaction Documents and such other related documents as such Authorized Representative deems necessary, advisable or appropriate, without further resolution or documentation thereof by the Board, as conclusively indicated by execution and delivery thereof by one or more of such Authorized Representatives (or one or more of their delegates) on behalf of the Corporation or by adoption of resolutions to that effect by one or more of Authorized Representatives:

Name	Title
Ronald Havner	Director, Partnership Committee
Paul Johnson	Director, Partnership Committee
David Kirchheimer	Director, Partnership Committee
Chris Mitchell	Director, Partnership Committee
Jaynie Studenmund	Chair, Director, Partnership Committee

6. Each Authorized Representative acting singly is hereby authorized, empowered and directed, in the name of and on behalf of the Corporation, to take or cause to be taken any and all further actions (including the filing of the Amended Articles with the Secretary of State of the State of California) and to execute, file and deliver (and to direct any officers of the Corporation to execute, file and deliver) on behalf of the Corporation such agreements and instruments as any Authorized Representative deems necessary, desirable, advisable or appropriate (as conclusively evidenced by the taking of such actions or the execution and delivery of such agreements or instruments) to permit the Corporation to complete the Cedars Affiliation, generally in accordance with the terms of the Transaction Documents, as they may be revised or amended in accordance with these resolutions.

7. The omission from these resolutions of any agreement or other arrangement contemplated by any of the agreements or instruments described in the foregoing resolutions or any action to be taken in accordance with any requirements of any of the agreements or instruments described in the foregoing resolutions will in no manner derogate from the authority of the Authorized Representatives to take all actions necessary, desirable, advisable or appropriate to consummate, effectuate, carry out or further the transactions contemplated by and the intent and purposes of the foregoing resolutions.

RATIFICATION

8. All actions previously taken by the members of the Partnership Committee, management of the Corporation, the Authorized Representatives, and their respective delegates and advisers, with respect to the Cedars Affiliation, the documents contemplated hereby and thereby, and the consummation of the transactions therein, which have been disclosed to the Board in accordance with these resolutions and which otherwise are consistent with and in furtherance of the intent and purposes of these resolutions, are hereby ratified, confirmed, and approved in all respects.

CERTIFICATE OF ADOPTION

The undersigned certifies that the undersigned is the Chair of the Board of the Corporation; that the foregoing is a true and correct copy of resolutions duly adopted by the Corporation at a meeting of the Board of Directors of the Corporation following appropriate notice; that the passage of the resolutions was in all respects legal; and that the resolutions are in full force and effect as of this date.

Dated as of the 14th day of July, 2020.

REDACTED

Jayne Studenmund
Chair, Board of Directors

Exhibit 29-B

PHA Board Chair Statement

DocuSign Envelope ID: 2500CD22-EA77-44BD-8BB8-B9B58B8BD86F

CHAIR'S STATEMENT

I, Jaynie Studenmund, Chair of the Board of Directors of Pasadena Hospital Association, Ltd , doing business as Huntington Hospital, believe that the contents of the attached written notice are true, accurate, and complete.

By: REDACTED

Jaynie Studenmund
Chair, Board of Directors

Title 11, California Code of Regulations, § 999.5(d)(9)

TRANSFEREE INFORMATION

#30

Title 11, California Code of Regulations, § 999.5(d)(9)

List of officers and directors of the transferee, the most recent audited financial statements, transferee's governance documents, and a description of the transferee's policies, procedures, and eligibility requirements for the provision of charity care

1. Attached to this Section 999.5(d)(9) as **Exhibit 30-A** is a list of the officers and directors of Cedars-Sinai.

2. Attached to this Section 999.5(d)(9) as **Exhibit 30-B** is a copy of Cedars-Sinai's most recent audited financial statements.

3. Attached to this Section 999.5(d)(9) as **Exhibit 30-C** is a copy of Cedars-Sinai's Articles of Incorporation.

4. Attached to this Section 999.5(d)(9) as **Exhibit 30-D** is a copy of Cedars-Sinai's current Bylaws.

5. Attached to this Section 999.5(d)(9) as **Exhibit 30-E** is a copy of Cedars-Sinai's Summary of Financial Assistance Policy and other Programs.

Exhibit 30-A

List of Officers and Directors of Cedars-Sinai

Cedars-Sinai Health System

Officers and Directors

Officers

- Thomas M. Priselac – President and CEO, Warschaw Law Chair in Health Care Leadership
- Linda Burnes Bolton, DrPH, RN – Senior Vice President and Chief Health Equity Officer
- Terri Wagner Cammarano, JD, LLM – Senior Vice President, Legal Affairs, General Counsel
- Bryan Croft – Senior Vice President of Operations
- Darren Dworkin – Senior Vice President of Enterprise Information Services and Chief Information Officer
- Richard B. Jacobs – Executive Vice President and Chief Strategy Officer
- John E. Jenrette, MD – Executive Vice President of the Cedars-Sinai Medical Network
- David Marshall, JD, DNP, RN, FAAN – Senior Vice President and Chief Nursing Executive
- Jill Martin – Senior Vice President and Chief Operating Officer of the Cedars-Sinai Medical Network
- Shlomo Melmed, MBChB – Executive Vice President of Academic Affairs, Dean of the Medical Faculty and Professor of Medicine
- Rekha Murthy, MD – Vice President of Medical Affairs and Acting Chief Medical Officer
- Arthur J. Ochoa, JD – Senior Vice President, Advancement and Chief Advancement Officer
- Andrew Ortiz – Senior Vice President of Human Resources
- Edward M. Prunchunas – Executive Vice President of Finance and Chief Financial Officer
- Richard V. Riggs, MD – Senior Vice President of Medical Affairs and Chief Medical Officer
- Jeffrey A. Smith, MD, JD, MMM – Executive Vice President of Hospital Operations and Chief Operating Officer of the Medical Center

- David M. Wrigley – Senior Vice President of Finance

Directors

- James Lippman – Chair
- Leslie Vermut – Vice Chair
- David Kaplan – Secretary
- Sonu Ahluwalia, MD
- Mohamed (Mike) Ahmar
- John Bendheim
- Laura W. Brill
- Dale Cochran
- Marc Edelstein, MD
- Ari Engelberg
- Abby Feinman
- Deborah Freund, PhD
- Russell Goldsmith
- Mark S. Greenfield
- Kimberly Gregory, MD
- Andy Heyward
- Eric Holoman
- Jeffrey Katzenberg
- Michelle Kittleson, MD
- Stewart Kwoh
- Thomas J. Leanse

- David Lee, MD, MPH, MBA
- Debra Lee, Esq.
- Jose de Jesus Legaspi
- Joshua Lobel
- Peggy Miles, MD
- Zuri Murrell, MD
- Christopher Ng, MD
- Patricia Salas Pineda
- Lawrence B. Platt*
- Thomas M. Priselac
- Marc H. Rapaport*
- Steven Romick
- David Sadkin
- Mark S. Siegel*
- G. Gabrielle "Gabi" Starr, PhD
- Emmeline Widjaja
- Jay Wintrob
- Clement Yang, MD

Exhibit 30-B

Cedars-Sinai's Most Recent Audited Financial Statements

Audited Consolidated Financial Statements and Supplementary Information

Cedars-Sinai Health System
Years Ended June 30, 2019 and 2018
With Report of Independent Auditors

Ernst & Young LLP



Cedars-Sinai Health System

Audited Consolidated Financial Statements
and Supplementary Information

Years Ended June 30, 2019 and 2018

Contents

Report of Independent Auditors....1

Audited Consolidated Financial Statements

Consolidated Balance Sheets....3
Consolidated Statements of Operations and Changes in Net Assets....5
Consolidated Statements of Cash Flows....7
Notes to Consolidated Financial Statements....9

Supplementary Information

Report of Independent Auditors on Supplementary Information....55
Consolidating Balance Sheets....56
Consolidating Statements of Operations and Changes in Net Assets....68

Building a better working world

Ernst & Young LLP
Suite 500
725 South Figueroa Street
Los Angeles, CA 90017-5418

Tel: +1 213 977 3200
Fax: +1 213 977 3152
ey.com

Report of Independent Auditors

The Board of Directors
Cedars-Sinai Health System

We have audited the accompanying consolidated financial statements of Cedars-Sinai Health System, which comprise the consolidated balance sheets as of June 30, 2019 and 2018, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

A member firm of Ernst & Young Global Limited

Building a better working world

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Cedars-Sinai Health System at June 30, 2019 and 2018, and the consolidated results of its operations and changes in net assets, and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

October 25, 2019

A member firm of Ernst & Young Global Limited

Cedars-Sinai Health System

Consolidated Balance Sheets
(Dollar Amounts Expressed in Thousands)

	June 30	
	2019	**2018**
Assets		
Current assets:		
Cash and cash equivalents	**$ 662,468**	$ 411,322
Short-term investments	**1,221,940**	1,255,144
Board-designated assets	**1,167,285**	1,087,653
Current portion of assets limited as to use:		
Funds held by trustee	**1,775**	397
Pledge receivable	**37,755**	33,015
Managed care reserve fund	**92,117**	78,867
Patient accounts receivable, less allowance for uncollectible accounts of $134,028 in 2018	**664,573**	626,508
Due from third-party payers	**6,583**	5,069
Inventory	**53,401**	46,754
Prepaid expenses and other assets	**218,866**	233,156
Total current assets	**4,126,763**	3,777,885
Assets limited as to use:		
Investments	**564,700**	547,585
Pledge receivable, less current portion	**190,535**	192,781
Funds held by trustee	**–**	382
	755,235	740,748
Property and equipment, net	**3,238,479**	3,036,489
Other assets	**494,370**	432,755
Total assets	**$ 8,614,847**	$ 7,987,877

Cedars-Sinai Health System

Consolidated Balance Sheets (continued)
(Dollar Amounts Expressed in Thousands)

	June 30 2019	2018
Liabilities and net assets		
Current liabilities:		
Accounts payable and other accrued liabilities	**$ 505,357**	$ 467,218
Accrued payroll and related liabilities	**364,537**	357,447
Risk pool liabilities	**117,707**	114,750
Current maturities of long-term debt	**51,919**	50,783
Total current liabilities	**1,039,520**	990,198
Long-term debt, less current maturities	**1,455,014**	1,507,146
Accrued workers' compensation and malpractice insurance claims, less current portion	**167,271**	150,962
Pension liability	**183,411**	59,170
Other liabilities	**97,552**	95,011
Net assets:		
Without donor restrictions:		
Controlling interests	**4,786,704**	4,320,002
Non-controlling interests	**53,123**	58,791
With donor restrictions	**832,252**	806,597
Total net assets	**5,672,079**	5,185,390
Total liabilities and net assets	**$ 8,614,847**	$ 7,987,877

See accompanying notes.

Cedars-Sinai Health System

Consolidated Statements of Operations and Changes in Net Assets
(Dollar Amounts Expressed in Thousands)

	Year Ended June 30	
	2019	**2018**
Net assets without donor restrictions		
Revenues, gains, and other support:		
Patient service revenue (net of contractual allowances and discounts)		$ 3,739,817
Provision for bad debts		(37,352)
Net patient service revenue before Medi-Cal Fee Program	**$ 4,354,791**	3,702,465
Medi-Cal Fee Program revenue	**132,625**	183,228
Net patient service revenue	**4,487,416**	3,885,693
Premium revenues	**263,941**	168,236
Other operating revenues	**134,295**	113,499
Net assets released from restrictions	**225,407**	198,434
Total revenues, gains, and other support	**5,111,059**	4,365,862
Expenses:		
Salaries and related costs	**2,359,996**	2,073,133
Professional fees	**349,357**	286,387
Materials, supplies, and other	**1,583,067**	1,333,224
Medi-Cal Fee Program expense	**129,849**	191,273
Interest	**45,165**	40,643
Depreciation and amortization	**239,881**	212,064
Total expenses	**4,707,315**	4,136,724
Income from operations	**403,744**	229,138
Investment income	**144,973**	110,620
Gain on equity method investments	**5,264**	8,001
Excess of revenues over expenses before inherent contribution from affiliation	**553,981**	347,759
Inherent contribution from affiliation	**–**	508,088
Excess of revenues over expenses	**553,981**	855,847
Deficit (excess) of revenues over expenses attributable to non-controlling interests	**2,687**	(2,938)
Excess of revenues over expenses attributable to the Health System	**$ 556,668**	$ 852,909

Cedars-Sinai Health System

Consolidated Statements of Operations and Changes in Net Assets (continued)
(Dollar Amounts Expressed in Thousands)

	Year Ended June 30 2019	2018
Net assets without donor restrictions (continued)		
Controlling interests activity:		
Excess of revenues over expenses attributable to the Health System	**$ 556,668**	$ 852,909
Net assets released from restrictions related to property and equipment	**951**	4,452
Change in pension liability	**(90,917)**	51,405
Increase in net assets without donor restrictions attributable to the Health System	**466,702**	908,766
Non-controlling interests activity:		
(Sale) purchase of non-controlling interest	**(132)**	4,122
(Deficit) excess of revenues over expenses attributable to non-controlling interests	**(2,687)**	2,938
Distributions to non-controlling interests	**(2,849)**	(2,289)
(Decrease) increase in net assets without donor restrictions attributable to non-controlling interests	**(5,668)**	4,771
Increase in net assets without donor restrictions	**461,034**	913,537
Net assets with donor restrictions		
Inherent contribution from affiliation	**–**	117,420
Contributions, grants and other	**239,204**	227,061
Investment income	**12,809**	12,206
Net assets released from restrictions	**(226,358)**	(202,886)
Increase in net assets with donor restrictions	**25,655**	153,801
Increase in net assets	**486,689**	1,067,338
Net assets at beginning of year	**5,185,390**	4,118,052
Net assets at end of year	**$ 5,672,079**	$ 5,185,390

See accompanying notes.

Cedars-Sinai Health System

Consolidated Statements of Cash Flows
(Dollar Amounts Expressed in Thousands)

	Year Ended June 30	
	2019	**2018**
Operating activities		
Increase in net assets	**$ 486,689**	$ 1,067,338
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Inherent contribution from affiliation	**–**	(571,658)
Depreciation	**216,650**	211,630
Amortization of goodwill and other intangibles	**23,231**	434
Amortization of deferred financing costs and bond premiums	**(11,835)**	(12,061)
Provision for bad debts	**–**	37,352
Restricted contributions	**(15,008)**	(20,687)
Sale (purchase) of non-controlling interests	**132**	(4,122)
Unrealized losses on investments	**62,376**	18,736
Gains on equity method investments	**(5,264)**	–
Distributions to non-controlling interests	**2,849**	–
Changes in operating assets and liabilities:		
Patient accounts receivable	**(38,065)**	14,269
Due from third-party payers	**(1,514)**	5,302
Inventory, prepaid expenses, and other current assets	**7,643**	(70,091)
Assets limited as to use, net of assets held by bond trustee	**(17,122)**	(4,773)
Accounts payable and other accrued liabilities	**5,347**	68,527
Accrued payroll and related liabilities	**7,090**	14,603
Risk pool liabilities	**2,957**	(2,113)
Other long-term liabilities	**146,473**	(62,826)
Net cash provided by operating activities before net purchases of trading investments	**872,629**	689,860
Net purchases of trading investments	**(164,975)**	(390,174)
Net cash provided by operating activities	**707,654**	299,686
Investing activities		
Expenditures for property and equipment	**(384,820)**	(285,313)
Purchase consideration for acquisitions	**(9,508)**	(4,693)
Decrease in assets held by bond trustee	**382**	120,372
Increase in other assets	**(71,012)**	(9,871)
Sales of alternative investments	**125,054**	51,289
Purchases of alternative investments	**(86,000)**	(29,947)
Net cash used in investing activities	**(425,904)**	(158,163)

Cedars-Sinai Health System

Consolidated Statements of Cash Flows (continued)

(Dollar Amounts Expressed in Thousands)

	Year Ended June 30	
	2019	**2018**
Financing activities		
Principal payments on long-term debt	**$ (42,763)**	$ (30,523)
Distributions to non-controlling interests	**(2,849)**	–
Restricted contributions	**15,008**	20,687
Net cash used in financing activities	**(30,604)**	(9,836)
Increase in cash and cash equivalents	**251,146**	131,687
Cash and cash equivalents – beginning of year	**411,322**	279,635
Cash and cash equivalents – end of year	**$ 662,468**	$ 411,322
Supplemental disclosure of cash flow information		
Interest paid	**$ 65,826**	$ 60,185

The Health System capitalized property and equipment of $77,685 and $42,839 at June 30, 2019 and 2018, respectively, that had not been paid and is included in the consolidated balance sheets under accounts payable and other accrued liabilities.

See accompanying notes.

1. Organization

Cedars-Sinai Health System, a California nonprofit, public benefit corporation (the Health System), is tax-exempt under the provisions of the Internal Revenue Code (the Code) and applicable provisions of the Franchise Tax Code of the state of California. Cedars-Sinai Health System was created and incorporated in May 2017 as the parent organization to facilitate an affiliation between Cedars-Sinai Medical Center and Torrance Health Association, Inc. Effective May 1, 2017, the Health System is the sole corporate member of Cedars-Sinai Medical Center and its affiliates. Effective February 1, 2018, the Health System became the sole corporate member of Torrance Health Association, Inc. and its affiliates. The accompanying consolidated financial statements include the accounts of the Health System and its affiliate or subsidiary organizations as detailed below:

Cedars-Sinai – The accompanying consolidated financial statements include the accounts of Cedars-Sinai Medical Center and its affiliates, collectively referred to as Cedars-Sinai, as of and for the years ended June 30, 2019 and 2018. The following entities are included in the accompanying consolidated financial statements:

Cedars-Sinai Medical Center (CSMC) is a California nonprofit, public benefit corporation that owns and operates a hospital with 886 licensed beds in Los Angeles, California, and provides patient care, medical research, health education, and community service. Cedars- Sinai Medical Center is the sole corporate member of Cedars-Sinai Medical Care Foundation and Marina Del Rey Hospital.

Cedars-Sinai Medical Care Foundation (CSMCF) is a California nonprofit, public benefit corporation that operates, manages, and maintains a multi-specialty clinic, holds payer contracts and the assets of acquired physician and physician group practices and independent practice associations; and contracts for physician services pursuant to professional services agreements.

CFHS Holdings, Inc. (dba Marina Del Rey Hospital) is a California nonprofit public benefit corporation, which owns and operates Marina Del Rey Hospital, a community hospital with 133 licensed beds.

1. Organization (continued)

Torrance Memorial – The accompanying consolidated financial statements include the accounts of Torrance Health Association, Inc. and its affiliates, collectively referred to as Torrance Memorial, as of and for the year ended June 30, 2019, and as of and for the five-month period ended June 30, 2018. The following entities are included in the accompanying consolidated financial statements:

Torrance Health Association, Inc. (THA) is a California nonprofit, public benefit corporation and is the parent organization for the entities listed below. THA was formed to engage in various health care related activities. THA is the sole corporate member of Torrance Memorial Medical Center and Torrance Memorial Medical Center Health Care Foundation.

Torrance Memorial Medical Center (TMMC) is a California nonprofit corporation and is licensed as a 610-bed general acute care hospital that provides inpatient, outpatient, and emergency care services for residents in the surrounding South Bay community.

Torrance Memorial Medical Center Health Care Foundation (TMMCF) is a California nonprofit corporation organized to raise funds for the support of TMMC.

On March 12, 2019, Providence St. Joseph Health (Providence) and Cedars-Sinai Medical Center formed Tarzana Medical Center, LLC (Tarzana), which CSMC owns a 49% membership interest, to own and operate Providence Tarzana Medical Center (PTMC). Providence and CSMC will jointly continue the build-out and redevelopment of the PTMC campus, including a new patient-care tower with all private rooms, an expanded Emergency Department, new diagnostic and treatment services, and enhanced outpatient and ambulatory services. Upon completion of the replacement facility construction, Providence will contribute to Tarzana all tangible and intangible assets pertaining to the existing PTMC business. The joint venture will expand primary and specialty care services on the PTMC campus, as well as enhance other programs, including heart, cancer and women's services. As of June 30, 2019, Cedars-Sinai Medical Center made an initial $60,495 capital contribution in Tarzana. This investment is recorded under the equity method of accounting in other assets.

2. Summary of Significant Accounting Policies

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States (U.S. GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimates include the carrying amounts for goodwill and property and equipment, valuation of deferred gifts, purchase accounting for acquisitions, valuation allowances for receivables, liabilities for medical claims incurred but not reported, third-party payables and receivables, risk pool liabilities, pension, and self-insured programs. Actual results could differ from those estimates.

Operating Revenues

The Health System records revenue in several financial statement categories: net patient service revenues (including Medi-Cal Fee Program revenue), premium revenues, other revenues, and net assets released from restrictions. Performance obligations are identified based on the nature of the services provided.

Net Patient Service Revenues

Net patient service revenue is reported at the amount that reflects the consideration to which the Health System expects to be entitled in exchange for providing patient care. These amounts, representing transaction price, are due from third-party payors (including health insurers and government programs), patients and others and include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Health System bills the third-party payers and patients several days after the services are performed and/or the patient is discharged. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided by the Health System. Generally, performance obligations satisfied over time apply to patients in the hospital receiving inpatient acute care services only. The Health System measures the performance obligation from admission into the hospital to the point when the medical condition upon admission has been resolved and it is no longer required to provide services to that patient, usually

2. Summary of Significant Accounting Policies (continued)

at the time of discharge. Revenue for performance obligations satisfied over time is recognized pro-rata based on actual charges incurred in relation to total expected (or actual) charges upon discharge. The Health System believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the services provided needed to satisfy the obligation. Outpatient services are performance obligations satisfied at a point in time and revenue is recognized when goods or services are provided, and the Health System does not believe it is required to provide additional goods or services.

The Health System has elected the practical expedient allowed under Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 606-10-32-18, *Revenue from Contracts with Customers,* and does not adjust the promised amount of consideration from patients and third-party payers for the effects of a significant financing component due to the Health System's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payer pays for that service will be one year or less. However, the Health System does, in certain instances, enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

Because all of its performance obligations relate to contracts with a duration of less than one year, the Health System has elected to apply the optional exemption provided in FASB ASC 606-10-50-14(a) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged.

The Health System is utilizing the portfolio approach practical expedient in ASC 606 for contracts related to patient service revenue. The Health System accounts for the contracts within each portfolio as a collective group, rather than individual contracts, based on the payment pattern expected in each portfolio category and the similar nature and characteristics of the patients within each portfolio. As a result, the Health System has concluded that revenue for a given portfolio would not be materially different than if accounting for revenue on a contract-by-contract basis.

2. Summary of Significant Accounting Policies (continued)

The Health System is reimbursed for services provided to patients under certain programs administered by governmental agencies. Laws and regulations governing the Medicare and Medi-Cal programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future governmental review and interpretation, as well as significant regulatory action, including fines, penalties, and exclusion from the Medicare and Medi-Cal programs. The Health System believes it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that may have a material impact on the accompanying consolidated financial statements.

Net patient service revenue by major payer source is as follows:

	Year Ended June 30	
	2019	**2018**
Medicare	**$ 1,013,208**	$ 907,748
Medi-Cal	**236,439**	252,096
Commercial and Managed Care	**2,991,563**	2,553,707
Self-pay and other	**246,206**	209,494
Patient service revenue, net of contractual allowances and discounts	**4,487,416**	3,923,045
Provision for bad debts	**–**	(37,352)
Net patient service revenues	**$ 4,487,416**	$ 3,885,693

The administrative procedures related to the cost reimbursement programs in effect generally preclude final determination of amounts due until cost reports are audited or otherwise reviewed and settled upon with the applicable administrative agencies. Estimation differences between final settlements and amounts accrued in previous years are reported as adjustments of the current year's net patient service revenue. In the opinion of management, adequate provision has been made for adjustments, if any, that might result from subsequent review.

2. Summary of Significant Accounting Policies (continued)

Prior to the adoption of ASC 606, patient service revenue, net of contractual allowances and discounts, is reduced by the provision for bad debts, and accounts receivable is reduced by an allowance for uncollectible accounts. The Health System establishes an allowance for uncollectible accounts based on many factors, including payer mix, age of receivables, historical cash collection experience, and other relevant information. A significant portion of the Health System's uninsured patients will be unable or unwilling to pay for services provided, and a significant portion of the Health System's insured patients will be unable or unwilling to pay for co-payments and deductibles. Thus, the Health System records a provision for bad debts related to these insured and uninsured patients in the period the services are provided. The Health System writes down the expected reimbursement after reasonable collection efforts have been exhausted.

The Health System applied the modified retrospective approach to all contracts when adopting ASC 606. As a result of the adoption of ASC 606 the majority of what was previously classified as the provision for bad debts in the consolidated statement of operations and changes in net assets is now reflected as implicit price concessions as defined in ASC 606 and, therefore, included as a reduction to net patient service revenues during fiscal year 2019. For changes in credit issues not assessed at the date of service, the Health System recognizes those amounts in materials, supplies, and other expenses on the statement of operations; the amount recognized in materials, supplies, and other related to impairment losses during the year ended June 30, 2019 was $1,366. For periods prior to the adoption of ASC 606, the provision for bad debts has been presented consistent with the previous revenue recognition standards that required it to be presented separately as a component of net patient service revenues. The adoption of ASC 606 did not have a material impact on the consolidated financial statements.

The Health System provides charity care to patients who meet certain criteria under its financial assistance policy. This policy defines charity care as uncompensated services provided to patients who are deemed indigent and to patients who are uninsured. During the years ended June 30, 2019 and 2018, the Health System incurred $35,572 and 27,231, respectively, in costs to provide charity care which is calculated based on a ratio of cost to gross charges.

2. Summary of Significant Accounting Policies (continued)

Medi-Cal Fee Program

As part of the American Recovery and Reinvestment Act economic stimulus package passed in 2009, Congress temporarily increased the Federal Medical Assistance Percentage (FMAP) for all states, allowing states to draw down increased federal dollars for hospitals that provide medical care for Medicaid patients. California hospitals organized to pursue this stimulus funding through the California Hospital Fee Programs (the Programs). Passed into law by the California state government and approved by the Centers for Medicare and Medicaid Services (CMS) in fiscal 2012, the Programs provide enhanced revenues related to provision of services to Medicaid patients, offset to a degree by the requirement to pay a fee (known as the Quality Assurance (QA) Fee) based on established rates applied to each hospital's historical patient days. Supplemental payments received met all criteria related to revenue recognition, and the related QA fees are both probable and estimable. Accordingly, all related supplemental payments have been recognized as revenue and related quality assurance fees recognized as expense in the consolidated statement of operations and changes in net assets pertaining to the 30-month Program covering the period from January 1, 2017, through June 30, 2019.

Specifically, total QA Fees incurred by the Health System were $129,849 and $191,273 for the years ended June 30, 2019 and 2018, respectively, while revenue from the Program totaled $132,625 and $183,228 for the years ended June 30, 2019 and 2018, respectively. In connection with the Program, the Health System applied for a grant from the California Health Foundation & Trust related to future shortfalls from the Program. The Health System recorded $7,957 and $4,883 for this grant for the years ended June 30, 2019 and 2018, respectively.

Premium Revenues

The Health System has agreements with various health maintenance organizations (HMOs) to provide medical services to subscribing participants. Under these agreements, monthly capitation payments are received based on the number of each HMO's participants, regardless of services actually performed. These agreements also contain risk-sharing provisions with medical groups whereby additional amounts may be due or paid. In addition, the HMOs make fee-for-service payments for non-capitated services based upon discounted fee schedules. Such payments received are recorded as premium revenues.

2. Summary of Significant Accounting Policies (continued)

The costs of health services provided by other health care providers to the participants, including administrative costs and out-of-area or emergency services, are included in professional fees, and totaled approximately $81,875 and $61,835 for the years ended June 30, 2019 and 2018, respectively. Such costs are accrued in the period in which the services are provided based in part on estimates, including an accrual for services provided by others, but not reported to Cedars-Sinai Medical Care Foundation and Torrance Health Association, Inc.

Other Operating Revenues

The Health System has additional revenue streams from tuition, health professionals, rental properties and parking. Revenue is recognized when obligations under the terms of the contract are satisfied. Revenues from these services are measured as the amount of consideration the Health System expects to receive for those services.

Net Assets Released from Restrictions

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. Conditional promises to give cash and indications of intentions to give are not recognized until the conditions are satisfied or removed. The gifts are reported as donor restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends, or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported on the consolidated statement of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reflected as without donor restrictions contributions in the accompanying consolidated financial statements as other operating revenues.

Excess of Revenues Over Expenses

The consolidated statements of operations and changes in net assets include the excess of revenues over expenses, which is considered the performance indicator. Changes in net assets without donor restrictions, which are excluded from the excess of revenues over expenses, include contributions of long-lived assets (including assets acquired using contributions which, by donor restrictions, were to be used for the purposes of acquiring such assets) and changes in pension plan liabilities.

2. Summary of Significant Accounting Policies (continued)

Inventory

Inventory is stated at cost (using the first-in, first-out method), which is not in excess of net realizable value.

Other Assets

Other non-current assets consist of the following:

	June 30 2019	2018
Goodwill and other intangible assets	**$ 209,767**	$ 223,880
Investments in unconsolidated entities	**165,975**	97,357
Property held for future use	**62,953**	63,501
Other	**55,675**	48,017
	$ 494,370	$ 432,755

Acquisitions and Affiliations

The accounting for acquisitions requires extensive use of estimates and judgments to measure the fair value of the identifiable tangible and intangible assets acquired and liabilities assumed. The fair value of acquired tangible and identifiable intangible assets and liabilities assumed are based on their estimated fair values at the acquisition date and are measured using an income and market approach with significant unobservable inputs.

On February 1, 2018, the Health System affiliated with Torrance Memorial with a goal of creating an integrated healthcare delivery system to improve the quality of healthcare within their communities and to further their mission of advancing the quality of care and furthering charitable services. The affiliation did not involve consideration and resulted in an excess of assets acquired over liabilities assumed under the business combination accounting guidance, which has been recorded as an inherent contribution from affiliation of $625,508 in the consolidated statement of operations and changes in net assets. The Health System recognized fair value estimates of assets acquired and liabilities assumed, and recorded cash and unrestricted investments of $62,986, working capital of $(8,777), property and equipment of $694,706, other assets of $332,462, long-term debt of $385,301, and other liabilities of $70,568.

2. Summary of Significant Accounting Policies (continued)

The following pro forma (unaudited) consolidated financial information presents the Health System's results for the year ended June 30, 2018, assuming the affiliation occurred on July 1, 2017:

	Actual	Pro Forma (Unaudited)
Total revenues	$ 4,365,862	$ 4,870,788
Income from operations	229,138	232,659
Excess of revenues over expenses attributable to the Health System	852,909	876,755
Change in net assets without donor restrictions	913,537	934,633
Change in net assets with donor restrictions	153,801	169,630

Pro forma results include historical Torrance Health Association, Inc., results (unaudited) for the seven-month period ended January 31, 2018, prior to the affiliation. Purchase accounting adjustments are included within pro forma results. A nonrecurring contribution of $625,508 is included within pro forma results.

Goodwill

Goodwill represents the excess of the consideration paid over the fair value of the net assets acquired, including identifiable intangible assets. The Health System elected to apply the goodwill accounting alternative in ASC 350, *Intangible – Goodwill and Other*, effective July 1, 2018 which allows non-for-profit entities to amortize goodwill on a straight-line basis over ten years and perform a one-step impairment test at the entity level only when an impairment indicator exists. The Health System concluded no indicators of impairment existed as of June 30, 2019. The guidance of the goodwill accounting alternative is applied to existing goodwill as of the beginning of the annual period of adoption and will be applied prospectively for goodwill recognized in the future. For the year ended June 30, 2019, the Health System recorded additional goodwill of $9,118 from an acquisition and recorded amortization of goodwill totaling $22,521. At June 30, 2019 and 2018, goodwill, which is included in other assets, totaled $208,011 and $221,415, respectively.

2. Summary of Significant Accounting Policies (continued)

Care of the Poor and Community Benefit (Unaudited)

The Health System's mission is to improve the health status of its community, regardless of the patient's ability to pay, including charity patients. The Health System provides programs and activities that contribute to charity care, care of the poor, and community benefit. These programs and activities serve a majority of persons who are beneficiaries of Medi-Cal, and county, state, and federal programs for which the costs of providing the services are not fully reimbursed. Also included are activities that improve the community's health status and educate or provide social services to the elderly and children. The Health System's unreimbursed costs for care of the poor and community benefits were approximately 20.9% and 22.4% of total operating expenses for the years ended June 30, 2019 and 2018, respectively. The costs associated with these programs and activities are as follows:

	For the Years Ended 2019	2018
Traditional charity care and uninsured patients (Category 1)	**$ 35,572**	$ 27,231
Unpaid cost of state programs (Category 2)	**105,601**	95,402
Unpaid cost of specialty government programs (Category 3)	**1,893**	2,148
Unpaid cost of federal programs (Category 4)	**473,378**	468,740
Research (Category 5)	**227,281**	213,662
Community benefit (Category 6)	**138,492**	118,541
Total community benefit	**982,217**	925,724
A portion of the above cost was supported by the help of:		
Federal, state, and local grants	**90,281**	82,594
Charitable giving	**50,155**	54,461
Community benefit, net of support by others	**$ 841,781**	$ 788,669

2. Summary of Significant Accounting Policies (continued)

The Health System uses the following six categories to classify care of the poor and community benefit:

Category 1: Traditional Charity Care and Uninsured Patients (care of the poor) – includes the cost of services provided to persons who cannot afford health care because of inadequate resources and/or who are uninsured. If there is any subsidy donated for these services, that amount is deducted from the gross amount.

Category 2: Unpaid Cost of State Programs – also benefits the poor, but is listed separately. This amount represents the unpaid cost of services provided to patients in the Medi-Cal program or enrolled in HMO and Preferred Provider Option (PPO) plans under contract with the Medi-Cal program.

Category 3: Unpaid Costs of Specialty Government Programs – also provides community benefit under such programs as the Veterans Administration, Los Angeles Police Department, Short Doyle, Proposition 99, and other programs to benefit the poor. This amount represents the unpaid cost of services provided to patients in these various programs. If this community benefit was not provided, federal, state, or local governments would need to furnish these services.

Category 4: Unpaid Cost of Federal Programs – primarily benefits the elderly. This amount represents the unpaid cost of services provided to patients in the Medicare program and enrolled in HMO and PPO plans under contract with the Medicare program. Included in these amounts are $19,349 and $24,692 for the years ended June 30, 2019 and 2018, respectively, of unpaid cost of services provided to patients in the Medicare program who are also in the Medi-Cal program.

Category 5: Research – cost of providing translational and clinical research and studies on health care delivery. During the years ended June 30, 2019 and 2018, the Health System received outside support for its research efforts totaling $140,436 and $137,055, respectively. Thus, for the years ended June 30, 2019 and 2018, the net cost incurred by the Health System was $86,845 and $76,607, respectively.

2. Summary of Significant Accounting Policies (continued)

Category 6: Community Benefit – cost of services that are beneficial to the broader community, i.e., other needy populations that may not qualify as poor, but that need special services and support. Examples include the elderly, substance abusers, the homeless, victims of child abuse, and persons with AIDS. They also include the cost of health promotion and education and health clinics and screenings.

Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Interest costs incurred during the period of construction of capital assets are capitalized as a component of the cost of acquiring those assets.

Gifts of long-lived assets such as land, buildings, or equipment that do not contain explicit donor stipulations, which specify how the donated assets must be used, are reported as support without donor restrictions, and are excluded from excess of revenue over expenses. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as support with donor restrictions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

The Health System accounts for software development costs in accordance with Accounting Standards Updated (ASU 2018-15), *Intangible – Goodwill and Other – Internal-use Software (Subtopic 350-40)*: All costs incurred in the planning stage of developing the software are expensed as incurred, as are internal and external training costs and maintenance costs. External and internal costs, excluding general and administrative costs and overhead costs, incurred during the applicable development stage of internally used software are capitalized. Such costs include external direct costs of materials and services consumed in development or obtaining the software, payroll, and payroll-related costs for employees who are directly associated with and who devote time to developing the software. Development changes that result in appropriate functionality of the software, which enable it to perform tasks that it was previously incapable of performing, are also capitalized.

Capitalized internal-use software development costs are amortized on a straight-line basis over their estimated useful life of three to seven years. Amortization begins when all substantial testing of the software is completed and the software is ready for its intended use.

2. Summary of Significant Accounting Policies (continued)

Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed of

The Health System accounts for the impairment and disposition of long-lived assets in accordance with ASC 360, *Property, Plant and Equipment Impairment or Disposal of Long-Lived Assets*. In accordance with ASC 360, long-lived assets to be held are reviewed for events or changes in circumstances that indicate that their carrying value may not be recoverable. The Health System determined that no assets are impaired at June 30, 2019 and 2018, respectively.

Assets Limited as to Use

Assets limited as to use include assets held by trustees that are for the payment of self-insurance liabilities, assets with donor restrictions, assets held by trustees under indenture agreement for future capital expenditures, and managed care capitation reserves. The current portion of assets limited as to use includes amounts that will be used to pay self-insurance classified as current liabilities.

Investments

The Health System has designated its investments in equity securities with readily determinable fair values and all investments in debt securities as trading, in accordance with ASC 954, *Health Care Entities*. Those securities are measured at fair value in the accompanying consolidated balance sheets. Fair value is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets. Management determines the appropriate classification of all investments at the date of purchase and re-evaluates such designations at each consolidated balance sheet date.

Investment income or loss on net assets with donor restrictions (including realized and unrealized gains and losses on investments, interest, and dividends) is reported as net assets without donor restrictions activity unless the income or loss is restricted by donor or law.

Cedars-Sinai's and Torrance Memorial's investments are invested in accordance with policies approved by its separate Board of Directors, which include, among other matters, targeted investment returns balanced by diversification of the investment portfolio, establishment of credit risk parameters, and limitation in the amount of investment in any single instrument. As part of its

2. Summary of Significant Accounting Policies (continued)

investment policies and strategies, each entity's Investment Committee meets periodically to review performance. At least annually, the Investment Committee reviews and formulates a specific investment and allocation plan. Any adjustments that are deemed necessary are based on specific criteria, i.e., the entity's necessary funding, obligations, expenses, and liquidity needs.

Alternative Investments

Certain of the Health System's investments are made through alternative investments, which include investments in limited partnerships and limited liability companies. The Health System generally contracts with fund managers, who have full discretionary authority over investment decisions. The Health System accounts for its ownership interests in the partnerships using the net asset value as a practical expedient for fair value. These investments provide the Health System with a proportionate share of the entities' gains and losses, which are included in investment income on the accompanying consolidated statements of operations and changes in net assets. As of June 30, 2019 and 2018, these alternative investments comprised approximately 14% and 17% of the Health System's total cash, cash equivalents, and investments.

Alternative investments include certain other risks that may not exist with other investments that are more widely traded. These risks include reliance on the skill of the fund managers, who often employ complex strategies with various financial instruments, including futures contracts, foreign currency contracts, structured notes, and other investment vehicles. Additionally, alternative investments may have limited information on a fund's underlying assets and valuation, and limited redemption or redemption-penalty provisions. Management believes that the Health System, in consultation with its Investment Committees, has the capacity to analyze and interpret the risks associated with alternative investments and, with this understanding, has determined that investing in these investments creates a balanced approach to its portfolio management.

Risk Pool Liabilities

Risk pool liabilities include amounts that THA estimates as payable under risk-sharing agreements through analysis of historical claims information using lag schedules and claims turnaround time. The liability also includes amounts payable to medical groups, as well as premiums received that are held in reserve for health plan agreements whose beneficiaries are primarily outside THA's service area. The funding, held in a managed care reserve and included in current portion of assets limited as to use in the accompanying consolidated balance sheets, totaled $92,117 and $78,867 at June 30, 2019 and 2018, respectively.

2. Summary of Significant Accounting Policies (continued)

Medical Malpractice Insurance

Cedars-Sinai is self-insured for the first $3,000 in professional malpractice and general liability losses per occurrence on a claims made basis effective October 1, 2005, and was self-insured for the first $2,000 effective October 1, 2004, and $1,000 for prior periods. Cedars-Sinai purchases excess insurance coverage resulting in total coverage of $200,000 per occurrence, insuring all employees, volunteers, and members of the medical faculty. Effective for the year beginning October 1, 2005, the insurance purchased was excess over an attachment point of $1,000 for each and every claim and another $2,000 per claim with a $10,000 annual aggregate. Effective October 1, 2013, the aggregate was raised to $15,000. Effective October 1, 2015, the aggregate was raised again to $17,000. Cedars-Sinai had no aggregate limit for the three years beginning October 1, 2002.

Similarly, Torrance Memorial is self-insured for professional liability (malpractice) claims up to $500 per occurrence on a claims-made basis. Torrance Memorial is covered by hospital malpractice insurance for claims in excess of this amount up to a maximum of $25,000 per occurrence, with an annual aggregate limit of $35,000. Combined accruals for insured and uninsured claims, and claims incurred but not reported are estimated by an actuary based on the Health System's claims experience. Such accruals, which totaled $79,243 and $70,635 at June 30, 2019 and 2018, are recorded using a 2.0% and 3.0% discount factor at June 30, 2019 and 2018, respectively. The current portion of the accruals of $12,996 and $11,023 at June 30, 2019 and 2018, is included in accounts payable and other accrued liabilities. The basis for the rate is the risk-free rate of return at the end of each year and the estimated period over which claims will be settled. The accruals represent the total actuarially determined loss without reduction for the portion that is expected to be recoverable through insurance ($15,017 and $11,313 at June 30, 2019 and 2018). The expected amounts to be recovered through insurance are included in other assets on the accompanying consolidated balance sheets.

Workers' Compensation Insurance

Cedars-Sinai carries workers' compensation insurance insuring employees with a self-insured primary limit of $1,000 effective February 1, 2005, and decreasing amounts in earlier years. Cedars-Sinai purchases excess insurance coverage on an occurrence basis to cover claims in excess of these amounts with an annual aggregate limit of $1,000. THA is also self-insured for workers' compensation claims up to $1,000 through August 31, 2013, and $350 thereafter. THA maintains

2. Summary of Significant Accounting Policies (continued)

insurance to cover claims in excess of these amounts with an annual aggregate limit of $1,000. Combined accruals for insured, uninsured claims and claims incurred but not reported are estimated by an actuary based upon the Health System's claims experience. Such accruals, which totaled $123,363 and $116,052 at June 30, 2019 and 2018, respectively, are recorded using a 2.0% and 3.0% discount factor at June 30, 2019 and 2018, respectively. The current portion of the accruals of $22,339 and $24,702 at June 30, 2019 and 2018, is included in accounts payable and other accrued liabilities. The basis of the rate is the risk-free rate of return at the end of each year and the estimated period over which claims will be settled. The accruals represent the total actuarially determined loss without reduction for the portion that is expected to be recoverable through insurance ($21,508 and $20,109 at June 30, 2019 and 2018). The expected amounts to be recovered through insurance are included in other assets in the accompanying consolidated balance sheets.

Cash and Cash Equivalents

The Health System considers all highly liquid debt instruments with original maturity dates at the time of purchase of three months or less to be cash equivalents.

Fair Value of Financial Instruments

The Health System's consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, patient accounts receivable, accounts payable and other accrued liabilities, pension liabilities, and long-term obligations. The Health System considers the carrying amounts of current assets and liabilities in the consolidated balance sheets to approximate the fair value of these financial instruments because of the relatively short period of time between origination of the instruments and their expected realization. Pledge receivable, accrued workers' compensation, malpractice insurance claims, and pension liabilities are recorded at their estimated present value using appropriate discount rates. Marketable securities are recorded at fair value based on quoted prices from recognized security exchanges and other methods, as further described in Note 5. Alternative investments are recorded at net asset value, which represents a practical expedient of fair value. Tax-exempt financings are carried at amortized cost. The fair value of tax-exempt financings is estimated based on current market rates, as further described in Note 4.

2. Summary of Significant Accounting Policies (continued)

Income Taxes

The Health System and its related affiliates have been determined to qualify as exempt from federal and state income taxes under Section 501(a) as organizations described in Section 501(c)(3) of the Code.

Most of the income received by the Health System is exempt from taxation, as income related to the mission of the organization. Accordingly, there is no material provision for income taxes for these entities. However, some of the income received by the exempt entities is subject to taxation as unrelated business income. The Health System and its subsidiaries file federal and state income tax returns.

The Health System completed an analysis of its tax positions, in accordance with ASC 740, *Income Taxes*, and determined that there are no uncertain tax positions taken or expected to be taken. The Health System has recognized no interest or penalties related to uncertain tax positions. The Health System is subject to routine audits by the taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The Health System believes it is no longer subject to income tax examinations for years prior to 2015.

The Tax Cuts and Jobs Act (the Act) was enacted on December 22, 2017. The provisions of the Act did not have a material tax effect on the Health System's consolidated financial statements. Certain regulatory guidance provides for a measurement period of up to one year during which accounting for the tax effects of the Act may be completed. The Health System will continue to evaluate the impact of the Act and may record adjustments as additional information and guidance is released by the Internal Revenue Service.

Concentrations of Credit Risk

Financial instruments, which potentially subject the Health System to concentrations of credit risk, consist primarily of investments and accounts receivable. Investments are made in a variety of financial instruments with prudent diversification requirements. The Health System seeks diversification among its investments by limiting the amount of investments that can be made with any one obligor. The investment portfolio is managed by professional investment managers within the guidelines established by the Boards, which, as a matter of policy, limit the amounts that may be invested in any one issuer.

2. Summary of Significant Accounting Policies (continued)

The Health System grants credit without collateral to its patients, most of whom are area residents and are insured under third-party agreements. The mix of net receivables from patients and third-party payers as of is as follows:

	June 30	
	2019	**2018**
Medicare	**18%**	18%
Medi-Cal	**2**	2
Commercial and managed care	**73**	73
Self-pay and other	**7**	7
	100%	100%

Recent Accounting Pronouncements

In May 2019, the FASB issued ASU 2019-06, *Intangible – Goodwill and Other (Topic 350), Business Combination (Topic 805), and Not-for-Profit Entities (Topic 958) Extending the Private Company Accounting Alternatives on Goodwill and Certain Identifiable Intangible Assets to Not-for-Profit Entities*, which allows not-for-profit entities to forgo testing goodwill for impairment annually at the reporting level and to instead use an accounting alternative in which goodwill is amortized over 10 years or less on a straight-line basis and to test for impairment upon a triggering event with the option to test for impairment at the entity level. ASU 2019-06 became effective upon issuance, and the Health System elected to apply the goodwill accounting alternative effective July 1, 2018 to the consolidated financial statements.

In August 2018, the FASB issued ASU 2018-15, *Intangibles – Goodwill and Other – Internal-Use Software (Topic 350): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract*, which aligns the requirements for deferring implementation costs incurred in a cloud computing arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. ASU 2018-15 is effective for annual periods beginning after December 15, 2020, and interim periods within fiscal years beginning after December 15, 2021. The Health System is currently evaluating the impact of this new standard on the consolidated financial statements.

2. Summary of Significant Accounting Policies (continued)

In July 2018, the FASB issued ASU No. 2018-11, *Leases (Topic 842): Targeted Improvements*, which enhances ASU 2016-02, *Leases (Topic 842)*, which requires the rights and obligations arising from the lease contracts, including existing and new arrangements, to be recognized as assets and liabilities on the balance sheet and allows for an option to apply the transition provisions of the new ASU at its adoption date instead of at the earliest comparative period presented in its consolidated financial statements. The ASU is effective for fiscal years (and interim reporting periods within fiscal years) beginning after December 15, 2018, with early adoption permitted for all entities, and the Health System has elected the practical expedient to initially apply the new leasing standard at the adoption date. The Health System is finalizing its analysis of certain key assumptions that will be utilized at the transition date, including the incremental borrowing rate. The primary effect of the new ASU will be to record right-of-use assets and obligations for current operating leases which will have a material impact on the consolidated balance sheets and significant incremental disclosures in the notes to the consolidated financial statements.

In June 2018, the FASB issued ASU No. 2018-08, *Not-for-Profit Entities (Topic 958): Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made*, which clarifies and improves the scope and the accounting guidance for contributions received and made with the objective of reducing the existing diversity in practice. The Health System adopted the new ASU for the year ended June 30, 2019, using a modified prospective basis. The adoption of ASU 2018-08 did not have a significant impact to the Health System's consolidated financial statements.

In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash*, which amends ASC 230 to add or clarify guidance on the classification and presentation of restricted cash in the statement of cash flows. For Public Business Entities (PBEs), the guidance is effective for fiscal years beginning after December 15, 2017, including interim periods within those fiscal years. For all other entities, it is effective for fiscal years beginning after December 15, 2018, and interim periods thereafter. The Health System is currently evaluating the impact of this new ASU on the consolidated financial statements.

In August 2016, the FASB issued ASU 2016-15, *Statement of Cash Flows (Topic 230): Classification of Certain Cash Receipts and Cash Payments*, which amends ASC 230 to add or clarify guidance on the classification of certain cash receipts and payments in the statement of cash

2. Summary of Significant Accounting Policies (continued)

flows. For PBEs, the guidance is effective for fiscal years beginning after December 15, 2017, including interim periods within those fiscal years. For all other entities, it is effective for fiscal years beginning after December 15, 2018, and interim periods within fiscal years beginning after December 15, 2019. The Health System is currently evaluating the impact of this new ASU on the consolidated financial statements.

In August 2016, the FASB issued ASU 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements for Not-For-Profit Entities*, which requires not-for-profit entities to revise financial presentation to include net asset classifications, provide quantitative and qualitative information as to available resources and management of liquidity and liquidity risk, information on investment expenses and returns, and the presentation of operating cash flows. The standard aims to help the reader of the financial statements to better understand the financial position of the organization and enhance consistency among similar organizations. The Health System has adjusted the presentation of these statements accordingly. The ASU has been applied retrospectively to all periods presented. Adopting ASU 2016-14 had no impact to total revenues, excess of revenues over expenses, or total net assets but modified the classification of net assets on the consolidated balance sheets and consolidated statements of operations and changes in net assets from three classes of net assets to two classes of net assets. Furthermore, the Health System added disclosure (Note 7) for the liquidity and availability of financial assets at the balance sheet date to meet cash needs for general expenditures within one year and disaggregated functional expense classifications by their natural expense classification of the consolidated financial statements (Note 10).

In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*. ASU 2014-09 provides a single, comprehensive revenue recognition model for entities to use in accounting for revenue arising from contracts with customers. The standard requires the entity to recognize revenue for the transfer of goods or services equal to the amount that it expects to be entitled to receive for those goods or services. The Health System adopted this guidance as of July 1, 2018, using the modified retrospective method of transition. As a result, at the adoption of ASC 606 the majority of what was previously classified as the provision for bad debts in the statement of operations is now reflected as implicit price concessions in ASC 606 and therefore included as a reduction to net patient service revenues during fiscal year 2019. For changes in credit issues not assessed at the date of service, the Health System recognized those amounts in materials, supplies, and other expenses on the statement of operations. For periods prior to the

2. Summary of Significant Accounting Policies (continued)

adoption of ASC 606, the provision for bad debts has been presented consistent with the previous revenue recognition standards that required it to be presented separately as a component of net patient service revenues. The adoption of ASC 606 did not have a material impact on the consolidated financial statements.

3. Property and Equipment

Property and equipment consist of the following:

	June 30	
	2019	**2018**
Land	**$ 258,962**	$ 258,962
Buildings and land improvements	**3,139,992**	3,026,224
Equipment	**613,044**	560,269
Software and software implementation costs	**696,576**	647,866
	4,708,574	4,493,321
Less accumulated depreciation and amortization	**2,009,940**	1,786,540
	2,698,634	2,706,781
Construction-in-progress	**539,845**	329,708
	$ 3,238,479	$ 3,036,489

Depreciation and amortization expense on property and equipment was $216,650 and $211,630 for the years ended June 30, 2019 and 2018, respectively.

Construction-in-progress consists of the following:

	June 30	
	2019	**2018**
Buildings and land improvements	**$ 441,100**	$ 245,659
Equipment	**18,559**	9,567
Software and software implementation costs	**69,597**	67,651
Capitalized interest	**10,589**	6,831
	$ 539,845	$ 329,708

3. Property and Equipment (continued)

If each project included in construction-in-progress were placed in service at June 30, 2019 and 2018, at the costs capitalized at that date, the Health System's annual depreciation would increase by approximately $28,446 and $20,956 (unaudited). This estimate of incremental annual depreciation is subject to change as additional costs are incurred to complete these projects. The Health System estimates that it will cost approximately $1,161,063 and $527,562 (unaudited) to complete the projects currently under construction.

4. Long-Term Debt

Cedars-Sinai and Torrance Memorial have public bonds. The entities do not assume any financial obligations related to payment of debt issued by each other. Revenue of each entity (excluding its affiliated or subsidiary organizations) is pledged to secure the payment of the principal and interest on all bonds and certificates under its separate Master Trust Indentures (Indentures). The Indentures contain covenants restricting additional debt and providing for the maintenance of certain financial ratios. Both entities were in compliance with these covenants at June 30, 2019 and 2018.

4. Long-Term Debt (continued)

Long-term debt issued and outstanding at as follows:

	June 30 2019	2018
Cedars-Sinai		
$535,000 Revenue Bonds, Series 2009; principal payments of $1,045 to $68,860 are due annually through 2039; interest is payable semiannually at 3.5% to 5.0%; the amount reported includes a face value of $8,685 and $16,960 at June 30, 2019 and 2018, respectively.	**$ 8,685**	$ 16,960
$148,400 Revenue Bonds, Series 2011; principal payments of $9,845 to $18,900 are due annually through 2021; interest is payable semiannually at 3.0% to 5.0%; the amount reported includes a face value of $56,730 and $73,860, unamortized premiums of $1,167 and $2,213, and unamortized deferred financing costs of $116 and $217 at June 30, 2019 and 2018, respectively;	**57,781**	75,856
$370,220 Revenue Bonds, Series 2015; principal payments of $480 to $39,680 are due annually through 2035; interest is payable semiannually at 2.0% to 5.0%; the amount reported includes a face value of $368,120 and $368,120, unamortized premiums of $47,390 and $53,174, and unamortized deferred financing costs of $1,727 and $1,951 at June 30, 2019 and 2018, respectively;	**413,783**	419,343
$267,420 Revenue Bonds, Series 2016A; principal payments of $5,040 to $38,905 are due annually through 2036; interest is payable semiannually at 4.0% to 5.0%; the amount reported includes a face value of $256,215 and $261,255, unamortized premiums of $42,408 and $46,199, and unamortized deferred financing costs of $1,232 and $1,343 at June 30, 2019 and 2018, respectively;	**297,391**	306,111
$402,305 Revenue Bonds, Series 2016B; principal payments of $1,625 to $66,900 are due annually beginning in 2020 through 2039; interest is payable semiannually at 3.0% to 5.0%; the amount reported includes a face value of $402,305 and $402,305, unamortized premiums of $28,327 and $30,038, and unamortized deferred financing costs of $2,057 and $2,184 at June 30, 2019 and 2018, respectively;	**428,575**	430,159
Other notes payable, secured by deeds of trust	**14,667**	15,507
Capital leases	**806**	930
Cedars-Sinai total	**$ 1,221,688**	$ 1,264,866

4. Long-Term Debt (continued)

	June 30 2019	2018
Torrance Memorial		
$135,000 Revenue Bonds, Series 2010A; principal payments of $1,910 to $12,290 are due annually through 2040; interest is payable semiannually at 3.0% to 5.0%; the amount reported includes a face value of $129,070 and $131,119, unamortized premiums of $6,626 and $6,939, and unamortized deferred financing costs of $1,486 and $1,553 at June 30, 2019 and 2018, respectively;	**$ 134,210**	$ 136,505
$64,860 Revenue Bonds, Series 2010B; principal payments are due semiannually through 2045; interest is payable based on a variable rate ranging from 2.88% to 3.06%; the amount reported includes a face value of $63,510 and $63,985, unamortized discounts of $0 and $0, and unamortized deferred financing costs of $987 and $825 at June 30, 2019 and 2018, respectively;	**62,523**	63,160
$35,140 Revenue Bonds, Series 2010C; principal payments are due semiannually through 2045; interest is payable semiannually based on a variable rate ranging from 2.88% to 3.06%; the amount reported includes a face value of $34,395 and $34,655, unamortized discounts of $0 and $0, and unamortized deferred financing costs of $437 and $448 at June 30, 2019 and 2018, respectively;	**33,958**	34,207
$34,795 Revenue Notes, Series 2016A; principal payments of $2,020 to $2,700 are due annually through 2026; interest is payable semiannually at 2.4%; the amount reported includes a face value of $30,755 and $32,775, unamortized discounts of $456 and $518, and unamortized deferred financing costs of $165 and $186 at June 30, 2019 and 2018, respectively;	**30,134**	32,071
$30,000 Revenue Notes, Series 2016B; principal payments of $2,770 to $3,285 are due annually through 2026; interest is payable semiannually at 2.3%; the amount reported includes a face value of $24,480 and $27,250, unamortized discounts of $405 and $460, and unamortized deferred financing costs of $160 and $175 at June 30, 2019 and 2018, respectively;	**23,915**	26,615
Other notes payable	**505**	505
Torrance Memorial total	**285,245**	293,063
Cedars-Sinai and Torrance Memorial total	**1,506,933**	1,557,929
Less current maturities for Cedars-Sinai and Torrance Memorial	**51,919**	50,783
	$ 1,455,014	$ 1,507,146

4. Long-Term Debt (continued)

In November 2016, Cedars-Sinai Medical Center issued $669,725 of California Health Facilities Financing Authority Revenue Bonds, composed of the 2016A Series Revenue Bonds totaling $267,420 and the 2016B Series Revenue Bonds totaling $402,305. The proceeds totaled $755,157, including a premium on the 2016A Series Revenue Bonds of $52,585 and a premium on the 2016B Series Revenue Bonds of $32,847, both of which will be amortized as a reduction of interest expense over the life of the bonds based on the effective interest rate. Total issuance costs of $3,975 were incurred in connection with the offerings. The proceeds from the 2016A Series Revenue Bonds were used to finance the costs of future capital expenditures, including the purchase of an administrative office building (including the land) that was previously leased by Cedars-Sinai Medical Center. The proceeds from the 2016B Series Revenue Bonds were used to advance refund the majority of the 2009 Series Revenue Bonds that were callable totaling $392,605. The remaining, unrefunded portion of the 2009 Series Revenue Bonds totaled $8,685 and $16,960 as of June 30, 2019 and 2018, respectively.

In November 2015, Cedars-Sinai Medical Center issued $370,220 of California Health Facilities Financing Authority Revenue Bonds. The proceeds totaled $438,580, including a premium of $68,360 which will be amortized as a reduction of interest expense over the life of the bonds. Issuance costs of $2,540 were incurred in connection with the offering. The proceeds were used to fully pay down the 2005 Series Revenue Bonds.

In December 2012, Cedars-Sinai Medical Center entered into a $50,000 credit agreement (the Agreement) with a bank that will expire in February 2023. Cedars-Sinai Medical Center may borrow under the Agreement with interest charged at either the London Interbank Offered Rate (LIBOR) plus an applicable margin of 0.375% based on Cedars-Sinai Medical Center's Moody's rating (currently Aa3), or at the greater of the bank's fluctuating prime rate minus 1.5%, or 1.0%. At June 30, 2019, the three-month LIBOR was 2.3% and the bank's prime rate was 5.5%. Cedars-Sinai Medical Center also pays a 0.125% annual commitment fee on the unused credit line. The Agreement is secured on a parity basis under the Bond Indenture with the tax-exempt financings of Cedars-Sinai Medical Center. No amounts have been borrowed under the Agreement.

4. Long-Term Debt (continued)

In November 2013, Cedars-Sinai Medical Center entered into a second $50,000 credit agreement with another bank that expired in November 2018 and was not renewed. In February 2019, Cedars-Sinai Medical Center entered into a new $50,000 credit agreement with a different bank that will expire in February 2024. The terms are substantially similar to the Agreement described above, except the commitment fee on the unused credit line is .10% as of June 30, 2019, and the applicable margin is 0.6% based on Cedars-Sinai Medical Center's maintaining its Moody's rating. No amounts have been borrowed under this agreement.

In December 2016, TMMC refunded the City of Torrance 2001 Series A Bonds with an aggregate principal amount of $44,865. The City of Torrance also issued Series 2016 A and 2016 B Revenue Notes for an aggregate principal amount of $64,795. The 2016 Series A and Series B Notes were issued to refund the 2001 Series A Bonds and to finance a portion of the costs of constructing and equipping certain additions and improvements to the facilities operated by TMMC. The 2016 Series A and Series B Notes mature on December 1, 2026.

In September 2010, the City of Torrance issued Series 2010 A, 2010 B, and 2010 C Bonds for an aggregate principal amount of $235,000. The 2010 Series A and Series B Bonds were issued to assist in financing the construction of the new patient tower. The 2010 Series C Bonds were issued to refund the 1992 Bonds. As of June 30, 2019 and 2018, the weighted-average interest rate on the 2010 Series A Bonds was 4.61% and 4.86%. The interest rate for the 2010 Series B and 2010 Series C Bonds at June 30, 2019 and 2018, was 3.06% and 3.13%.

In June 2015, TMMC entered into a direct purchase agreement with JP Morgan for the 2010 Series B and 2010 Series C bonds. Under terms of this agreement, JP Morgan purchased the entire amount of the two issuances at face value. The interest rate mode was changed from variable rate demand bonds that priced weekly to a semi-variable interest rate formula that is a function of the one-month LIBOR and reprices monthly. The term of the direct purchase is for a four-year period, after which JP Morgan has the option to continue or to exit the direct purchase relationship. The agreement was renewed in July 2018. The underlying line of credit backing the issuances was canceled. Other significant terms and covenants of the debt remain substantially the same.

The fair value of the tax-exempt financings for the Health System, determined using Level 2 inputs (refer to Note 5 for description) primarily related to comparable market prices, was estimated to be $1,543,090 and $1,551,219 at June 30, 2019 and 2018, respectively.

4. Long-Term Debt (continued)

The combined aggregate amount of maturities and sinking fund requirements (excluding the unamortized premium of $125,057 and unamortized deferred financing costs of $8,367 at June 30, 2019) for the five fiscal years succeeding June 30, 2019, and thereafter is as follows:

2020	$ 40,510
2021	42,140
2022	43,455
2023	45,445
2024	47,580
Thereafter	1,171,113
	$ 1,390,243

For the years ended June 30, 2019 and 2018, interest costs incurred totaled $52,930 and $47,474, of which $7,765 and $6,831, respectively, was capitalized as part of the cost of construction-in-progress.

5. Retirement Plans

In 1990, the Board of Directors of Cedars-Sinai authorized the suspension of Cedars-Sinai's non-contributory, defined benefit plan, which covered substantially all eligible employees (the Suspended Employee Plan). Benefit accruals under the Suspended Employee Plan were suspended effective December 31, 1990. Effective July 1, 2003, Cedars-Sinai began offering a defined benefit plan to its employees. Rather than design a new plan, Cedars-Sinai amended the Suspended Employee Plan (the Cedars-Sinai Defined Benefit Plan) to capture the new defined benefit activity.

In 1991, Cedars-Sinai implemented a defined contribution plan (the Cedars-Sinai Defined Contribution Plan), covering substantially all employees covered under the Suspended Employee Plan. Contributions under the Cedars-Sinai Defined Contribution Plan are calculated based on each employee's salary and totaled $76,040 and $72,732 for the years ended June 30, 2019 and 2018, respectively. Employees have the choice of participation in either the Cedars-Sinai Defined Benefit Plan or the Cedars-Sinai Defined Contribution Plan and can change the selection once during their employment.

5. Retirement Plans (continued)

Cedars-Sinai employees participate in a 403(b) plan sponsored by Cedars-Sinai. Under the provisions of the plan, participating employees may make voluntary contributions up to 100% of pretax annual compensation, subject to statutory limitations. Cedars-Sinai contributes 50% of the first 6% of compensation that a participant contributes to the plan.

In addition, certain key employees of Cedars-Sinai are covered by separate defined contribution and defined benefit retirement plans, which are not governed by the Employee Retirement Income Security Act of 1974. Contributions under these plans are calculated based on each key employee's salary and totaled $23,521 and $21,873 for the years ended June 30, 2019 and 2018, respectively.

Torrance Memorial has a noncontributory defined benefit retirement plan (the THA Defined Benefit Plan) under which employees, upon retirement, are provided a monthly pension if conditions related to age and length of service have been met. During 2009, Torrance Memorial adopted an amendment, effective January 1, 2010, that reduces benefits accrued under plan provisions and freezes participation in the THA Defined Benefit Plan to those individuals employed by Torrance Memorial on or before December 31, 2009. Individuals employed subsequent to this date become eligible for participation in a defined contribution plan, to be funded 100% by Torrance Memorial.

On January 1, 2010, Torrance Memorial began a new 401(a) defined contribution plan (THA 401(a) Plan). Torrance Memorial employees hired on or after January 1, 2010, and who are at least 21 years of age, are eligible to participate in the THA 401(a) Plan. Under the provisions of the plan, employees become members on January 1 or July 1, whichever is sooner, following the completion of one year of employment in which the employee was credited with at least 1,000 hours of service. Contributions to the plan are made entirely by Torrance Memorial and range from 3% to 6% of annual compensation, based on years of service. Contributions to employee accounts vest based upon years of service, with accounts becoming fully vested upon completion of five years of service with Torrance Memorial. Torrance Memorial's contributions to the plan amounted to approximately $4,377 for the year ended June 30, 2019, and $1,243 for the five months ended June 30, 2018.

Torrance Memorial's employees participate in a 403(b) plan sponsored by THA. Under the provisions of the plan, participating employees may make voluntary contributions through salary deductions. Torrance Memorial matches eligible employee contributions at rates between 20% to

5. Retirement Plans (continued)

100% with a maximum limit of eight hundred dollars per year based upon years of service with Torrance Memorial. Torrance Memorial's contributions related to the 403(b) plan amounted to approximately $1,135 for the year ended June 30, 2019, and $490 for the five months ended June 30, 2018.

The following tables present information related to changes in projected benefit obligations, plan assets and their composition, funded status, the accumulated benefit obligation, and net periodic pension cost for all Cedars-Sinai and THA defined benefit plans (the Plans) at June 30, 2019 and 2018, and for the years then ended. Cedars-Sinai contributed $77,851 to fully fund the Cedars-Sinai Defined Benefit Plan in September 2019. Torrance Memorial contributed $31,845 in September 2019 to fund the THA Defined Benefit Plan.

In addition, Torrance Memorial has recorded liabilities for pension benefits of $6,530 and $4,795 as of June 30, 2019 and 2018, respectively, relating to Torrance Memorial's other retirement plans.

	Year Ended June 30, 2019		
	Cedars- Sinai	**THA**	**Total**
Change in projected benefit obligations:			
Projected benefit obligation at beginning of year	**$ 555,769**	**$ 400,521**	**$ 956,290**
Service cost	**37,179**	**15,855**	**53,034**
Interest cost	**22,076**	**16,180**	**38,256**
Actuarial losses	**54,667**	**39,073**	**93,740**
Benefits paid	**(17,045)**	**(12,271)**	**(29,316)**
Projected benefit obligation at end of year	**652,646**	**459,358**	**1,112,004**
Change in plan assets:			
Fair value of plan assets at beginning of year	**542,246**	**359,669**	**901,915**
Actual gain on plan assets	**35,961**	**13,340**	**49,301**
Employer contributions	**2,024**	**12,339**	**14,363**
Benefits paid	**(17,045)**	**(12,271)**	**(29,316)**
Expenses paid	**(1,140)**	–	**(1,140)**
Fair value of plan assets at end of year	**562,046**	**373,077**	**935,123**
Funded status	**$ (90,600)**	**$ (86,281)**	**$ (176,881)**

5. Retirement Plans (continued)

	June 30, 2019	
	Cedars-Sinai	**THA**
Composition of plan assets:		
Short-term money market funds	**16%**	**7%**
Government and corporate debt	**5**	**18**
U.S. government agencies and asset backed securities	**1**	**13**
Equity securities	**9**	**27**
Mutual funds	**65**	**32**
Common/collective trusts	**4**	**3**
	100%	**100%**

	June 30, 2019		
	Cedars-Sinai	**THA**	**Total**
Amounts recognized as pension liability in the consolidated balance sheet	**$ 90,600**	**$ 86,281**	**$ 176,881**
Accumulated benefit obligation	**$ 614,160**	**$ 430,925**	**$ 1,045,085**

	Year Ended June 30, 2019		
	Cedars-Sinai	**THA**	**Total**
Net periodic benefit cost recognized:			
Service cost	**$ 37,179**	**$ 15,855**	**$ 53,034**
Interest cost	**22,076**	**16,180**	**38,256**
Expected return on plan assets	**(30,356)**	**(23,296)**	**(53,652)**
Amortization of net loss	**8,044**	**–**	**8,044**
Amortization of prior service costs	**270**	**–**	**270**
Net periodic benefit cost	**$ 37,213**	**$ 8,739**	**$ 45,952**

5. Retirement Plans (continued)

	June 30, 2019	
	Cedars-Sinai	**THA**
Weighted-average assumptions used to determine benefit obligations consist of the following:		
Discount rate used to determine service cost	**4.37%**	**4.37%**
Discount rate used to determine projected benefit obligation	**3.68**	**3.72**
Expected long-term rate of return on plan assets	**5.75**	**6.50**
Rate of increase in future compensation levels	**4.00**	**4.00**

	Year Ended June 30, 2018		
	Cedars- Sinai	**THA**	**Total**
Change in projected benefit obligations:			
Projected benefit obligation at beginning of year	$ 554,332	$ 415,022	$ 969,354
Service cost	38,277	6,848	45,125
Interest cost	21,502	6,258	27,760
Actuarial gains	(31,149)	(22,608)	(53,757)
Benefits paid	(14,045)	(4,999)	(19,044)
Settlement	(13,148)	–	(13,148)
Projected benefit obligation at end of year	555,769	400,521	956,290
Change in plan assets:			
Fair value of plan assets at beginning of year	488,819	363,775	852,594
Actual gain (loss) on plan assets	29,491	(7,757)	21,734
Employer contributions	52,253	8,650	60,903
Benefits paid	(14,045)	(4,999)	(19,044)
Expenses paid	(1,124)	–	(1,124)
Settlement	(13,148)	–	(13,148)
Fair value of plan assets at end of year	542,246	359,669	901,915
Funded status	$ (13,523)	$ (40,852)	$ (54,375)

5. Retirement Plans (continued)

	June 30, 2018	
	Cedars-Sinai	**THA**
Composition of plan assets:		
Short-term money market funds	21%	8%
Government and corporate debt	–	29
Equity securities	4	27
Mutual funds	75	33
Common/collective trusts	–	3
	100%	100%

	June 30, 2018		
	Cedars-Sinai	**THA**	**Total**
Amounts recognized as pension liability in the consolidated balance sheet	$ 13,523	$ 40,852	$ 54,375
Accumulated benefit obligation	$ 525,133	$ 377,653	$ 902,786

	Year Ended June 30, 2018		
	Cedars-Sinai	**THA**	**Total**
Net periodic benefit cost recognized:			
Service cost	$ 38,277	$ 6,848	$ 45,125
Interest cost	21,502	6,258	27,760
Expected return on plan assets	(29,716)	(9,890)	(39,606)
Amortization of net loss	14,674	–	14,674
Amortization of prior service costs	270	–	270
Net periodic benefit cost	$ 45,007	$ 3,216	$ 48,223

	June 30, 2018	
	Cedars-Sinai	**THA**
Weighted-average assumptions used to determine benefit obligations consist of the following:		
Discount rate used to determine service cost	4.00%	4.02%
Discount rate used to determine projected benefit obligation	4.31	4.33
Expected long-term rate of return on plan assets	5.75	6.50
Rate of increase in future compensation levels	4.00	4.00

5. Retirement Plans (continued)

The expected rate of return on plan assets is updated annually, taking into consideration the Plans' asset allocation, historical returns on the types of assets held in the trusts, and the current economic environment.

Amounts included in net assets without donor restrictions that have not been recognized in net periodic pension cost as of June 30, 2019:

	Cedars-Sinai	**THA**	**Total**
Unrecognized prior service costs	**$ 877**	**$ –**	**$ 877**
Unrecognized prior loss	**172,689**	**44,068**	**216,757**
	$ 173,566	**$ 44,068**	**$ 217,634**

Amounts included in net assets without donor restrictions that have not been recognized in net periodic pension cost as of June 30, 2018:

	Cedars-Sinai	**THA**	**Total**
Unrecognized prior service costs	$ 1,147	$ –	$ 1,147
Unrecognized prior loss (gain)	130,531	(4,961)	125,570
	$ 131,678	$ (4,961)	$ 126,717

The unrecognized prior losses and unamortized prior service costs expected to be recognized over the fiscal year ending June 30, 2020, are $10,627 and $270, respectively, for the Cedars-Sinai Defined Benefit Plan and $0 and $0, respectively, for the THA Defined Benefit Plan.

Plans Assets

Approximately 96% of plan assets relate to long-term investment activities covering the Health System's general employee population. The other 4% of the assets relate to a special plan for highly compensated employees closer to retirement age. The combined target allocation is approximately 65% equities, 25% fixed income, and 10% short-term instruments, with no allocation to alternative investments. All investments are highly liquid.

5. Retirement Plans (continued)

The Health System uses a three-level valuation hierarchy for disclosure of fair value measurements. The valuation hierarchy is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

- Level 1 – Inputs to the valuation methodology are quoted prices (unadjusted) for identical assets or liabilities in active markets.

- Level 2 – Inputs to the valuation methodology include quoted prices for similar assets or liabilities in active markets, and inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the financial instruments. This includes model-derived valuations whose significant inputs are observable.

- Level 3 – Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

Fair values are based on the market approach valuation technique which is based on prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities.

5. Retirement Plans (continued)

A financial instrument's categorization within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement. The following table presents the financial instruments in the Cedars-Sinai Defined Benefit Plan and THA Defined Benefit Plan carried at fair value as of June 30, 2019 and 2018, by valuation hierarchy.

	Level 1	Level 2	Fair Value
June 30, 2019			
Cash and cash equivalents	**$ 116,545**	**$ –**	**$ 116,545**
Equities	**149,746**	**–**	**149,746**
U.S. government issues	**29,303**	**–**	**29,303**
U.S. government agencies and asset backed securities	**–**	**52,295**	**52,295**
Corporate bonds	**–**	**67,167**	**67,167**
Mutual funds	**486,819**	**–**	**486,819**
	$ 782,413	**$ 119,462**	**901,875**
Common/collective trusts measured at net asset value			**33,248**
			$ 935,123

	Level 1	Level 2	Fair Value
June 30, 2018			
Cash and cash equivalents	$ 141,000	$ –	$ 141,000
Equities	121,306	–	121,306
U.S. government issues	43,765	–	43,765
Corporate bonds	–	61,903	61,903
Mutual funds	521,497	–	521,497
	$ 827,568	$ 61,903	889,471
Common/collective trusts measured at net asset value			12,444
			$ 901,915

5. Retirement Plans (continued)

Plans' Investment Strategy

The Health System's investment policy generally reflects the long-term nature of the pension plans' funding obligations. Assets are invested to achieve a rate of return consistent with policy allocation targets, which significantly contributes to meeting the current and future obligations of the plans, and strives to help ensure solvency of the plans over time. This objective is to be achieved through a well-diversified asset portfolio and emphasis on long-term capital appreciation as a primary source of return. The plans utilize a multi-manager structure of complementary investment styles and classes. Manager qualitative performance is continually evaluated, while a manager's investment performance is judged over an investment market cycle of at least three years.

Plans assets are exposed to risk and fluctuations in market value from year to year. To minimize risk, each manager maintains a diversification of their portfolio to insulate the portfolio from substantial losses in any single security or sector of the market. The asset allocation is reviewed for deviations in the allowable range for each asset class, and rebalancing is implemented as necessary.

The long-term rate of return of the plans' investment allocation is designed to be commensurate with a conservatively managed balance allocation. Fixed-income securities consist ofinvestment-grade bonds.

Each investment type is managed by an asset manager specializing in various security types. The investment objective of the plans over a three- to five-year period is to produce a rate of return that equals or exceeds the appropriate bond index, S&P 500 stock index, or other appropriate international equity index.

As part of investment policies and strategies, the plans' Investment and Pension Committees meet periodically to review performance. At least annually, the Investment and Pension Committees review and formulate the specific investment and allocation plan. Any adjustments that are deemed necessary are based on specific criteria, i.e., necessary plan funding, plan obligations, plan expenses, and plan liquidity needs.

5. Retirement Plans (continued)

Plans' Cash Flows

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid as follows:

	Cedars-Sinai	THA	Total
2020	$ 27,604	$ 16,199	$ 43,803
2021	26,658	16,123	42,781
2022	29,839	17,641	47,480
2023	32,082	19,078	51,160
2024	34,012	20,440	54,452
2025 through 2029	198,501	120,524	319,025

6. Investments

Investment loss or income on cash and cash equivalents, investments, board-designated assets, and assets limited as to use consists of the following:

	Year Ended June 30	
	2019	2018
Interest and dividend income	**$ 73,656**	$ 53,689
Realized gains	**146,502**	87,873
Unrealized losses	**(62,376)**	(18,736)
Investment gain included in the consolidated statement of operations and changes in net assets	**$ 157,782**	$ 122,826

The following table presents the financial instruments carried at fair value as of June 30, 2019 and 2018, by valuation hierarchy as defined in Note 5. Alternative investments are recorded at net asset value, which is a practical expedient for fair value. The alternative investments are redeemable monthly, quarterly, semiannually, annually, or at the end of the term.

There were no significant transfers between Levels 1, 2, or 3 during the years ended June 30, 2019 and 2018. Fair values are based on the market approach valuation technique as defined in Note 5. There are no capital commitments associated alternative investments.

6. Investments (continued)

	Level 1	Level 2	Fair Value
June 30, 2019			
Cash and cash equivalents in assets limited to use	**$ 79,510**	**$ –**	**$ 79,510**
Equities	**443,972**	**–**	**443,972**
U.S. government debt	**160,595**	**–**	**160,595**
U.S. government agencies and asset backed securities	**–**	**618,044**	**618,044**
Corporate debt (domestic)	**–**	**428,215**	**428,215**
Foreign government debt	**–**	**79,121**	**79,121**
Mutual funds and other	**719,978**	**–**	**719,978**
	$ 1,404,055	**$ 1,125,380**	**2,529,435**
Alternative investments measured at net asset value			**518,382**
			$ 3,047,817

	Level 1	Level 2	Fair Value
June 30, 2018			
Cash and cash equivalents in assets limited to use	$ 21,796	$ –	$ 21,796
Equities	439,528	–	439,528
U.S. government debt	255,899	–	255,899
U.S. government agencies and asset backed securities	–	657,470	657,470
Corporate debt (domestic)	–	291,345	291,345
Foreign government debt	–	41,239	41,239
Mutual funds and other	701,846	–	701,846
	$ 1,419,069	$ 990,054	2,409,123
Alternative investments measured at net asset value			560,905
			$ 2,970,028

7. Availability of Financial Assets

The following reflects the Health System's financial assets at June 30, 2019, reduced by amounts not available for general use within one year of the balance sheet date because of contractual or donor-imposed restrictions or internal designations.

Cash and cash equivalents	$ 662,468
Short-term investments	1,221,940
Board-designated assets	1,167,285
Patient accounts receivable	664,573
	$ 3,716,266

Board-designated assets include investments designated by the Health System's Board of Directors (the Board) for future capital expenditures, physician programs, academic programs, and fundraising. However, the Board retains control of these assets and will, at its discretion, and if necessary, use these assets for operating purposes. Therefore, Board-designated assets are included in the amounts above.

The Health System has assets limited to use as described in Note 2 which are not reflected in the amounts above. As part of the Health System's liquidity management plan, cash in excess of daily requirements for general expenditures is invested in short-term investments that can be drawn upon, if necessary, to meet the liquidity needs of the Health System.

The Health System has two $50,000 credit agreements as discussed in Note 4. As of June 30, 2019, $50,000 was available at each bank.

8. Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following purposes:

	2019	2018
Health care services	**$ 331,136**	$ 322,445
Purchase of capital assets	**14,564**	15,072
Health education and research	**138,556**	140,632
Endowment funds	**347,996**	328,448
	$ 832,252	$ 806,597

8. Net Assets with Donor Restrictions (continued)

During the years ended June 30, 2019 and 2018, net assets were released from donor restrictions by incurring expenses satisfying the restricted purposes of health care services and health education totaling $225,407 and $198,434, respectively, and capital expenditures and contributions totaling $951 and $4,452, respectively.

Endowment funds at June 30, 2019 and 2018 are restricted to investments that are to be held in perpetuity to provide a permanent source of income.

Pledges are recognized as contributions at the present value of expected future payments. The discount rate used is the estimated risk-free discount rate at the time of the donation (ranging from 1.08% to 13.82%). Pledges receivable in donor restricted net assets are scheduled to be received as follows:

	2019	2018
Due in one year or less	**$ 37,755**	$ 33,015
Due after one year through five years	**89,415**	99,820
Due after five years	**140,944**	145,485
Total balance, less allowance of $13,645 and $18,071 in 2019 and 2018, respectively	**268,114**	278,320
Less discount to present value	**39,824**	52,524
Pledges receivable, net	**$ 228,290**	$ 225,796

8. Net Assets with Donor Restrictions (continued)

During the years ended June 30, 2019 and 2018, the Health System had the following endowment-related activities:

	With Donor Restrictions	Without Donor Restrictions	Total
Endowment net assets, beginning of year July 1, 2017	$ 309,320	$ 444,430	$ 753,750
Contributions	15,815	8,283	24,098
Inherent contribution from affiliation	3,313	–	3,313
Investment income	2,039	33,538	35,577
Transfers of investment income	(2,039)	(1,668)	(3,707)
Endowment net assets, end of year June 30, 2018	328,448	484,583	813,031
Contributions	**19,548**	**11,098**	**30,646**
Investment income	**2,168**	**28,728**	**30,896**
Transfers of investment income	**(2,168)**	**(1,643)**	**(3,811)**
Endowment net assets, end of year June 30, 2019	**$ 347,996**	**$ 522,766**	**$ 870,762**

The Health System's endowment consists of 231 individual funds for a variety of purposes. Its endowment includes both donor-restricted endowment funds and funds designated by the Board to function as endowments. As required by U.S. GAAP, net assets associated with endowment funds, including funds designated by the Board to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions.

8. Net Assets with Donor Restrictions (continued)

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor requires the Health System to retain as a fund of perpetual duration. Deficiencies of this nature are reported in net assets with donor restrictions. There were no such deficiencies as of June 30, 2019 or 2018.

The Health System's Board has interpreted the Uniform Prudent Management of Institutional Funds Act as requiring the preservation of the corpus of the various donor-restricted endowment funds, absent explicit donor stipulations to the contrary. As a result of this interpretation, the Health System classifies as donor restricted net assets: (a) the original value of gifts donated, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund.

The Health System has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowments. Endowment assets include those assets of donor-restricted funds that the organization must hold in perpetuity, as well as Board-designated funds. Under this policy, as approved by the Board, the endowment assets are invested in a manner that is intended to produce results that exceed the price and yield of market benchmarks. Actual returns in any given year may vary from this goal.

To satisfy the long-term rate of return objectives, the Health System relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Health System targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term objectives within prudent constraints.

9. Commitments and Contingencies

Pending claims and legal proceedings at June 30, 2019, are set forth below. For all matters where a loss is probable and reasonably estimable, an estimate of the loss or a range of loss is provided. Where no estimate is provided, a loss is not probable or an amount of loss is not reasonably estimable at this time.

9. Commitments and Contingencies (continued)

Litigation – Employment Practices (Class Action). Wage and hour complaints have multiplied in the hospital field in the last few years. The Health System is now defending a series of separate cases which in various forms contend that there has been a failure to pay overtime wages; failure to pay minimum wages; failure to provide meal periods or compensation in lieu thereof; failure to provide rest periods or compensation in lieu thereof; failure to pay wages in a timely manner at separation; failure to provide accurate itemized wage statements; and/or unfair business practices.

These cases have been assigned to the "complex" division of the Superior Court. Outside counsel has been retained to defend these cases and the Health System will vigorously defend the class action function and other allegations. The cost and outcome of these cases cannot be ascertained at this time.

Other. In addition to the above, the Health System is a defendant in various other legal actions arising from the normal conduct of business. Management believes that the ultimate resolution of all proceedings will not have a material adverse effect upon the consolidated financial position, results of operations, or cash flows of the Health System. Further, new claims or inquiries may be initiated against the Health System and its affiliates from time to time. These matters could (1) require the Health System to pay substantial damages or amounts in judgments or settlements, which individually or in the aggregate could exceed amounts, if any, that may be recovered under the insurance policies where coverage applies and is available; (2) cause the Health System to incur substantial expenses; and (3) require significant time and attention from management.

The Health System cannot predict the results of current or future claims and lawsuits. The Health System recognizes that, where appropriate, the Health System's interests may be best served by resolving certain matters without litigation. If a non-litigated resolution is not appropriate or possible with respect to a particular matter, the Health System will defend itself vigorously. The ultimate resolution of claims against the Health System, individually or in the aggregate, could have a material adverse effect on the Health System's business (both in the near and long term), consolidated financial position, results of operations, or cash flows.

Finance Method Leases

In 2013, THA financed $39,600 of the Torrance Memorial Specialty Center through a sale leaseback transaction with Continental Development Corp. (CDC). THA received $23,100 in cash and $16,500 in five year notes receivable from CDC for the sale of the property. In 2012, THA

9. Commitments and Contingencies (continued)

financed $24,900 of certain properties through sale leaseback transactions with CDC. THA received $14,900 in cash and $10,000 in five-year notes receivable from CDC for the sale of the properties. THA recorded the sale of these properties based on the relative fair value on the date of the transaction. As a result, no gains or losses were recorded in THA's statement of operations. The amount in property and equipment under these leases as of June 30, 2019, is $41,358 after accumulated depreciation. Future finance method lease payments as of June 30, 2019, are as follows:

2020	$ 4,135
2021	4,238
2022	4,344
2023	4,452
2024	4,564
Thereafter	75,947
	$ 97,680

Operating Leases

The Health System leases certain office space under the terms of non-cancelable operating leases, whose terms vary in length from month to month to 15 years, with renewal options upon prior written notice, typically for 5 years depending upon the agreed-upon terms with the local landlord. Rents under the Health System's lease amounts generally increase from 2% to 5% on an annual basis. Future minimum lease commitments under non-cancelable operating leases are as follows:

2020	$ 83,105
2021	70,390
2022	63,621
2023	47,132
2024	43,331
Thereafter	173,269
	$ 480,848

Rental expense was $118,693 and $92,002 during the years ended June 30, 2019 and 2018, respectively.

10. Functional Expenses

The Health System provides general health care services to residents within its geographic location. Expenses related to providing these services for the years ended June 30, 2019 and 2018 are as follows:

	Healthcare Services	General and Administrative	Fundraising	Total
June 30, 2019				
Salaries and related costs	**$ 2,082,028**	**$ 269,232**	**$ 8,736**	**$ 2,359,996**
Professional fees	**349,357**	**–**	**–**	**349,357**
Materials, supplies, and other	**1,345,853**	**235,392**	**1,822**	**1,583,067**
Medi-Cal Fee Program expense	**129,849**	**–**	**–**	**129,849**
Interest	**37,657**	**7,508**	**–**	**45,165**
Depreciation and amortization	**210,723**	**28,668**	**490**	**239,881**
	$ 4,155,467	**$ 540,800**	**$ 11,048**	**$ 4,707,315**

	Healthcare Services	General and Administrative	Fundraising	Total
June 30, 2018				
Salaries and related costs	$ 1,826,366	$ 238,365	$ 8,402	$ 2,073,133
Professional fees	286,387	–	–	286,387
Materials, supplies, and other	1,092,881	237,364	2,979	1,333,224
Medi-Cal Fee Program expense	191,273	–	–	191,273
Interest	34,568	6,075	–	40,643
Depreciation and amortization	188,888	22,615	561	212,064
	$ 3,620,363	$ 504,419	$ 11,942	$ 4,136,724

The consolidated financial statements report certain expense categories that are attributable to more than one function. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Costs not directly attributable to a function, including interest, depreciation, amortization, and other occupancy costs, are allocated to a function based on total functional cost before allocation.

11. Subsequent Events

The Health System evaluated subsequent events through October 25, 2019, which is the date these consolidated financial statements were issued.

Supplementary Information

Ernst & Young LLP
Suite 500
725 South Figueroa Street
Los Angeles, CA 90017-5418

Tel: +1 213 977 3200
Fax: +1 213 977 3152
ey.com

Building a better working world

Report of Independent Auditors on Supplementary Information

The Board of Directors
Cedars-Sinai Health System

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying consolidating balance sheets as of June 30, 2019 and 2018, and the consolidating statements of operations and changes in net assets for the years then ended, are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Ernst & Young LLP

October 25, 2019

A member firm of Ernst & Young Global Limited

Cedars-Sinai Health System

Consolidating Balance Sheets
(Dollar Amounts Expressed in Thousands)

June 30, 2019

	Cedars-Sinai	THA	CSHS	Eliminations/ Reclassifications	Consolidated
Assets					
Current assets:					
Cash and cash equivalents	$ 625,465	$ 36,129	$ 874	$ –	$ 662,468
Short-term investments	1,214,648	7,292	–	–	1,221,940
Board-designated assets	934,269	233,016	–	–	1,167,285
Current portion of assets limited to use:					
Funds held by trustee	1,775	–	–	–	1,775
Pledge receivable	28,421	9,334	–	–	37,755
Managed care reserve fund	–	92,117	–	–	92,117
Patient accounts receivable	580,089	84,484	–	–	664,573
Due from third-party payers	9,527	–	–	(2,944)	6,583
Due from affiliates or parent	3,802	–	–	(3,802)	–
Inventory	40,105	13,296	–	–	53,401
Prepaid expenses and other assets	175,746	43,120	–	–	218,866
Total current assets	3,613,847	518,788	874	(6,746)	4,126,763
Assets limited to use:					
Investments	547,864	16,836	–	–	564,700
Pledge receivable, less current portion	105,176	85,359	–	–	190,535
	653,040	102,195	–	–	755,235
Property and equipment, net	2,528,650	709,829	–	–	3,238,479
Other assets	482,641	11,729	625,508	(625,508)	494,370
Total assets	$ 7,278,178	$ 1,342,541	$ 626,382	$ (632,254)	$ 8,614,847

Cedars-Sinai Health System

Consolidating Balance Sheets (continued)
(Dollar Amounts Expressed in Thousands)

June 30, 2019

	Cedars-Sinai	THA	CSHS	Eliminations/ Reclassifications	Consolidated
Liabilities and net assets					
Current liabilities:					
Accounts payable and other accrued liabilities	$ 414,616	$ 90,741	$ –	$ –	$ 505,357
Due to third-party payers	–	2,944	–	(2,944)	–
Accrued payroll and related liabilities	318,738	45,799	–	–	364,537
Due to affiliates	–	2,802	1,000	(3,802)	–
Risk pool liabilities	–	117,707	–	–	117,707
Current maturities of long-term debt	44,109	7,810	–	–	51,919
Total current liabilities	777,463	267,803	1,000	(6,746)	1,039,520
Long-term debt, less current maturities	1,177,579	277,435	–	–	1,455,014
Accrued workers' compensation and malpractice insurance claims, less current portion	153,050	14,221	–	–	167,271
Pension liability	90,600	92,811	–	–	183,411
Other liabilities	7,861	89,691	–	–	97,552
Net assets:					
Without donor restrictions:					
Controlling interests	4,307,876	478,954	625,382	(625,508)	4,786,704
Non-controlling interests	53,123	–	–	–	53,123
With donor restrictions	710,626	121,626	–	–	832,252
Total net assets	5,071,625	600,580	625,382	(625,508)	5,672,079
Total liabilities and net assets	$ 7,278,178	$ 1,342,541	$ 626,382	$ (632,254)	$ 8,614,847

Cedars-Sinai Health System

Consolidating Balance Sheets
(Dollar Amounts Expressed in Thousands)

June 30, 2018

	Cedars-Sinai	THA	CSHS	Eliminations/ Reclassifications	Consolidated
Assets					
Current assets:					
Cash and cash equivalents	$ 360,804	$ 49,644	$ 874	$ –	$ 411,322
Short-term investments	1,248,194	6,950	–	–	1,255,144
Board-designated assets	858,545	229,108	–	–	1,087,653
Current portion of assets limited to use:					
Funds held by trustee	397	–	–	–	397
Pledge receivable	25,177	7,838	–	–	33,015
Managed care reserve fund	–	78,867	–	–	78,867
Patient accounts receivable, net	540,429	86,079	–	–	626,508
Due from third-party payers	9,114	–	–	(4,045)	5,069
Due from affiliates or parent	1,000	–	–	(1,000)	–
Inventory	36,204	10,550	–	–	46,754
Prepaid expenses and other assets	190,151	43,005	–	–	233,156
Total current assets	3,270,015	512,041	874	(5,045)	3,777,885
Assets limited to use:					
Investments	533,265	14,320	–	–	547,585
Pledge receivable, less current portion	114,713	78,068	–	–	192,781
Funds held by trustee	382	–	–	–	382
	648,360	92,388	–	–	740,748
Property and equipment, net	2,338,755	697,734	–	–	3,036,489
Other assets	421,482	11,273	625,508	(625,508)	432,755
Total assets	**$ 6,678,612**	**$ 1,313,436**	**$ 626,382**	**$ (630,553)**	**$ 7,987,877**

Cedars-Sinai Health System

Consolidating Balance Sheets (continued)

(Dollar Amounts Expressed in Thousands)

June 30, 2018

	Cedars-Sinai	THA	CSHS	Eliminations/ Reclassifications	Consolidated
Liabilities and net assets					
Current liabilities:					
Accounts payable and other accrued liabilities	$ 383,453	$ 83,765	$ –	$ –	$ 467,218
Due to third-party payers	–	4,045	–	(4,045)	–
Accrued payroll and related liabilities	316,109	41,338	–	–	357,447
Due to affiliates	–	–	1,000	(1,000)	–
Risk pool liabilities	–	114,750	–	–	114,750
Current maturities of long-term debt	43,208	7,575	–	–	50,783
Total current liabilities	742,770	251,473	1,000	(5,045)	990,198
Long-term debt, less current maturities	1,221,658	285,488	–	–	1,507,146
Accrued workers' compensation and malpractice insurance claims, less current portion	138,104	12,858	–	–	150,962
Pension liability	13,524	45,646	–	–	59,170
Other liabilities	1,941	93,070	–	–	95,011
Net assets:					
Without donor restrictions:					
Controlling interests	3,808,374	511,754	625,382	(625,508)	4,320,002
Non-controlling interests	58,791	–	–	–	58,791
With donor restrictions	693,450	113,147	–	–	806,597
Total net assets	4,560,615	624,901	625,382	(625,508)	5,185,390
Total liabilities and net assets	$ 6,678,612	$ 1,313,436	$ 626,382	$ (630,553)	$ 7,987,877

Cedars-Sinai and Affiliates

Consolidating Balance Sheets
(Dollar Amounts Expressed in Thousands)

June 30, 2019

	Cedars-Sinai Medical Center	Cedars-Sinai Medical Care Foundation	Marina Del Rey Hospital	Others	Eliminations/ Reclassifications	Cedars-Sinai Total
Assets						
Current assets:						
Cash and cash equivalents	$ 551,464	$ 53,642	$ 13,845	$ 6,514	$ –	$ 625,465
Short-term investments	1,214,648	–	–	–	–	1,214,648
Board-designated assets	934,269	–	–	–	–	934,269
Current portion of assets limited to use:						
Funds held by trustee	1,775	–	–	–	–	1,775
Pledge receivable	28,421	–	–	–	–	28,421
Patient accounts receivable	509,604	38,112	18,692	13,681	–	580,089
Due from third-party payers	10,830	–	–	–	(1,303)	9,527
Due from affiliates	48,527	–	–	–	(44,725)	3,802
Inventory	36,099	2,372	1,204	430	–	40,105
Prepaid expenses and other assets	143,709	18,105	12,943	989	–	175,746
Total current assets	3,479,346	112,231	46,684	21,614	(46,028)	3,613,847
Assets limited to use:						
Investments	547,864	–	–	–	–	547,864
Pledge receivable, less current portion	105,176	–	–	–	–	105,176
	653,040	–	–	–	–	653,040
Property and equipment, net	2,280,130	139,764	101,544	7,212	–	2,528,650
Other assets	481,500	32,512	18,542	107,341	(157,254)	482,641
Total assets	$ 6,894,016	$ 284,507	$ 166,770	$ 136,167	$ (203,282)	$ 7,278,178

Cedars-Sinai and Affiliates

Consolidating Balance Sheets (continued)
(Dollar Amounts Expressed in Thousands)

June 30, 2019

	Cedars-Sinai Medical Center	Cedars-Sinai Medical Care Foundation	Marina Del Rey Hospital	Others	Eliminations/ Reclassifications	Cedars-Sinai Total
Liabilities and net assets						
Current liabilities:						
Accounts payable and other accrued liabilities	$ 347,284	$ 44,641	$ 14,623	$ 8,068	$ –	$ 414,616
Due to third-party payers	–	–	1,303	–	(1,303)	–
Accrued payroll and related liabilities	298,484	13,037	6,325	892	–	318,738
Due to affiliates	–	–	40,057	4,668	(44,725)	–
Current maturities of long-term debt	43,379	–	35	695	–	44,109
Total current liabilities	689,147	57,678	62,343	14,323	(46,028)	777,463
Long-term debt, less current maturities	1,177,504	–	–	75	–	1,177,579
Accrued workers' compensation and malpractice insurance claims, less current portion	145,021	–	8,029	–	–	153,050
Pension liability	90,600	–	–	–	–	90,600
Other liabilities	–	–	850	7,011	–	7,861
Net assets:						
Without donor restrictions:						
Controlling interests	4,081,118	226,829	95,548	58,401	(154,020)	4,307,876
Non-controlling interests	–	–	–	56,357	(3,234)	53,123
With donor restrictions	710,626	–	–	–	–	710,626
Total net assets	4,791,744	226,829	95,548	114,758	(157,254)	5,071,625
Total liabilities and net assets	$ 6,894,016	$ 284,507	$ 166,770	$ 136,167	$ (203,282)	$ 7,278,178

Cedars-Sinai and Affiliates

Consolidating Balance Sheets
(Dollar Amounts Expressed in Thousands)

June 30, 2018

	Cedars-Sinai Medical Center	Cedars-Sinai Medical Care Foundation	Marina Del Rey Hospital	Others	Eliminations/ Reclassifications	Cedars-Sinai Total
Assets						
Current assets:						
Cash and cash equivalents	$ 320,173	$ 28,619	$ 7,985	$ 4,027	$ –	$ 360,804
Short-term investments	1,248,194	–	–	–	–	1,248,194
Board-designated assets	858,545	–	–	–	–	858,545
Current portion of assets limited to use:						
Funds held by trustee	397	–	–	–	–	397
Pledge receivable	25,177	–	–	–	–	25,177
Patient accounts receivable, net	480,437	35,860	12,740	11,392	–	540,429
Due from third-party payers	10,417	–	–	–	(1,303)	9,114
Due from affiliates	43,376	–	–	–	(42,376)	1,000
Inventory	32,369	1,754	1,387	694	–	36,204
Prepaid expenses and other assets	157,574	20,078	12,268	231	–	190,151
Total current assets	3,176,659	86,311	34,380	16,344	(43,679)	3,270,015
Assets limited to use:						
Investments	533,265	–	–	–	–	533,265
Pledge receivable, less current portion	114,713	–	–	–	–	114,713
Funds held by trustee	382	–	–	–	–	382
	648,360	–	–	–	–	648,360
Property and equipment, net	2,212,605	16,093	103,784	6,273	–	2,338,755
Other assets	409,523	36,506	20,185	103,323	(148,055)	421,482
Total assets	$ 6,447,147	$ 138,910	$ 158,349	$ 125,940	$ (191,734)	$ 6,678,612

Cedars-Sinai and Affiliates

Consolidating Balance Sheets (continued)

(Dollar Amounts Expressed in Thousands)

June 30, 2018

	Cedars-Sinai Medical Center	Cedars-Sinai Medical Care Foundation	Marina Del Rey Hospital	Others	Eliminations/ Reclassifications	Cedars-Sinai Total
Liabilities and net assets						
Current liabilities:						
Accounts payable and other accrued liabilities	$ 337,484	$ 28,628	$ 10,909	$ 6,432	$ –	$ 383,453
Due to third-party payers	–	–	1,303	–	(1,303)	–
Accrued payroll and related liabilities	298,337	11,058	5,513	1,201	–	316,109
Due to affiliates	–	–	42,376	–	(42,376)	–
Current maturities of long-term debt	42,813	–	68	327	–	43,208
Total current liabilities	678,634	39,686	60,169	7,960	(43,679)	742,770
Long-term debt, less current maturities	1,220,883	–	35	740	–	1,221,658
Accrued workers' compensation and malpractice insurance claims, **less current portion**	131,381	–	6,723	–	–	138,104
Pension liability	13,524	–	–	–	–	13,524
Other liabilities	–	–	850	1,091	–	1,941
Net assets:						
Without donor restrictions:						
Controlling interests	3,709,275	99,224	90,572	54,095	(144,792)	3,808,374
Non-controlling interests	–	–	–	62,054	(3,263)	58,791
With donor restrictions	693,450	–	–	–	–	693,450
Total net assets	4,402,725	99,224	90,572	116,149	(148,055)	4,560,615
Total liabilities and net assets	$ 6,447,147	$ 138,910	$ 158,349	$ 125,940	$ (191,734)	$ 6,678,612

Torrance Health Association, Inc. and Affiliates

Consolidating Balance Sheets
(Dollar Amounts Expressed in Thousands)

June 30, 2019

	Torrance Health Association, Inc. (THA)	Torrance Memorial Medical Center	Torrance Memorial Medical Center Health Care Foundation	Eliminations/ Reclassifications	THA Total
Assets					
Current assets:					
Cash and cash equivalents	$ 8,038	$ 15,886	$ 12,205	$ –	$ 36,129
Short-term investments	7,292	–	–	–	7,292
Board-designated assets	–	233,016	–	–	233,016
Current portion of assets limited to use:					
Pledge receivable	–	–	9,334	–	9,334
Managed care reserve fund	–	92,117	–	–	92,117
Patient accounts receivable	11,153	73,331	–	–	84,484
Inventory	238	13,058	–	–	13,296
Prepaid expenses and other assets	2,541	40,579	–	–	43,120
Total current assets	29,262	467,987	21,539	–	518,788
Assets limited to use:					
Investments	–	6,000	13,836	(3,000)	16,836
Pledge receivable, less current portion	–	–	85,359	–	85,359
	–	6,000	99,195	(3,000)	102,195
Property and equipment, net	94,021	619,250	–	(3,442)	709,829
Interest in TMMCF net assets	–	119,761	–	(119,761)	–
Other assets	4,367	7,362	–	–	11,729
Total assets	$ 127,650	$ 1,220,360	$ 120,734	$ (126,203)	$ 1,342,541

Torrance Health Association, Inc. and Affiliates

Consolidating Balance Sheets (continued)
(Dollar Amounts Expressed in Thousands)

June 30, 2019

	Torrance Health Association, Inc. (THA)	Torrance Memorial Medical Center	Torrance Memorial Medical Center Health Care Foundation	Eliminations/ Reclassifications	THA Total
Liabilities and net assets					
Current liabilities:					
Accounts payable and other accrued liabilities	$ 23,863	$ 65,942	$ 936	$ –	$ 90,741
Due to third-party payers	–	2,944	–	–	2,944
Accrued payroll and related liabilities	8,387	37,412	–	–	45,799
Due to affiliates	2,002	763	37	–	2,802
Risk pool liabilities	–	117,707	–	–	117,707
Current maturities of long-term debt	–	7,810	–	–	7,810
Total current liabilities	34,252	232,578	973	–	267,803
Long-term debt, less current maturities	3,503	276,932	–	(3,000)	277,435
Accrued workers' compensation and malpractice insurance claims, less current portion	1,648	12,573	–	–	14,221
Pension liability	6,530	86,281	–	–	92,811
Other liabilities	89,691	–	–	–	89,691
Net assets:					
Without donor restrictions:	(7,974)	490,370	12,173	(15,615)	478,954
With donor restrictions	–	121,626	107,588	(107,588)	121,626
Total net assets	(7,974)	611,996	119,761	(123,203)	600,580
Total liabilities and net assets	$ 127,650	$ 1,220,360	$ 120,734	$ (126,203)	$ 1,342,541

Torrance Health Association, Inc. and Affiliates

Consolidating Balance Sheets
(Dollar Amounts Expressed in Thousands)

June 30, 2018

	Torrance Health Association, Inc. (THA)	Torrance Memorial Medical Center	Torrance Memorial Medical Center Health Care Foundation	Eliminations/ Reclassifications	THA Total
Assets					
Current assets:					
Cash and cash equivalents	$ 9,415	$ 26,193	$ 14,036	$ –	$ 49,644
Short-term investments	6,950	–	–	–	6,950
Board-designated assets	–	229,108	–	–	229,108
Current portion of assets limited to use:					
Pledge receivable	–	–	7,838	–	7,838
Managed care reserve fund	–	78,867	–	–	78,867
Patient accounts receivable, net	11,439	74,640	–	–	86,079
Due from affiliates	830	–	–	(830)	–
Inventory	185	10,365	–	–	10,550
Prepaid expenses and other assets	3,306	39,699	–	–	43,005
Total current assets	32,125	458,872	21,874	(830)	512,041
Assets limited to use:					
Investments	–	6,000	11,320	(3,000)	14,320
Pledge receivable, less current portion	–	–	78,068	–	78,068
	–	6,000	89,388	(3,000)	92,388
Property and equipment, net	90,434	610,742	–	(3,442)	697,734
Interest in TMMCF net assets	–	111,247	–	(111,247)	–
Other assets	4,679	6,594	–	–	11,273
Total assets	$ 127,238	$ 1,193,455	$ 111,262	$ (118,519)	$ 1,313,436

Torrance Health Association, Inc. and Affiliates

Consolidating Balance Sheets (continued)
(Dollar Amounts Expressed in Thousands)

June 30, 2018

	Torrance Health Association, Inc. (THA)	Torrance Memorial Medical Center	Torrance Memorial Medical Center Health Care Foundation	Eliminations/ Reclassifications	THA Total
Liabilities and net assets					
Current liabilities:					
Accounts payable and other accrued liabilities	$ 22,853	$ 60,912	$ –	$ –	$ 83,765
Due to third-party payers	–	4,045	–	–	4,045
Accrued payroll and related liabilities	6,302	35,036	–	–	41,338
Due to affiliates	–	814	16	(830)	–
Risk pool liabilities	–	114,750	–	–	114,750
Current maturities of long-term debt	–	7,575	–	–	7,575
Total current liabilities	29,155	223,132	16	(830)	251,473
Long-term debt, less current maturities	3,503	284,985	–	(3,000)	285,488
Accrued workers' compensation and malpractice insurance claims, less current portion	1,394	11,464	–	–	12,858
Pension liability	4,794	40,852	–	–	45,646
Other liabilities	93,070	–	–	–	93,070
Net assets:					
Without donor restrictions:	(4,678)	519,875	12,033	(15,476)	511,754
With donor restrictions	–	113,147	99,213	(99,213)	113,147
Total net assets	(4,678)	633,022	111,246	(114,689)	624,901
Total liabilities and net assets	$ 127,238	$ 1,193,455	$ 111,262	$ (118,519)	$ 1,313,436

Cedars-Sinai Health System

Consolidating Statements of Operations and Changes in Net Assets
(Dollar Amounts Expressed in Thousands)

Year Ended June 30, 2019

	Cedars-Sinai	THA	CSHS	Eliminations/ Reclassifications	Consolidated
Net assets without donor restrictions					
Revenues, gains, and other support:					
Net patient service revenue before Medi-Cal Fee Program	$ 3,728,302	$ 626,489	$ –	$ –	$ 4,354,791
Medi-Cal Fee Program revenue	110,347	22,278	–	–	132,625
Net patient service revenue	3,838,649	648,767	–	–	4,487,416
Premium revenues	116,753	147,188	–	–	263,941
Other operating revenues	113,271	21,024	–	–	134,295
Net assets released from restrictions	209,274	16,133	–	–	225,407
Total revenues, gains, and other support	4,277,947	833,112	–	–	5,111,059
Expenses:					
Salaries and related costs	1,950,099	409,897	–	–	2,359,996
Professional fees	275,531	73,826	–	–	349,357
Materials, supplies, and other	1,313,233	269,834	–	–	1,583,067
Medi-Cal Fee Program expense	102,575	27,274	–	–	129,849
Interest	33,126	12,039	–	–	45,165
Depreciation and amortization	204,076	35,805	–	–	239,881
Total expenses	3,878,640	828,675	–	–	4,707,315
Income from operations	399,307	4,437	–	–	403,744
Investment income	133,181	11,792	–	–	144,973
Gain on equity method investments	5,264	–	–	–	5,264
Excess of revenues over expenses	537,752	16,229	–	–	553,981
Deficit (excess) of revenues over expenses attributable to non-controlling interests	2,687	–	–	–	2,687
Excess of revenues over expenses attributable to the Health System	$ 540,439	$ 16,229	$ –	$ –	$ 556,668

Cedars-Sinai Health System

Consolidating Statements of Operations and Changes in Net Assets (continued)

(Dollar Amounts Expressed in Thousands)

Year Ended June 30, 2019

	Cedars-Sinai	THA	CSHS	Eliminations/ Reclassifications	Consolidated
Net assets without donor restrictions (continued)					
Controlling interests activity:					
Excess of revenues over expenses attributable to the Health System	$ 540,439	$ 16,229	$ –	$ –	$ 556,668
Net assets released from restrictions related to property and equipment	951	–	–	–	951
Change in pension liability	(41,888)	(49,029)	–	–	(90,917)
Increase (decrease) in net assets without donor restrictions attributable to the Health System	499,502	(32,800)	–	–	466,702
Non-controlling interests activity:					
Sale of non-controlling interest	(132)	–	–	–	(132)
Deficit of revenues over expenses attributable to non-controlling interests	(2,687)	–	–	–	(2,687)
Distributions to non-controlling interests	(2,849)	–	–	–	(2,849)
Decrease in net assets without donor restrictions attributable to non-controlling interests	(5,668)	–	–	–	(5,668)
Increase (decrease) in net assets without donor restrictions	493,834	(32,800)	–	–	461,034
Net assets with donor restrictions					
Contributions, grants, and other	214,592	24,612	–	–	239,204
Investment income	12,809	–	–	–	12,809
Net assets released from restrictions	(210,225)	(16,133)	–	–	(226,358)
Increase in net assets with donor restrictions	17,176	8,479	–	–	25,655
Increase (decrease) in net assets	511,010	(24,321)	–	–	486,689
Net assets at beginning of year	4,560,615	624,901	625,382	(625,508)	5,185,390
Net assets at end of year	$ 5,071,625	$ 600,580	$ 625,382	$ (625,508)	$ 5,672,079

Cedars-Sinai Health System

Consolidating Statements of Operations and Changes in Net Assets
(Dollar Amounts Expressed in Thousands)

Year Ended June 30, 2018

	Cedars-Sinai	THA	CSHS	Eliminations/ Reclassifications	Consolidated
Net assets without donor restrictions					
Revenues, gains, and other support:					
Patient service revenue (net of contractual allowances and discounts)	$ 3,478,385	$ 261,432	$ –	$ –	$ 3,739,817
Provision for bad debts	(34,325)	(3,027)	–	–	(37,352)
Net patient service revenue less provision for bad debts before Medi-Cal Fee Program	3,444,060	258,405	–	–	3,702,465
Medi-Cal Fee Program revenue	172,473	10,755	–	–	183,228
Net patient service revenue	3,616,533	269,160	–	–	3,885,693
Premium revenues	107,350	60,886	–	–	168,236
Other operating revenues	105,560	7,939	–	–	113,499
Net assets released from restrictions	191,030	7,404	–	–	198,434
Total revenues, gains, and other support	4,020,473	345,389	–	–	4,365,862
Expenses:					
Salaries and related costs	1,912,952	160,181	–	–	2,073,133
Professional fees	255,341	31,046	–	–	286,387
Materials, supplies, and other	1,220,164	113,059	1	–	1,333,224
Medi-Cal Fee Program expense	178,143	13,130	–	–	191,273
Interest	34,686	5,957	–	–	40,643
Depreciation and amortization	194,901	17,163	–	–	212,064
Total expenses	3,796,187	340,536	1	–	4,136,724
Income (loss) from operations	224,286	4,853	(1)	–	229,138
Investment income (loss)	116,768	(6,148)	–	–	110,620
Gain on equity method investments	8,001	–	–	–	8,001
Excess (deficit) of revenues over expenses before inherent contribution from affiliation	349,055	(1,295)	(1)	–	347,759
Inherent contribution from affiliation	–	508,088	508,088	(508,088)	508,088
Excess (deficit) of revenues over expenses	349,055	506,793	508,087	(508,088)	855,847
Excess of revenues over expenses attributable to non-controlling interests	(2,938)	–	–	–	(2,938)
Excess of revenues over expenses attributable to the Health System	$ 346,117	$ 506,793	$ 508,087	$ (508,088)	$ 852,909

Cedars-Sinai Health System

Consolidating Statements of Operations and Changes in Net Assets (continued)

(Dollar Amounts Expressed in Thousands)

Year Ended June 30, 2018

	Cedars-Sinai	THA	CSHS	Eliminations/ Reclassifications	Consolidated
Net assets without donor restrictions (continued)					
Controlling interests activity:					
Excess (deficit) of revenues over expenses attributable to the Health System	$ 346,117	$ 506,793	$ 508,087	$ (508,088)	$ 852,909
Net assets released from restrictions related to property and equipment	4,452	–	–	–	4,452
Change in pension liability	46,444	4,961	–	–	51,405
Increase (decrease) in net assets without donor restrictions attributable to the Health System	397,013	511,754	508,087	(508,088)	908,766
Non-controlling interests activity:					
Purchase of non-controlling interest	4,122	–	–	–	4,122
Excess of revenues over expenses attributable to non-controlling interests	2,938	–	–	–	2,938
Distributions to non-controlling interests	(2,289)	–	–	–	(2,289)
Increase (decrease) in net assets without donor restrictions attributable to non-controlling interests	4,771	–	–	–	4,771
Increase (decrease) in net assets without donor restrictions	401,784	511,754	508,087	(508,088)	913,537
Net assets with donor restrictions					
Inherent contribution from affiliation	–	117,420	117,420	(117,420)	117,420
Contributions, grants, and other	223,930	3,131	–	–	227,061
Investment income	12,206	–	–	–	12,206
Net assets released from restrictions	(195,482)	(7,404)	–	–	(202,886)
Increase (decrease) in net assets with donor restrictions	40,654	113,147	117,420	(117,420)	153,801
Increase (decrease) in net assets	442,438	624,901	625,507	(625,508)	1,067,338
Net assets at beginning of year	4,118,177	–	(125)	–	4,118,052
Net assets at end of year	$ 4,560,615	$ 624,901	$ 625,382	$ (625,508)	$ 5,185,390

Cedars-Sinai and Affiliates

Consolidating Statements of Operations and Changes in Net Assets

(Dollar Amounts Expressed in Thousands)

Year Ended June 30, 2019

	Cedars-Sinai Medical Center	Cedars-Sinai Medical Care Foundation	Marina Del Rey Hospital	Others	Eliminations/ Reclassifications	Cedars-Sinai Total
Net assets without donor restrictions						
Revenues, gains, and other support:						
Net patient service revenue before Medi-Cal Fee Program	$ 3,219,810	$ 320,219	$ 125,118	$ 71,612	$ (8,457)	$ 3,728,302
Medi-Cal Fee Program revenue	111,656	–	(1,309)	–	–	110,347
Net patient service revenue	3,331,466	320,219	123,809	71,612	(8,457)	3,838,649
Premium revenues	20,975	95,392	–	386	–	116,753
Other operating revenues	87,540	26,107	7,454	711	(8,541)	113,271
Net assets released from restrictions	209,274	–	–	–	–	209,274
Total revenues, gains, and other support	3,649,255	441,718	131,263	72,709	(16,998)	4,277,947
Expenses:						
Salaries and related costs	1,732,994	127,406	66,670	24,275	(1,246)	1,950,099
Professional fees	26,533	243,070	2,499	1,299	2,130	275,531
Materials, supplies, and other	1,080,594	162,966	45,977	41,578	(17,882)	1,313,233
Medi-Cal Fee Program expense	97,177	–	5,398	–	–	102,575
Interest	33,035	–	4	87	–	33,126
Depreciation and amortization	175,843	9,396	5,739	13,098	–	204,076
Total expenses	3,146,176	542,838	126,287	80,337	(16,998)	3,878,640
Income (loss) from operations	503,079	(101,120)	4,976	(7,628)	–	399,307
Investment income	132,530	651	–	–	–	133,181
Gain (loss) on equity method investments	7,179	–	–	(70)	(1,845)	5,264
Excess (deficit) of revenues over expenses	642,788	(100,469)	4,976	(7,698)	(1,845)	537,752
Less deficit of revenues over expenses attributable to non-controlling interests	–	–	–	2,687	–	2,687
Excess (deficit) of revenues over expenses attributable to Cedars-Sinai	$ 642,788	$ (100,469)	$ 4,976	$ (5,011)	$ (1,845)	$ 540,439

Cedars-Sinai and Affiliates

Consolidating Statements of Operations and Changes in Net Assets (continued)

(Dollar Amounts Expressed in Thousands)

Year Ended June 30, 2019

	Cedars-Sinai Medical Center	Cedars-Sinai Medical Care Foundation	Marina Del Rey Hospital	Others	Eliminations/ Reclassifications	Cedars-Sinai Total
Net assets without donor restrictions (continued)						
Controlling interests activity:						
Controlling interests from acquisitions	$ –	$ –	$ –	$ 9,508	$ (9,508)	$ –
Excess (deficit) of revenues over expenses attributable to Cedars-Sinai	642,788	(100,469)	4,976	(5,011)	(1,845)	540,439
Contributions and net assets released from restrictions related to property and equipment	951	–	–	–	–	951
Change in pension liability	(41,888)	–	–	–	–	(41,888)
Distributions to controlling interests	–	–	–	(2,126)	2,126	–
Transfer (to) from affiliates	(230,008)	228,074	–	1,934	–	–
Increase (decrease) in net assets without donor restrictions attributable to Cedars-Sinai	371,843	127,605	4,976	4,305	(9,227)	499,502
Non-controlling interests activity:						
Sale of non-controlling interest	–	–	–	(132)	–	(132)
Deficit of revenues over expenses attributable to non-controlling interests	–	–	–	(2,687)	–	(2,687)
Distributions to non-controlling interests	–	–	–	(2,877)	28	(2,849)
Increase (decrease) in net assets without donor restrictions attributable to non-controlling interests	–	–	–	(5,696)	28	(5,668)
Increase (decrease) in net assets without donor restrictions	371,843	127,605	4,976	(1,391)	(9,199)	493,834
Net assets with donor restrictions						
Contributions, grants, and other	214,592	–	–	–	–	214,592
Investment income	12,809	–	–	–	–	12,809
Net assets released from restrictions	(210,225)	–	–	–	–	(210,225)
Increase in net assets with donor restrictions	17,176	–	–	–	–	17,176
Increase (decrease) in net assets	389,019	127,605	4,976	(1,391)	(9,199)	511,010
Net assets at beginning of year	4,402,725	99,224	90,572	116,149	(148,055)	4,560,615
Net assets at end of year	$ 4,791,744	$ 226,829	$ 95,548	$ 114,758	$ (157,254)	$ 5,071,625

Cedars-Sinai and Affiliates

Consolidating Statements of Operations and Changes in Net Assets

(Dollar Amounts Expressed in Thousands)

Year Ended June 30, 2018

	Cedars-Sinai Medical Center	Cedars-Sinai Medical Care Foundation	Marina Del Rey Hospital	Others	Eliminations/ Reclassifications	Cedars-Sinai Total
Net assets without donor restrictions						
Revenues, gains, and other support:						
Patient service revenue (net of contractual allowances and discounts)	$ 3,022,463	$ 292,012	$ 111,717	$ 60,102	$ (7,909)	$ 3,478,385
Provision for bad debts	(8,806)	(16,139)	(9,092)	(288)	–	(34,325)
Net patient service revenue less provision for bad debts before Medi-Cal Fee Program	3,013,657	275,873	102,625	59,814	(7,909)	3,444,060
Medi-Cal Fee Program revenue	168,701	–	3,772	–	–	172,473
Net patient service revenue	3,182,358	275,873	106,397	59,814	(7,909)	3,616,533
Premium revenues	17,251	89,658	–	441	–	107,350
Other operating revenues	79,583	29,228	7,150	742	(11,143)	105,560
Net assets released from restrictions	191,030	–	–	–	–	191,030
Total revenues, gains, and other support	3,470,222	394,759	113,547	60,997	(19,052)	4,020,473
Expenses:						
Salaries and related costs	1,732,936	105,641	53,341	23,593	(2,559)	1,912,952
Professional fees	25,318	226,442	1,596	1,011	974	255,341
Materials, supplies, and other	1,020,198	141,182	45,734	30,517	(17,467)	1,220,164
Medi-Cal Fee Program expense	170,639	–	7,504	–	–	178,143
Interest	34,546	3	13	124	–	34,686
Depreciation and amortization	180,872	5,768	6,273	1,988	–	194,901
Total expenses	3,164,509	479,036	114,461	57,233	(19,052)	3,796,187
Income (loss) from operations	305,713	(84,277)	(914)	3,764	–	224,286
Investment income	116,676	91	1	–	–	116,768
(Loss) gain on equity method investment	(1,703)	–	–	–	9,704	8,001
Excess (deficit) of revenues over expenses	420,686	(84,186)	(913)	3,764	9,704	349,055
Less excess of revenues over expenses attributable to non-controlling interests	–	–	–	(2,938)	–	(2,938)
Excess (deficit) of revenues over expenses attributable to Cedars-Sinai	$ 420,686	$ (84,186)	$ (913)	$ 826	$ 9,704	$ 346,117

Cedars-Sinai and Affiliates

Consolidating Statements of Operations and Changes in Net Assets (continued)

(Dollar Amounts Expressed in Thousands)

Year Ended June 30, 2018

	Cedars-Sinai Medical Center	Cedars-Sinai Medical Care Foundation	Marina Del Rey Hospital	Others	Eliminations/ Reclassifications	Cedars-Sinai Total
Net assets without donor restrictions (continued)						
Controlling interests activity:						
Controlling interests from acquisitions	$ –	$ –	$ –	$ 4,993	$ (4,993)	$ –
Excess (deficit) of revenues over expenses attributable to Cedars-Sinai	420,686	(84,186)	(913)	826	9,704	346,117
Contributions and net assets released from restrictions related to property and equipment	4,452	–	–	–	–	4,452
Change in pension liability	46,444	–	–	–	–	46,444
Distributions to controlling interests	–	–	–	(2,426)	2,426	–
Transfer (to) from affiliates	(94,238)	92,804	–	1,434	–	–
Increase (decrease) in net assets without donor restrictions attributable to Cedars-Sinai	377,344	8,618	(913)	4,827	7,137	397,013
Non-controlling interests activity:						
Purchase of non-controlling interest	–	–	–	4,122	–	4,122
Excess of revenues over expenses attributable to non-controlling interests	–	–	–	2,938	–	2,938
Distributions to non-controlling interests	–	–	–	(2,390)	101	(2,289)
Increase in net assets without donor restrictions attributable to non-controlling interests	–	–	–	4,670	101	4,771
Increase (decrease) in net assets without donor restrictions	377,344	8,618	(913)	9,497	7,238	401,784
Net assets with donor restrictions						
Contributions and grants	223,930	–	–	–	–	223,930
Investment income	12,206	–	–	–	–	12,206
Net assets released from restrictions	(195,482)	–	–	–	–	(195,482)
Increase in net assets with donor restrictions	40,654	–	–	–	–	40,654
Increase (decrease) in net assets	417,998	8,618	(913)	9,497	7,238	442,438
Net assets at beginning of year	3,984,727	90,606	91,485	106,652	(155,293)	4,118,177
Net assets at end of year	$ 4,402,725	$ 99,224	$ 90,572	$ 116,149	$ (148,055)	$ 4,560,615

Torrance Health Association, Inc. and Affiliates

Consolidating Statements of Operations and Changes in Net Assets

(Dollar Amounts Expressed in Thousands)

Year Ended June 30, 2019

	Torrance Health Association, Inc. (THA)	Torrance Memorial Medical Center	Torrance Memorial Medical Center Health Care Foundation	Eliminations/ Reclassifications	THA Total
Net assets without donor restrictions					
Revenues, gains, and other support:					
Net patient service revenue before Medi-Cal Fee Program	$ 88,641	$ 556,517	$ –	$ (18,669)	$ 626,489
Medi-Cal Fee Program revenue	–	22,278	–	–	22,278
Net patient service revenue	88,641	578,795	–	(18,669)	648,767
Premium revenues	82,904	73,997	–	(9,713)	147,188
Other operating revenues	14,691	9,732	2	(3,401)	21,024
Net assets released from restrictions	39	16,154	120	(180)	16,133
Total revenues, gains, and other support	186,275	678,678	122	(31,963)	833,112
Expenses:					
Salaries and related costs	64,411	345,486	–	–	409,897
Professional fees	82,543	19,666	–	(28,383)	73,826
Materials, supplies, and other	55,119	217,273	842	(3,400)	269,834
Medi-Cal Fee Program expense	–	27,274	–	–	27,274
Interest	2,279	9,940	–	(180)	12,039
Depreciation and amortization	2,800	33,005	–	–	35,805
Total expenses	207,152	652,644	842	(31,963)	828,675
(Loss) income from operations	(20,877)	26,034	(720)	–	4,437
Investment income	81	10,851	860	–	11,792
(Deficit) excess of revenues over expenses	(20,796)	36,885	140	–	16,229

Torrance Health Association, Inc. and Affiliates

Consolidating Statements of Operations and Changes in Net Assets (continued)

(Dollar Amounts Expressed in Thousands)

Year Ended June 30, 2019

	Torrance Health Association, Inc. (THA)	Torrance Memorial Medical Center	Torrance Memorial Medical Center Health Care Foundation	Eliminations/ Reclassifications	THA Total
Net assets without donor restrictions (continued)					
(Deficit) excess of revenues over expenses	$ (20,796)	$ 36,885	$ 140	$	$ 16,229
Change in pension liability	–	(49,029)	–	–	(49,029)
Transfer from (to) affiliates	17,500	(17,500)	–	–	–
(Decrease) increase in net assets without donor restrictions	(3,296)	(29,644)	140	–	(32,800)
Net assets with donor restrictions					
Contributions, grants and other	39	15,122	24,440	(14,989)	24,612
Net assets released from restrictions	(39)	(15,074)	(16,065)	15,045	(16,133)
Change in interest in TMMCF net assets	–	8,570	–	(8,570)	–
Increase (decrease) in net assets with donor restrictions	–	8,618	8,375	(8,514)	8,479
(Decrease) increase in net assets	(3,296)	(21,026)	8,515	(8,514)	(24,321)
Net assets at beginning of year	(4,678)	633,022	111,246	(114,689)	624,901
Net assets at end of year	$ (7,974)	$ 611,996	$ 119,761	$ (123,203)	$ 600,580

Torrance Health Association, Inc. and Affiliates

Consolidating Statements of Operations and Changes in Net Assets

(Dollar Amounts Expressed in Thousands)

Year Ended June 30, 2018

	Torrance Health Association, Inc. (THA)	Torrance Memorial Medical Center	Torrance Memorial Medical Center Health Care Foundation	Eliminations/ Reclassifications	THA Total
Net assets without donor restrictions					
Revenues, gains, and other support:					
Patient service revenue (net of contractual allowances and discounts)	$ 36,781	$ 229,915	$ –	$ (5,264)	$ 261,432
Provision for bad debts	(490)	(2,537)	–	–	(3,027)
Net patient service revenue less provision for bad debts before Medi-Cal Fee Program	36,291	227,378	–	(5,264)	258,405
Medi-Cal Fee Program revenue	–	10,755	–	–	10,755
Net patient service revenue	36,291	238,133	–	(5,264)	269,160
Premium revenues	33,205	31,121	–	(3,440)	60,886
Other operating revenues	6,441	3,094	64	(1,660)	7,939
Net assets released from restrictions	64	7,340	75	(75)	7,404
Total revenues, gains, and other support	76,001	279,688	139	(10,439)	345,389
Expenses:					
Salaries and related costs	24,305	135,876	–	–	160,181
Professional fees	32,187	7,563	–	(8,704)	31,046
Materials, supplies, and other	23,877	90,510	332	(1,660)	113,059
Medi-Cal Fee Program expense	–	13,130	–	–	13,130
Interest	1,508	4,524	–	(75)	5,957
Depreciation and amortization	1,052	16,111	–	–	17,163
Total expenses	82,929	267,714	332	(10,439)	340,536
(Loss) income from operations	(6,928)	11,974	(193)	–	4,853
Investment loss	(185)	(5,916)	(47)	–	(6,148)
(Deficit) excess of revenues over expenses before inherent contribution from affiliation	(7,113)	6,058	(240)	–	(1,295)
Inherent contribution from affiliation	(3,815)	515,106	12,273	(15,476)	508,088
(Deficit) excess of revenues over expenses	$ (10,928)	$ 521,164	$ 12,033	$ (15,476)	$ 506,793

Torrance Health Association, Inc. and Affiliates

Consolidating Statements of Operations and Changes in Net Assets (continued)

(Dollar Amounts Expressed in Thousands)

Year Ended June 30, 2018

	Torrance Health Association, Inc. (THA)	Torrance Memorial Medical Center	Torrance Memorial Medical Center Health Care Foundation	Eliminations/ Reclassifications	THA Total
Net assets without donor restrictions (continued)					
(Deficit) excess of revenues over expenses	$ (10,928)	$ 521,164	$ 12,033	$ (15,476)	$ 506,793
Change in pension liability	–	4,961	–	–	4,961
Transfer from (to) affiliates	6,250	(6,250)	–	–	–
(Decrease) increase in net assets without donor restrictions	(4,678)	519,875	12,033	(15,476)	511,754
Net assets with donor restrictions					
Inherent contribution from affiliation	–	117,659	103,424	(103,663)	117,420
Contributions, grants and other	64	7,275	2,907	(7,115)	3,131
Net assets released from restrictions	(64)	(7,340)	(7,118)	7,118	(7,404)
Change in interest in TMMCF net assets	–	(4,447)	–	4,447	–
Increase (decrease) in net assets with donor restrictions	–	113,147	99,213	(99,213)	113,147
(Decrease) increase in net assets	(4,678)	633,022	111,246	(114,689)	624,901
Net assets at beginning of year	–	–	–	–	–
Net assets at end of year	$ (4,678)	$ 633,022	$ 111,246	$ (114,689)	$ 624,901

EY | Assurance | Tax | Transactions | Advisory

About EY

EY is a global leader in assurance, tax, transaction and advisory services. The insights and quality services we deliver help build trust and confidence in the capital markets and in economies the world over. We develop outstanding leaders who team to deliver on our promises to all of our stakeholders. In so doing, we play a critical role in building a better working world for our people, for our clients and for our communities.

EY refers to the global organization, and may refer to one or more, of the member firms of Ernst & Young Global Limited, each of which is a separate legal entity. Ernst & Young Global Limited, a UK company limited by guarantee, does not provide services to clients. Information about how EY collects and uses personal data and a description of the rights individuals have under data protection legislation is available via ey.com/privacy. For more information about our organization, please visit ey.com.

© 2019 Ernst & Young LLP.
All Rights Reserved.

ey.com

Exhibit 30-C

Cedars-Sinai's Articles of Incorporation

A0808302

4018536

FILED
Secretary of State
State of California
JAN 30 2018

AMENDED AND RESTATED ARTICLES OF INCORPORATION
OF
CEDARS-SINAI HEALTH SYSTEM

EFFECTIVE DATE
2/1/18

THE UNDERSIGNED CERTIFY THAT:

1. They are the President and Secretary, respectively, of Cedars-Sinai Health System, a California nonprofit public benefit corporation (this "Corporation").

2. The Articles of Incorporation of this Corporation are amended and restated to read as follows:

ARTICLE I

The name of this corporation is CEDARS-SINAI HEALTH SYSTEM.

ARTICLE II

A. This corporation is a nonprofit public benefit corporation and is not organized for the private gain of any person. It is organized under the Nonprofit Public Benefit Corporation Law for charitable purposes.

B. This corporation is organized and operated exclusively for charitable, scientific and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or the corresponding provision of any future United States internal revenue law (the "Code"). Specifically, this corporation shall be organized, and at all times operated, exclusively for the benefit of, to perform the functions of, or to carry out the purposes of, and to support: (i) Cedars-Sinai Medical Center, a California nonprofit public benefit corporation; and (ii) Torrance Memorial Medical Center, a California nonprofit public benefit corporation (collectively, the "Named Member Organizations"), which are nonprofit health care organizations organized for the purpose of establishing, maintaining, sponsoring and promoting activities relating to the improvement of human health and well-being, though only as long as that Named Member Organization is exempt from Federal income taxation under Section 501(c)(3) of the Code and classified as other than a private foundation pursuant to Section 509(a)(1) or 509(a)(2) of the Code. In support and in furtherance of the charitable purposes of

the Named Member Organizations, the corporation may: (i) establish, maintain, sponsor and promote activities relating to the improvement of human health and the provision of care to the sick, injured or disabled; (ii) establish, maintain, sponsor and promote educational and research programs relating to the promotion of health and the provision of care to the sick, injured or disabled; (iii) coordinate, sponsor, promote and advance programs and activities designed and carried on to improve the physical, psychological and emotional health and welfare of persons living in and around the territory which it serves; (iv) provide management support and direction to those specified nonprofit corporations that this corporation was organized to support; (v) evaluate, develop and implement long-range health care objectives, strategies, plans, and alternative health care delivery systems, in furtherance of the purposes of this corporation and the purposes of those nonprofit health care organizations that this corporation was organized to support; (vi) otherwise function as a functionally integrated parent organization of the Named Member Organizations, within the meaning of the applicable regulations promulgated under the Code; and (vii) carry out such other acts and undertake such other activities as may be necessary, appropriate or desirable in furtherance of or in connection with the conduct, promotion or attainment of the foregoing purposes, provided that none of such activities shall be undertaken that would cause this corporation to lose its status as an organization described in Section 501(c)(3) of the Code, or as a supporting organization within the meaning of Section 509(a)(3) of the Code.

ARTICLE III

A. No substantial part of the activities of this corporation shall consist of carrying on propaganda, or otherwise attempting to influence legislation, and this corporation shall not participate or intervene in any political campaign (including the publishing or distribution of statements) on behalf of or in opposition to any candidate for public office.

B. Notwithstanding any other provision of these articles, this corporation shall not, except to an insubstantial degree, engage in any activities or exercise any powers that are not in furtherance of the purposes of this corporation as stated herein, and this corporation shall not carry on any other activities not permitted to be carried on: (i) by a corporation exempt

from federal income tax under Section 501(c)(3) of the Code, or (ii) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

ARTICLE IV

A. This corporation shall not have members.

B. The powers of this corporation shall be exercised, its properties controlled, and its affairs conducted by the corporation's board of directors as provided in the bylaws of this corporation.

ARTICLE V

A. The property of this corporation is irrevocably dedicated to charitable purposes. No part of the net income or assets of this corporation shall ever inure to the benefit of any director or officer thereof, or to the benefit of any other private person.

B. Upon the dissolution or winding up of this corporation, its assets remaining after payment, or provision for payment, of all debts and liabilities of this corporation shall be distributed to the Named Member Organizations. If, at the time of the dissolution or winding up of this corporation, the Named Member Organizations are not organizations which are organized and operated exclusively for charitable purposes which at such time have established their tax-exempt status under Section 501(c)(3) of the Code, then upon the dissolution or winding up of this corporation, its assets remaining after payment, or provision for payment, of all debts and liabilities of this corporation shall be distributed to an organization which is organized and operated exclusively for charitable purposes which at such time has established its tax-exempt status under Section 501(c)(3) of the Code.

3. The foregoing Amended and Restated Articles of Incorporation of this Corporation have been duly approved by the required vote of the board of directors of this Corporation.

4. The Corporation has no members.

5. The foregoing Amended and Restated Articles of Incorporation of this Corporation shall be effective as of February 1, 2018.

[Remainder of page intentionally left blank]

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this certificate are true and correct of our knowledge.

Dated: January 31, 2018

REDACTED

Thomas M. Priselac, President

Edward Prunchunas, Secretary

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this certificate are true and correct of our knowledge.

Dated: January 31, 2018

Thomas M. Priselac, President

REDACTED

Edward Prunchunas, Secretary

Exhibit 30-D

Cedars-Sinai's Bylaws

RECEIVED
Attorney General's Office
JUL 05 2017
Registry of Charitable Trusts

BYLAWS

OF

CEDARS-SINAI HEALTH SYSTEM

TABLE OF CONTENTS

Page

ARTICLE I HEALTH SYSTEM PARENT ENTITY 1

Section 1.1 Corporate Name; Preamble 1
Section 1.2 Purposes 1
Section 1.3 Location 1
Section 1.4 Members 1

ARTICLE II BOARD OF DIRECTORS 2

Section 2.1 Powers 2
Section 2.2 Numbers 4
Section 2.3 Qualifications of Directors 4
Section 2.4 Term of Office 4
Section 2.5 Election of Directors 5
Section 2.6 Vacancies 5
Section 2.7 Board Orientation 5
Section 2.8 Quorum of Board of Directors; Adjournment 5
Section 2.9 Annual Meeting of the Board 6
Section 2.10 Regular Meetings of the Board 6
Section 2.11 Special Meetings of the Board 6
Section 2.12 Written Notice of Meetings 6
Section 2.13 Failure to Attend Meetings 7
Section 2.14 Telephonic Meetings 7
Section 2.15 Action by Written Consent 7
Section 2.16 Retirement from Board Membership 7
Section 2.17 Conflict of Interest Policies 7
Section 2.18 Emergency Powers 8

ARTICLE III MEETINGS OF THE BOARD 9

Section 3.1 Annual Meetings of the Board 9
Section 3.2 Vote 9

ARTICLE IV OFFICERS OF HEALTH SYSTEM PARENT ENTITY 9

Section 4.1 Enumeration of Officers 9
Section 4.2 Election of Officers 9
Section 4.3 Removal, Appointment and Term 10
Section 4.4 Powers and Duties of Officers 10
Section 4.5 Compensation of Employees 13

ARTICLE V BOARD COMMITTEES 13

Section 5.1 Creation of Committees; Function 13
Section 5.2 Board Committees 13
Section 5.3 Vacancies in Board Committees; Removal 13

TABLE OF CONTENTS
(continued)

Page

Section 5.4 Audit and Finance Committee 13
Section 5.5 Quality Committee 13
Section 5.6 Written Consent 14

ARTICLE VI FISCAL PROVISIONS 14

Section 6.1 Fiscal Year 14
Section 6.2 Withdrawal of Funds 14
Section 6.3 Deposit of Securities 14
Section 6.4 Transfer of Securities 14
Section 6.5 Financial Records 14
Section 6.6 Inspection 14
Section 6.7 No Proprietary Interest 14

ARTICLE VII INDEMNIFICATION 15

Section 7.1 Indemnity of Officers and Directors 15
Section 7.2 Employees and Agents 15
Section 7.3 Insurance 15

ARTICLE VIII AMENDMENT AND REPEAL OF BYLAWS 16

Section 8.1 General Provisions 16

CERTIFICATE OF SECRETARY 17

BYLAWS

OF

CEDARS-SINAI HEALTH SYSTEM

ARTICLE I
Health System Parent Entity

Section 1.1 Corporate Name; Preamble. The name of the corporation shall be Cedars-Sinai Health System (the "Health System Parent Entity"). The Health System Parent Entity is a nonprofit public benefit corporation organized and existing under the laws of the State of California. These Bylaws of the Health System Parent Entity ("Bylaws") are adopted as of May 1, 2017 (the "Effective Date") for the purpose of providing for the governance of the Health System Parent Entity.

Section 1.2 Purposes. The Health System Parent Entity's purposes shall at all times be as set forth in the Articles of Incorporation of the Health System Parent Entity (the "Articles of Incorporation"), which provide that the Health System Parent Entity shall be organized, and at all times operated, exclusively for the benefit of, to perform the functions of, or to carry out the purposes of, and to support certain specified nonprofit health care organizations organized for the purpose of establishing, maintaining, sponsoring and promoting activities relating to the improvement of human health and well-being, including the provision of clinical health care services, engaging in community benefit activities and undertaking health care research and professional education (the "Member Organizations"), which Member Organizations are exempt from Federal income taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or the corresponding provision of any future United States Internal Revenue law (the "Code") and which are exempt from classification as a private foundation pursuant to Section 509(a)(1) or 509(a)(2) of the Code. The Member Organizations set forth in the Articles of Incorporation as of the Effective Date include Cedars-Sinai Medical Center, a California nonprofit public benefit corporation ("CSMC").

Section 1.3 Location. The principal office of the Health System Parent Entity shall be located at 8700 Beverly Boulevard, Suite #2622, Los Angeles, CA 90048. The Health System Parent Entity may also have offices at such other locations both within and without of the State of California as the Board of Directors may from time to time determine or as the business of the Health System Parent Entity may require.

Section 1.4 Members. The Health System Parent Entity shall have no members.

ARTICLE II
Board of Directors

Section 2.1 Powers.

(a) General Powers of the Board. The powers of the Health System Parent Entity shall be exercised, its property controlled, and its affairs conducted by the Board of Directors. Additionally, the Board of Directors shall exercise those powers reserved to the Health System Parent Entity as identified in the governing documents of the Member Organizations.

(b) Approval of Certain Actions by Board. The following actions shall only be taken by the Health System Parent Entity upon affirmative vote of a majority of the Board of Directors:

(i) Establish or consummate a transaction that results in a Change of Control (as defined below) of the Health System Parent Entity;

(ii) Adopt, repeal, modify, amend or restate the Health System Parent Entity's Articles of Incorporation or Bylaws;

(iii) Remove individuals from the Board of Directors of the Health System Parent Entity with or without cause;

(iv) Elect to voluntarily dissolve the Health System Parent Entity;

(v) Change the name of the Health System Parent Entity;

(vi) Establish the mission, vision and values of the Health System Parent Entity, or make any change thereto;

(vii) Change the corporate structure of the Health System Parent Entity if such change would affect the Health System Parent Entity's status as an exempt organization under Section 501(c)(3) of the Code;

(viii) Add a new entity as a Member Organization;

(ix) Elect individuals to the Board of Directors who are nominated in accordance with Section 2.5;

(x) Elect, renew or remove the Health System Parent Entity CEO;

(xi) Approve the Health System Parent Entity's strategic plans, capital budgets and operating budgets;

(xii) Adopt a charity care policy for the Health System Parent Entity or make any change or modification thereto;

(xiii) Select the independent auditor that will serve as auditor for the Health System Parent Entity and the Member Organizations and their Affiliates; and

(xiv) Form an obligated group amongst the Health System Parent Entity and the Member Organizations.

For the purposes of these Bylaws, "Change of Control" means: (a) any transaction or series of related transactions of an entity (including, without limitation, merger or consolidation, sale, transfer or other disposition of equity, amendment to the articles of incorporation or bylaws or other applicable governing documents of such entity or other contract or arrangement) that results in another entity becoming the beneficial owner of more than fifty percent (50%) of the voting ownership interests of such entity, (b) the sale, lease, transfer, exchange, disposition or change in use of all or substantially all of the property and assets of an entity, (c) the substitution of a new corporate member or members that transfers the control of, responsibility for, or governance of the entity; or (d) a joint venture, management arrangement or similar transaction by an entity with another entity that results in the other entity becoming the owner, operator or manager of all or substantially all of the assets of the entity.

For purposes of these Bylaws, an "Affiliate" of a Member Organization means an entity that, directly or indirectly through one or more intermediaries, is controlled by the Member Organization. For purposes of this definition, "control" means the power or possession, direct or indirect, to direct or cause the direction of the management and policies of an entity, whether through the ownership of securities, election or appointment of directors, by contract or otherwise. Without limiting the generality of the foregoing, "Affiliate" shall include those entities of which a Member Organization is a corporate member and those entities in which a Member Organization own at least fifty-one percent (51%) of the voting securities.

(c) Approval of Certain Actions of a Member Organization. The following actions shall only be taken by the Health System Parent Entity with respect to a Member Organization upon affirmative vote of a majority of the Board of Directors, subject to the approval rights set forth in a Member Organization's organizational documents:

(i) Adopt, repeal, modify, amend or restate the Articles of Incorporation, Bylaws or other governing documents, as applicable, of a Member Organization or any of its Affiliates;

(ii) Elect individuals to the Board of Directors of a Member Organization in accordance with the nomination and election process set forth in the Member Organization's Bylaws;

(iii) Transfer non-cash assets from a Member Organization or any of its Affiliates to the Health System Parent Entity;

(iv) Remove individuals from the Board of Directors of the Member Organization with or without cause;

(v) Establish or consummate a transaction that results in a Change of Control of a Member Organization or any of its Affiliates;

(vi) Change the mission, vision and values of the Member Organization or any of its Affiliates;

(vii) Change the corporate structure of the Member Organization or any of its Affiliates if such change would affect the Member Organization's or its Affiliate's status as an exempt organization under Section 501(c)(3) of the Code;

(viii) Elect to voluntarily dissolve the Member Organization or any of its Affiliates;

(ix) Change the name of the Member Organization or a licensed hospital owned and operated by the Member Organization or any of its Affiliates;

(x) Sell any real property owned by a Member Organization or any of its Affiliates;

(xi) Approve a Member Organization's strategic plans, capital budgets and operating budgets; and

(xii) Approve the incurrence of debt or lending of money in material amounts by the Member Organization or any of its Affiliates.

Section 2.2 Numbers. The Board of Directors shall consist of not less than nine (9) persons and no more than fifteen (15) persons. The exact number of authorized Directors shall be fixed from time to time, within said range, by resolution of the Board of Directors. All Directors shall be nominated by CSMC except the President/Chief Executive Officer ("CEO"), who shall serve as an ex-officio voting member.

(a) CSMC Representative. At all times at least one (1) member of the Board of Directors shall be a director or officer of CSMC.

Section 2.3 Qualifications of Directors. Members of the Board of Directors ("Directors") shall be individuals who have demonstrated leadership, civic interest and community involvement; have exhibited an awareness of and interest in the provision of health care services, educational or research activities; and have the ability to contribute to the appropriate governance of the Health System Parent Entity. Additionally, the individual Directors should at all times have complementary and diverse skill sets, backgrounds and experiences to contribute to Board effectiveness.

Section 2.4 Term of Office. At each annual meeting of the Board, Directors shall be elected to fill the expiring terms of office and any other vacancies on the Board which have not been previously filled. Vacancies on the Board may remain unfilled at the discretion of the Board; provided, however, the Board shall not leave a vacancy unfilled if doing so would result in the Board being comprised of fewer Directors than as of the Effective Date. Except as expressly set forth herein, persons elected as Directors at each annual meeting of the Board

may be elected to serve for a one (1) or two (2) year term. As used in these Bylaws, the expression "year" means the period from the annual meeting of the Board at which a Director is elected to the next succeeding annual meeting of the Board. The exceptions to this provision relate to the CEO, who shall serve as a member of the Board of Directors as long as he or she holds office.

Section 2.5 Election of Directors. At least fifteen (15) days before each annual meeting of the Board of the Health System Parent Entity, CSMC shall select a list of nominees to fill the offices of the Directors whose terms will expire and such other vacancies of Directors which have not been previously filled, subject to the discretion of the Board to retain vacancies. Notwithstanding the foregoing, the Board may not retain a vacancy of a Director without the approval of CSMC. CSMC shall file with the Secretary of the Health System Parent Entity a written list of such nominees. At least three (3) business days before the date of such meeting, the Secretary shall send notice of the names of the nominees to each member of the Board of Directors. The term "business days" means Monday through Friday, unless one of those days is a legal holiday as defined under California law.

(a) Nomination a Prerequisite to Election. No person shall be eligible for election as a Director at an annual meeting of the Board unless he or she has been nominated in the manner provided for in this Section 2.5, except that at any time before the annual meeting of the Board, if by reason of the death, declination or incapacity of any nominee, the number of nominees remaining is less than the number of Directors to be elected, nominations to supply such deficiency may be made by CSMC at, or any time before, the annual meeting.

(b) Vote Required for Election. The nominees receiving a majority vote at such annual meeting of the Board shall be declared elected. If, at the annual meeting of the Board, the Board fails to elect any of the individuals nominated by CSMC, CSMC shall promptly propose alternative nominees for election by the Board, and a special meeting of the Board shall promptly be called for the purpose of voting on the election of such alternative nominees. The process set forth in the foregoing sentence shall continue until such time as the Board has elected individuals to fill the offices of all Directors with expiring terms.

Section 2.6 Vacancies. Vacancies occurring in the Board of Directors from time to time shall be filled in accordance with Section 2.5. Each Director elected to fill a vacancy shall hold office for the unexpired term of such Director's predecessor.

Section 2.7 Board Orientation. The Board will require each newly elected member of the Board of Directors to participate in an orientation program designed to enhance that Director's understanding of the Director's new responsibilities.

Section 2.8 Quorum of Board of Directors; Adjournment.

(a) A majority of the actual number of Directors shall constitute a quorum for any meeting of the Board.

(b) If a quorum is not present at any meeting of the Board, such meeting may be adjourned from time to time until a quorum shall be obtained. Each such adjournment, and the reason therefore, shall be recorded in the minutes of the Health System Parent Entity.

(c) Every act or decision done or made by a majority of the Directors present at a meeting duly held at which a quorum is present shall be regarded as the act of the Board of Directors, unless a greater number be required by law, by the Articles of Incorporation, or by another provision of these Bylaws.

(d) A majority of the Directors present, whether or not a quorum is present, may adjourn any meeting to another time and place. If the meeting is adjourned to a different calendar date, notice of an adjournment to another time and place shall be given prior to the time of the adjourned meeting to the Directors who were not present at the time of the adjournment in accordance with the notice procedure set forth in Section 2.12.

Section 2.9 Annual Meeting of the Board. An annual meeting of the incumbent Board of Directors shall be held as provided by Section 3.1 for the election of Directors for the succeeding year. At this meeting, in addition to any other business of the Health System Parent Entity, the officers of the Health System Parent Entity shall be elected.

Section 2.10 Regular Meetings of the Board. In addition to the annual meeting of the Board of Directors, the Board of Directors shall hold at least three (3) regular meetings of the Board of Directors per year at the time and place fixed by the Board of Directors.

Section 2.11 Special Meetings of the Board. On call of either the Chairperson of the Board of Directors or one-third (1/3) of the members of the Board of Directors then in office, a special meeting of the Board may be held at a time and place designated in the call.

Section 2.12 Written Notice of Meetings. The Secretary shall give notice of each regular or special meeting to each member of the Board of Directors by any of the following means:

(a) In person at least forty-eight (48) hours prior to the time designated for the holding of the meeting;

(b) Electronically directed to the electronic address of a Director as set forth in the books and records of the Health System Parent Entity, sent at least forty-eight (48) hours prior to the time designated for the holding of the meeting; or

(c) By written notice directed to the address of the Director as it appears on the books and records of the Health System Parent Entity and deposited in the United States mail in the County of Los Angeles at least four (4) calendar days prior to the time designated for the holding of the meeting.

(d) Any notice of a special meeting of the Board of Directors shall specify the primary purpose therefor.

(e) Any Director shall be deemed to have waived the requirement of a formal notice of a meeting of the Board of Directors when he or she:

(i) Does so in writing either before, at or after the meeting;

(ii) Participates in or attends such meeting; or

(iii) Ratifies or approves in writing such action (and such assent is recorded in the minutes).

Section 2.13 Failure to Attend Meetings. The Board of Directors may declare vacant the office of a Director who does not attend annually at least fifty percent (50%) of the regular meetings of the Board or any committee of the Board to which such individual has been duly elected or appointed, held in the respective calendar year, or grant any Director a leave of absence for any period of time upon the affirmative vote of a majority of the remaining Directors.

Section 2.14 Telephonic Meetings. Directors are encouraged to attend meetings in person. In certain circumstances, with the approval of the Chairperson of the Board and, if applicable, the Chairperson of the relevant Board Committee, members of the Board or members of any such Board Committee may participate in meetings through the use of conference telephone or similar communications equipment, so long as all members participating in such meeting can hear one another. Participation in a meeting by these means constitutes presence in person at such meeting.

Section 2.15 Action by Written Consent. Except as otherwise provided in these Bylaws, any action required or permitted to be taken by the Board of Directors under any provision of law or by these Bylaws may be taken without a meeting if all members of the Board shall individually or collectively consent in writing to such action. Such written consent shall be filed with the Board minutes. Such action by written consent shall have the same force and effect as a unanimous vote of the Board of Directors. Any certificate or other document filed under this Section which relates to an action so taken shall state that the action was taken by unanimous written consent of the Board of Directors without a meeting, and that the Bylaws authorize the Directors to so act, and such statement shall be prima facie evidence of such authority.

Section 2.16 Retirement from Board Membership. Except as otherwise provided in this Article II, individuals shall be eligible to serve as members of the Board of Directors until the annual meeting of the Board next succeeding such individual's seventy-second (72nd) birthday. For purposes of these Bylaws, the retirement age for Board members shall be as set forth in this Section 2.16. Members of the Board of Directors who reach retirement age during the first year of election to a two (2) year term shall serve as a member of the Board only until the annual Board meeting next succeeding such individual's retirement age and not beyond that date.

Section 2.17 Conflict of Interest Policies. The Board shall establish and adopt for the Health System Parent Entity policies and procedures for determining when an actual or potential conflict of interest exists, addressing all such conflicts of interest, and ensuring appropriate remedies for failure to comply with said policies. All members of the Board shall annually complete an accurate Conflict of Interest Questionnaire consistent with the Health System Parent Entity's Conflict of Interest Policy from time to time in effect. Any Board member who fails to return the required Conflict of Interest Questionnaire within sixty (60) days of the date it is sent to such Board member may be removed from Board membership. Individuals who are not

members of the Board but who are otherwise required to return a complete and accurate Conflict of Interest Questionnaire as "Covered Individuals" under the Board-approved Conflict of Interest policies shall be removed by the Board of Directors from Board Committees, research responsibilities or key administrative positions (as the case may be) for failure to return the Conflict of Interest Questionnaire within sixty (60) days of the date it is sent to such Covered Individual, subject to the provisions of the relevant policies. Nothing contained herein shall alter the requirement that conflicts of interest be disclosed in writing more frequently than annually should one arise between the dates that the annual Conflict of Interest Questionnaire is required to be completed.

Section 2.18 Emergency Powers.

(a) "Emergency" is defined as any of the following events or circumstances as a result of which, and only so long as, a quorum of the Board of Directors cannot be readily convened for action:

(i) A natural catastrophe, including, but not limited to, a hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought, or regardless of cause, any fire, flood, or explosion;

(ii) An attack on the State of California or the nation by an enemy of the United States of America, or upon receipt by the State of California of a warning from the federal government indicating that an enemy attack is probable or imminent;

(iii) An act of terrorism or other man-made disaster that results in extraordinary levels of casualties or damage or disruption severely affecting the infrastructure, environment, economy, government functions, or population, including, but not limited to, mass evacuations.

(iv) A state of emergency proclaimed by the Governor of the State of California or by the President of the United States of America which impacts the Cedars-Sinai Health System, its property, officers or activities or its surroundings.

(b) In anticipation of or during an Emergency, the Board of Directors may take either or both of the following actions necessary to conduct the Health System Parent Entity's ordinary business operations and affairs:

(i) Modify lines of succession to accommodate the incapacity of any director, officer, employee, or agent resulting from the Emergency.

(ii) Relocate the principal office, designate alternative principal offices or regional offices, or authorize the officers to do so.

(c) During an Emergency, the Board of Directors may give notice to a Director in any practicable manner under the circumstances, including but not limited to, by

publication and radio, when notice of a meeting of the Board of Directors cannot be given to that Director in the manner otherwise prescribed by these Bylaws.

(d) In the event of an Emergency, a quorum of the Board shall be reduced to a minimum number of seven (5) Directors.

(e) Notwithstanding anything in these Bylaws to the contrary, the Board of Directors may not, in anticipation of or during an Emergency, take any action that is not in the Health System Parent Entity's ordinary course of business, unless the required vote of the Board of Directors was obtained prior to the Emergency.

(f) Those Directors representing a quorum of the Board during an Emergency shall use their best efforts to report what actions they have taken during the Emergency to the full Board within a reasonable time period after the Emergency has ended.

(g) Any actions taken in good faith in anticipation of or during an Emergency under this Section 2.18 shall bind the Health System Parent Entity and may not be used to impose liability on a director, officer, employee or agent of the Health System Parent Entity.

(h) All other provisions of these Bylaws consistent with the provisions in this Section 2.18 shall remain in full force and effect during the Emergency. The provisions of this Section 2.18 shall cease to apply once the Emergency has been reasonably deemed ended.

ARTICLE III
Meetings of the Board

Section 3.1 Annual Meetings of the Board. The annual meeting of the Board of Directors shall be held at such place and time as may be determined by the Board.

Section 3.2 Vote. Each member of the Board of Directors shall have one (1) vote in any action voted upon by the Board or a Board Committee to which such member is appointed. Votes may be cast only by members in attendance at a meeting except as provided in Sections 2.14 and 2.15. Votes may not be cast by proxy.

ARTICLE IV
Officers of Health System Parent Entity

Section 4.1 Enumeration of Officers. The officers of the Health System Parent Entity shall be: Chairperson of the Board of Directors (the "Chairperson"), Vice-Chairperson of the Board of Directors (the "Vice Chairperson"), the CEO, Treasurer, Secretary, and such other officers as may be elected or appointed in accordance with Sections 4.2 and 4.3, as the case may be.

Section 4.2 Election of Officers.

(a) Election to these offices of the Chairperson, Vice-Chairperson, CEO, Treasurer and Secretary shall occur at the annual meeting of the Board by a majority vote of the Board of Directors. A vacancy in the offices of the Chairperson, Vice-Chairperson, CEO,

Treasurer and Secretary may be filled prior to the next annual meeting of the Health System Parent Entity by majority vote at the next succeeding regular meeting of the Board of the Health System Parent Entity.

(b) The term of office for all persons elected at the annual meeting shall commence at the conclusion of such meeting.

Section 4.3 Removal, Appointment and Term.

(a) The Board of Directors shall have the authority to remove officers and to promote persons to officer positions from time to time during the year; provided, however, the CEO shall have the authority to appoint an individual to any office except those offices specifically referred to in Section 4.2.

(b) The CEO shall be elected to serve for a term of three (3) years. There shall be no restriction on the number of terms that the CEO may serve.

(c) The Chairperson shall be elected to serve for a term of three (3) years. No person shall serve as Chairperson for more than one (1) term

(d) The Vice-Chairperson shall be elected to serve for a term of one (1) year. No person shall serve as Vice-Chairperson for more than three (3) consecutive terms

(e) The Secretary shall be elected to serve for a term of one (1) year. No person shall serve as Secretary for more than three (3) consecutive terms.

(f) The Treasurer shall be elected to serve for a term of one (1) year. There shall be no restriction on the number of terms that the Treasurer may serve

(g) Notwithstanding the limitations of Section 2.4, each of the officers referenced in this Section 4.1 may complete the term of that office, even if completion of the term results in Board membership extending beyond such individual's Board retirement age as set forth in Section 2.16 (provided that all individuals must be elected prior to reaching their Section 2.16 retirement age). The respective limitations on the term of office set forth in Sections 4.3(b), 4.3(c), 4.3(d), 4.3(e) and 4.3(f) shall not include that part of an officer's tenure to the extent that such officer was elected to fill the unexpired term of office for his or her predecessor.

(h) It is not the intention of the Health System Parent Entity to provide that election to any officer position necessarily presumes that such officer is then in line to succeed to any other officer position, including, but not limited to, Chairperson of the Board of Directors.

Section 4.4 Powers and Duties of Officers.

(a) The Chairperson shall:

(i) preside at all meetings of the Board of Directors;

(ii) periodically review and evaluate the performance of the CEO in the discharge of that office's responsibilities, and have the authority to direct the CEO in the execution of the policies and programs established from time to time by the Board of Directors;

(iii) exercise the powers and duties accorded to the Chairperson pursuant to these Bylaws,

(iv) exercise such other powers and duties requested from time to time by the Board of Directors;

(v) be an ex officio member of all Board Committees; and

(vi) serve as the liaison between the Board of Directors and all of the Board Committees, and in this regard the Chairpersons of all such Board Committees periodically and promptly shall report to the Chairperson all decisions, recommendations and proposed actions of their respective Board Committees

(b) The Vice Chairperson of the Board of Directors shall:

(i) assist the Chairperson in carrying out the duties and responsibilities of the Chairperson;

(ii) act in place of the Chairperson when requested by the Chairperson;

(iii) serve as the Chairperson of the Board of Directors in the event the Chairperson retires, resigns or is otherwise incapable, unable or unwilling to complete the elected term until a new Chairperson is elected by the Board of Directors; and

(iv) perform such other duties as the Board of Directors may from time to time designate.

In the event the Vice Chairperson of the Board of Directors becomes the Chairperson under circumstances set forth in subsection (b)(iii), such individual shall serve as the Chairperson of the Board of Directors until the next annual meeting of the Board. At such meeting, the individual who has completed the year as Chairperson of the Board shall be eligible for nomination and election to a new three (3) year term as Chairperson of the Board in a manner consistent with these Bylaws. Notwithstanding anything else to the contrary set forth in the Bylaws, a Vice Chairperson who succeeds to the office of Chairperson of the Board shall serve as the Chairperson regardless of such individual's age upon the date of succession provided that an individual who has reached the Section 2.16 retirement age shall not be eligible for election to a subsequent term.

(c) The CEO shall:

(i) be the chief executive officer of the Health System Parent Entity and by reason of that office be deemed to be an elected member of the Board of Directors and be counted as a member of the Board for all purposes;

(ii) act as the representative of the Board of Directors in all matters pertaining to the administration of the business and the affairs of the Health System Parent Entity;

(iii) execute the policies of the Board of Directors in managing the Health System Parent Entity's business and affairs;

(iv) participate in the formulation of policies and the development, coordination and execution of corporate programs; and

(v) be responsible to the Board of Directors;

(d) The Treasurer shall be the Chief Financial Officer of the Health System Parent Entity (unless otherwise determined by vote of the Board) and shall:

(i) supervise the collecting, receipt, deposit and distribution of all funds of the Health System Parent Entity as directed by the Board of Directors;

(ii) cause to be kept regular books of account financial records of the Health System Parent Entity and account for the Treasurer's actions and of the financial condition of the Health System Parent Entity as the Board of Directors requires from time to time; and

(iii) perform such other duties as are assigned the Treasurer from time to time by the Board of Directors.

(e) The Secretary shall, or shall cause the appropriate officers to:

(i) keep full and complete minutes of the meetings of the Board of Directors and Board Committees, and when notice of a meeting is required by law or by these Bylaws give notice of each such meeting;

(ii) keep at the principal office of the Health System Parent Entity records containing the name and address of each member of the Board of Directors and the Board Committee members and record the date of election of such member, the duration of that membership, and the date on which the membership ceased;

(iii) keep the seal of the Health System Parent Entity and affix it to all instruments executed by the Health System Parent Entity when required;

(iv) keep at the principal office of the Health System Parent Entity a book in which the Secretary shall record all Bylaws of the Health System Parent

Entity as amended to date which Bylaws and amendments shall be reviewed annually, revised as necessary, and dated to indicate the time of last review;

(v) maintain custody of and keep the books of account and other records of the Health System Parent Entity except such books or records which are in the custody of the Treasurer; and

(vi) generally perform such other duties as are assigned to the Secretary from time to time by the Board of Directors.

Section 4.5 Compensation of Employees. Compensation may be paid by the Health System Parent Entity to officers who are also employees of the Health System Parent Entity in such amounts as are determined from time to time by the Board of Directors.

ARTICLE V
Board Committees

Section 5.1 Creation of Committees; Function. The Chairperson of the Board of Directors shall appoint the members and the Chairpersons of the standing committees duly constituted by the Board (the "Board Committees"). Except for Board Committees delegated to act on behalf of the Board by specific Board resolutions, Board Committees of the Board shall act by making recommendations to the Board. Each Board Committee with delegated authority shall be comprised solely of persons who are members of the Board provided that individuals serving as non-voting advisors may also be asked to routinely attend such meetings. Each Board Committee shall be chaired and co-chaired solely by members of the Board. Board Committees shall not otherwise establish policy for the Health System Parent Entity or act on behalf of the Board except pursuant to a specific resolution adopted by the Board.

Section 5.2 Board Committees. The Health System Parent Entity shall have the following standing Board Committees: Audit and Finance Committee, Quality Committee, and such other committees as the Board of Directors shall designate. The term of each standing Board Committee shall terminate at the discretion of the Board.

Section 5.3 Vacancies in Board Committees; Removal. Vacancies in any Board Committee shall be filled by appointment by the Chairperson of the Board of Directors. Board Committee members may be removed from a standing Board Committee by the Chairperson of the Board of Directors.

Section 5.4 Audit and Finance Committee. The roles and purposes of the Audit and Finance Committee shall be defined by the Board of Directors of the Health System Parent Entity and at a minimum shall include those responsibilities required under applicable law.

Section 5.5 Quality Committee. The roles and purposes of the Quality Committee shall be defined by the Board of Directors of the Health System Parent Entity. In general, the Quality Committee shall serve to oversee and support the respective quality initiatives, overall quality of care, and maintenance of accreditation and licensure undertaken by each Member Organization and their Affiliates.

Section 5.6 Written Consent. Except as otherwise provided in these Bylaws, any action required or permitted to be taken by any Board Committee under any provision of law or by these Bylaws may be taken without a meeting if all members of the Board Committee shall individually or collectively consent in writing to such action. Such written consent or consents shall be filed with the minutes of the proceedings of the applicable committee. Such action by written consent shall have the same force and effect as a unanimous vote of the Board Committee. Any certificate or other document filed under this Section which relates to an action so taken shall state that the action was taken by unanimous written consent of the Board Committee without a meeting, and that the Bylaws authorize the Board Committees to so act, and such statement shall be prima facie evidence of such authority.

ARTICLE VI
Fiscal Provisions

Section 6.1 Fiscal Year. The fiscal year of the Health System Parent Entity shall be fixed by the Board of Directors.

Section 6.2 Withdrawal of Funds. Funds of the Health System Parent Entity on deposit with any bank or other financial institution shall be subject to withdrawal on the signatures of such persons as are determined from time to time by resolution of the Board of Directors.

Section 6.3 Deposit of Securities. Securities of the Health System Parent Entity held by any custodian approved by the Board shall be subject to withdrawal by such persons (not less than two) as are determined from time to time by resolution of the Board of Directors.

Section 6.4 Transfer of Securities. Any two (2) or more persons designated by the Board of Directors by appropriate resolution shall have authority to execute such forms of transfer and assignment as are customary to effect transfer of shares or other securities in the name of the Health System Parent Entity.

Section 6.5 Financial Records. The books and accounts of the Health System Parent Entity shall be kept in accordance with approved accounting procedures and shall be audited annually by independent auditors selected by the Board of Directors.

Section 6.6 Inspection. Subject to applicable law, every member of the Board of Directors shall have the absolute right at any reasonable time to inspect the books, records, documents of every kind, and physical properties of the Health System Parent Entity, provided reasonable advance notice of such inspection is given to the Chairperson of the Board or the CEO. Upon receipt, the Chairperson and the CEO shall then consult regarding the nature of the particular request and to make suitable arrangements. Subject to applicable law, the right of inspection includes the right to copy and make extracts of documents.

Section 6.7 No Proprietary Interest. By virtue of being a member of the Board, no individual shall have any proprietary interest whatsoever in or to the assets of the Health System Parent Entity; there shall be no distribution of gains, profits or dividends to any members of the Board, and no income, increments or other pecuniary or proprietary gain, benefit or advance of any kind arising from or growing out of the assets of the Health System Parent Entity or its

operations and activities shall in any way inure to, go to or vest in any member of the Board. Nothing herein contained shall prevent payment of compensation, by affirmative vote of the Board, to any director or officer for services rendered to the Health System Parent Entity provided any such payment is not prohibited by law.

ARTICLE VII
Indemnification

Section 7.1 Indemnity of Officers and Directors. Every person who serves, or has in the past served, as a director or officer of the Health System Parent Entity, and every person who serves, or has in the past served, at the written request of the Health System Parent Entity (or at its oral request subsequently confirmed in writing) as a director or officer of the Health System Parent Entity, except as otherwise provided by law, shall be indemnified to the full extent permitted by law and held harmless by the Health System Parent Entity from and against any loss, cost, liability or expense that may be imposed on or incurred by such individual in connection with or resulting from any claim, action, suit or proceeding, civil or criminal, in which he or she may become a party or otherwise involved because of his or her being or having been a director or officer of the Health System Parent Entity, whether or not he has this relationship when the loss, cost, liability or expense was imposed or incurred. The phrase "loss, cost, liability or expense" shall include all expenses incurred in defense of the claim, action, suit or proceeding and the amounts of judgments, fines or penalties levied or rendered against the indemnified person, provided that, except as otherwise provided by law, no person shall be entitled to indemnity under this section unless he or she was acting in good faith and within the scope of his or her employment or authority and for a purpose that he or she reasonably believed to be in the Health System Parent Entity's best interests. Payments authorized under this Section shall include amounts paid and expenses incurred in settling the claim, action, suit or proceeding, whether actually begun or only threatened. Expenses incurred with respect to a claim, action, suit or proceeding indemnified against under this section may be advanced by the Health System Parent Entity before final disposition of the matter on receipt of an undertaking by or on behalf of the recipient to repay this amount if it is ultimately determined that he or she is not entitled to indemnification. This undertaking shall be satisfactory in form and amount to the Board of Directors. This right of indemnification shall not affect any other rights to which any person may otherwise be entitled by law or contract.

Section 7.2 Employees and Agents. The Health System Parent Entity may indemnify any employee or agent of the Health System Parent Entity to the maximum extent permitted by law as approved by majority vote of the Board of Directors.

Section 7.3 Insurance. Except as prohibited by law, the Board of Directors may (but shall not be required to) adopt a resolution authorizing the purchase and maintenance of insurance on behalf of the Health System Parent Entity and any Director, officer, employee or other agent of the Health System Parent Entity, against any liability asserted against or incurred by such person in such capacity or arising out of such person's status as such, whether or not the Health System Parent Entity would have the power to indemnify such person against the liability under the provisions of this Article VII. The Directors shall receive advance notice of any action by the Health System Parent Entity to eliminate or substantially reduce Directors and officers insurance coverage.

ARTICLE VIII
Amendment and Repeal of Bylaws

Section 8.1 General Provisions. These Bylaws or any of them may be repealed or amended or new or additional Bylaws may be adopted at a duly held meeting by the affirmative vote of a majority of the actual number of members of the Board of Directors, or by unanimous written consent in accordance with Section 2.15. Notice of the proposed repeal, amendment, or adoption of new or additional Bylaws must be included in the notice calling the meeting to consider such proposal.

CERTIFICATE OF SECRETARY

I, the undersigned, do hereby certify:

(1) That I am the duly elected and acting Secretary of Cedars-Sinai Health System, a California nonprofit public benefit corporation; and

(2) That the foregoing Bylaws constitute true and accurate Bylaws adopted by the action of the Board of Directors on May 1, 2017.

CEDARS-SINAI HEALTH SYSTEM,
a California nonprofit public benefit corporation

May 1, 2017
Date

By: REDACTED
Edward Prunchunas
Secretary

DM US 77804026 4-044248 0530

Exhibit 30-E

Cedars-Sinai's Summary of Financial Assistance Policy and Other Programs

CEDARS-SINAI

SUMMARY OF FINANCIAL ASSISTANCE POLICY AND OTHER PROGRAMS

This document is the "in plain language summary" of the Full and Partial Financial Assistance for Financially Qualified Patients Policy (the "Policy) of Cedars-Sinai Medical Center and Cedars-Sinai Medical Care Foundation (together "Cedars-Sinai"). It is also a description of other financial assistance programs Cedars-Sinai makes available to Patients.

As part of our mission, Cedars-Sinai is committed to providing access to quality health care for the community and treating all of our Patients with dignity, compassion and respect. This includes providing services without charge, or at significantly discounted prices, to eligible Patients who cannot afford to pay for part or all of their care as provided by the Policy. In addition, we offer our Patients a variety of payment plans and options to meet their financial needs even if they do not qualify for assistance under the Policy.

A. Cedars-Sinai program for low-income patients – the Policy.

As provided in detail in the Policy, Cedars-Sinai makes free or discounted care available to Patients whose limited income is within the parameters of the Policy.

1. Eligibility requirements and assistance offered under the Policy.

Full Financial Assistance (no charge to Patient) will be made available to Patients whose income and monetary assets (together "income") are at or below 200 percent of the current year's Federal Poverty Level. Partial Financial Assistance will be made available to Patients whose income is in the range of 201 percent to 450 percent of the current year's Federal Poverty Level. Discounts available to Patients will be on a sliding scale based on family size and income level. Examples: (a) a Patient in a family of four with no insurance and an annual family income of $71,000 could be eligible for a 90 percent discount from amounts generally billed and (b) a Patient in a family of two with insurance that is not sufficient to pay for the services and an annual family income of $55,000 could be eligible for a 70 percent discount from amounts generally billed. Patients who are not able to verify their income status may also be eligible for assistance under the Policy. As the Federal Poverty Level is updated on an annual basis, these examples are subject to change each year.

Patients seeking elective services to be covered by the Policy arrangements will require prior approval for Financial Assistance by the Vice President of Patient Financial Services or his or her designee. Only medically necessary procedures are eligible for approval. Financial assistance for elective procedures and for follow-up care following discharge is limited to Patients who live in the Cedars-Sinai service area or as otherwise approved by an officer of Cedars-Sinai.

If a Patient does not qualify for free services but is eligible for a discount under the Policy, the Patient will not be charged more than "amounts generally billed" by Cedars-Sinai for emergency or other medically necessary care. How we calculate "amounts generally billed" is set out in the Policy, but is an approximate of our Medicare reimbursement.

2. Physicians covered by the Policy.

The Policy only applies to services provided by Cedars-Sinai. These services will include physician services if provided at Cedars-Sinai by Cedars-Sinai's emergency department physicians of Community Urgent Care Medical Group, Inc., Cedars-Sinai faculty physicians in their capacity as faculty or physicians employed by Cedars-Sinai Medical Care Foundation or by medical groups which have an exclusive Professional Services Agreement with Cedars-Sinai Medical Care Foundation.

3. How to apply for assistance under the Policy.

Patients seeking free or discounted care under the Policy will need to complete an Application that will be reviewed by Cedars-Sinai. In addition to asking representatives at Cedars-Sinai registration and admission desks, Patients can obtain the Application form and assistance with the Application process by contacting us as provided below.

4. How to obtain copies of the Policy and the Application form including translations.

You may obtain free copies of the Policy and Application in various ways:

- On our website: cedars-sinai.edu type "Financial Assistance Policy" in the search box and follow the instructions. You may also go to the State website oshpd.ca.gov and type "Hospital Fair Pricing Policies" in the search bar and follow the instructions.
- For patients who are currently admitted to the hospital, contact Patient Financial Advocates at 310-423-5071. Their office is in the hospital building on the street level of the South Tower, Room 1740.
- If you are not an inpatient, you may contact Patient Financial Services Customer Service at 323-866-8600. The physical address is 6500 Wilshire Blvd, Suite 800, Los Angeles, CA, 90048.
- By telephone: 323-866-8600.
- By Mail: 6500 Wilshire Blvd, Suite 800, Los Angeles, CA, 90048.

Translations of the Policy, the Application form and this Plain Language Summary are also available by reaching out to us by any of the means listed above. The available Translations are in Farsi, Russian and Spanish.

B. How to contact us with questions, for additional information about the Policy or for assistance with the Application and Application process as well as other assistance programs.

For additional information including questions on how to apply for Financial Assistance or to request copies of the Financial Assistance Policy, you may contact our Patient Financial Services Customer Service office at 323-866-8600. They are located at 6500 Wilshire Boulevard, Suite 800, Los Angeles, CA 90048.

For patients with questions regarding government insurance (Medi-Cal, Victims of Crime, etc.) you may contact the Patient Financial Advocates office at 310-423-5071. They are located in the hospital building South Tower, Room 1740.

For patients with questions regarding other insurance, please call 800-233-2771 or e-mail insurance@cshs.org.

C. Governmental programs for low income and certain other patients.

Cedars-Sinai participates in several government assistance programs that are not part of the arrangements under the Policy. These include Medi-Cal, the California Healthy Families Program and the California Victims of Crime Compensation Program. Patients may be eligible for subsidized coverage through the California Health Benefit Exchange (Covered California). See above for our contact information.

D. Arrangements with Patients who pay directly (self-pay).

Patients who do not qualify for free or discounted care under the Policy may find other Cedars-Sinai programs helpful. Patients who lack insurance may receive a substantial discounts, similar to the discounts we provide to managed-care insurance plans. Eligible services include outpatient, emergency, and inpatient services. Additionally, Patients who lack insurance or who do not wish to use their commercial insurance are eligible at their request for cash package pricing for selected services. Cash packages generally cover the hospital and anesthesiologist fees for outpatient procedures.

E. Regulatory notice regarding collection activities.

We do refer some delinquent accounts to third-party debt collection agencies. State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8 a.m. or after 9 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 877-FTC-HELP (877-382-4357) or online at ftc.gov/os/statutes/fdcpajump.shtm. Additionally, in the event your account is referred to a collection agency and you have problems with that agency, please contact us immediately at 323-866-8600.

Title 11, California Code of Regulations, § 999.5(d)(10)

PUBLIC COMMUNICATIONS

#31

Title 11, California Code of Regulations, § 999.5(d)(10)

A description of the Applicant's efforts to inform local governmental entities, professional staff, and employees of the health facilities, and the general public of the proposed transaction

PHA was quick to inform its community of the proposed Affiliation with Cedars-Sinai, issuing announcements on March 9, 2020, just three days after the PHA Board meeting at which it identified Cedars-Sinai as the best possible affiliation partner and approved moving forward with this proposed transaction. PHA issued these announcements to the public at large, as well as to its internal community, including its employees, donors, volunteers, and physicians. Copies of PHA's March 9, 2020 announcements to its various stakeholders and the accompanying FAQs are attached to this Section 999.5(d)(10) as **Exhibit 31-A**.

PHA and Cedars-Sinai issued a formal press release on March 9, 2020 regarding the proposed Affiliation. A copy of this press release is attached to this Section 999.5(d)(10) as **Exhibit 31-B**.

PHA and Cedars-Sinai also issued a formal press release on July 16, 2020 regarding the parties' signing of the Affiliation Agreement. A copy of this press release is attached to this Section 999.5(d)(1) as **Exhibit 31-C**.

The reaction has been positive, with many staff members and doctors sharing their experiences with Cedars-Sinai and commending it for its commitment to high quality care.

Exhibit 31-A

March 9, 2020 PHA's Announcements

Huntington Hospital

March 9, 2020

Dear Huntington Donor,

I write today with important and exciting news about Huntington Hospital's future. Following careful consideration and a thorough review of many options, our Board of Directors has signed a Letter of Intent to affiliate with Cedars-Sinai Health System.

As many of you know, Cedars-Sinai Health System is consistently ranked as one of the nation's top hospitals and has proven its ability to build on the strengths of its affiliates to advance clinical quality and outcomes, provide outstanding patient care and engage with the communities it serves. As an affiliate of the Cedars-Sinai Health System, Huntington would continue to operate separately and have its own Board of Directors, employees and medical staff, but this step would strengthen our long-term ability to serve the community through collaborations and sharing of resources with Cedars-Sinai Health System.

Today, Huntington Hospital is stable and strong, with a healthy financial position and a reputation for clinical excellence. Some months ago, our Board of Directors, led by Chair Jaynie Studenmund, undertook a strategic review to evaluate what is necessary to secure our future, enabling us to continue to provide high-quality care to the community years to come. The Board concluded that becoming part of a strong health system will enable Huntington to continue to excel in meeting its historic commitment to the communities we serve.

After reviewing a variety of alternatives, it became clear that an affiliation with Cedars-Sinai Health System is the right choice. This affiliation would make Huntington Hospital part of Cedars-Sinai Health System, alongside Cedars-Sinai Medical Center and Torrance Memorial Hospital, while preserving the services and benefits that we provide for our community.

As I mention in the news release we will be issuing today, "This step will allow for a continued focus on quality patient care, excellence in our nursing and medical staff, and the ongoing fulfillment of our historic mission for the benefit of our physicians, employees and the communities of the San Gabriel Valley." (cont.)

While Cedars-Sinai Health System would become our parent organization, the agreement envisions an ongoing commitment to advancing our existing mission and unique culture as a community institution governed by our local community board. It also includes commitments for continued investment in Huntington Hospital—in enterprise information technology, ambulatory services and physician development. For now, it remains business as usual at Huntington Hospital. There is currently no plan for a change in job positions based on the Letter of Intent.

Cedars-Sinai Health System was established in 2017 to provide a platform for high-quality healthcare institutions to collaborate and share resources and expertise, while maintaining an optimal level of local control at each institution. It currently comprises Cedars-Sinai (which includes Cedars-Sinai Medical Center and Cedars-Sinai Marina del Rey Hospital, as well as its network of physicians and medical offices throughout Southern California) and Torrance Memorial (which includes Torrance Memorial Medical Center, its network of physicians and medical offices throughout the South Bay).

It has demonstrated a commitment to build on the strengths of its affiliates to advance clinical quality and outcomes, provide outstanding patient care and engage with the communities it serves. Huntington would be both a strong contributor to this world-renowned, nonprofit system and enjoy the benefits of joining a larger, regional organization.

In addition, the shared clinical expertise from partnering with a system that includes one of the nation's most esteemed academic and research medical centers, Cedars Sinai Medical Center, will benefit our patients, physicians and allied clinical staff in many ways in the years ahead.

Today's announcement marks the beginning of a process, not an end. This is a letter of intent to develop a definitive agreement for the proposed affiliation between Huntington Hospital and Cedars-Sinai Health System. Completing this affiliation also requires satisfying customary closing conditions, including securing necessary regulatory approvals. While this is a complex process that requires confidentiality in the discussions, we will be in touch as we have new information to share.

We know you probably have questions. Attached to this letter is a list of Frequently Asked Questions (FAQ) that addresses many of the most common ones. Please feel free to direct any further questions or concerns to questions@huntingtonhospital.com . While we may not have all the answers now, we will answer questions as we are able.

We appreciate your continued commitment to this hospital, our patients and our community, and we look forward to working together to preserve our legacy of compassionate, community-based care well into the future.

Sincerely,

Jaynie Studenmund

Huntington Hospital Board Chairman

Huntington Hospital

Donor FAQ, March 9, 2020

1. **What is a letter of intent?**

A Letter of Intent, like the one we have signed with Cedars-Sinai Health System, is followed by the development of a definitive agreement. Subject to reaching a final agreement, the Letter of Intent signals the view of the Huntington board that there is great potential for an affiliation with Cedars-Sinai Health System that would be good for all our stakeholders. The definitive agreement is subject to review by various regulatory agencies that approve proposed affiliations of this type.

2. **Is Huntington being sold?**

No, we are not for sale or being sold. The Letter of Intent marks the beginning of the process described above that would ultimately allow us to join Cedars-Sinai Health System and benefit from the strength of their system to secure our future, enabling us to continue to provide high-quality care to the community for years to come in a rapidly changing healthcare sector.

3. **Why do we need to combine with another health system?**

The Board believes that joining with another strong institution is the best way to secure Huntington's future serving patients and the community for decades to come. This is especially true in light of the challenges we and the rest of our field face, including intensified competition; the ongoing costs of new medical and information technology; the increasing focus on accessible, coordinated care and the need to make healthcare as affordable as possible.

4. **Why is Cedars-Sinai Health System the right health system for Huntington to join?**

Cedars-Sinai Health System supports the continuation of our legacy as a community institution focused on clinical excellence through continued investment in Huntington Hospital. Cedars-Sinai Health System has already proven itself able to successfully navigate many of the same challenges that have caused us to seek to join a health system; for example, Cedars-Sinai Health System will bring its experience in implementing a next-generation Electronic Health Records system to Huntington, giving us a smoother transition than if we tried to implement one on our own.

In addition, the shared clinical expertise from partnering with a system that includes one of the nation's most esteemed academic and research medical centers, Cedars-Sinai Medical Center, will benefit our patients, physicians and allied clinical staff in many ways in the years ahead.

5. **Will we still have local governance?**

Yes, our Board of Directors will continue to have oversight of Huntington Hospital. In fact, one of the key principles of Cedars-Sinai Health System is the value placed on continued local community support and maintaining the Board of Directors' involvement in assuring high-quality care and oversight of Huntington's operations. Maintaining Huntington's legacy as a community institution is a key part of why we entered into a Letter of Intent with Cedars-Sinai Health System.

6. **What will happen to our physicians and employees at this time?**

Our intent in joining Cedars-Sinai Health System is to make Huntington better and stronger for the benefit of our entire community, including staff and physicians. Cedars-Sinai Health System has said that they would respect the current relationships that Huntington has with its employees and physicians. For now, it remains business as usual at Huntington Hospital. There is currently no plan for a change in job positions based on the Letter of Intent.

7. **How long will this process take?**

It is difficult to estimate when, but it is a lengthy process of many months. Both Huntington Hospital and Cedars-Sinai Health System are committed to negotiating the definitive agreement in a timely way. Once

we reach a definitive agreement, it would be submitted for review by various regulatory agencies that approve proposed affiliations of this type.

8. What if we don't reach a definitive agreement with Cedars-Sinai Health System?

While the Board is confident that joining Cedars-Sinai Health System is the best way to fulfill Huntington's vision, the Hospital's future and financial position are sound, whether as a standalone institution or as a part of Cedars-Sinai Health System.

9. Will our donors or volunteers be affected by an agreement?

All donors can be confident that past and future gifts will continue to be used exclusively for the purposes for which they are designated; similarly, volunteers will continue to serve Huntington, just as they do today. Our donors and volunteers are part of what make us special and successful as a community institution, and we remain grateful for their support.

10. Huntington has a longstanding tradition of serving the needs of its local community. How might that change with Cedars-Sinai Health System?

This was a critical element in our selection. Our commitment to the communities of the San Gabriel Valley will not change; in fact, one of the reasons for joining forces with Cedars-Sinai Health System is to ensure the ongoing fulfillment of our historic mission for years to come.

11. Were any community members consulted about this process? If not, why not?

Our Board of Directors includes over 20 community members who have been involved in this process from the start.

12. Will community members have any opportunity to provide input?

The interests of the community are critical to the Board of Directors' decision-making process on behalf of Huntington Hospital, and this will continue to be the case as this process moves forward.

13. I donated with the assumption that Huntington was here to stay. Will my money stay in the community?

Huntington Hospital is here to stay and will remain dedicated to its charitable purposes. All past and current gifts will continue to be used at Huntington exclusively for the purposes for which they are designated. The Board firmly believes that pursuing an affiliation with Cedars-Sinai Health System is the best way to ensure the sustainability of our mission.

14. How does this affect planned giving? Do I need to change my will?

As a member of Cedars-Sinai Health System, Huntington would continue to operate as its own entity, so no changes are needed to any planned giving documents. All current and future gifts will continue to be used at Huntington exclusively for the purposes for which they are designated.

Huntington Hospital

March 9, 2020

Dear Huntington,

I write today with important and exciting news about Huntington Hospital's future. Following careful consideration and a thorough review of many options, our Board of Directors has signed a Letter of Intent to affiliate with Cedars-Sinai Health System.

As many of you know, Cedars-Sinai Health System is consistently ranked as one of the nation's top hospitals and has proven its ability to build on the strengths of its affiliates to advance clinical quality and outcomes, provide outstanding patient care and engage with the communities it serves. As an affiliate of the Cedars-Sinai Health System, Huntington would continue to operate separately and have its own Board of Directors, employees and medical staff, but this step would strengthen our long-term ability to serve the community through collaborations and sharing of resources with Cedars-Sinai Health System.

Today, Huntington Hospital is stable and strong, with a healthy financial position and a reputation for clinical excellence. Some months ago, our Board of Directors, led by Chair Jaynie Studenmund, undertook a strategic review to evaluate what is necessary to secure our future, enabling us to continue to provide high-quality care to the community years to come. The Board concluded that becoming part of a strong health system will enable Huntington to continue to excel in meeting its historic commitment to the communities we serve.

After reviewing a variety of alternatives, it became clear that an affiliation with Cedars-Sinai Health System is the right choice. This affiliation would make Huntington Hospital part of Cedars-Sinai Health System, alongside Cedars-Sinai Medical Center and Torrance Memorial Hospital, while preserving the services and benefits that we provide for our community.

As Jaynie Studenmund, our Board Chair says in the news release we will be issuing today, "This step will allow for a continued focus on quality patient care, excellence in our nursing and medical staff, and the ongoing fulfillment of our historic mission for the benefit of our physicians, employees and the communities of the San Gabriel Valley."

(cont.)

While Cedars-Sinai Health System would become our parent organization, the agreement envisions an ongoing commitment to advancing our existing mission and unique culture as a community institution governed by our local community board. It also includes commitments for continued investment in Huntington Hospital—in enterprise information technology, ambulatory services and physician development. For now, it remains business as usual at Huntington Hospital. There is currently no plan for a change in job positions based on the Letter of Intent.

Cedars-Sinai Health System was established in 2017 to provide a platform for high-quality healthcare institutions to collaborate and share resources and expertise, while maintaining an optimal level of local control at each institution. It currently comprises Cedars-Sinai (which includes Cedars-Sinai Medical Center and Cedars-Sinai Marina del Rey Hospital, as well as its network of physicians and medical offices throughout Southern California) and Torrance Memorial (which includes Torrance Memorial Medical Center, its network of physicians and medical offices throughout the South Bay).

It has demonstrated a commitment to build on the strengths of its affiliates to advance clinical quality and outcomes, provide outstanding patient care and engage with the communities it serves. Huntington would be both a strong contributor to this world-renowned, nonprofit system and enjoy the benefits of joining a larger, regional organization.

In addition, the shared clinical expertise from partnering with a system that includes one of the nation's most esteemed academic and research medical centers, Cedars Sinai Medical Center, will benefit our patients, physicians and allied clinical staff in many ways in the years ahead.

Today's announcement marks the beginning of a process, not an end. This is a letter of intent to develop a definitive agreement for the proposed affiliation between Huntington Hospital and Cedars-Sinai Health System. Completing this affiliation also requires satisfying customary closing conditions, including securing necessary regulatory approvals. While this is a complex process that requires confidentiality in the discussions, we will be in touch as we have new information to share.

We know you probably have questions. Attached to this letter is a list of Frequently Asked Questions (FAQ) that addresses many of the most common ones. Please feel free to direct any further questions or concerns to questions@huntingtonhospital.com . While we may not have all the answers now, we will answer questions as we are able.

We appreciate your continued commitment to this hospital, our patients and our community, and we look forward to working together to preserve our legacy of compassionate, community-based care well into the future.

Sincerely,

LJM

Lori J. Morgan, MD, MBA

Huntington Hospital President & CEO

Huntington Hospital

March 9, 2020

1. **What is a Letter of Intent?**

A Letter of Intent, like the one we have signed with Cedars-Sinai Health System, is followed by the development of a definitive agreement. Subject to reaching a final agreement, the Letter of Intent signals the view of the Huntington board that there is great potential for an affiliation with Cedars-Sinai Health System that would be good for all our stakeholders. The definitive agreement is subject to review by various regulatory agencies that approve proposed affiliations of this type.

2. **Is Huntington being sold?**

No, we are not for sale or being sold. The Letter of Intent marks the beginning of the process described above that would ultimately allow us to join Cedars-Sinai Health System and benefit from the strength of their system to secure our future, enabling us to continue to provide high-quality care to the community for years to come in a rapidly changing health care sector.

3. **Why do we need to combine with another health system?**

The Board believes that joining with another strong institution is the best way to secure Huntington's future serving patients and the community for decades to come. This is especially true in light of the challenges we and the rest of our field face, including intensified competition; the ongoing costs of new medical and information technology; the increasing focus on accessible, coordinated care and the need to make healthcare as affordable as possible.

4. **Why is Cedars-Sinai Health System the right health system for Huntington to join?**

Cedars-Sinai Health System supports the continuation of our legacy as a community institution focused on clinical excellence through continued investment in Huntington Hospital. Cedars-Sinai has already proven itself able to successfully navigate many of the same challenges that have caused us to seek to join a health system; for example, Cedars-Sinai will bring its experience in implementing a next-generation Electronic Health Records system to Huntington, giving us a smoother transition than if we tried to implement one on our own.

In addition, the shared clinical expertise from partnering with a system that includes one of the nation's most esteemed academic and research medical centers, Cedars-Sinai Medical Center, will benefit our patients, physicians and allied clinical staff in many ways in the years ahead.

5. **Will we still have local governance?**

Yes, our Board of Directors will continue to have oversight of Huntington Hospital. In fact, one of the key principles of Cedars-Sinai Health System is the value placed on continued local community support and maintaining the Board of Directors' involvement in assuring high-quality care and oversight of Huntington's operations. Maintaining Huntington's legacy as a community institution is a key part of why we entered into a Letter of Intent with Cedars-Sinai Health System.

6. **What will happen to our physicians and employees at this time?**

Our intent in joining Cedars-Sinai Health System is to make Huntington better and stronger for the benefit of our entire community, including staff and physicians. Cedars-Sinai has said that they would respect the current relationships that Huntington has with its employees and physicians. For now, it remains business as usual at Huntington Hospital. There is currently no plan for a change in job positions based on the Letter of Intent.

7. **How long will this process take?**

It is difficult to estimate when, but it is a lengthy process of many months. Both Huntington Hospital and Cedars-Sinai Health System are committed to negotiating the definitive agreement in a timely way. Once

we reach a definitive agreement, it would be submitted for review by various regulatory agencies that approve proposed affiliations of this type.

8. What if we don't reach a definitive agreement with Cedars-Sinai Health System?

While the Board is confident that joining Cedars-Sinai Health System is the best way to fulfill Huntington's vision, the Hospital's future and financial position are sound, whether as a standalone institution or as a part of Cedars-Sinai Health System.

9. Will our donors or volunteers be affected by an agreement?

All donors can be confident that past and future gifts will continue to be used exclusively for the purposes for which they are designated; similarly, volunteers will continue to serve Huntington, just as they do today. Our donors and volunteers are part of what make us special and successful as a community institution, and we remain grateful for their support.

10. Are staffing reductions at Huntington part of the goal of joining Cedars-Sinai Health System?

We did not choose to pursue this affiliation in order to manage costs, but rather to ensure a continued focus on quality patient care, excellence in our nursing and medical staff and the ongoing fulfillment of our historic mission through investment in enterprise information technology, ambulatory services and physician development.

The agreement would respect the current relationships that Huntington has with its employees and physicians. For now, it remains business as usual at Huntington Hospital. There is currently no plan for a change in job positions based on the Letter of Intent.

Your work remains critical to our success, and we encourage you to continue working just as you do today. Our intent in joining Cedars-Sinai Health System is to make Huntington better and stronger for the benefit of our entire community, including staff.

11. Could I choose to transfer to Cedars-Sinai or Torrance Memorial?

For now, nothing changes. It is premature to say with certainty if there may be opportunities in the future for transfers from one health system entity to another. As always, we support the professional growth of our employees.

12. Will my position, supervisor or elements of my role change?

For now, it remains business as usual at Huntington Hospital. There is currently no plan for a change in job positions based on the Letter of Intent. Huntington remains solely responsible for all employment decisions, and any future changes would be communicated well in advance.

13. Could my pay or benefits change?

Huntington would remain solely responsible for determining pay or benefits.

14. Were employees consulted about this process?

It was not possible to open this process up to consideration beyond our Board of Directors. Our staff are key to fulfilling our historic mission as a community institution, and we remain fully committed to making sure your needs are a central part of our plans for Huntington's future.

15. I have additional questions. To whom should I address them?

Please feel free to direct any questions or concerns to questions@huntingtonhospital.com . In addition, we will be holding a number of information sessions over the coming weeks to address questions and keep you up to date.

Huntington Hospital

March 9, 2020

Dear Huntington Physician,

I write today with important and exciting news about Huntington Hospital's future. Following careful consideration and a thorough review of many options, our Board of Directors has signed a Letter of Intent to affiliate with Cedars-Sinai Health System.

As many of you know, Cedars-Sinai Health System is consistently ranked as one of the nation's top hospitals and has proven its ability to build on the strengths of its affiliates to advance clinical quality and outcomes, provide outstanding patient care and engage with the communities it serves. As an affiliate of the Cedars-Sinai Health System, Huntington would continue to operate separately and have its own Board of Directors, employees and medical staff, but this step would strengthen our long-term ability to serve the community through collaborations and sharing of resources with Cedars-Sinai Health System.

Today, Huntington Hospital is stable and strong, with a healthy financial position and a reputation for clinical excellence. Some months ago, our Board of Directors, led by Chair Jaynie Studenmund, undertook a strategic review to evaluate what is necessary to secure our future, enabling us to continue to provide high-quality care to the community years to come. The Board concluded that becoming part of a strong health system will enable Huntington to continue to excel in meeting its historic commitment to the communities we serve.

After reviewing a variety of alternatives, it became clear that an affiliation with Cedars-Sinai Health System is the right choice. This affiliation would make Huntington Hospital part of Cedars-Sinai Health System, alongside Cedars-Sinai Medical Center and Torrance Memorial Hospital, while preserving the services and benefits that we provide for our community.

As Jaynie Studenmund, our Board Chair says in the news release we will be issuing today, "This step will allow for a continued focus on quality patient care, excellence in our nursing and medical staff, and the ongoing fulfillment of our historic mission for the benefit of our physicians, employees and the communities of the San Gabriel Valley."

(cont.)

While Cedars-Sinai Health System would become our parent organization, the agreement envisions an ongoing commitment to advancing our existing mission and unique culture as a community institution governed by our local community board. It also includes commitments for continued investment in Huntington Hospital—in enterprise information technology, ambulatory services and physician development. For now, it remains business as usual at Huntington Hospital. There is currently no plan for a change in job positions based on the Letter of Intent.

Cedars-Sinai Health System was established in 2017 to provide a platform for high-quality healthcare institutions to collaborate and share resources and expertise, while maintaining an optimal level of local control at each institution. It currently comprises Cedars-Sinai (which includes Cedars-Sinai Medical Center and Cedars-Sinai Marina del Rey Hospital, as well as its network of physicians and medical offices throughout Southern California) and Torrance Memorial (which includes Torrance Memorial Medical Center, its network of physicians and medical offices throughout the South Bay).

It has demonstrated a commitment to build on the strengths of its affiliates to advance clinical quality and outcomes, provide outstanding patient care and engage with the communities it serves. Huntington would be both a strong contributor to this world-renowned, nonprofit system and enjoy the benefits of joining a larger, regional organization.

In addition, the shared clinical expertise from partnering with a system that includes one of the nation's most esteemed academic and research medical centers, Cedars Sinai Medical Center, will benefit our patients, physicians and allied clinical staff in many ways in the years ahead.

Today's announcement marks the beginning of a process, not an end. This is a letter of intent to develop a definitive agreement for the proposed affiliation between Huntington Hospital and Cedars-Sinai Health System. Completing this affiliation also requires satisfying customary closing conditions, including securing necessary regulatory approvals. While this is a complex process that requires confidentiality in the discussions, we will be in touch as we have new information to share.

We know you probably have questions. Attached to this letter is a list of Frequently Asked Questions (FAQ) that addresses many of the most common ones. Please feel free to direct any further questions or concerns to questions@huntingtonhospital.com . While we may not have all the answers now, we will answer questions as we are able.

We appreciate your continued commitment to this hospital, our patients and our community, and we look forward to working together to preserve our legacy of compassionate, community-based care well into the future.

Sincerely,

LJM

Lori J. Morgan, MD, MBA

Huntington Hospital President & CEO

Huntington Hospital

Physician FAQ, March 9, 2020

1. **What is a Letter of Intent?**

A Letter of Intent, like the one we have signed with Cedars-Sinai Health System, is followed by the development of a definitive agreement. Subject to reaching a final agreement, the Letter of Intent signals the view of the Huntington board that there is great potential for an affiliation with Cedars-Sinai Health System that would be good for all our stakeholders. Finally, the definitive agreement is subject to review by various regulatory agencies that approve proposed affiliations of this type.

2. **Is Huntington being sold?**

No, we are not for sale or being sold. The Letter of Intent marks the beginning of the process described above that would ultimately allow us to join Cedars-Sinai Health System and benefit from the strength of their system to secure our future, enabling us to continue to provide high-quality care to the community for years to come in a rapidly changing health care sector.

3. **Why do we need to combine with another health system?**

The Board believes that joining with another strong institution is the best way to secure Huntington's future serving patients and the community for decades to come. This is especially true in light of the challenges we and the rest of our field face, including intensified competition; the ongoing costs of new medical and information technology; the increasing focus on accessible, coordinated care and the need to make healthcare as affordable as possible.

4. **Why is Cedars-Sinai Health System the right health system for Huntington to join?**

Cedars-Sinai Health System supports the continuation of our legacy as a community institution focused on clinical excellence through continued investment in Huntington Hospital. Cedars-Sinai Health System has already proven itself able to successfully navigate many of the same challenges that have caused us to seek to join a health system; for example, Cedars-Sinai Health System will bring its experience in implementing a next-generation Electronic Health Records system to Huntington, giving us a smoother transition than if we tried to implement one on our own.

In addition, the shared clinical expertise from partnering with a system that includes one of the nation's most esteemed academic and research medical centers, Cedars-Sinai Medical Center, will benefit our patients, physicians and allied clinical staff in many ways in the years ahead.

5. **Will we still have local governance?**

Yes, our Board of Directors will continue to have oversight of Huntington Hospital. In fact, one of the key principles of Cedars-Sinai Health System is the value placed on continued local community support and maintaining the Board of Directors' involvement in assuring high-quality care and oversight of Huntington's operations. Maintaining Huntington's legacy as a community institution is a key part of why we entered into a Letter of Intent with Cedars-Sinai Health System.

6. **What will happen to our physicians and employees at this time?**

Our intent in joining Cedars-Sinai Health System is to make Huntington better and stronger for the benefit of our entire community, including staff and physicians. Cedars-Sinai Health System has said that they would respect the current relationships that Huntington has with its employees and physicians. For now, it remains business as usual at Huntington Hospital. There is currently no plan for a change in job positions based on the Letter of Intent.

7. **How long will this process take?**

It is difficult to estimate when, but it is a lengthy process of many months. Both Huntington Hospital and Cedars-Sinai Health System are committed to negotiating the definitive agreement in a timely way. Once we

reach a definitive agreement, it would be submitted for review by various regulatory agencies that approve proposed affiliations of this type.

8. **What if we don't reach a definitive agreement with Cedars-Sinai Health System?**

While the Board is confident that joining Cedars-Sinai Health System is the best way to fulfill Huntington's vision, the Hospital's future and financial position are sound, whether as a standalone institution or as a part of Cedars-Sinai Health System.

9. **Will our donors or volunteers be affected by an agreement?**

All donors can be confident that past and future gifts will continue to be used exclusively for the purposes for which they are designated; similarly, volunteers will continue to serve Huntington, just as they do today. Our donors and volunteers are part of what make us special and successful as a community institution, and we remain grateful for their support.

10. **Will my practice change?**

The affiliation with Cedars-Sinai Health System will not affect your ability to continue providing the excellent care you provide in your practice. Medical staff governance will remain local, with Huntington maintaining its own medical staff and independent governance for medical affairs.

Our intent in joining Cedars-Sinai Health System is to make Huntington better and stronger for the benefit of our entire community, including staff and physicians. Our focus on quality patient care and the excellence of our nursing and medical staff is a big part of what makes Cedars-Sinai Health System a good fit for Huntington.

11. **Could we potentially have to compete with doctors from Cedars-Sinai?**

Our goal in joining with Cedars-Sinai Health System is to help you continue to excel in your work. As in the past, Huntington physicians will continue to decide on the consultants they choose, and patients will decide what is best for their care.

12. **Will there be opportunities to practice at Cedars-Sinai Medical Center?**

As is the case today, physicians interested in practicing at Cedars-Sinai are eligible to apply for medical staff privileges there.

13. **Will my privileges change? What would an agreement mean for contracting with Medical Staff? If Cedars-Sinai Health System has different contracting procedures, what will that mean for the physicians on staff at Huntington?**

Our medical staff governance will remain local, with Huntington maintaining its own medical staff and independent governance for medical affairs, consistent with California law.

14. **How will physician leadership / seniority be determined? Will we maintain our own leadership structure?**

Our medical staff governance will remain local, with Huntington maintaining its own medical staff and independent governance for medical affairs, consistent with California law.

15. **Were any physicians on staff consulted about this process?**

Our Board of Directors includes several physicians who are elected leaders of Medical Staff.

16. I have additional questions. To whom should I address them?

Please feel free to direct any questions or concerns to questions@huntingtonhospital.com . In addition, we will be holding a number of information sessions over the coming weeks to address questions and keep you up to date.

Huntington Hospital

March 9, 2020

Dear Huntington Volunteer,

I write today with important and exciting news about Huntington Hospital's future. Following careful consideration and a thorough review of many options, our Board of Directors has signed a Letter of Intent to affiliate with Cedars-Sinai Health System.

As many of you know, Cedars-Sinai Health System is consistently ranked as one of the nation's top hospitals and has proven its ability to build on the strengths of its affiliates to advance clinical quality and outcomes, provide outstanding patient care and engage with the communities it serves. As an affiliate of the Cedars-Sinai Health System, Huntington would continue to operate separately and have its own Board of Directors, employees and medical staff, but this step would strengthen our long-term ability to serve the community through collaborations and sharing of resources with Cedars-Sinai Health System.

Today, Huntington Hospital is stable and strong, with a healthy financial position and a reputation for clinical excellence. Some months ago, our Board of Directors, led by Chair Jaynie Studenmund, undertook a strategic review to evaluate what is necessary to secure our future, enabling us to continue to provide high-quality care to the community years to come. The Board concluded that becoming part of a strong health system will enable Huntington to continue to excel in meeting its historic commitment to the communities we serve.

After reviewing a variety of alternatives, it became clear that an affiliation with Cedars-Sinai Health System is the right choice. This affiliation would make Huntington Hospital part of Cedars-Sinai Health System, alongside Cedars-Sinai Medical Center and Torrance Memorial Hospital, while preserving the services and benefits that we provide for our community.

As Jaynie Studenmund, our Board Chair says in the news release we will be issuing today, "This step will allow for a continued focus on quality patient care, excellence in our nursing and medical staff, and the ongoing fulfillment of our historic mission for the benefit of our physicians, employees and the communities of the San Gabriel Valley."

(cont.)

While Cedars-Sinai Health System would become our parent organization, the agreement envisions an ongoing commitment to advancing our existing mission and unique culture as a community institution governed by our local community board. It also includes commitments for continued investment in Huntington Hospital—in enterprise information technology, ambulatory services and physician development. For now, it remains business as usual at Huntington Hospital. There is currently no plan for a change in job positions based on the Letter of Intent.

Cedars-Sinai Health System was established in 2017 to provide a platform for high-quality healthcare institutions to collaborate and share resources and expertise, while maintaining an optimal level of local control at each institution. It currently comprises Cedars-Sinai (which includes Cedars-Sinai Medical Center and Cedars-Sinai Marina del Rey Hospital, as well as its network of physicians and medical offices throughout Southern California) and Torrance Memorial (which includes Torrance Memorial Medical Center, its network of physicians and medical offices throughout the South Bay).

It has demonstrated a commitment to build on the strengths of its affiliates to advance clinical quality and outcomes, provide outstanding patient care and engage with the communities it serves. Huntington would be both a strong contributor to this world-renowned, nonprofit system and enjoy the benefits of joining a larger, regional organization.

In addition, the shared clinical expertise from partnering with a system that includes one of the nation's most esteemed academic and research medical centers, Cedars Sinai Medical Center, will benefit our patients, physicians and allied clinical staff in many ways in the years ahead.

Today's announcement marks the beginning of a process, not an end. This is a letter of intent to develop a definitive agreement for the proposed affiliation between Huntington Hospital and Cedars-Sinai Health System. Completing this affiliation also requires satisfying customary closing conditions, including securing necessary regulatory approvals. While this is a complex process that requires confidentiality in the discussions, we will be in touch as we have new information to share.

We know you probably have questions. Attached to this letter is a list of Frequently Asked Questions (FAQ) that addresses many of the most common ones. Please feel free to direct any further questions or concerns to questions@huntingtonhospital.com . While we may not have all the answers now, we will answer questions as we are able.

We appreciate your continued commitment to this hospital, our patients and our community, and we look forward to working together to preserve our legacy of compassionate, community-based care well into the future.

Sincerely,

LJM

Lori J. Morgan, MD, MBA

Huntington Hospital President & CEO

Huntington Hospital

March 9, 2020

Dear Huntington Community,

I write today with important and exciting news about Huntington Hospital's future. Following careful consideration and a thorough review of many options, our Board of Directors has signed a Letter of Intent to affiliate with Cedars-Sinai Health System.

As many of you know, Cedars-Sinai Health System is consistently ranked as one of the nation's top hospitals and has proven its ability to build on the strengths of its affiliates to advance clinical quality and outcomes, provide outstanding patient care and engage with the communities it serves. As an affiliate of the Cedars-Sinai Health System, Huntington would continue to operate separately and have its own Board of Directors, employees and medical staff, but this step would strengthen our long-term ability to serve the community through collaborations and sharing of resources with Cedars-Sinai Health System.

Today, Huntington Hospital is stable and strong, with a healthy financial position and a reputation for clinical excellence. Some months ago, our Board of Directors, led by Chair Jaynie Studenmund, undertook a strategic review to evaluate what is necessary to secure our future, enabling us to continue to provide high-quality care to the community years to come. The Board concluded that becoming part of a strong health system will enable Huntington to continue to excel in meeting its historic commitment to the communities we serve.

After reviewing a variety of alternatives, it became clear that an affiliation with Cedars-Sinai Health System is the right choice. This affiliation would make Huntington Hospital part of Cedars-Sinai Health System, alongside Cedars-Sinai Medical Center and Torrance Memorial Hospital, while preserving the services and benefits that we provide for our community.

As I mention in the news release we will be issuing today, "This step will allow for a continued focus on quality patient care, excellence in our nursing and medical staff, and the ongoing fulfillment of our historic mission for the benefit of our physicians, employees and the communities of the San Gabriel Valley." (cont.)

While Cedars-Sinai Health System would become our parent organization, the agreement envisions an ongoing commitment to advancing our existing mission and unique culture as a community institution governed by our local community board. It also includes commitments for continued investment in Huntington Hospital—in enterprise information technology, ambulatory services and physician development. For now, it remains business as usual at Huntington Hospital. There is currently no plan for a change in job positions based on the Letter of Intent.

Cedars-Sinai Health System was established in 2017 to provide a platform for high-quality healthcare institutions to collaborate and share resources and expertise, while maintaining an optimal level of local control at each institution. It currently comprises Cedars-Sinai (which includes Cedars-Sinai Medical Center and Cedars-Sinai Marina del Rey Hospital, as well as its network of physicians and medical offices throughout Southern California) and Torrance Memorial (which includes Torrance Memorial Medical Center, its network of physicians and medical offices throughout the South Bay).

It has demonstrated a commitment to build on the strengths of its affiliates to advance clinical quality and outcomes, provide outstanding patient care and engage with the communities it serves. Huntington would be both a strong contributor to this world-renowned, nonprofit system and enjoy the benefits of joining a larger, regional organization.

In addition, the shared clinical expertise from partnering with a system that includes one of the nation's most esteemed academic and research medical centers, Cedars Sinai Medical Center, will benefit our patients, physicians and allied clinical staff in many ways in the years ahead.

Today's announcement marks the beginning of a process, not an end. This is a letter of intent to develop a definitive agreement for the proposed affiliation between Huntington Hospital and Cedars-Sinai Health System. Completing this affiliation also requires satisfying customary closing conditions, including securing necessary regulatory approvals. While this is a complex process that requires confidentiality in the discussions, we will be in touch as we have new information to share.

We know you probably have questions. Attached to this letter is a list of Frequently Asked Questions (FAQ) that addresses many of the most common ones. Please feel free to direct any further questions or concerns to questions@huntingtonhospital.com . While we may not have all the answers now, we will answer questions as we are able.

We appreciate your continued commitment to this hospital, our patients and our community, and we look forward to working together to preserve our legacy of compassionate, community-based care well into the future.

Sincerely,

Jaynie Studenmund

Huntington Hospital Board Chairman

Huntington Hospital

FAQ March 9, 2020

1. **What is a Letter of Intent?**

A Letter of Intent, like the one we have signed with Cedars-Sinai Health System, is followed by the development of a definitive agreement. Subject to reaching a final agreement, the Letter of Intent signals the view of the Huntington board that there is great potential for an affiliation with Cedars-Sinai Health System that would be good for all our stakeholders. The definitive agreement is subject to review by various regulatory agencies that approve proposed affiliations of this type.

2. **Is Huntington being sold?**

No, we are not for sale or being sold. The Letter of Intent marks the beginning of the process described above that would ultimately allow us to join Cedars-Sinai Health System and benefit from the strength of their system to secure our future, enabling us to continue to provide high-quality care to the community for years to come in a rapidly changing healthcare sector.

3. **Why do we need to combine with another health system?**

The Board believes that joining with another strong institution is the best way to secure Huntington's future serving patients and the community for decades to come. This is especially true in light of the challenges we and the rest of our field face, including intensified competition; the ongoing costs of new medical and information technology; the increasing focus on accessible, coordinated care and the need to make healthcare as affordable as possible.

4. **Why is Cedars-Sinai Health System the right health system for Huntington to join?**

Cedars-Sinai Health System supports the continuation of our legacy as a community institution focused on clinical excellence through continued investment in Huntington Hospital. Cedars-Sinai has already proven itself able to successfully navigate many of the same challenges that have caused us to seek to join a health system; for example, Cedars-Sinai will bring its experience in implementing a next-generation Electronic Health Records system to Huntington, giving us a smoother transition than if we tried to implement one on our own.

In addition, the shared clinical expertise from partnering with a system that includes one of the nation's most esteemed academic and research medical centers, Cedars-Sinai Medical Center, will benefit our patients, physicians and allied clinical staff in many ways in the years ahead.

5. **Will we still have local governance?**

Yes, our Board of Directors will continue to have oversight of Huntington Hospital. In fact, one of the key principles of Cedars-Sinai Health System is the value placed on continued local community support and maintaining the Board of Directors' involvement in assuring high-quality care and oversight of Huntington's operations. Maintaining Huntington's legacy as a community institution is a key part of why we entered into a Letter of Intent with Cedars-Sinai Health System.

6. **What will happen to our physicians and employees at this time?**

Our intent in joining Cedars-Sinai Health System is to make Huntington better and stronger for the benefit of our entire community, including staff and physicians. Cedars-Sinai has said that they would respect the current relationships that Huntington has with its employees and physicians. For now, it remains business as usual at Huntington Hospital. There is currently no plan for a change in job positions based on the Letter of Intent.

7. **How long will this process take?**

It is difficult to estimate when, but it is a lengthy process of many months. Both Huntington Hospital and Cedars-Sinai Health System are committed to negotiating the definitive agreement in a timely way. Once

we reach a definitive agreement, it would be submitted for review by various regulatory agencies that approve proposed affiliations of this type.

8. What if we don't reach a definitive agreement with Cedars-Sinai Health System?

While the Board is confident that joining Cedars-Sinai Health System is the best way to fulfill Huntington's vision, the Hospital's future and financial position are sound, whether as a standalone institution or as a part of Cedars-Sinai Health System.

9. Will our donors or volunteers be affected by an agreement?

All donors can be confident that past and future gifts will continue to be used exclusively for the purposes for which they are designated; similarly, volunteers will continue to serve Huntington, just as they do today. Our donors and volunteers are part of what make us special and successful as a community institution, and we remain grateful for their support.

Exhibit 31-B

March 9, 2020 Press Release

Huntington Hospital Signs Letter of Intent to Join Cedars-Sinai Health System

Letter of Intent Provides for Continued Local Governance, Ongoing Community Commitment

Pasadena, Calif. March 9, 2020 – Huntington Hospital and Cedars-Sinai Health System today announced the signing of a Letter of Intent for Huntington to affiliate with Cedars-Sinai Health System.

Cedars-Sinai Health System was established in 2017 to provide a platform for high-quality healthcare institutions to collaborate and share resources and expertise. It currently comprises Cedars-Sinai (which includes Cedars-Sinai Medical Center and Cedars-Sinai Marina del Rey Hospital, as well as its network of physicians and medical offices throughout Southern California) and Torrance Memorial (which includes Torrance Memorial Medical Center, its network of physicians and medical offices throughout the South Bay).

The Letter of Intent includes commitments for continued investment in Huntington Hospital—in enterprise information technology, ambulatory services and physician development. It resulted from a strategic review by a special committee of the Huntington Hospital Board of Directors, led by Chair Jaynie Studenmund.

“I am delighted to announce this first step toward creating an affiliation between Cedars-Sinai Health System and Huntington Hospital that will further strengthen the communities we serve,” said Studenmund. “After reviewing a variety of alternatives, it became clear to our board that connecting our trusted brand of care to Cedars-Sinai Health System is the right choice to secure our future, enabling us to continue to provide high-quality care to the community for years to come.”

Studenmund continued, “Cedars-Sinai Health System is among the nation’s top hospitals across a variety of metrics and has demonstrated a commitment to build on the strengths of its affiliates to advance clinical quality and outcomes, provide outstanding patient care and engage with the communities it serves. This step will allow for a continued focus on quality patient care, excellence in our nursing and medical staff, and the ongoing fulfillment of our historic mission for the benefit of our physicians, employees and the communities of the San Gabriel Valley.”

“Huntington Hospital’s longstanding commitment to the community, its reputation for quality and its outstanding physicians, nurses and other staff make it a very good fit for Cedars-Sinai Health System,” said Vera Guerin, chair of the Cedars-Sinai Health System Board of Directors. “Collaborations and sharing of resources throughout the health system will further strengthen Huntington’s ability to serve the community for decades to come.”

Huntington Hospital anticipates that the shared clinical expertise from affiliating with a system that includes one of the nation's most esteemed academic and research medical centers—Cedars-Sinai Medical Center—will benefit its patients, physicians and allied clinical staff in many ways in the years ahead.

The Letter of Intent sustains Huntington's 128-year legacy and its connection to the communities it serves. It provides for an ongoing commitment to advancing Huntington's existing mission and unique culture as a community institution governed by its local community board. In addition, philanthropy and volunteer support will remain locally controlled and utilized for Huntington Hospital and its existing community.

For now, it remains business as usual at Huntington Hospital. There is currently no plan for a change in job positions based on the Letter of Intent.

Dr. Lori Morgan, CEO of Huntington noted, "Cedars-Sinai Health System has demonstrated a commitment to build on the strengths of its affiliates to advance clinical quality and outcomes, provide outstanding patient care and engage with the communities it serves, making it the clear choice for Huntington and our stakeholders. We expect that Huntington would be both a strong contributor to this world-renowned, nonprofit system and enjoy the benefits of joining a larger, regional organization to preserve our legacy of compassionate, community-based care well into the future."

"The Huntington board, along with Lori Morgan and her colleagues, has a great vision for Huntington's future, which will further strengthen an already outstanding institution for the benefit of the community," said Thomas M. Priselac, Cedars-Sinai Health System president and CEO. "Being part of Cedars-Sinai Health System would help them achieve that vision, as well as enable collaborations with other health system members to increase access to high-quality care throughout the region."

With the Letter of Intent completed, Cedars-Sinai Health System and Huntington Hospital now begin work on a definitive agreement. Completing the affiliation is subject to customary closing conditions, including securing necessary regulatory approvals.

About Cedars-Sinai Health System

Cedars-Sinai Health System was established in 2017 to bring together a collaborative network of high-quality healthcare institutions to share resources and expertise. Expanding patient access to convenient and affordable clinical care is a fundamental goal of the health system. Currently, the Cedars-Sinai Health System comprises Cedars-Sinai (which includes the 890-bed Cedars-Sinai Medical Center and the 145-bed Cedars-Sinai Marina del Rey Hospital), joint ventures with California Rehabilitation Institute and Cedars-Sinai Providence Tarzana Medical Center, as well as its network of physicians and ambulatory services at more than 40 locations throughout Southern California and Torrance Memorial (which includes the 470-bed Torrance Memorial Medical Center, its network of physicians and medical offices throughout the South Bay). The institutions in the health system serve nearly 2 million people each year.

About Huntington Hospital

Huntington Hospital, www.huntingtonhospital.org, is a 619-bed not-for-profit hospital in Pasadena, California. We are named among the top hospitals in California and nationally ranked in two specialties by U.S. News & World Report. Learn more about us on Facebook www.facebook.com/huntingtonmemorialhospital and on Twitter @huntingtonnews.

Media Contacts

Cedars-Sinai Health System

Duke Helfand
Executive Director, Communications
310-423-4714
duke.helfand@cshs.org

Huntington Hospital

Eileen Neuwirth
Executive Director, Communications and Brand Strategy
(626) 397-5464
eileen.neuwirth@huntingtonhospital.com

Abernathy MacGregor
John Peter Kaytrosh / James Bourne
(213) 630-6550
jp@abmac.com / jab@abmac.com

Exhibit 31-C

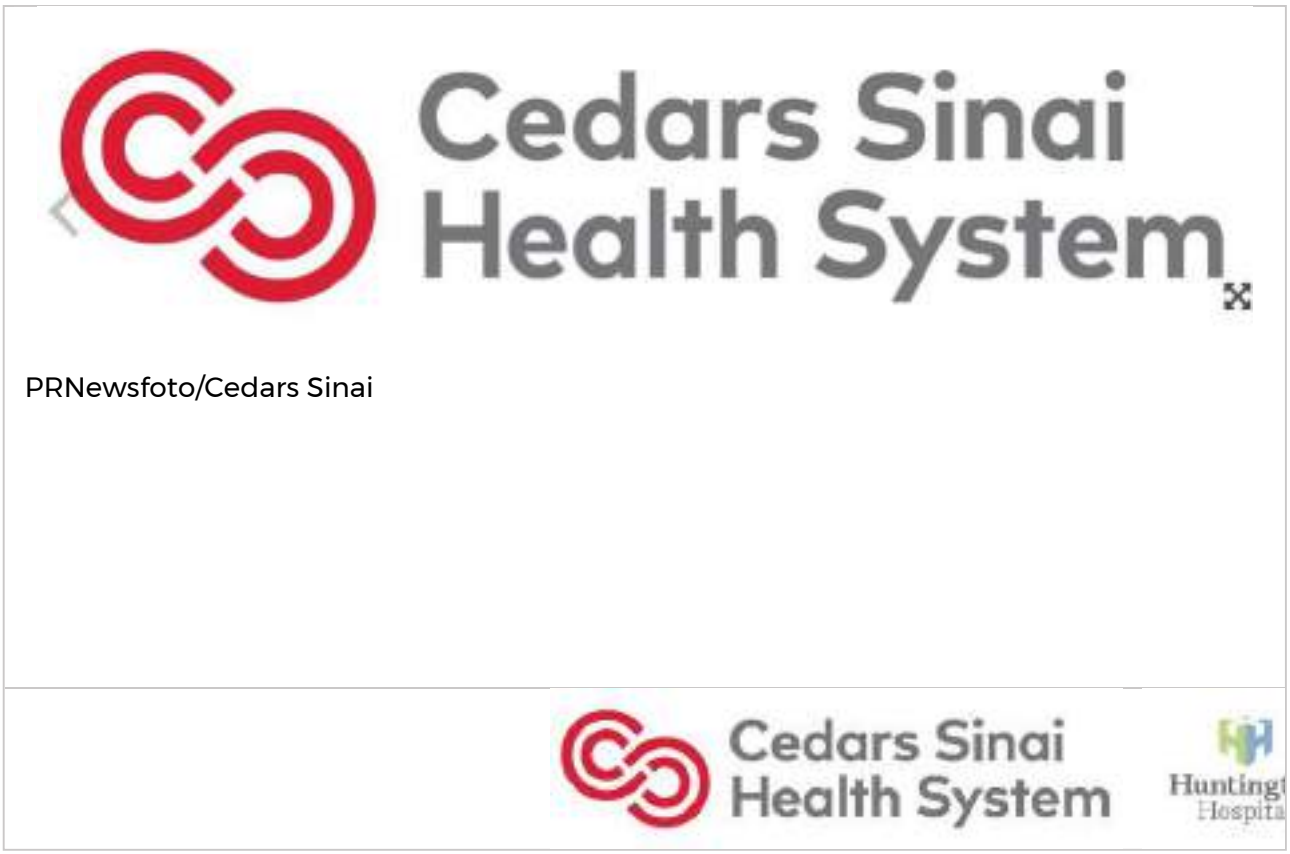
July 16, 2020 Press Release

Huntington Hospital Signs Definitive Agreement to Join Cedars-Sinai Health System

Definitive Agreement Provides for Continued Local Governance, Ongoing Community Commitment

NEWS PROVIDED BY
Huntington Hospital →
Jul 16, 2020, 17:00 ET

LOS ANGELES, July 16, 2020 /PRNewswire/ -- Today Huntington Hospital and Cedars-Sinai Health System announced that they have signed a definitive agreement for Huntington to affiliate with Cedars-Sinai Health System. On March 9, the organizations announced that they had signed a Letter of Intent.



Following the Letter of Intent, both organizations engaged in due diligence and negotiations that led to the definitive agreement. The definitive agreement will now be submitted for review and approval to all the appropriate government regulators, including the Office of the California Attorney General. The review process usually takes several months.

The proposed affiliation includes commitments for continued investment in Huntington Hospital in enterprise information technology, growth of ambulatory services and physician development. It will also enable collaborations with the other entities in the Cedars-Sinai Health System to ensure access to high-quality, accessible and affordable care throughout the region. The proposed affiliation is intended to build upon Huntington's 128-year legacy, and to preserve its unique culture as a community institution governed by a local board, with its own

employees and medical staff. In addition, philanthropy and volunteer support will remain locally controlled and used for Huntington Hospital and its existing community.

Cedars-Sinai Health System was established in 2017 to provide a platform for high-quality health care institutions to collaborate and share resources and expertise. It currently comprises Cedars-Sinai (which includes Cedars-Sinai Medical Center and Cedars-Sinai Marina del Rey Hospital, as well as its network of physicians and medical offices throughout Southern California), Torrance Memorial (which includes Torrance Memorial Medical Center and its network of physicians and medical offices throughout the South Bay), and such joint ventures as California Rehabilitation Institute and Cedars-Sinai Providence Tarzana Medical Center.

"On behalf of everyone at Huntington Hospital, we are all very pleased to have reached this important milestone," said Jaynie Studenmund, chair of the Huntington Hospital Board of Directors. "With the definitive agreement now complete, we can move forward with our joint effort to secure the necessary regulatory approvals. We pledge to work cooperatively with all the relevant parties and believe that this proposed affiliation is in the best interest of all of our stakeholders and the greater San Gabriel Valley community."

"The goal of Cedars-Sinai Health System is to strengthen access to and affordability of quality care for more Southern Californians through the sharing of resources and expertise among our facilities," said Vera Guerin, chair of the Cedars-Sinai Health System Board of Directors. "The addition of Huntington Hospital, with its strong commitment to serving the community and the quality of its physicians, nurses and other staff, would further strengthen the ability to provide this for the region."

"With our institutions' shared focus on delivering exceptional, compassionate care to those we serve, I am confident that an affiliation with Cedars-Sinai Health System will enable Huntington Hospital to advance clinical quality and outcomes, sustain our legacy of providing outstanding patient care and maintain active engagement with all our communities," said Lori J. Morgan, MD, MBA, president and CEO of Huntington Hospital.

"Huntington Hospital is a great fit with Cedars-Sinai Health System, as its focus on meeting the community's needs is aligned with the similar goals of Cedars-Sinai and Torrance Memorial," said Thomas M. Priselac, president and CEO of Cedars-Sinai Health System. "Dr. Morgan and the Huntington board have a great vision for Huntington's future, and we are looking forward to strong collaborations with them."

About Cedars-Sinai Health System

Cedars-Sinai Health System was established in 2017 to bring together a collaborative network of high-quality healthcare institutions to share resources and expertise. Expanding patient access to convenient and affordable clinical care is a fundamental goal of the health system. Currently, the nonprofit Cedars-Sinai Health System comprises Cedars-Sinai (which includes the 890-bed Cedars-Sinai Medical Center and the 145-bed Cedars-Sinai Marina del Rey Hospital), joint ventures with California Rehabilitation Institute and Cedars-Sinai Providence Tarzana Medical Center, as well as its network of physicians and ambulatory services at more than 40 locations throughout Southern California and Torrance Memorial (which includes the 470-bed Torrance Memorial Medical Center, its network of physicians and medical offices throughout the South Bay). The institutions in the health system serve nearly 2 million people each year.

About Huntington Hospital

Huntington Hospital, www.huntingtonhospital.org, is a 619-bed nonprofit hospital in Pasadena, California. The hospital offers the full spectrum of care for

every need, in a variety of settings and through community partnerships. From primary care to urgent care, and from emergency care to trauma care, Huntington Hospital and its partners, ensure that community members receive the right care, in the right place, at the right time. The hospital has received six consecutive 'A' grades by The Leapfrog Group, a national distinction recognizing Huntington Hospital's achievements protecting patients from harm and providing safer health care. Learn more about us on Facebook www.face-book.com/huntingtonmemorialhospital and on Twitter @huntingtonnews.

SOURCE Huntington Hospital

Related Links

http://www.huntingtonhospital.com

Title 11, California Code of Regulations, § 999.5(d)(11)

ADDITIONAL ATTACHMENTS

#32

Title 11, California Code of Regulations, § 999.5(d)(11)(A)

Board minutes or other documents relating or referring to consideration by the Board of Directors of the applicant and any related entity, or any committee thereof of the transaction or of any other possible transaction involving any of the health facilities that are the subject of the transaction

For information regarding the PHA's Board evaluation of potential transactions and selection of Cedars-Sinai and its health system as the best option for an affiliation partner, see the responses to Sections 999.5(d)(1)(C) and 999.5(d)(2)(D).

For information about the consideration of alternative transactions, we will be submitting Letters of Intent from other Interested Parties and related PHA Board presentations evaluating such proposals, follow-up questions sent to Interested Parties by Huntington and responses to those follow-up questions under separate cover to the California Attorney General as a confidential document in accordance with Section 999.5(c)(3).

#33

Title 11, California Code of Regulations, § 999.5(d)(11)(B)

Copies of all documents relating or referring to the reasons why any potential transferee was excluded from further consideration as a potential transferee for any of the health facilities that are the subject of the agreement or transaction

For information regarding the PHA Board's evaluation of potential transactions and selection of Cedars-Sinai as the best option for an affiliation partner, please see the responses to Sections 999.5(d)(1)(C), 999.5(d)(2)(D), and 999.5(d)(11)(A).

#34

Title 11, California Code of Regulations, § 999.5(d)(11)(C)

Copies of all Requests for Proposal sent to any potential transferee, and all responses received

Please see the supporting materials included in response to Section 999.5(d)(2)(D) and Section 999.5(d)(11)(A).

#35

Title 11, California Code of Regulations, § 999.5(d)(11)(D)

All documents reflecting the deliberative process used by the applicant and any related entity in selecting the transferee as the entity to participate in the proposed agreement or transaction

For information regarding the PHA Board's evaluation of potential transactions and selection of Cedars-Sinai as the best option for an affiliation partner, please see the responses to Sections 999.5(d)(1)(C), 999.5(d)(2)(D), and 999.5(d)(11)(A).

#36

Title 11, California Code of Regulations, § 999.5(d)(11)(E)

Copies of each Proposal received by the applicant from any potential transferee suggesting the terms of a potential transfer of Applicant's health facilities, and any analysis of each such Proposal

Please see the supporting materials included in response to Section 999.5(d)(2)(D) and Section 999.5(d)(11)(A).

#37

Title 11, California Code of Regulations, § 999.5(d)(11)(F)

The Applicant's prior two annual audited financial statements, the Applicant's most current unaudited financial statement, business projection data, and current capital asset valuation data

1. Attached to this Section 999.5(d)(11)(F) as **Exhibit 37-A** are PHA's 2019 audited financial statements. Note 7 appearing on page 30 contains current capital asset valuation data.

2. Attached to this Section 999.5(d)(11)(F) as **Exhibit 37-B** are PHA's 2018 audited financial statements.

3. Attached to this Section 999.5(d)(11)(F) as **Exhibit 37-C** are PHA's unaudited consolidated financial statements for the first quarter of 2020.

PHA's business projection data will be submitted under separate cover as a confidential document in accordance with Section 999.5(c)(3).

Exhibit 37-A

PHA's 2019 Audited Financial Statements

Consolidated Financial Statements and Supplementary Information

Collis P. and Howard Huntington Memorial Hospital Trust,
Pasadena Hospital Association, Ltd. and Affiliates
Years Ended December 31, 2019 and 2018
With Report of Independent Auditors

Ernst & Young LLP



Collis P. and Howard Huntington Memorial Hospital Trust,
Pasadena Hospital Association, Ltd. and Affiliates

Consolidated Financial Statements and Supplementary Information

Years Ended December 31, 2019 and 2018

Contents

Report of Independent Auditors 1

Consolidated Financial Statements

Consolidated Balance Sheets 3
Consolidated Statements of Operations 5
Consolidated Statements of Changes in Net Assets 6
Consolidated Statements of Cash Flows 7
Notes to Consolidated Financial Statements 8

Supplementary Information

Consolidating Balance Sheets 52
Consolidating Statements of Operations and Changes in Net Assets Without Donor Restrictions 54

Building a better working world

Ernst & Young LLP
Suite 500
725 South Figueroa Street
Los Angeles, CA 90017-5418

Tel: +1 213 977 3200
Fax: +1 213 977 3152
ey.com

Report of Independent Auditors

The Board of Trustees
The Collis P. and Howard Huntington Memorial Hospital Trust,
Pasadena Hospital Association, Ltd. and Affiliates

We have audited the accompanying consolidated financial statements of the Collis P. and Howard Huntington Memorial Hospital Trust, Pasadena Hospital Association, Ltd. and Affiliates which comprise the consolidated balance sheets as of December 31, 2019 and 2018, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

A member firm of Ernst & Young Global Limited

Building a better working world

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of the Collis P. and Howard Huntington Memorial Hospital Trust, Pasadena Hospital Association, Ltd. and Affiliates at December 31, 2019 and 2018, and the consolidated results of their operations and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Adoption of Accounting Standards Update No. 2016-02, *Leases* (Topic 842)

As discussed in Note 2 to the consolidated financial statements, the Collis P. and Howard Huntington Memorial Hospital Trust, Pasadena Hospital Association, Ltd. and Affiliates changed their method for accounting for leases as a result of the adoption of the amendments to the Financial Accounting Standards Board Accounting Standards Codification resulting from Accounting Standards Update No. 2016-02, *Leases* (Topic 842), effective January 1, 2019. Our opinion is not modified with respect to this matter.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying consolidating balance sheets and statements of operations and changes in net assets without donor restrictions are presented for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Ernst & Young LLP

April 29, 2020

A member firm of Ernst & Young Global Limited

Collis P. and Howard Huntington Memorial Hospital Trust,
Pasadena Hospital Association, Ltd. and Affiliates

Consolidated Balance Sheets
(In Thousands)

	December 31	
	2019	**2018**
Assets		
Current assets:		
Cash and cash equivalents	**$ 46,391**	$ 21,258
Investments:		
Short-term investments	**416,915**	372,556
Held in trust for current debt service	**9,435**	9,561
Total investments	**426,350**	382,117
Accounts receivable:		
Patient accounts receivable	**102,972**	108,187
Provider fee receivable	**52,791**	42,349
Estimated settlements from third-party payors	**5,344**	6,631
Total accounts receivable	**161,107**	157,167
Inventories	**14,184**	15,237
Prepaid expenses and other	**28,362**	25,769
Total current assets	**676,394**	601,548
Investments restricted or designated for specific purposes:		
Held in trust under bond master indenture	**66,129**	114,680
Designated by Board for specific purposes	**63,530**	62,948
Donor restricted for capital expenditures or to provide a permanent source of income	**57,211**	58,627
Interest in charitable remainder annuity trusts	**11,163**	10,069
Total investments restricted or designated for specific purposes	**198,033**	246,324
Property, plant, and equipment, net	**587,749**	508,728
Operating lease right-of-use assets	**59,990**	–
Other assets:		
Goodwill	**10,006**	10,006
Other noncurrent assets	**21,201**	12,311
Total assets	**$ 1,553,373**	$ 1,378,917

	December 31	
	2019	**2018**
Liabilities and net assets		
Current liabilities:		
Accounts payable	**$ 51,640**	$ 39,907
Current maturities of long-term debt	**7,780**	4,734
Current portion of accrued self-insurance claims	**6,898**	8,720
Accrued payroll and employee benefits	**36,781**	35,364
Current portion of operating lease liability	**7,417**	–
Accrued provider fee	**45,379**	31,675
Other accrued liabilities	**14,117**	17,832
Revolving credit line	**18,000**	–
Total current liabilities	**188,012**	138,232
Long-term debt, less current maturities	**318,564**	316,537
Accrued pension liability	**75,292**	66,022
Accrued self-insurance claims, less current portion	**20,036**	18,474
Long-term operating lease liability	**52,573**	–
Other	**4,002**	5,030
Total liabilities	**658,479**	544,295
Net assets:		
Without donor restrictions	**771,259**	722,252
With donor restrictions	**123,635**	112,370
Total net assets	**894,894**	834,622
Total liabilities and net assets	**$ 1,553,373**	$ 1,378,917

See accompanying notes.

Collis P. and Howard Huntington Memorial Hospital Trust,
Pasadena Hospital Association, Ltd. and Affiliates

Consolidated Statements of Operations
(In Thousands)

	Year Ended December 31	
	2019	**2018**
Revenues without donor restrictions:		
Patient service revenues	**$ 659,859**	$ 658,228
Contributions	**4,887**	8,839
Other	**40,931**	41,632
Net assets released from restrictions	**4,909**	5,182
Total revenue without donor restrictions	**710,586**	713,881
Expenses:		
Salaries and benefits	**385,243**	381,865
Supplies and purchased services	**218,100**	209,653
Provider fee expense	**45,379**	43,701
Depreciation and amortization	**36,297**	34,272
Interest	**8,064**	6,758
Other expenses	**45,992**	40,804
Total expenses	**739,075**	717,053
Deficiency of revenues over expenses before other income and expense	**(28,489)**	(3,172)
Other income and expense:		
Investment income (loss)	**71,774**	(27,855)
Other	**(1,557)**	(2,448)
Excess (deficiency) of revenues over expenses	**$ 41,728**	$ (33,475)

See accompanying notes.

Collis P. and Howard Huntington Memorial Hospital Trust, Pasadena Hospital Association, Ltd. and Affiliates

Consolidated Statements of Changes in Net Assets
(In Thousands)

	Net Assets		
	Without Restrictions	**With Restrictions**	**Total**
Balances at January 1, 2018	$ 757,112	$ 111,302	$ 868,414
Deficiency of revenues over expenses	(33,475)	–	(33,475)
Assets released from restrictions for capital purposes	1,903	(1,903)	–
Contributions and grants	–	11,531	11,531
Net investment loss	–	(3,378)	(3,378)
Net assets released from restrictions used for operations included in other income	–	(5,182)	(5,182)
Change in pension liability	(3,261)	–	(3,261)
Other	(27)	–	(27)
Change in net assets	(34,860)	1,068	(33,792)
Balances at December 31, 2018	722,252	112,370	834,622
Excess of revenues over expenses	**41,728**	**–**	**41,728**
Assets released from restrictions for capital purposes	**11,245**	**(11,245)**	**–**
Contributions and grants	**–**	**14,413**	**14,413**
Net investment income	**–**	**13,006**	**13,006**
Net assets released from restrictions used for operations	**–**	**(4,909)**	**(4,909)**
Change in pension liability	**(6,346)**	**–**	**(6,346)**
Other	**2,380**	**–**	**2,380**
Change in net assets	**49,007**	**11,265**	**60,272**
Balances at December 31, 2019	**$ 771,259**	**$ 123,635**	**$ 894,894**

See accompanying notes.

Collis P. and Howard Huntington Memorial Hospital Trust, Pasadena Hospital Association, Ltd. and Affiliates

Consolidated Statements of Cash Flows
(In Thousands)

	Year Ended December 31	
	2019	**2018**
Operating activities		
Change in net assets	**$ 60,272**	$ (33,792)
Adjustments to reconcile change in net assets to net cash (used in) provided by operating activities:		
Unrealized (gains) losses on investments	**(71,544)**	50,060
Depreciation and amortization	**36,297**	34,272
Other	**(118)**	(769)
Contributions restricted for capital expenditures	**(9,799)**	(5,627)
Changes in operating assets and liabilities:		
Accounts receivable	**(3,941)**	4,864
Prepaids, inventories, and other current assets	**(1,539)**	(3,278)
Other assets and liabilities	**(11,671)**	(3,257)
Accounts payable and accrued expenses	**13,188**	(3,137)
Accrued pension liability	**9,270**	(819)
Net cash provided by operating activities	**20,415**	38,517
Investing activities		
Purchases of property, plant, and equipment	**(94,665)**	(50,830)
Decrease (increase) in investments – restricted for capital expenditures as required by bond issuance	**49,322**	(81,468)
Other net purchases and sales of investments	**27,373**	(6,820)
Net change in cash equivalents reported in long-term investments	**(81,258)**	103,566
Change in interest in charitable remainder annuity trusts	**(1,094)**	1,872
Net cash used in investing activities	**(100,322)**	(33,680)
Financing activities		
Proceeds from borrowings under revolving line of credit	**18,000**	–
Repayment of revolving line of credit	**–**	(9,664)
Proceeds from issuance of long-term debts	**–**	108,842
Payments on other long-term debt	**(1,440)**	(3,290)
Payments on finance leases	**(2,577)**	(1,098)
Contributions restricted for capital expenditures	**9,799**	5,627
Net cash provided by financing activities	**23,782**	100,417
(Decrease) increase in cash, cash equivalents and restricted cash	**(56,125)**	105,254
Cash, cash equivalents and restricted cash at beginning of year	**189,733**	84,479
Cash, cash equivalents and restricted cash at end of year	**$ 133,608**	$ 189,733
Supplemental disclosure of cash flow information		
Cash paid during the year for:		
Interest	**$ 8,908**	$ 3,731
Supplemental disclosure of noncash transactions		
Assets acquired through finance leases and other financing agreements	**$ 10,963**	$ 2,813
Accounts payable accruals for property, plant and equipment	**$ 9,691**	$ 5,759

See accompanying notes.

Collis P. and Howard Huntington Memorial Hospital Trust,
Pasadena Hospital Association, Ltd. and Affiliates

Notes to Consolidated Financial Statements

December 31, 2019

1. Organization

In 1892, Pasadena Hospital Association, Ltd, now doing business as Huntington Hospital (HH or the Hospital), was formed with the goal of providing a hospital for the people of Pasadena, California. In 1936, Pasadena Hospital Association, Ltd. agreed to transfer control when the land and facilities of the Hospital were acquired and became the hospital provided for under the terms of the Collis P. and Howard Huntington Memorial Hospital Trust (the Trust).

HMH is a California nonprofit public benefit corporation and an organization exempt from federal and state income taxes under Section 501(c)(3) of the Internal Revenue Code. The Trust is a charitable trust, registered with the Registry of Charitable Trusts pursuant to the Supervision of Trustees and Fundraisers for Charitable Purposes Act. The Trust was established in 1932 under the terms of the will of Mr. Henry E. Huntington. The bequest was invested and loaned by the Trustees for the purpose of making the best available profit thereon so as to yield income for the perpetual maintenance of HH. The five Trustees of the Trust and their successors serve for life. The Trust exercises influence on HH by means of the Hospital's bylaws, which provide that the Trustees serve on HH's 25-member board of directors and that any significant transaction must be approved by a majority of the Trustees and HH's board members. The Trustees actively participate in the Hospital's affairs and serve on its key committees.

The Trust owns the real property on which HH is located. In addition to this property, the Trust has other properties and investments. In fulfillment of the will of Mr. Henry E. Huntington, these assets are held to produce a return to be used for the benefit of HH's programs.

The Trust and the following organizations (collectively, the Group) are included in the accompanying consolidated financial statements.

HH operates a hospital and medical center. HH is the sole corporate member of the Huntington Medical Foundation (Foundation) and is the parent of the for-profit subsidiary, Congress Services Corporation (Congress).

The Foundation is organized as a 1206(l) clinic operated by HH that conducts medical research and health education and provides health care to its patients through a group of physicians who are independent contractors.

Congress is a California for-profit corporation, which has interests in joint ventures that perform a variety of health care services, including outpatient surgery and outpatient imaging.

2. Summary of Significant Accounting Policies

Principles of Consolidation

All intercompany balances and transactions among the Group have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates.

Concentrations of Credit Risk

Financial instruments that potentially subject the Group to concentrations of credit risk consist primarily of cash and cash equivalents, investments, and patient accounts receivable. The Group may be exposed from time to time to credit risk with bank deposits in excess of the Federal Deposit Insurance Corporation insurance limits. There have been no losses in such accounts, and management does not believe that credit risk on cash and cash equivalents is significant. By policy, the Group limits the amount of its credit exposure by defining the types of investments that may be held and the percentage of the investment portfolio that may be maintained in any given investment type.

Cash and Cash Equivalents

The Group considers all highly liquid debt instruments with maturities, on the acquisition date, of three months or less to be cash equivalents. Cash equivalents are recorded at fair value in the consolidated balance sheet and exclude amounts held for long-term investment purposes and amounts included in long-term investment portfolios as those amounts are commingled with long-term investments.

2. Summary of Significant Accounting Policies (continued)

The reconciliation of cash, cash equivalents and restricted cash within the consolidated balance sheets that comprise the amount reported on the consolidated statements of cash flows at December 31, 2019 and 2018 is as follows:

	2019	2018
	(In Thousands)	
Cash and cash equivalents	**$ 46,391**	$ 21,258
Investments for current use	**87,103**	168,468
Restricted cash in investments	**114**	7
Total cash, cash equivalents and restricted cash	**$ 133,608**	$ 189,733

Investments for current use includes restricted cash deposits with the trustee to fund current principal and interest payments on debt and various programs.

Investments

Investments in equity securities and mutual funds with readily determinable fair values and all investments in debt securities are measured at fair value on the consolidated balance sheets. Management determines the appropriate classification of all marketable securities at the date of purchase and re-evaluates such designations at each balance sheet date. The Group designated all of its investment portfolio at December 31, 2019 and 2018, as trading securities. Accordingly, unrealized gains or losses on marketable securities are reported as investment income. In addition, cash flows from the purchases and sales of the Group's investment portfolio designated as trading are reported as a component of investing activities.

Inventories

Inventories, primarily supplies and pharmaceuticals, are recorded at cost (by the first-in, first-out method), which is not in excess of net realizable value.

2. Summary of Significant Accounting Policies (continued)

Investments Designated by Board for Specific Purposes

Investments designated by the Board of Directors for specific purposes include specific unrestricted gifts and investment earnings for the acquisition and development of property, plant, equipment, and patient and senior care over which the Board retains control and may, at its discretion, subsequently use for other purposes.

Property, Plant, and Equipment

Property, plant, and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable assets, which ranges from 2 to 65 years and is computed using the straight-line method. Equipment under finance lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the consolidated financial statements. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. Repair and maintenance costs are expensed in the period incurred.

Gifts of long-lived assets such as land, buildings, or equipment are reported as support without donor restrictions, and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as support with donor restrictions. Absent explicit donor stipulations about how long those long-lived assets must be maintained; expirations of donor restrictions are reported as net assets released from restrictions when the donated or acquired long-lived assets are placed in service.

Long-Lived Asset Impairment

Situations may arise where the carrying value of a long-lived asset may exceed the undiscounted value of the expected cash flows associated with that asset. In such circumstances, the asset is impaired. The Group reviews its long-lived assets for impairment on an annual basis, as well as when events or changes in business conditions suggest potential impairment. Impaired assets are written down to fair value. The Group determined that no long-lived assets were impaired at December 31, 2019 or 2018.

2. Summary of Significant Accounting Policies (continued)

Goodwill

The Group's goodwill is the result of the acquisition by the Group of a controlling interest in a surgery center in March 2012. The Group tests the carrying value of goodwill for impairment on an annual basis, or more frequently if indicators of impairment exist. The Group performed a qualitative assessment for its annual impairment assessment in 2019 and determined that no impairment existed.

Accrued Self-Insurance Claims

The Group is self-insured for certain employee health care claims. The Group accrues employee health care claims, including management's estimate of incurred but not reported claims, based on the Group's claims experience. Such accruals totaled $2.0 million and $2.2 million for December 31, 2019 and December 31, 2018, respectively.

The Group purchases reinsurance policies to insure for workers' compensation claims incurred above the self-insured retention (SIR) limits per claim. The policies have limits of $1.0 million per occurrence and in aggregate. Accruals for SIR risks are estimated by an actuary based on the Group's claims experience and were discounted at 2.5% in 2019 and 2018. Such accruals totaled $16.2 million and $16.6 million at December 31, 2019 and 2018, respectively. The accruals represent the total actuarially determined liability. The portion that is expected to be recoverable through reinsurance ($2.5 million and $2.7 million at December 31, 2019 and 2018, respectively) is included in prepaid expenses and other assets.

The Group purchases claims-made insurance policies to insure for professional (malpractice) and general liability claims reported above the SIR limits per claim. The policies have limits of $30.0 million per occurrence and $40.0 million in aggregate. Accruals for SIR risks are estimated by an actuary based on the Group's claims experience and were discounted at 2.5% in 2019 and 2018. Such accruals totaled $9.1 million and $8.4 million at December 31, 2019 and 2018, respectively. The accruals represent the total actuarially determined liability. The portion that is expected to be recoverable through reinsurance ($2.6 million and $1.0 million at December 31, 2019 and 2018, respectively) is included in prepaid expenses and other assets.

2. Summary of Significant Accounting Policies (continued)

Net Assets with Donor Restrictions

Net assets with donor restrictions are those whose use by the Group has been restricted by donors to a specific time period or purpose or those whose use has been restricted by donors and are to be maintained by the Group in perpetuity.

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as net assets with donor restrictions if they are received with donor stipulations that restrict the use of the donated assets. When a donor restriction expires – that is, when a stipulated time restriction ends or purpose restriction is accomplished – net assets with donor restrictions are reclassified as net assets without donor restrictions and reported as Net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reflected as contributions without donor restrictions. Net assets released for use in operations are included in excess of revenues over expenses, while net assets released for acquisition of property and equipment are excluded from excess of revenues over expenses and recorded as an increase in net assets without donor restrictions.

The Group is a beneficiary of several split-interest agreements, primarily charitable remainder annuity trusts (CRATs) held by others. The Group recognizes its interest in these trusts as net assets with donor restrictions based on the Group's interest in the fair value of assets and the net present value of future payment obligations of the trust.

Patient Service Revenues and Patient Account Receivable

Patient service revenue is reported at the amount that reflects the consideration to which the Group expects to be entitled in exchange for providing patient care. These amounts, representing transaction price, are due from third-party payors (including health insurers and government programs), patients and others and include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Group bills the third-party payors and patients several days after the services are performed and/or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

2. Summary of Significant Accounting Policies (continued)

Performance obligations are determined based on the nature of the services provided by the Group. Generally, performance obligations satisfied over time apply to patients in the hospital receiving inpatient acute care services only. The Group measures the performance obligation from admission into the hospital to the point when the medical condition upon admission has been resolved and it is no longer required to provide services to that patient, usually at the time of discharge. Revenue for performance obligations satisfied over time is recognized pro-rata based on actual charges incurred in relation to total expected (or actual) charges upon discharge. The Group believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the services provided needed to satisfy the obligation.

Because all of its performance obligations relate to contracts with a duration of less than one year, the Group has elected to apply the optional exemption provided in Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 606-10-50-14(a) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs on average within a week of the end of the reporting period.

The Group is utilizing the portfolio approach practical expedient in ASC 606 for contracts related to patient service revenue. The Group accounts for the contracts within each portfolio as a collective group, rather than individual contracts, based on the payment pattern expected in each portfolio category and the similar nature and characteristics of the patients within each portfolio.

As a result, the Group has concluded that revenue for a given portfolio would not be materially different than if accounting for revenue on a contract-by-contract basis.

The Group has agreements with third-party payors that generally provide for payments to the Group at amounts different from its established rates. For patients who do not qualify for charity care, the Group recognizes revenue based on established or contracted rates, subject to certain discounts and implicit price concessions as determined by the Group. The Group determines the transaction price based on standard charges for services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Group’s policy, and implicit price concessions provided to patients. Implicit price

2. Summary of Significant Accounting Policies (continued)

concessions represent differences between amounts billed and the estimated consideration the Group expects to receive from payors and patients, which are determined based on historical collection experience, current market conditions and other factors. The Group determines its estimates of contractual adjustments and discounts based on contractual agreements, discount policies, and historical experience.

Generally, patients who are covered by third-party payors are responsible for patient responsibility balances, including deductibles and coinsurance established by their insurance plans, which vary in amount. The Group estimates the transaction price for patients with deductibles and coinsurance based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period such changes occur or it can be reasonably determined such change is probable. Adjustments arising from a change in the transaction price were not significant in the years ended December 31, 2019 and 2018.

The Group is paid a prospectively determined rate for the majority of inpatient acute care and outpatient services provided (principally Medicare, Medicaid, and certain insurers). These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. In addition, the Group is paid by Medicare for certain add-on payments such as medical education training costs and disproportionate share at a tentative rate, with final settlement determined after submission of annual cost reports by the Group and audits thereof by the Medicare Administrative Contractor.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation as well as significant regulatory action, and, in the normal course of business, the Group is subject to contractual reviews and audits, including audits initiated by the Medicare Recovery Audit Contractor program. As a result, there is at least a reasonable possibility that recorded estimates will change in the near term. The Group believes it is in compliance with applicable laws and regulations governing the Medicare and Medicaid programs and that adequate provisions have been made for any adjustments that may result from final settlements.

2. Summary of Significant Accounting Policies (continued)

Settlements with third-party payors for retroactive adjustments due to reviews and audits are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care in the period the related services are provided or when results of audits and appeals can reasonably be determined or finalized. These settlements are estimated based on the terms of the payment agreement with the payor, regulations, notification from the payor and the Group's historical settlement activity, including an assessment to establish that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as new or revised information become known or as years are settled or are no longer subject to such reviews and audits. Adjustments arising from a change in the transaction price were not significant for the years ended December 31, 2019 or 2018.

The Group has elected the practical expedient allowed under FASB ASC 606-10-32-18 and does not adjust the promised amount of consideration from patients and third-party payors for the effects of a significant financing component due to the Group's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payor pays for that service will be one year or less. However, the Group does, in certain instances, enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

The Group entered into a restructured, shared savings contractual agreement with a local medical group that receives professional and institutional at-risk capitation funding. This agreement establishes rates that include a monthly fixed institutional-based fee and claims-based rate for care provided to both commercial and Medicare Advantage members. Patient service revenue attributed to this medical group totaled $148.5 million and $127.2 million in 2019 and 2018, respectively.

Charity Care and Unreimbursed Cost of State Programs

HMH provides care without charge to patients who meet certain criteria under its financial assistance policy. Because HMH does not pursue collection of amounts determined to qualify as charity care, they are not reported as patient service revenues. Unreimbursed costs of charity care provided to the uninsured and patients in state and federal programs totaled approximately $3.1 million and $4.4 million in 2019 and 2018, respectively. The cost of uncompensated care is derived from the cost accounting system taking into account the cost of resources used such as labor, supplies, drugs, and equipment to provide the care.

2. Summary of Significant Accounting Policies (continued)

In addition, in 2019 and 2018, the unreimbursed costs (unaudited) of non-charity care provided to patients in state programs, including the Medi-Cal program or enrolled in HMO and PPO plans under contract with the Medi-Cal program, are estimated by management to be approximately $34.0 million and $33.1 million, respectively.

California Hospital Quality Assurance Fee Program

In 2010, California legislation established a program that imposes a Hospital Quality Assurance (QA) Fee on certain general acute care hospitals in order to make supplemental and grant payments and increased capitation payments (Supplemental Payments) to hospitals up to the aggregate upper payment limit for various periods.

The California Hospital Quality Assurance (CHQA) Programs are designed to make supplemental inpatient and outpatient Medi-Cal payments to private hospitals, including additional payments for certain facilities that provide high-acuity care and trauma services to the Medi-Cal population.

The CHQA Programs provide a mechanism for increasing payments to hospitals that serve Medi-Cal patients, with no impact on the state's General Fund. Some of these payments will be made directly by the state, while others will be made by Medi-Cal managed care plans, which will receive increased capitation rates from the state in amounts equal to the Supplemental Payments. Outside of the legislation, the California Hospital Association has created a private program, operated by the California Health Foundation and Trust (CHFT), which was established to alleviate disparities potentially resulting from the implementation of the CHQA Programs and, therefore, resulted in pledges of grant income to these hospitals.

There are three CHQA programs that had activity in 2019 and 2018: a 36-month hospital fee program covering the period from January 1, 2014 through December 31, 2016, a 30-month hospital fee program covering the period from January 1, 2017 through June 30, 2019, and a 30-month hospital fee program coving the period from July 1, 2019 through December 30, 2021. Patient service revenues and provider fee expenses include amounts for the CHQA program as follows:

2. Summary of Significant Accounting Policies (continued)

For the years ended December 31:

	2019	2018
	(In Thousands)	
CHQA program revenue	**$ 44,005**	$ 47,354
CHQA program expense	**(45,379)**	(43,701)
(Loss) income from operations from CHQA program	**$ (1,374)**	$ 3,653
2019-2021 hospital fee program summary (30 months)	**$ 335**	$ –
2017-2019 hospital fee program summary (30 months)	**(1,714)**	2,005
2014-2016 hospital fee program summary (30 months)	**5**	1,648
Total	**$ (1,374)**	$ 3,653

Contributions

Contributions without donor restrictions or those released from donor restrictions in a given year generated from the Group's philanthropy operations, along with the related expenses, are included in total revenues and expenses.

Excess (Deficiency) of Revenues over Expenses

The consolidated statements of operations include the excess (deficiency) of revenues over expenses, which is considered the performance indicator. Changes in net assets without donor restrictions that are excluded from the excess (deficiency) of revenues over expenses, consistent with industry practice, primarily include contributions of long-lived assets (including assets acquired using contributions that by donor restrictions were to be used for the purposes of acquiring such assets) and changes in pension liabilities.

2. Summary of Significant Accounting Policies (continued)

Income Taxes

HMH has been determined to qualify as exempt from federal and state income taxes under Section 501(a) as organizations described in Section 501(c)(3) of the Code. Most of the income received by the Group is exempt from taxation, as income related to the mission of the organization. Accordingly, there is no material provision for income taxes for these entities.

However, some of the income received by the exempt entities is subject to taxation as unrelated business income. The Group and its affiliates file federal and state income tax returns.

The Group completed an analysis of its tax positions, in accordance with ASC 740, *Income Taxes*, and determined that there are no uncertain tax positions taken or expected to be taken. The Group has recognized no interest or penalties related to uncertain tax positions. The Group is subject to routine audits by the taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The Group believes it is no longer subject to income tax examinations for years prior to 2016.

Subsequent Events

On March 9, 2020, Pasadena Hospital Association, Ltd. signed a letter of intent to affiliate with Cedars-Sinai Health System. The letter includes commitments for continued investment in the Hospital – in enterprise information technology, ambulatory services and physician development. A definitive agreement is being negotiated and completion of the affiliation is subject to customary closing conditions, including securing necessary regulatory approvals.

On April 24, 2020, the Group extended its $30.0 million line of credit agreement until April 23, 2021 and entered into an additional revolving credit facility in the amount of $50.0 million with the same institution, also maturing on April 23, 2021. The full amount of $30.0 million and $50.0 million were subsequently drawn down on April 24, 2020.

Due to the global viral outbreak caused by Coronavirus Disease 2019 (COVID-19) in 2020, there have been resulting effects which could negatively impact the Group's financial condition, including significant stock market exchange volatility, various temporary volatility trading halts, which commenced initially on March 9, 2020 due to market declines, various temporary business closures and event cancellations, and other effects which have resulted in supply disruptions and deferrals of elective procedures and other medical treatments at the Hospital as the broader

2. Summary of Significant Accounting Policies (continued)

economic impact of COVID-19 develops. The Group is the recipient of significant relief funding from U.S. Department of Health and Human Services (HHS) and forward funding from Centers for Medicare & Medicaid Services (CMS). Along with the increased borrowing capacity under its line of credit and existing investments, the Group believes it has sufficient liquidity in place during the pandemic to maintain operational capacity. The ultimate impact of these matters to the Hospital and its financial condition is presently unknown. The accompanying consolidated financial statements as of and for the year ended December 31, 2019 do not reflect the effects of these subsequent events.

The Group evaluated subsequent events through April 29, 2020, which is the date these consolidated financial statements were issued.

Recently Adopted Accounting Guidance

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842),* which amends the existing accounting standards for lease accounting, including requiring lessees to recognize most leases on their balance sheets and making targeted changes to lessor accounting. The new standard, effective on January 1, 2019, requires a modified retrospective transition approach for all leases existing at, or entered into after, the date of initial application, with an option to use certain transition relief and allows for early adoption on January 1, 2017. In July 2018, the FASB issued ASU 2018-08, *Leases (Topic 842): Targeted Improvements,* which further amended this standard to allow for a new transition method that provides the option to use the effective date as the date of initial application.

The Group adopted the new standard on January 1, 2019, which allows for a modified retrospective transition approach, applying the new standard to all leases existing at the date of initial adoption. The Group elected the alternative transition method, which allows for a cumulative effect adjustment in the period of adoption, and prior periods are not restated and continue to be reported in accordance with historic accounting under ASC 840 *Leases.* In addition, the Group has elected the package of practical expedients permitted under the transition guidance of the new standard to not reassess prior conclusions related to contracts that contain leases, lease classification and initial direct costs. The primary effect of adopting the new standard was to record right-of-use assets and the corresponding present value of lease obligations liabilities for current operating leases. Adoption of the new standard resulted in the recording of operating right-of-use assets of $63.0 million and operating lease liabilities of $63.0 million as of January 1, 2019. The adoption of the lease standard did not result in a cumulative catch-up adjustment to beginning net assets.

2. Summary of Significant Accounting Policies (continued)

In March 2017, the FASB issued ASU No. 2017-07, *Compensation – Retirement Benefits (Topic 745): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. The new guidance requires entities to 1) disaggregate the current-service-cost component from the other components of net benefit cost and present it with other current compensation costs for related employees in the income statement and 2) present the other components elsewhere in the income statement and outside of income from operations if that subtotal is presented. In addition, entities are required to disclose the income statement lines that contain the other components if they are not presented on appropriately described separate lines.

The Group adopted the guidance in January 2019 and the change did not have a material effect on its consolidated statements.

In June 2018, the FASB issued ASU No. 2018-08, *Not-for-Profit Entities – Clarifying the Scope and Accounting Guidance for Contributions Received and Contributions Made* (Topic 958). This ASU provides a more robust framework to determine when a transaction should be accounted for as a contribution or as an exchange transaction and provides additional guidance about how to determine whether a contribution is conditional. The Group adopted the new standard in January 2019 and the change did not have a material effect on its consolidated financial statements.

In January 2017, the FASB issued ASU 2017-04, *Intangibles – Goodwill and Other (Topic 350)* that eliminates the requirement to calculate the implied fair value of goodwill (i.e., Step 2 of today's goodwill impairment test) to measure goodwill impairment charges. Instead, entities would record an impairment charge based on the excess of a reporting unit's carrying amount over its fair value (i.e., measure the charge based on today's Step 1). All other goodwill impairment guidance would remain unchanged. The new standard, effective on January 1, 2021, requires prospective application. Early adoption is permitted for interim or annual goodwill impairment tests performed on testing dates after January 1, 2017. The Group adopted the new standard in 2019 and the change in calculation did not have a material effect on its consolidated financial statements.

The FASB issued final guidance that may change how an entity classifies certain cash receipts and cash payments on its statement of cash flows. The new guidance, ASU No. 2016-15 and 2016-18, *Statement of Cash Flows (Topic 230),* addresses certain issues where diversity in practice was identified. The guidance will be applied retrospectively and is effective for fiscal years beginning after December 15, 2018. The Group adopted the guidance as of January 1, 2019 and has applied such guidance retroactively to 2018 in its consolidated statements of cash flows.

2. Summary of Significant Accounting Policies (continued)

New Accounting Standards Not Yet Adopted

In August 2018, the FASB issued ASU No. 2018-13, *Fair Value Measurement* (Topic 820). This ASU improves the effectiveness of the notes to financial statements through changes in the disclosure requirements for fair value measurement. The ASU is effective January 1, 2020, and will be applied using a retrospective approach. The Group does not expect that ASU 2018-13 will have a material effect on its consolidated financial statements.

In August 2018, the FASB issued ASU 2018-14, *Compensation – Retirement Benefits – Defined Benefit Plans – General*. This standard intends to make minor changes to the disclosure requirements for employers that sponsor defined benefit pension and other postretirement benefit plans. The amendments in this standard remove disclosures that no longer are considered cost beneficial, clarify the specific requirements of disclosures, and add disclosure requirements identified as relevant. ASU 2018-14 is effective for the Group for annual reporting periods beginning after December 15, 2021, with early adoption permitted. Upon adoption, the Group is required to apply the new standard retrospectively to all periods presented in the consolidated financial statements. The Group is currently evaluating the impact that ASU 2018-14 will have on its consolidated financial statements and will adopt the provisions on or before the effective date.

In August 2018, the FASB issued ASU No. 2018-15, *Intangibles – Goodwill and Other, Internal-Use Software (Subtopic 350-40), Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract*. This ASU aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. The ASU is effective January 1, 2021, and will be applied using a prospective approach. The Group is currently evaluating the impact that ASU 2018-15 will have on its consolidated financial statements and will adopt the provisions on or before the effective date.

3. Patient Accounts Receivable

Patient service revenue by major payor source for the years ended December 31 are as follows:

	2019	2018
	(In Thousands)	
Government (excluding provider fee)	**$ 170,361**	$ 179,970
Contracted and others	**441,497**	427,721
Self-pay	**3,996**	3,183
Patient service revenues, excluding provider fee	**615,854**	610,874
Provider fee revenue	**44,005**	47,354
Patient service revenues	**$ 659,859**	$ 658,228

Concentrations of credit risk with respect to patient accounts receivable are limited, except with respect to larger insurers' programs under contract with federal and state governments, due to the large number of payors comprising the Group's patient base. With respect to larger insurers, patient accounts receivable was comprised of amounts due from Anthem Blue Cross, Blue Shield and LA Care of $15.1 million, $11.9 million and $6.1 million, respectively, at December 31, 2019 and $13.1 million, $12.6 million and $3.7 million at December 31, 2018, respectively. With respect to programs under contract with federal and state governments, patient accounts receivable due directly or indirectly from Medicare and Medi-Cal were $23.6 million and $14.1 million, respectively, at December 31, 2019, and $23.8 million and $16.6 million, respectively, at December 31, 2018.

During the year ended December 31, 2019, the Group recorded a decrease of $17.1 million in patient revenue resulting from changes in estimates related to the collectability of patient service revenue earned prior to January 1, 2019. This change in estimate resulted from temporary challenges in revenue cycle processes that became more fully apparent after the issuance of the December 31, 2018 audited consolidated financial statements. The change in estimate is based on a deficit of cash collected subsequent to December 31, 2018 and resulted in an increase in the reserves for collectability on accounts receivable as of December 31, 2018. During 2019, management made significant changes in systems, processes and personnel which has enhanced the ability to manage, bill and accurately collect patient accounts receivable.

4. Investments

The Group's investments as of December 31 by financial statement line item are as follows:

	2019	2018
	(In Thousands)	
Short-term investments	**$ 416,915**	$ 372,556
Investments held in trust for current debt service	**9,435**	9,561
Investments held in trust under bond master indenture	**66,129**	114,680
Investments designated by Board for specific purposes	**63,530**	62,948
Investments restricted by donors for capital expenditures or to provide a permanent source of income	**57,211**	58,627
Interest in charitable remainder annuity trusts	**11,163**	10,069
	$ 624,383	$ 628,441

Investment income or loss on marketable securities included in donor restricted net assets (including realized and unrealized gains and losses on investments, interest, and dividends) is reported as other income unless the income or loss is restricted by donor or law, in which case the investment income or loss is recorded directly to net assets with donor restrictions.

4. Investments (continued)

Investment income includes the following for the years ended December 31:

	Investment Income (Loss)		
	Without Donor Restrictions	**With Donor Restrictions**	**Total**
	(In Thousands)		
2019			
Interest and dividends	**$ 7,927**	**$ 964**	**$ 8,891**
Net realized gains	**4,171**	**174**	**4,345**
Net unrealized gains	**59,676**	**11,868**	**71,544**
	$ 71,774	**$ 13,006**	**$ 84,780**

	Investment Income (Loss)		
	Without Donor Restrictions	**With Donor Restrictions**	**Total**
	(In Thousands)		
2018			
Interest and dividends	$ 5,074	$ 675	$ 5,749
Net realized gains	10,482	2,595	13,077
Net unrealized gains	(43,411)	(6,649)	(50,060)
	$ (27,855)	$ (3,378)	$ (31,234)

5. Fair Value Measurements

Fair value is defined as the price that would be received upon sale of an asset or paid upon transfer of a liability in an orderly transaction between market participants. As such, fair value is a market-based measurement that should be determined based on assumptions that market participants would use in pricing an asset or liability.

5. Fair Value Measurements (continued)

As a basis for considering such assumptions, the Group establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value as follows:

Level 1 – Quoted prices are available in active markets for identical assets as of the measurement date.

Level 2 – Assets that are based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Assets whose fair value cannot be determined by using observable measures and can only be calculated using estimates or risk-adjusted value ranges when little or no market data is available. The inputs into the determination of fair value require management's judgment or estimation of assumptions that market participants would use in pricing the assets or liabilities. The fair values are therefore determined using factors that involve considerable judgment and interpretations, including, but not limited to, private and public comparables, third-party appraisals, discounted cash flow models, and fund manager estimates. The Group held no Level 3 financial instruments at December 31, 2019 and 2018.

Financial assets and liabilities measured at fair value are based on one or more of the following three valuation techniques:

(a) Market approach – Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities.

(b) Cost approach – Amount that would be required to replace the service capacity of an asset (replacement cost).

(c) Income approach – Techniques to convert future amounts to a single present amount based on market expectations (including present value techniques, option-pricing, and excess earnings models).

5. Fair Value Measurements (continued)

The Group's assets and liabilities measured at fair value and net asset value on a recurring basis are as follows as of December 31:

	Investments at Fair Value			Valuation
	Total	**Level 1**	**Level 2**	**Technique**
2019				
Liquid investments:				
Cash and equivalents	**$ 87,217**	**$ 87,217**	**$ –**	**(a)**
Equity securities:				
Marketable equity securities	**2,183**	**2,183**	**–**	**(a)**
U.S. equity mutual fund	**120,905**	**120,905**	**–**	**(a)**
Fixed income securities:				
Global fixed income and equity mutual funds	**248,814**	**248,814**	**–**	**(a)**
Debt securities – corporate and other	**1,454**	**–**	**1,454**	**(a)**
Charitable remainder annuity trusts:				
Interest charitable remainder annuity trusts	**11,163**	**–**	**11,163**	**(c)**
Total	**471,736**	**$ 459,119**	**$ 12,617**	
Investments measured at net asset value:				
U.S. fixed income mutual fund	**23,096**			
Global equity mutual fund	**86,301**			
Pooled hedge funds	**36,597**			
Private equity fund	**6,653**			
Total	**152,647**			
Total investments	**$ 624,383**			
Liabilities				
Gift annuity/CRAT	**$ 1,110**	**$ –**	**$ 1,110**	**(c)**
Total	**$ 1,110**	**$ –**	**$ 1,110**	

Please refer to Note 2 for valuation technique descriptions (a) and (c).

5. Fair Value Measurements (continued)

	Investments at Fair Value			Valuation
	Total	**Level 1**	**Level 2**	**Technique**
2018				
Liquid investments:				
Cash and equivalents	$ 168,475	$ 168,475	$ –	(a)
Equity securities:				
Marketable equity securities	3,364	3,364	–	(a)
U.S. equity mutual fund	97,231	97,231	–	(a)
Fixed income securities:				
Global fixed income and equity mutual funds	211,062	211,062	–	(a)
Debt securities – corporate and other	145	–	145	(a)
Charitable remainder annuity trusts:				
Interest charitable remainder annuity trusts	10,069	–	10,069	(c)
Total	490,346	$ 480,132	$ 10,214	
Investments measured at net asset value:				
U.S. fixed income mutual fund	21,177			
Global equity mutual fund	73,855			
Pooled hedge funds	35,783			
Private equity fund	7,280			
Total	138,095			
Total investments	$ 628,441			
Liabilities				
Gift annuity/CRAT	$ 1,537	$ –	$ 1,537	(c)
Total	$ 1,537	$ –	$ 1,537	

Please refer to Note 2 for valuation technique descriptions (a) and (c).

5. Fair Value Measurements (continued)

At December 31, 2019 and 2018, the Group's investments of $152.6 million and $138.1 million, respectively, in alternative investment funds, including hedge funds, mutual funds, and private equity funds, are measured using the fund's net asset value per unit as a practical expedient to estimate fair value. For the mutual funds and hedge funds, redemption clauses range between monthly and biannually with various notice requirements between 10 and 95 days. The Group may not withdraw or sell, assign, or transfer its interest in the private equity fund except in certain limited circumstances, subject to consent by the general partners of the fund.

The total unfunded commitments related to private equity funds were $2.3 million at December 31, 2019 and 2018.

The fair value of the Group's receivable from charitable remainder annuity trusts (CRAT) is based on the Group's percentage of the fair value of the trust's assets adjusted for any outstanding liabilities (discounted using a rate per Internal Revenue Service regulations), based on each trust arrangement.

The fair value of gift annuity/CRAT liabilities was determined using techniques that are consistent with the income approach. The fair value is determined using a net present value approach based on IRS 1457 tables and Applicable Federal Rates. The rates used were 2% and 3.6% at December 31, 2019 and 2018, respectively. Mortality tables regularly published by the federal government are utilized to estimate remaining lives of trust donors.

The fair value of the Group's tax-exempt financings at December 31, 2019 and 2018, based on current market rates (Level 2), was $331.3 million and $322.9 million, respectively (carrying value, excluding premium – $295.0 million and $298.3 million, respectively).

6. Availability of Financial Assets

The following reflects the Group's financial assets at December 31, 2019, reduced by amounts not available for general use within one year of the balance sheet date because of contractual or donor-imposed restrictions or internal designations. Amounts not available include amounts set aside for long-term investing in the operating and capital reserves that could be drawn upon if the governing board approves that action.

	2019	2018
Financial assets:		
Cash and cash equivalents	**$ 46,391**	$ 21,258
Short-term investments	**416,915**	372,556
Accounts receivable	**161,107**	157,167
Total financial assets	**$ 624,413**	$ 550,981

The Group has certain board designated and donor-restricted assets limited to use which are available for general expenditure within one year in the normal course of operations. Accordingly, these assets have been included in the information above for financial assets to meet general expenditures within one year. The Group has other assets limited to use for donor-restricted purposes and debt service. Additionally, certain other board-designated assets are designated for future capital expenditures. These restricted investments, which are more fully described in Note 9, are not available for general expenditure within the next year. However, the board-designated amounts could be made available, if necessary.

As part of the Group's liquidity management plan, cash in excess of daily requirements are invested in in short-term investments and money market funds. Additionally, the Group maintains a $30.0 million revolving line of credit, as discussed in more detail in Note 8. As of December 31, 2019, $12.0 million remained available on the Group's revolving line of credit.

7. Property, Plant, and Equipment

Property, plant, and equipment consist of the following as of December 31:

	2019	2018
	(In Thousands)	
Land	**$ 21,848**	$ 21,470
Buildings and improvements	**628,947**	614,558
Leasehold improvements	**22,738**	27,924
Equipment	**236,336**	223,401
Equipment – finance leases	**62,238**	51,464
Construction in progress	**158,239**	84,631
	1,130,346	1,023,449
Accumulated depreciation and amortization	**(509,658)**	(491,079)
Accumulated depreciation and amortization – finance leases	**(32,939)**	(23,642)
	$ 587,749	$ 508,728

8. Long-Term Debt and Revolving Line of Credit

Long-term debt consists of the following as of December 31:

	Interest Rate(s)	Final Maturity	2019	2018
			(In Thousands)	
Bonds payable:				
Series 2018 Bonds, including unamortized premiums of $8,786 and $8,842 at December 31, 2019 and 2018, respectively	5%	2048	**$ 108,546**	$ 108,842
Series 2014A Bonds, including unamortized premiums of $1,169 and $1,174 at December 31, 2019 and 2018, respectively	5%	2044	**51,169**	51,174
Series 2014B Bonds, including unamortized premiums of $13,680 and $14,191 at December 31, 2019 and 2018, respectively	3%–5%	2044	**158,926**	162,486
Obligations under finance leases			**12,101**	3,368
			330,742	325,870
Less current maturities			**(7,780)**	(4,734)
			322,962	321,136
Less debt issuance costs			**(4,398)**	(4,599)
			$ 318,564	$ 316,537

Bond premiums, net of debt discounts, are amortized over the term of the bonds using the effective interest method.

Debt issuance costs are classified as a direct deduction from the carrying amount of the debt liability. Costs incurred in obtaining long-term financing are deferred and amortized over the terms of the related obligations using the effective interest method.

8. Long-Term Debt and Revolving Line of Credit (continued)

HMH and the Trust are co-obligors on the bonds, comprising the Obligated Group. The Obligated Group members are jointly and severally liable for the debt.

The bonds are collateralized by the Gross Receivables of the Obligated Group, and trustee-held funds established in accordance with the bond indenture. Certain receivables are excluded from the Gross Receivables pledge, such as donations or grants restricted for purposes other than debt service, as well as real property held by the Trust. The Obligated Group must comply with certain covenants, including a required minimum debt service coverage ratio, the maintenance of certain required funds, and limitations on the use of bond proceeds. At December 31, 2019 and 2018, the Obligated Group was in compliance with all bond covenants.

On June 22, 2017, the Group entered into a revolving credit agreement with a commitment amount of $30.0 million and a term of three years, with the option to extend in writing, no sooner than 120 days prior to the current maturity date, should both parties desire to continue with the arrangement. The facility is provided by a major bank at 1-month LIBOR +50BPS and contains covenants similar to those associated with the Group's bonds noted above. Amounts outstanding under the revolving credit agreement were $18.0 million and $0 as of December 31, 2019 and 2018, respectively. Please refer to the subsequent events section of Note 2 for additional information regarding the revolving credit agreement.

On May 2, 2018, the Group completed a bond offering resulting in net proceeds of $108.8 million. The proceeds of the bonds are to be used to finance the seismic rehabilitation, construction, improvement, renovation, and equipping of existing health care facilities owned and operated by the Group.

8. Long-Term Debt and Revolving Line of Credit (continued)

The aggregate amounts of annual maturities and sinking fund payments on all long-term debt, including finance leases, for the years subsequent to December 31, 2019, are as follows (in thousands):

2019	$ 7,276
2020	7,596
2021	7,935
2022	8,099
2023	6,350
2024	269,850
Thereafter	307,107
Unamortized bond premiums (including current portion of $504)	23,635
Total principal payments	$ 330,742

Interest costs incurred totaled $12.1 million and $11.2 million in 2019 and 2018, respectively, of which $4.0 million and $4.4 million in 2019 and 2018, respectively, was capitalized.

9. Net Assets and Contributions

Net assets with donor restrictions are available for the following purposes as of December 31:

	2019	**2018**
	(In Thousands)	
Patient care services	**$ 64,931**	$ 53,413
Nursing/residency programs	**16,748**	16,420
Building and maintenance	**28,944**	30,666
Research and others	**1,653**	1,624
Time restricted under CRT	**11,359**	10,247
	$ 123,635	$ 112,370

9. Net Assets and Contributions (continued)

Restricted net assets for building and equipment are included in investments restricted for capital expenditures and other assets on the consolidated balance sheets. Net assets restricted for noncapital purposes are included in short-term investments, other assets, and receivable from charitable remainder annuity trusts.

Net unconditional promises to give, included in current and other non-current assets, consist of the following as of December 31. Promises to give are discounted using approximate 5-year U.S. Treasury rates with active promises currently carrying rates between 2% and 6%.

	2019	2018
	(In Thousands)	
Unconditional promises to give, less	**$ 15,573**	$ 13,819
Discounts	**(311)**	(224)
Allowance for uncollectibility	**(628)**	(202)
Total unconditional promises to give, net	**$ 14,634**	$ 13,393

As of December 31, 2019, future discounted receipts anticipated from unconditional promises to give, net of an allowance for uncollectibility, are as follows (in thousands):

2020	$ 6,325
2021 through 2024	8,280
Thereafter	29
	$ 14,634

9. Net Assets and Contributions (continued)

Split-interest Agreements

The Hospital is party to many gift annuity arrangements. These generally take the form of charitable remainder annuity trusts (CRATs) or charitable remainder unit trusts (CRUTs) where the Hospital pays a fixed return to the donor while still living and the remaining undistributed trust assets revert to the hospital upon the donor's passing. The Hospital is also a named beneficiary under many legacy and bequest arrangements where it will receive all or a portion of the irrevocable trusts upon the passing of the donors. The fair value of these assets and the associated liabilities for amounts payable under the gift annuities are remeasured at each year-end as outlined in Note 5, Fair Value Measurements. Assets and liabilities recorded in relation to these split-interest agreements as of December 31 are as follows:

	2019	2018
	(In Thousands)	
Gift annuities and CRTs:		
Assets	**$ 3,827**	$ 3,545
Liabilities	**(1,110)**	(1,537)
Legacies and bequests:		
Assets	**$ 11,163**	$ 10,069

No contribution revenue was recognized in relation to split-interest agreements for both years ended December 31, 2019 and 2018, respectively. Changes in the value of split-interest agreements recognized totaled $210,000 and $(266,000) for the years ended December 31, 2019 and 2018, respectively.

9. Net Assets and Contributions (continued)

Endowment

The Group's endowment includes all net assets that contain donor restrictions as well as Board-designated funds.

The changes in endowment net assets are as follows:

	Without Donor Restrictions	With Donor Restrictions	Total
	(In Thousands)		
Endowment net assets, January 1, 2018	$ 62,387	$ 90,863	$ 153,250
Investment return	–	640	640
Net appreciation	–	(3,826)	(3,826)
Contributions	562	4,257	4,819
Adjustment to CRTs and legacies and bequests	–	(3,588)	(3,588)
Appropriation of endowment assets for expenditure	(200)	(4,271)	(4,471)
Transfers to create board-designated endowment funds	199	(199)	–
Endowment net assets, December 31, 2018	62,948	83,876	146,824
Investment return	**–**	**918**	**918**
Net depreciation	**–**	**11,581**	**11,581**
Contributions	**689**	**3,091**	**3,780**
Adjustment to CRTs and legacies and bequests	**–**	**2,006**	**2,006**
Appropriation of endowment assets for expenditure	**(300)**	**(4,610)**	**(4,910)**
Transfers to create board-designated endowment funds	**193**	**–**	**193**
Endowment net assets, December 31, 2019	**$ 63,530**	**$ 96,862**	**$ 160,392**

9. Net Assets and Contributions (continued)

The endowment net asset composition by type of fund as of December 31 consists of the following:

	2019		
	Without Donor Restrictions	**With Donor Restrictions**	**Total**
	(In Thousands)		
Donor-restricted endowment funds	**$ –**	**$ 96,862**	**$ 96,862**
Board-designated endowment funds	**63,530**	**–**	**63,530**
Total funds	**$ 63,530**	**$ 96,862**	**$ 160,392**

	2018		
	Without Donor Restrictions	**With Donor Restrictions**	**Total**
	(In Thousands)		
Donor-restricted endowment funds	$ –	$ 83,876	$ 83,876
Board-designated endowment funds	62,948	–	62,948
Total funds	$ 62,948	$ 83,876	$ 146,824

Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor requires the Group to retain as a fund of perpetual duration. Deficiencies of this nature are reported in net assets without donor restrictions. There were no such deficiencies as of December 31, 2019 or 2018.

Return Objectives and Risk Parameters

The Group has investment policies that attempt to provide a predictable stream of funding to programs supported by operations as well as endowment donations. Assets are invested in a manner that is intended to produce results that exceed the respective benchmark while assuming a moderate level of investment risk. Actual returns in any given year may vary from this amount.

9. Net Assets and Contributions (continued)

Strategies Employed for Achieving Objectives

To satisfy its long-term rate-of-return objectives, the Group relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Group targets a diversified asset allocation to achieve its long-term return objectives within prudent risk constraints.

Interpretation of Relevant Law

In 2009, the Uniform Prudent Management of Institutional Funds Act (UPMIFA) was enacted to update and replace Ohio's previous law, the Uniform Management of Institutional Funds Act. The Group has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds, absent explicit donor stipulations to the contrary. As a result of this interpretation, the Group classifies as net assets with donor restrictions (1) the original value of gifts donated to the permanent endowment, (2) the original value of subsequent gifts to the permanent endowment, and (3) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in the permanent endowment is available for appropriation for expenditure by the Group in a manner consistent with the standard for expenditure prescribed by UPMIFA. In accordance with UPMIFA, the Group considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

(1) The duration and preservation of the fund

(2) The purposes of the Group and the donor-restricted endowment fund

(3) General economic conditions

(4) The possible effect of inflation and deflation

(5) The expected total return from income and the appreciation of investments

(6) Other resources of the Group

(7) The investment policies of the Group

9. Net Assets and Contributions (continued)

A description of endowment assets is as follows as of December 31:

	2019	2018
	(In Thousands)	
Net assets with donor restrictions		
(1) Term endowment funds	**$ 53,773**	$ 41,646
(2) The portion of perpetual endowment funds subject to a time restriction under UPMIFA:		
Without purpose restrictions	**161**	161
With purpose restrictions	**42,928**	42,069
Total endowment funds classified as net assets with donor restrictions	**$ 96,862**	$ 83,876

Fundraising & Contributed Services

Fundraising costs consist solely of direct costs associated with philanthropic activities, such as salaries and benefits of individuals pursuing donations, costs of fundraising events, and the like. No allocations of general expense are made.

Contributed services consist of volunteer hours worked through the Hospital's volunteer program. The Group does not recognize these donated service hours as revenue. 126,723 and 126,353 volunteer hours (unaudited) were donated to the Hospital in 2019 and 2018, respectively. These services represent an approximate value (unaudited) of $3.2 million and $3.1 million for 2019 and 2018, utilizing hourly rates of $25.43 and $24.69 in 2019 and 2018, respectively.

10. Leases

The Group leases property and equipment under operating and finance leases. The related assets and obligations are recorded at the present value of lease payments over the term of the agreements. Some of the Group's leases include rental escalation clauses, renewal options and/or termination options that are factored into the determination of lease payments. Variable lease payments are non-lease services related to the lease and are excluded from the right-of-use assets and lease liabilities and are recognized in the period in which the obligation of those payments is incurred. Generally, the Group does not include renewal options in the lease terms for calculating

10. Leases (continued)

the lease liability, as the Group maintains operational flexibility and is not reasonably certain the renewal options will be exercised. When a lease does not provide a readily determinable implicit rate in the contract the incremental borrowing rate is estimated and utilized to discount the lease payments based on information available at lease commencement. Upon adoption of the new lease standard, discount rates for existing leases were established at January 1, 2019.

The Group elected the package of practical expedients permitted under the transition guidance within the new standard which, among other things, allowed the historical lease classification not to be reassessed. The Group made an accounting policy election to not apply the recognition requirements of the guidance to short-term leases with a term of 12 months or less. The Group also made an accounting policy election not to separate non-lease components from lease components for all classes of assets. The Group did not elect the hindsight practical expedient, which permits entities to use hindsight in determining the lease term and assessing impairment.

The Group leases office space and facilities under leases ranging from 5 to 20 years. Building rent expense totaled approximately $11.1 million and $10.3 million in 2019 and 2018, respectively. The Group leases the Pavilion Medical Building under three master lease agreements. The rental agreements commenced on June 1, 2009, and have 20-year terms plus two consecutive options to extend the terms of the leases for ten years each. The leases also include annual CPI escalation clauses (with a 3% floor and 6% cap). The Group subleases certain portions of the Pavilion Medical Building to an unconsolidated equity method investee. The Group’s portion of rental income and rental expense related to this unconsolidated equity method investee is eliminated in consolidation.

Huntington Medical Foundation has eight building leases with 3–10 year terms, with short-term renewal options and annual escalation clauses from 0% to 3%.

10. Leases (continued)

Leases	Consolidated Balance Sheets	December 31, 2019
Assets		
Operating lease right-of-use assets	Other noncurrent assets	$ 59,990
Finance lease right-of-use assets	Operating lease right-of-use assets	12,101
		$ 72,091
Current liabilities		
Operating lease liabilities	Other accrued liabilities	$ 7,417
Finance lease liabilities	Current portion of long-term obligations	2,546
Non-current liabilities		
Operating lease liabilities	Long-term operating lease liability	52,573
Finance lease liabilities	Long-term obligations, less current portion	9,555
		$ 72,091

Weighted-average operating leases remaining lease term	8.72 years
Weighted-average finance leases remaining lease term	4.62 years
Weighted-average operating lease discount rate	3.27%
Weighted-average finance lease discount rate	3.28%

The components of lease costs are as follows:

	Year Ended December 31, 2019
Lease costs:	
Operating lease cost	$ 13,379
Finance lease cost:	
Amortization of leased assets	2,324
Interest on lease liabilities	426

10. Leases (continued)

	Year Ended December 31, 2019
Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash outflows for operating leases	$ 13,227
Operating cash outflows for finance leases	–
Financing cash outflows for finance leases	2,577
Right-of-use assets obtained in exchange for lease obligations:	
Operating leases	8,575
Finance leases	10,963

Future payments as of December 31, 2019, for operating and finance leases are as follows:

	Operating Leases	Finance Leases
2020	$ 11,754	$ 2,917
2021	11,170	2,917
2022	10,993	2,889
2023	10,183	2,671
2024	9,245	595
Thereafter	38,024	1,191
	91,369	13,180
Less imputed interest	(31,379)	(1,079)
	$ 59,990	$ 12,101

10. Leases (continued)

Future minimum payment, by year and in the aggregate, under noncancelable operating leases with terms of one or more at inception consist of the following as of December 31, 2018:

	Lease Payments
2019	$ 9,121
2020	8,729
2021	8,658
2022	8,798
2023	8,706
Thereafter	49,622
	93,634
Less: Sublease rental income	1,618
Total	$ 92,016

11. Commitments and Contingencies

Contingencies

The Group records accruals for loss contingencies to the extent it is probable that a liability has been incurred and the amount of the related loss can be reasonably estimated. Certain legal actions arising in the ordinary course of business are pending against the Group. Management believes that the ultimate resolution of the various proceedings will not have a material adverse effect upon the consolidated financial position, results of operations, or cash flows of the Group.

The Hospital has been named in several lawsuits related to the treatment of patients in an inappropriate manner by an affiliated (not employed) private practice physician at his medical office and the Hospital. Litigation in this matter involves numerous complex issues and discovery is still ongoing. Additional litigation could be filed or the cases could be dismissed. Accordingly, based upon information currently available, it is not possible to predict the final resolution of these matters and their impact on the future consolidated financial position and results of operations of the Group.

12. Retirement Plans

HMH has a defined benefit retirement plan. This plan was contributory through June 30, 2005, and became noncontributory on July 1, 2005. Effective July 1, 2013, the plan was closed to new participants and all benefit accruals under the plan were frozen. Additionally, HMH adopted a 457(f) defined benefit retirement plan, effective December 31, 2005, covering key executives.

In 2019, the plans had a net actuarial loss of $29.0 million, resulting in an increase in the plans' projected benefit obligation that was primarily driven by a decrease in the discount rate from 4.35% at December 31, 2018, to 3.49% at December 31, 2019. Plan related cost components are presented in salaries and benefits expense.

In 2018, the plans had a net actuarial gain of $15.5 million, resulting in the plans' projected benefit obligations, that was primarily driven by an increase in the discount rate from 3.75% at December 31, 2017, to 4.35% at December 31, 2018.

The changes in benefit obligation and plan assets of the plans are as follows for the years ended December 31:

	2019	2018
	(In Thousands)	
Actuarial loss at beginning of year	**$ 218,492**	$ 239,868
Service cost	**–**	2,439
Interest cost	**8,345**	8,720
Benefits paid	**(3,634)**	(4,663)
Actuarial loss (gain)	**29,369**	(15,541)
Settlement	**(26,127)**	(12,331)
Actuarial loss at end of year	**$ 226,445**	$ 218,492
Fair value of plan assets at beginning of year	**$ 152,470**	$ 173,027
Actual return on plan assets	**22,072**	(11,482)
Employer contributions	**6,371**	7,905
Benefits paid	**(3,634)**	(4,649)
Settlement	**(26,127)**	(12,331)
Fair value of plan assets at end of year	**$ 151,152**	$ 152,470
Funded status (long-term accrued pension liability)	**$ (75,292)**	$ (66,022)

12. Retirement Plans (continued)

Lump sum settlements in 2019 reached a level requiring the current year recognition of $6.9 million in losses from changes in net assets without restrictions arising from a defined benefit plan but not yet included in net periodic benefit cost, representing the settlement of 10.9% of the plan's obligations.

Lump sum settlements in 2018 reached a level requiring the current year recognition of $3.1 million in losses from changes in net assets without restrictions arising from a defined benefit plan but not yet included in net periodic benefit cost, representing the settlement of 0.14% of the plan's obligations.

	2019	2018
	(In Thousands)	
Pension liability recorded as changes in net assets without donor restrictions:		
Unrecognized prior actuarial loss	**$ 60,823**	$ 54,476
	60,823	54,476
Pension liability recorded through earnings	**14,469**	11,546
Total pension liability recorded	**$ 75,292**	$ 66,022
Accumulated benefit obligation	**$ 226,445**	$ 218,492

	2019	2018
	(In Thousands)	
Net periodic benefit cost recognized:		
Service cost	**$ –**	$ 2,439
Interest cost	**8,345**	8,720
Expected return on plan assets	**(7,082)**	(11,327)
Net actuarial loss amortization	**1,118**	895
Net periodic benefit cost	**$ 2,381**	$ 727

12. Retirement Plans (continued)

The actuarial assumptions as of December 31 are as follows:

	2019	2018
Weighted-average assumptions:		
Discount rate (used for funded status)	**3.49%**	4.35%
Discount rate (used for pension cost)	**3.27%–4.35%**	3.75%
Expected return on plan assets (based on historical investment returns)	**5.90%**	6.75%

The following benefit payments are expected to be paid during the years ending December 31 (in thousands):

2020	$ 21,503
2021	11,982
2022	14,351
2023	12,427
2024	13,310
Years 2025– 2029	65,726

Employer contributions for fiscal 2019 are expected to be $7.8 million.

The pension plan's weighted-average asset allocation as of December 31, by asset category, is as follows:

	2019	2018
Asset categories:		
Equity securities	**58%**	55%
Debt securities	**41%**	44%
Other	**1%**	1%
Total	**100%**	100%

The pension plans' asset allocation and investment strategies are designed to earn returns on plan assets consistent with a reasonable and prudent level of risk. Investments are diversified across classes, sectors, and manager style to minimize the risk of large losses. The Group uses investment managers specializing in each asset category and, where appropriate, provides the investment manager with specific guidelines, which include allowable and/or prohibited investment types. The Group regularly monitors manager performance and compliance with investment guidelines.

12. Retirement Plans (continued)

The target allocations for plan assets are 50%-80% equity fund, 25%-45% fixed income fund. The equity fund includes U.S. and international investments and range from large-cap to small-cap companies. The fixed income fund includes bonds and cash equivalents. The plan has also entered into an annuity contract in which the funds are held in an insurance company general account that is reported at fair value which approximates the contract value. The expected rate of return actuarial assumption considers the historical long-term rate of return of assets across these asset classes.

Fair Value Measurement

A fair value hierarchy has been established with three levels that prioritize the valuation inputs into each level (see Note 5).

The plans' assets measured at fair value and net asset value on a recurring basis as of December 31 were as follows:

	Investments at Fair Value			Valuation
	Total	**Level 1**	**Level 2**	**Technique**
2019				
Cash and equivalents	**$ 1,951**	**$ 1,951**	**$ –**	**(a)**
Corporate bond mutual fund	**32,869**	**32,869**	**–**	**(a)**
Funds held in insurance company general account	**957**	**–**	**–**	**(b)**
Total	**35,777**	**$ 34,820**	**$ –**	
Investments measured at net asset value:				
Commingled global equity fund	**40,784**			
U.S. equity securities and fixed income mutual funds	**74,876**			
Total investments	**$ 151,437**			

Please refer to Note 2 for valuation technique descriptions (a) and (b).

12. Retirement Plans (continued)

	Investments at Fair Value			Valuation
	Total	**Level 1**	**Level 2**	**Technique**
2018				
Cash and equivalents	$ 2,505	$ 2,505	$ –	(a)
Corporate bond mutual fund	39,574	39,574	–	(a)
Funds held in insurance company general account	1,001	–	1,001	(b)
Total	43,080	$ 42,079	$ 1,001	
Investments measured at net asset value:				
Commingled global equity fund	40,237			
U.S. equity securities and fixed income mutual funds	69,153			
Total investments	$ 152,470			

Please refer to Note 2 for valuation technique descriptions (a) and (b).

There were no transfers to or from Level 1 or 2 during the years presented. The changes in fair value of the Plans' Level 3 assets are as follows for the year ended December 31:

	2019	**2018**
	(In Thousands)	
Beginning balance	**$ 1,001**	$ 809
Contributions	**14,082**	15,526
Distributions	**(14,158)**	15,562)
Deposit in transit	**35**	250
Administrative charges	**(3)**	(22)
Ending balance	**$ 957**	$ 1,001

12. Retirement Plans (continued)

At December 31, 2019 and 2018, the Group's plan investments of $115.7 million and $109.4 million, respectively, in alternative investment funds, including hedge funds, mutual funds, and private equity funds, are measured using the fund's net asset value per unit as a practical expedient to estimate fair value. For the mutual funds and hedge funds, redemption clauses range between monthly and biannually with various notice requirements between 10 and 95 days. The Group may not withdraw or sell, assign, or transfer its interest in the private equity fund except in certain limited circumstances, subject to consent by the general partners of the fund.

Defined Contribution Plan

The Group sponsors a defined contribution benefit plan for its employees. For the years ended December 31, 2019 and 2018, employer contributions of $12.1 million and $14.1 million, respectively, were recorded in salaries and benefits expense.

13. Functional Expenses

The Group provides general health care services to residents within its geographic location. The following table presents the Group's expenses by function for the years 2019 and 2018.

	Healthcare Services		Support Services		
	Hospital	Physician	Management, General Administration	Fundraising	Total
			(In Thousands)		
December 31, 2019					
Salaries and benefits	**$ 272,898**	**$ 3,649**	**$ 107,345**	**$ 1,351**	**$ 385,243**
Supplies and purchased services	**158,547**	**8,345**	**50,302**	**906**	**218,100**
Provider fee expense	**45,379**	**–**	**–**	**–**	**45,379**
Depreciation and amortization	**8,608**	**716**	**26,966**	**7**	**36,297**
Interest	**–**	**–**	**8,064**	**–**	**8,064**
Other	**5,991**	**4,246**	**35,169**	**586**	**45,992**
	$ 491,423	**$ 16,956**	**$ 227,846**	**$ 2,850**	**$ 739,075**

13. Functional Expenses (continued)

	Healthcare Services		Support Services		
	Hospital	Physician	Management, General Administration	Fundraising	Total
	(In Thousands)				
December 31, 2018					
Salaries and benefits	$ 270,311	$ 10,976	$ 99,371	$ 1,207	$ 381,865
Supplies and purchased services	154,985	9,421	44,331	917	209,653
Provider fee expense	43,701	–	–	–	43,701
Depreciation and amortization	7,571	999	25,694	8	34,272
Interest	–	–	6,758	–	6,758
Other	6,669	5,952	27,301	883	40,804
	$ 483,236	$ 27,348	$ 203,455	$ 3,014	$ 717,053

The consolidated financial statements report certain expense categories that are attributable to more than one health care service or support function. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Costs not directly attributable to a function, including depreciation, amortization, interest, and other occupancy costs, are allocated to a function based on a square footage or units of service basis. Allocated health care services cost not allocated on a units-of-service basis are otherwise allocated on revenue.

Supplementary Information

Collis P. and Howard Huntington Memorial Hospital Trust, Pasadena Hospital Association, Ltd. and Affiliates

Consolidating Balance Sheets

(In Thousands)

	As of December 31, 2019					As of December 31, 2018				
	Trust	**HMH**	**Foundation**	**Eliminations**	**Consolidated**	**Trust**	**HMH**	**Foundation**	**Eliminations**	**Consolidated**
Assets										
Current assets:										
Cash and cash equivalents	**$ 5,952**	**$ 37,664**	**$ 2,775**	**$ –**	**$ 46,391**	$ 2,969	$ 17,386	$ 903	$ –	$ 21,258
Investments:										
Short-term investments	**260,084**	**156,831**	**–**	**–**	**416,915**	221,458	151,098	–	–	372,556
Held in trust for current debt service	**–**	**9,435**	**–**	**–**	**9,435**	–	9,561	–	–	9,561
Total investments	**260,084**	**166,266**	**–**	**–**	**426,350**	221,458	160,659	–	–	382,117
Accounts receivable:										
Patient accounts receivable	**–**	**98,801**	**4,171**	**–**	**102,972**	–	104,790	3,397	–	108,187
Provider fee receivable	**–**	**52,791**	**–**	**–**	**52,791**	–	42,349	–	–	42,349
Estimated settlements from third-party payors	**–**	**5,344**	**–**	**–**	**5,344**	–	6,631	–	–	6,631
Total accounts receivable	**–**	**156,936**	**4,171**	**–**	**161,107**	–	153,770	3,397	–	157,167
Inventories	**–**	**14,148**	**36**	**–**	**14,184**	–	15,194	43	–	15,237
Prepaid expenses and other	**946**	**59,211**	**1,440**	**(33,235)**	**28,362**	1,158	47,887	1,470	(24,746)	25,769
Total current assets	**266,982**	**434,225**	**8,422**	**(33,235)**	**676,394**	225,585	394,896	5,813	(24,746)	601,548
Investments restricted or designated for specific purposes:										
Held in trust under bond master indenture	**–**	**66,129**	**–**	**–**	**66,129**	–	114,680	–	–	114,680
Designated by Board for specific purposes	**–**	**63,530**	**–**	**–**	**63,530**	–	62,948	–	–	62,948
Donor restricted for capital expenditures or to provide a permanent source of income	**2,034**	**55,177**	**–**	**–**	**57,211**	2,034	56,593	–	–	58,627
Receivable from charitable remainder annuity trusts	**–**	**11,163**	**–**	**–**	**11,163**	–	10,069	–	–	10,069
Total investments restricted or designated for specific purposes	**2,034**	**195,999**	**–**	**–**	**198,033**	2,034	244,290	–	–	246,324
Property, plant, and equipment, net	**56,196**	**527,448**	**4,105**	**–**	**587,749**	50,068	453,698	4,962	–	508,728
Operating lease right-of-use assets	**–**	**51,913**	**8,077**	**–**	**59,990**	–	–	–	–	–
Other assets:										
Due from affiliates	**5,799**	**–**	**–**	**(5,799)**	**–**	7,266	–	–	(7,266)	–
Goodwill	**–**	**10,006**	**–**	**–**	**10,006**	–	10,006	–	–	10,006
Other noncurrent assets	**–**	**21,201**	**–**	**–**	**21,201**	3	12,308	–	–	12,311
Total assets	**$ 331,011**	**$ 1,240,792**	**$ 20,604**	**$ (39,034)**	**$ 1,553,373**	$ 284,956	$ 1,115,198	$ 10,775	$ (32,012)	$ 1,378,917

Collis P. and Howard Huntington Memorial Hospital Trust, Pasadena Hospital Association, Ltd. and Affiliates

Consolidating Balance Sheets (continued)

(In Thousands)

	As of December 31, 2019					As of December 31, 2018				
	Trust	**HMH**	**Foundation**	**Eliminations**	**Consolidated**	**Trust**	**HMH**	**Foundation**	**Eliminations**	**Consolidated**
Liabilities and net assets										
Current liabilities:										
Accounts payable	**$ 766**	**$ 48,026**	**$ 7,646**	**$ (4,798)**	**$ 51,640**	$ 671	$ 37,055	$ 5,962	$ (3,781)	$ 39,907
Current maturities of long-term debt	**–**	**7,780**	**–**	**–**	**7,780**	–	5,247	–	(513)	4,734
Current portion of accrued self-insurance claims	**–**	**6,898**	**–**	**–**	**6,898**	–	8,720	–	–	8,720
Accrued payroll and employee benefits	**–**	**35,820**	**961**	**–**	**36,781**	–	34,324	1,040	–	35,364
Current portion of operating lease liability	**–**	**6,113**	**1,304**	**–**	**7,417**	–	–	–	–	–
Current maturities of notes payable to affiliate	**–**		**23,932**	**(23,932)**	**–**	–	–	18,285	(18,285)	–
Accrued provider fee	**–**	**45,379**	**–**	**–**	**45,379**	–	31,675	–	–	31,675
Other accrued liabilities	**3,041**	**14,015**	**123**	**(3,062)**	**14,117**	1,050	17,961	3	(1,182)	17,832
Revolving credit line	**–**	**18,000**	**–**	**–**	**18,000**	–	–	–	–	–
Total current liabilities	**3,807**	**182,031**	**33,966**	**(31,792)**	**188,012**	1,721	134,982	25,290	(23,761)	138,232
Long-term debt, less current maturities	**–**	**318,564**	**–**	**–**	**318,564**	–	316,537	–	–	316,537
Accrued pension liability	**–**	**75,292**	**–**	**–**	**75,292**	–	66,022	–	–	66,022
Accrued self-insurance claims, less current portion	**–**	**20,036**	**–**	**–**	**20,036**	–	18,474	–	–	18,474
Long-term due to affiliates	**–**	**5,742**	**–**	**(5,742)**	**–**	–	6,751	–	(6,751)	–
Long-term operating lease liability	**–**	**45,800**	**6,773**	**–**	**52,573**	–	–	–	–	–
Other	**3,851**	**151**	**–**	**–**	**4,002**	4,080	950	–	–	5,030
Total liabilities	**7,658**	**647,616**	**40,739**	**(37,534)**	**658,479**	5,801	543,716	25,290	(30,512)	544,295
Net assets:										
Without donor restrictions	**321,025**	**471,869**	**(20,135)**	**(1,500)**	**771,259**	277,033	461,234	(14,515)	(1,500)	722,252
With donor restrictions	**2,328**	**121,307**	**–**	**–**	**123,635**	2,122	110,248	–	–	112,370
Total net assets (deficits)	**323,353**	**593,176**	**(20,135)**	**(1,500)**	**894,894**	279,155	571,482	(14,515)	(1,500)	834,622
Total liabilities and net assets	**$ 331,011**	**$ 1,240,792**	**$ 20,604**	**$ (39,034)**	**$ 1,553,373**	$ 284,956	$ 1,115,198	$ 10,775	$ (32,012)	$ 1,378,917

Collis P. and Howard Huntington Memorial Hospital Trust, Pasadena Hospital Association, Ltd. and Affiliates

Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions

(In Thousands)

	Year Ended December 31, 2019					Year Ended December 31, 2018				
	Trust	**HMH**	**Foundation**	**Eliminations**	**Consolidated**	**Trust**	**HMH**	**Foundation**	**Eliminations**	**Consolidated**
Revenues without donor restrictions:										
Net patient service revenue	**$ –**	**$ 659,859**	**$ –**	**$ –**	**$ 659,859**	$ –	$ 658,228	$ –	$ –	$ 658,228
Contributions	**–**	**4,887**	**–**	**–**	**4,887**	–	8,839	–	–	8,839
Other	**10,163**	**8,932**	**22,765**	**(929)**	**40,931**	10,826	9,940	22,415	(1,549)	41,632
Net assets released from restrictions	**300**	**4,609**	**–**	**–**	**4,909**	241	4,941	–	–	5,182
Total revenue without donor restrictions	**10,463**	**678,287**	**22,765**	**(929)**	**710,586**	11,067	681,948	22,415	(1,549)	713,881
Expenses:										
Salaries and benefits	**–**	**373,779**	**11,464**	**–**	**385,243**	–	370,889	10,976	–	381,865
Supplies and purchased services	**2,753**	**204,660**	**10,687**	**–**	**218,100**	3,236	196,996	9,421	–	209,653
Provider fee expense	**–**	**45,379**	**–**	**–**	**45,379**	–	43,701	–	–	43,701
Depreciation and amortization	**2,077**	**33,251**	**969**	**–**	**36,297**	1,925	31,348	999	–	34,272
Interest	**(358)**	**8,422**	**–**	**–**	**8,064**	(452)	7,210	–	–	6,758
Other expenses	**1,423**	**40,075**	**5,423**	**(929)**	**45,992**	832	35,569	5,952	(1,549)	40,804
Total expenses before provider fee	**5,895**	**705,566**	**28,543**	**(929)**	**739,075**	5,541	685,713	27,348	(1,549)	717,053
Excess (deficiency) of revenues over expenses before other income & expense	**4,568**	**(27,279)**	**(5,778)**	**–**	**(28,489)**	5,526	(3,765)	(4,933)	–	(3,172)
Other income and expense:										
Investment (loss) income	**44,370**	**27,404**	**–**	**–**	**71,774**	(16,714)	(11,141)	–	–	(27,855)
Other	**–**	**(1,716)**	**159**	**–**	**(1,557)**	–	(2,539)	91	–	(2,448)
Excess (deficiency) revenues over expenses	**48,938**	**(1,591)**	**(5,619)**	**–**	**41,728**	(11,188)	(17,445)	(4,842)	–	(33,475)
Change in pension liability	**–**	**(6,346)**	**–**	**–**	**(6,346)**	–	(3,261)	–	–	(3,261)
Net assets released from restrictions used for acquisition of plant and equipment	**–**	**11,245**	**–**	**–**	**11,245**	–	1,903	–	–	1,903
Transactions with related parties	**–**	**–**	**–**	**–**	**–**	–	(587)	560	–	(27)
Other changes in unrestricted net assets	**(4,945)**	**7,325**	**–**	**–**	**2,380**	(4,973)	4,973	–	–	–
Change in unrestricted net assets	**$ 43,993**	**$ 10,633**	**$ (5,619)**	**$ –**	**$ 49,007**	$ (16,161)	$ (14,417)	$ (4,282)	$ –	$ (34,860)

EY | Assurance | Tax | Transactions | Advisory

About EY
EY is a global leader in assurance, tax, transaction and advisory services. The insights and quality services we deliver help build trust and confidence in the capital markets and in economies the world over. We develop outstanding leaders who team to deliver on our promises to all of our stakeholders. In so doing, we play a critical role in building a better working world for our people, for our clients and for our communities.

EY refers to the global organization, and may refer to one or more, of the member firms of Ernst & Young Global Limited, each of which is a separate legal entity. Ernst & Young Global Limited, a UK company limited by guarantee, does not provide services to clients. Information about how EY collects and uses personal data and a description of the rights individuals have under data protection legislation are available via ey.com/privacy. For more information about our organization, please visit ey.com.

© 2020 Ernst & Young LLP.
All Rights Reserved.

ey.com

Exhibit 37-B

PHA's 2018 Audited Financial Statements

Consolidated Financial Statements and Supplementary Information

Collis P. and Howard Huntington Memorial Hospital Trust,
Pasadena Hospital Association, Ltd. and Affiliates
Years Ended December 31, 2018 and 2017
With Report of Independent Auditors

Ernst & Young LLP



Collis P. and Howard Huntington Memorial Hospital Trust,
Pasadena Hospital Association, Ltd. and Affiliates

Consolidated Financial Statements and Supplementary Information

Years Ended December 31, 2018 and 2017

Contents

Report of Independent Auditors....1

Consolidated Financial Statements

Consolidated Balance Sheets....3
Consolidated Statements of Operations....5
Consolidated Statements of Changes in Net Assets....6
Consolidated Statements of Cash Flows....7
Notes to Consolidated Financial Statements....9

Supplementary Information

Consolidating Balance Sheets....51
Consolidating Statements of Operations and Changes in Net Assets Without Donor Restrictions....53

Ernst & Young LLP
Suite 500
725 South Figueroa Street
Los Angeles, CA 90017-5418

Tel: +1 213 977 3200
Fax: +1 213 977 3152
ey.com

Report of Independent Auditors

The Board of Trustees
The Collis P. and Howard Huntington Memorial Hospital Trust,
Pasadena Hospital Association, Ltd. and Affiliates

We have audited the accompanying consolidated financial statements of the Collis P. and Howard Huntington Memorial Hospital Trust, Pasadena Hospital Association, Ltd. and Affiliates which comprise the consolidated balance sheets as of December 31, 2018 and 2017, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

A member firm of Ernst & Young Global Limited

Building a better working world

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of the Collis P. and Howard Huntington Memorial Hospital Trust, Pasadena Hospital Association, Ltd. and Affiliates at December 31, 2018 and 2017, and the consolidated results of their operations and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying consolidating balance sheets and statements of operations and changes in net assets without donor restrictions are presented for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Ernst & Young LLP

April 29, 2019

A member firm of Ernst & Young Global Limited

Collis P. and Howard Huntington Memorial Hospital Trust,
Pasadena Hospital Association, Ltd. and Affiliates

Consolidated Balance Sheets
(In Thousands)

	December 31	
	2018	**2017**
Assets		
Current assets:		
Cash and cash equivalents	**$ 21,258**	$ 19,570
Investments:		
Short-term investments	**372,556**	420,533
Held in Trust for current debt service	**9,561**	6,098
Total investments	**382,117**	426,631
Accounts receivable:		
Patient accounts receivable	**108,187**	98,656
Provider fee receivable	**42,349**	57,491
Estimated settlements from third-party payors	**6,631**	5,886
Total accounts receivable	**157,167**	162,033
Inventories	**15,237**	13,660
Prepaid expenses and other	**25,769**	24,069
Total current assets	**601,548**	645,963
Investments restricted or designated for specific purposes:		
Held in Trust under bond master indenture	**114,680**	36,313
Designated by Board for specific purposes	**62,948**	62,387
Donor restricted for capital expenditures or to provide a permanent source of income	**58,627**	54,811
Receivable from charitable remainder annuity trusts	**10,069**	11,941
Total investments restricted or designated for specific purposes	**246,324**	165,452
Property, plant and equipment, net	**508,728**	483,597
Other assets:		
Goodwill	**10,006**	10,006
Other noncurrent assets	**12,311**	10,408
Total assets	**$ 1,378,917**	$ 1,315,426

Collis P. and Howard Huntington Memorial Hospital Trust,
Pasadena Hospital Association, Ltd. and Affiliates

Consolidated Balance Sheets
(In Thousands)

	December 31	
	2018	**2017**
Liabilities and net assets		
Current liabilities:		
Accounts payable	**$ 39,907**	$ 29,327
Current maturities of long-term debt	**4,734**	3,441
Current portion of accrued self-insurance claims	**8,720**	7,881
Accrued payroll and employee benefits	**35,364**	32,982
Accrued provider fee	**31,675**	45,826
Other accrued liabilities	**17,832**	13,731
Revolving credit line	**–**	9,664
Total current liabilities	**138,232**	142,852
Long-term debt, less current maturities	**316,537**	211,827
Accrued pension liability	**66,022**	66,841
Accrued self-insurance claims, less current portion	**18,474**	19,605
Other	**5,030**	5,887
Total liabilities	**544,295**	447,012
Net assets:		
Without donor restrictions	**722,252**	757,112
With donor restrictions	**112,370**	111,302
Total net assets	**834,622**	868,414
Total liabilities and net assets	**$ 1,378,917**	$ 1,315,426

See accompanying notes.

Collis P. and Howard Huntington Memorial Hospital Trust,
Pasadena Hospital Association, Ltd. and Affiliates

Consolidated Statements of Operations

(In Thousands)

	Year Ended December 31	
	2018	**2017**
Revenues without donor restrictions:		
Patient service revenues	**$ 658,228**	$ 668,120
Contributions	**8,839**	5,615
Other	**41,632**	42,280
Net assets released from restrictions	**5,182**	7,395
Total revenues without donor restrictions	**713,881**	723,410
Expenses:		
Salaries and benefits	**381,865**	388,902
Supplies and purchased services	**209,653**	209,969
Provider fee expense	**43,701**	55,656
Depreciation and amortization	**34,272**	41,829
Interest	**6,758**	7,586
Other expenses	**40,804**	35,771
Total expenses	**717,053**	739,713
Deficiency of revenues over expenses before other income and expense	**(3,172)**	(16,303)
Other income and expense:		
Investment (loss) income	**(27,855)**	68,277
Other	**(2,448)**	(1,081)
(Deficiency) excess of revenues over expenses	**$ (33,475)**	$ 50,893

See accompanying notes.

Collis P. and Howard Huntington Memorial Hospital Trust, Pasadena Hospital Association, Ltd. and Affiliates

Consolidated Statements of Changes in Net Assets

(In Thousands)

	Net Assets		
	Without Donor Restrictions	**With Donor Restrictions**	**Total**
Controlling			
Net assets at January 1, 2017	$ 701,087	$ 105,058	$ 806,145
Excess of revenues over expenses	50,893	–	50,893
Assets released from restrictions for capital purposes	1,866	(1,866)	–
Contributions and grants	–	5,686	5,686
Net investment income	–	9,819	9,819
Net assets released from restrictions used for operations	–	(7,395)	(7,395)
Change in pension liability	1,609	–	1,609
Other	1,657	–	1,657
Change in net assets	56,025	6,244	62,269
Net assets at December 31, 2017	757,112	111,302	868,414
Deficiency of revenues over expenses	**(33,475)**	–	**(33,475)**
Assets released from restrictions for capital purposes	**1,903**	**(1,903)**	–
Contributions and grants	–	**11,531**	**11,531**
Net investment loss	–	**(3,378)**	**(3,378)**
Net assets released from restrictions for operations	–	**(5,182)**	**(5,182)**
Change in pension liability	**(3,261)**	–	**(3,261)**
Other	**(27)**	–	**(27)**
Change in net assets	**(34,860)**	**1,068**	**(33,792)**
Net assets at December 31, 2018	**$ 722,252**	**$ 112,370**	**$ 834,622**
Non-controlling			
Net assets at January 1, 2017	$ 1,461	$ –	$ 1,461
Purchase of non-controlling interests	(1,461)	–	(1,461)
Net assets at December 31, 2017	$ –	$ –	$ –

Collis P. and Howard Huntington Memorial Hospital Trust,
Pasadena Hospital Association, Ltd. and Affiliates

Consolidated Statements of Cash Flows
(In Thousands)

	Year Ended December 31	
	2018	**2017**
Operating activities		
Change in net assets	**$ (33,792)**	$ 60,808
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Unrealized losses (gains) on investments	**50,060**	(58,735)
Depreciation and amortization	**34,272**	41,829
Gain on extinguishment of debt	**–**	(105)
Purchase of noncontrolling interest	**–**	1,461
Other	**(769)**	(114)
Contributions restricted for capital expenditures	**(5,627)**	(5,145)
Changes in operating assets and liabilities:		
Accounts receivable	**4,864**	(30,732)
Prepaids, inventories, and other current assets	**(3,278)**	1,025
Other assets and liabilities	**(3,257)**	3,431
Accounts payable and accrued expenses	**(3,137)**	30,570
Accrued pension liability	**(819)**	774
Net cash provided by operating activities	**38,517**	45,067
Investing activities		
Purchases of property, plant, and equipment	**(50,830)**	(35,947)
(Increase) decrease in investments – restricted for capital expenditures as required by bond issuance	**(81,468)**	9,556
Other net purchases and sales of investments	**(6,820)**	(16,462)
Change in receivable from charitable remainder annuity trusts	**1,872**	1,551
Net cash used in investing activities	**(137,246)**	(41,302)

Collis P. and Howard Huntington Memorial Hospital Trust,
Pasadena Hospital Association, Ltd. and Affiliates

Consolidated Statements of Cash Flows (continued)

(In Thousands)

	Year Ended December 31	
	2018	**2017**
Financing activities		
Proceeds from borrowings under revolving line of credit	**$ –**	$ 9,664
Repayment of revolving line of credit	**(9,664)**	–
Proceeds from issuance of long-term debt	**108,842**	–
Repayment of debt upon extinguishment	**–**	(11,380)
Payments on other long-term debt	**(3,290)**	(2,676)
Payments on capital lease obligations	**(1,098)**	(1,483)
Purchase of noncontrolling interest	**–**	(1,461)
Contributions restricted for capital expenditures	**5,627**	5,145
Net cash provided by (used in) financing activities	**100,417**	(2,191)
Net increase in cash and cash equivalents	**1,688**	1,574
Cash and cash equivalents at beginning of year	**19,570**	17,996
Cash and cash equivalents at end of year	**$ 21,258**	$ 19,570
Supplemental disclosure of cash flow information		
Cash paid during the year for:		
Interest	**$ 3,731**	$ 7,251
Supplemental disclosure of noncash transactions		
Capital leases	**$ 2,813**	$ 277
Property, plant, and equipment	**$ 5,759**	$ 1,933

See accompanying notes.

Collis P. and Howard Huntington Memorial Hospital Trust,
Pasadena Hospital Association, Ltd. and Affiliates

Notes to Consolidated Financial Statements

December 31, 2018

1. Organization

In 1892, Pasadena Hospital Association, Ltd, now doing business as Huntington Memorial Hospital (HMH or the Hospital), was formed with the goal of providing a hospital for the people of Pasadena, California. In 1936, Pasadena Hospital Association, Ltd. agreed to transfer control when the land and facilities of the Hospital were acquired and became the hospital provided for under the terms of the Collis P. and Howard Huntington Memorial Hospital Trust (the Trust).

HMH is a California nonprofit public benefit corporation and an organization exempt from federal and state income taxes under Section 501(c)(3) of the Internal Revenue Code. The Trust is a charitable trust, registered with the Registry of Charitable Trusts pursuant to the Supervision of Trustees and Fundraisers for Charitable Purposes Act. The Trust was established in 1932 under the terms of the will of Mr. Henry E. Huntington. The bequest was invested and loaned by the Trustees for the purpose of making the best available profit thereon so as to yield income for the perpetual maintenance of HMH. The five Trustees of the Trust and their successors serve for life. The Trust exercises influence on HMH by means of the Hospital's bylaws, which provide that the Trustees serve on HMH's 25-member board of directors and that any significant transaction must be approved by a majority of the Trustees and HMH's board members. The Trustees actively participate in the Hospital's affairs and serve on its key committees.

The Trust owns the real property on which HMH is located. In addition to this property, the Trust has other properties and investments. In fulfillment of the will of Mr. Henry E. Huntington, these assets are held to produce a return to be used for the benefit of HMH's programs.

The Trust and the following organizations (collectively, the Group) are included in the accompanying consolidated financial statements.

HMH operates a hospital and medical center. HMH is the sole corporate member of the Huntington Medical Foundation (Foundation) and is the parent of the for-profit subsidiary, Congress Services Corporation (Congress).

The Foundation is organized as a 1206(l) clinic operated by HMH that conducts medical research and health education and provides health care to its patients through a group of physicians who are independent contractors.

Congress is a California for-profit corporation, which has interests in joint ventures that perform a variety of health care services, including outpatient surgery and outpatient imaging.

2. Summary of Significant Accounting Policies

Principles of Consolidation

All significant balances and transactions among the Group have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates.

Concentrations of Credit Risk

Financial instruments that potentially subject the Group to concentrations of credit risk consist primarily of cash and cash equivalents, investments, and patient accounts receivable. The Group may be exposed from time to time to credit risk with bank deposits in excess of the Federal Deposit Insurance Corporation insurance limits. There have been no losses in such accounts, and management does not believe that credit risk on cash and cash equivalents is significant. By policy, the Group limits the amount of its credit exposure by defining the types of investments that may be held and the percentage of the investment portfolio that may be maintained in any given investment type.

Cash and Cash Equivalents

The Group considers all highly liquid debt instruments with maturities, on the acquisition date, of three months or less to be cash equivalents. The carrying amount approximates fair value because of the short maturity of the investments.

2. Summary of Significant Accounting Policies (continued)

Investments

Investments in equity securities and mutual funds with readily determinable fair values and all investments in debt securities are measured at fair value on the consolidated balance sheets. Management determines the appropriate classification of all marketable securities at the date of purchase and re-evaluates such designations at each balance sheet date. The Group designated all of its investment portfolio at December 31, 2018 and 2017, as trading securities. Accordingly, unrealized gains or losses on marketable securities are reported as investment income. In addition, cash flows from the purchases and sales of the Group's investment portfolio designated as trading are reported as a component of investing activities.

Inventories

Inventories, primarily supplies and pharmaceuticals, are recorded at cost (by the first-in, first-out method), which is not in excess of net realizable value.

Investments Designated by Board for Specific Purposes

Investments designated by the Board of Directors for specific purposes include specific unrestricted gifts and investment earnings for the acquisition and development of property, plant, equipment, and patient and senior care over which the Board retains control and may, at its discretion, subsequently use for other purposes.

Property, Plant, and Equipment

Property, plant, and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable assets, which ranges from 2 to 65 years and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the consolidated financial statements. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. Repair and maintenance costs are expensed in the period incurred. In 2018, the Group performed an asset

2. Summary of Significant Accounting Policies (continued)

lifing study and, as a result, changes were made to the estimated remaining lives assigned to its various asset categories in order to more closely mirror actual usage; this study resulted in a change in estimate reflected as a deduction to depreciation expense for 2018 of $8.4 million.

Gifts of long-lived assets such as land, buildings, or equipment are reported as support without donor restrictions, and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as support with donor restrictions. Absent explicit donor stipulations about how long those long-lived assets must be maintained; expirations of donor restrictions are reported as net assets released from restrictions when the donated or acquired long-lived assets are placed in service.

Long-Lived Asset Impairment

Situations may arise where the carrying value of a long-lived asset may exceed the undiscounted value of the expected cash flows associated with that asset. In such circumstances, the asset is impaired. The Group reviews its long-lived assets for impairment on an annual basis, as well as when events or changes in business conditions suggest potential impairment. Impaired assets are written down to fair value. The Group determined that no long-lived assets were impaired at December 31, 2018 or 2017.

Goodwill

The Group’s goodwill is the result of the acquisition by the Group of a controlling interest in a surgery center in March 2012. The Group tests the carrying value of goodwill for impairment on an annual basis, or more frequently if indicators of impairment exist. The Group performed a qualitative assessment for its annual impairment assessment in 2018 and determined that no impairment existed.

2. Summary of Significant Accounting Policies (continued)

Accrued Self-Insurance Claims

The Group is self-insured for certain employee health care claims. The Group accrues employee health care claims, including management's estimate of incurred but not reported claims, based on the Group's claims experience. Such accruals totaled $2.7 million at December 31, 2018 and 2017, respectively.

The Group purchases reinsurance policies to insure for workers' compensation claims incurred above the self-insured retention (SIR) limits per claim. The policies have limits of $1 million per occurrence and in aggregate. Accruals for SIR risks are estimated by an actuary based on the Group's claims experience and were discounted at 2.5% in 2018 and 2017. Such accruals totaled $16.6 million and $17.5 million at December 31, 2018 and 2017, respectively. The accruals represent the total actuarially determined liability. The portion that is expected to be recoverable through reinsurance ($2.7 million and $3.2 million at December 31, 2018 and 2017, respectively) is included in prepaid expenses and other assets.

The Group purchases claims-made insurance policies to insure for professional (malpractice) and general liability claims reported above the SIR limits per claim. The policies have limits of $30.0 million per occurrence and in aggregate. Accruals for SIR risks are estimated by an actuary based on the Group's claims experience and were discounted at 2.5% in 2018 and 2017. Such accruals totaled $8.4 million and $7.3 million at December 31, 2018 and 2017, respectively. The accruals represent the total actuarially determined liability. The portion that is expected to be recoverable through reinsurance ($1.0 million and $1.1 million at December 31, 2018 and 2017, respectively) is included in prepaid expenses and other assets.

Net Assets with Donor Restrictions

Net assets with donor restrictions are those whose use by the Group has been limited by donors to a specific time period or purpose or those whose use has been restricted by donors and are to be maintained by the Group in perpetuity.

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as net assets with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires – that is, when a stipulated time restriction ends or purpose restriction is accomplished – net assets

2. Summary of Significant Accounting Policies (continued)

with donor restrictions are reclassified as net assets without donor restrictions and reported as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reflected as contributions without donor restrictions. Net assets released for use in operations are included in excess of revenues over expenses, while net assets released for acquisition of property and equipment are excluded from excess of revenues over expenses and recorded as an increase in net assets without donor restrictions.

The Group is a beneficiary of several split-interest agreements, primarily charitable remainder annuity trusts (CRATs) held by others. The Group recognizes its interest in these trusts as net assets with donor restrictions based on the Group's interest in the fair value of assets and the net present value of future payment obligations of the trust.

Patient Service Revenues and Patient Account Receivable

Patient service revenue is reported at the amount that reflects the consideration to which the Group expects to be entitled in exchange for providing patient care. These amounts, representing transaction price, are due from third-party payors (including health insurers and government programs), patients and others and include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Group bills the third-party payors and patients several days after the services are performed and/or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided by the Group. Generally, performance obligations satisfied over time apply to patients in the hospital receiving inpatient acute care services only. The Group measures the performance obligation from admission into the hospital to the point when the medical condition upon admission has been resolved and it is no longer required to provide services to that patient, usually at the time of discharge. Revenue for performance obligations satisfied over time is recognized pro-rata based on actual charges incurred in relation to total expected (or actual) charges upon discharge. The Group believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the services provided needed to satisfy the obligation.

Because all of its performance obligations relate to contracts with a duration of less than one year, the Group has elected to apply the optional exemption provided in Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 606-10-50-14(a) and, therefore, is not

2. Summary of Significant Accounting Policies (continued)

required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs on average within a week of the end of the reporting period.

The Group is utilizing the portfolio approach practical expedient in ASC 606 for contracts related to patient service revenue. The Group accounts for the contracts within each portfolio as a collective group, rather than individual contracts, based on the payment pattern expected in each portfolio category and the similar nature and characteristics of the patients within each portfolio. As a result, the Group has concluded that revenue for a given portfolio would not be materially different than if accounting for revenue on a contract-by-contract basis.

The Group has agreements with third-party payors that generally provide for payments to the Group at amounts different from its established rates. For patients who do not qualify for charity care, the Group recognizes revenue based on established or contracted rates, subject to certain discounts and implicit price concessions as determined by the Group. The Group determines the transaction price based on standard charges for services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Group's policy, and implicit price concessions provided to patients. Implicit price concessions represent differences between amounts billed and the estimated consideration the Group expects to receive from payors and patients, which are determined based on historical collection experience, current market conditions and other factors. The Group determines its estimates of contractual adjustments and discounts based on contractual agreements, discount policies, and historical experience.

Generally, patients who are covered by third-party payors are responsible for patient responsibility balances, including deductibles and coinsurance established by their insurance plans, which vary in amount. The Group estimates the transaction price for patients with deductibles and coinsurance based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period such changes occur or it can be reasonably determined such change is probable. Adjustments arising from a change in the transaction price were not significant in the years ending December 31, 2018 and 2017.

2. Summary of Significant Accounting Policies (continued)

The Group is paid a prospectively determined rate for the majority of inpatient acute care and outpatient services provided (principally Medicare, Medicaid, and certain insurers). These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. In addition, the Group is paid by Medicare for certain add-on payments such as medical education training costs and disproportionate share at a tentative rate, with final settlement determined after submission of annual cost reports by the Group and audits thereof by the Medicare Administrative Contractor.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation as well as significant regulatory action, and, in the normal course of business, the Group is subject to contractual reviews and audits, including audits initiated by the Medicare Recovery Audit Contractor program. As a result, there is at least a reasonable possibility that recorded estimates will change in the near term. The Group believes it is in compliance with applicable laws and regulations governing the Medicare and Medicaid programs and that adequate provisions have been made for any adjustments that may result from final settlements.

Settlements with third-party payors for retroactive adjustments due to reviews and audits are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care in the period the related services are provided or when results of audits and appeals can reasonably be determined or finalized. These settlements are estimated based on the terms of the payment agreement with the payor, regulations, notification from the payor and the Group's historical settlement activity, including an assessment to establish that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as new or revised information become known or as years are settled or are no longer subject to such reviews and audits. Adjustments arising from a change in the transaction price were not significant for the years ended December 31, 2018 or 2017.

The Group has elected the practical expedient allowed under FASB ASC 606-10-32-18 and does not adjust the promised amount of consideration from patients and third-party payors for the effects of a significant financing component due to the Group's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payor pays for that service will be one year or less. However, the Group does, in certain instances, enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

2. Summary of Significant Accounting Policies (continued)

The Group entered into a restructured, shared savings contractual agreement with a local medical group that receives professional and institutional at-risk capitation funding. This agreement establishes rates that include a monthly fixed institutional-based fee and claims-based rate for care provided to both commercial and Medicare Advantage members. Patient service revenue attributed to this medical group totaled $127.2 million and $127.1 million in 2018 and 2017, respectively.

Charity Care and Unreimbursed Cost of State Programs

HMH provides care without charge to patients who meet certain criteria under its financial assistance policy. Because HMH does not pursue collection of amounts determined to qualify as charity care, they are not reported as patient service revenue. Unreimbursed costs of charity care provided to the uninsured and patients in state and federal programs totaled approximately $4.4 million and $4.7 million in 2018 and 2017, respectively. The cost of uncompensated care is derived from the cost accounting system taking into account the cost of resources used such as labor, supplies, drugs, and equipment to provide the care.

In addition, in 2018 and 2017, the unreimbursed costs (unaudited) of non-charity care provided to patients in state programs, including the Medi-Cal program or enrolled in HMO and PPO plans under contract with the Medi-Cal program, are estimated by management to be approximately $33.1 million and $35.3 million, respectively.

California Hospital Quality Assurance Fee Program

In 2010, California legislation established a program that imposes a Hospital Quality Assurance (QA) Fee on certain general acute care hospitals in order to make supplemental and grant payments and increased capitation payments (Supplemental Payments) to hospitals up to the aggregate upper payment limit for various periods.

The California Hospital Quality Assurance (CHQA) Programs are designed to make supplemental inpatient and outpatient Medi-Cal payments to private hospitals, including additional payments for certain facilities that provide high-acuity care and trauma services to the Medi-Cal population.

2. Summary of Significant Accounting Policies (continued)

The CHQA Programs provide a mechanism for increasing payments to hospitals that serve Medi-Cal patients, with no impact on the state's General Fund. Some of these payments will be made directly by the state, while others will be made by Medi-Cal managed care plans, which will receive increased capitation rates from the state in amounts equal to the Supplemental Payments. Outside of the legislation, the California Hospital Association has created a private program, operated by the California Health Foundation and Trust (CHFT), which was established to alleviate disparities potentially resulting from the implementation of the CHQA Programs and, therefore, resulted in pledges of grant income to these hospitals.

There are two CHQA programs that had activity in 2018 and 2017: a 36-month hospital fee program covering the period from January 1, 2014 through December 31, 2017, and a 30-month hospital fee program covering the period from January 1, 2018 through June 30, 2019. The Group recorded a net benefit of $3.7 million during 2018, with $1.7 million from the 36-month program, and $2.0 million from the 30-month program in 2018. Patient service revenues and provider fee expenses include amounts for the CHQA program as follows:

For the years ended December 31,

	2018	2017
	(In Thousands)	
CHQA program revenue	**$ 47,354**	$ 56,689
CHQA program expense	**(43,701)**	(55,656)
Income from operations from CHQA program	**$ 3,653**	$ 1,033

Contributions without donor restrictions or those released from donor restrictions in a given year generated from the Group's philanthropy operations, along with the related expenses, are included in total revenues and expenses.

(Deficiency) Excess of Revenues over Expenses

The consolidated statements of operations include the (deficiency) excess of revenues over expenses, which is considered the performance indicator. Changes in net assets without donor restrictions that are excluded from the (deficiency) excess of revenues over expenses, consistent

2. Summary of Significant Accounting Policies (continued)

with industry practice, primarily include contributions of long-lived assets (including assets acquired using contributions that by donor restrictions were to be used for the purposes of acquiring such assets) and changes in pension liabilities.

Income Taxes

HMH has been determined to qualify as exempt from federal and state income taxes under Section 501(a) as organizations described in Section 501(c)(3) of the Code. Most of the income received by the Group is exempt from taxation, as income related to the mission of the organization. Accordingly, there is no material provision for income taxes for these entities.

However, some of the income received by the exempt entities is subject to taxation as unrelated business income. The Group and its affiliates file federal and state income tax returns.

The Group completed an analysis of its tax positions, in accordance with ASC 740, *Income Taxes*, and determined that there are no uncertain tax positions taken or expected to be taken. The Group has recognized no interest or penalties related to uncertain tax positions. The Group is subject to routine audits by the taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The Group believes it is no longer subject to income tax examinations for years prior to 2014.

Reclassifications

The Group previously classified contributions without donor restrictions as other income in the consolidated statement of operations. The Group reclassified $5.6 million of contributions for the year ended December 31, 2017, to total revenues to conform with current year presentation.

Subsequent Events

The Hospital has been named as a beneficiary in a certain estate plan. Based upon current valuations, such future gift is estimated to be no less than $70.0 million. Due to changes in circumstances in early 2019, the Hospital currently is obtaining a complete understanding of the terms of the estate plan and other relevant factors so that a determination can be made as to the amount and timing of recording this potential future gift as a contribution in the consolidated financial statements.

2. Summary of Significant Accounting Policies (continued)

The Group evaluated subsequent events through April 29, 2019, which is the date these consolidated financial statements were issued.

New Accounting Pronouncements

Effective January 1, 2018, the Group adopted FASB Accounting Standard Update (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606),* using the full retrospective method of transition. This ASU converged and replaced existing revenue recognition guidance, including industry-specific guidance, and requires revenue to be recognized in an amount that reflects the consideration the entity expects to be entitled in an exchange of goods or services. The adoption of this ASU did not materially impact the consolidated financial statements.

On August 18, 2016, the FASB completed Phase I of its Presentation of Financial Statements of Not-for-Profit Entities project by issuing ASU No. 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities*. The new guidance simplifies and improves the face of the financial statements and enhances the disclosures in the footnote of not-for-profit entities (NFPs). The Group adopted the new standard for the year ended December 31, 2018, and has applied it retrospectively to all periods presented. The impact of adopting ASU 2016-14 had no impact to total revenues, (deficiency) excess of revenues over expenses or total net assets.

The FASB issued final guidance that may change how an entity classifies certain cash receipts and cash payments on its statement of cash flows. The new guidance, ASU No. 2016-15 and 2016-18, *Statement of Cash Flows (Topic 230),* addresses certain issues where diversity in practice was identified. The guidance will be applied retrospectively and is effective for fiscal years beginning after December 15, 2018. The Group adopted the guidance as of December 31, 2018, and it did not have a material effect on its consolidated financial statements.

New Accounting Standards Not Yet Adopted

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842),* which amends the existing accounting standards for lease accounting, including requiring lessees to recognize most leases on their balance sheets and making targeted changes to lessor accounting. The new standard, effective on January 1, 2019, requires a modified retrospective transition approach for all leases existing at, or entered into after, the date of initial application, with an option to use certain transition relief

2. Summary of Significant Accounting Policies (continued)

and allows for early adoption on January 1, 2017. In July 2018, the FASB issued ASU 2018-08, *Leases (Topic 842): Targeted Improvements,* which further amended this standard to allow for a new transition method that provides the option to use the effective date as the date of initial application. The Group intends to elect this alternative transition method and therefore will not adjust comparative-period financial information. In addition, the Group intends to elect the package of practical expedients permitted under the transition guidance of the new standard to not reassess prior conclusions related to contracts that contain leases, lease classification and initial direct costs. The primary effect of adopting the new standard will be to record right-of-use assets and the corresponding present value of lease obligations liabilities for current operating leases.

In March 2017, the FASB issued ASU No. 2017-07, *Compensation – Retirement Benefits (Topic 745): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. The new guidance requires entities to 1) disaggregate the current-service-cost component from the other components of net benefit cost and present it with other current compensation costs for related employees in the income statement and 2) present the other components elsewhere in the income statement and outside of income from operations if that subtotal is presented. In addition, entities are required to disclose the income statement lines that contain the other components if they are not presented on appropriately described separate lines. The guidance will be effective in 2019, and the Group does not expect it to have a material effect on its consolidated statements.

In January 2017, the FASB issued ASU 2017-04, *Intangibles – Goodwill and Other (Topic 350)* that eliminates the requirement to calculate the implied fair value of goodwill (i.e., Step 2 of today's goodwill impairment test) to measure goodwill impairment charges. Instead, entities would record an impairment charge based on the excess of a reporting unit's carrying amount over its fair value (i.e., measure the charge based on today's Step 1). All other goodwill impairment guidance would remain unchanged. The new standard, effective on January 1, 2021, requires prospective application. Early adoption is permitted for interim or annual goodwill impairment tests performed on testing dates after January 1, 2017. The Group does not expect the change in calculation to have a material effect on its consolidated financial statements.

In June 2018, the FASB issued ASU No. 2018-08, *Not-for-Profit Entities – Clarifying the Scope and Accounting Guidance for Contributions Received and Contributions Made* (Topic 958). This ASU provides a more robust framework to determine when a transaction should be accounted for as a contribution or as an exchange transaction and provides additional guidance about how to

2. Summary of Significant Accounting Policies (continued)

determine whether a contribution is conditional. This ASU is effective January 1, 2019, and will be applied on a modified prospective basis. The Group does not expect the change to have a material effect on its consolidated financial statements.

In August 2018, the FASB issued ASU No. 2018-13, *Fair Value Measurement* (Topic 820). This ASU improves the effectiveness of the notes to financial statements through changes in the disclosure requirements for fair value measurement. The ASU is effective January 1, 2020, and will be applied using a retrospective approach. The Group is currently evaluating the impact that ASU 2018-13 will have on its consolidated financial statements and will adopt the provisions on or before the effective date.

In August 2018, the FASB issued ASU 2018-14, *Compensation – Retirement Benefits – Defined Benefit Plans – General*. This standard intends to make minor changes to the disclosure requirements for employers that sponsor defined benefit pension and other postretirement benefit plans. The amendments in this standard remove disclosures that no longer are considered cost beneficial, clarify the specific requirements of disclosures, and add disclosure requirements identified as relevant. ASU 2018-14 is effective for the Group for annual reporting periods beginning after December 15, 2021, with early adoption permitted. Upon adoption, the Group is required to apply the new standard retrospectively to all periods presented in the consolidated financial statements. The Group is currently evaluating the impact that ASU 2018-14 will have on its consolidated financial statements and will adopt the provisions on or before the effective date.

In August 2018, the FASB issued ASU No. 2018-15, *Intangibles – Goodwill and Other, Internal-Use Software (Subtopic 350-40), Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract*. This ASU aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. The ASU is effective January 1, 2021, and will be applied using a prospective approach. The Group is currently evaluating the impact that ASU 2018-15 will have on its consolidated financial statements and will adopt the provisions on or before the effective date.

3. Patient Accounts Receivable

Patient service revenue by major payor source for the years ended December 31 are as follows:

	2018	2017
	(In Thousands)	
Government (excluding provider fee)	**$ 179,970**	$ 185,980
Contracted and others	**427,721**	422,129
Self-pay	**3,183**	3,322
Patient service revenue, excluding provider fee	**610,874**	611,431
Provider fee revenue	**47,354**	56,689
Patient service revenue	**$ 658,228**	$ 668,120

Concentrations of credit risk with respect to patient accounts receivable are limited, except with respect to larger insurers programs under contract with federal and state governments, due to the large number of payors comprising the Group's patient base. With respect to larger insurers patient accounts receivable due from Anthem Blue Cross, Blue Shield and United Health Group comprised of $13.1 million, $12.6 million and $5.8 million, respectively, at December 31, 2018 and $9.7 million, $11.2 million and $5.9 million at December 31, 2017, respectively. With respect to programs under contract with federal and state governments, patient accounts receivable due directly or indirectly from Medicare and Medi-Cal were $23.4 million and $16.6 million, respectively, at December 31, 2018, and $19.0 million and $12.0 million, respectively, at December 31, 2017.

As a result of certain changes required by ASU 2014-09, the majority of the Group's provision for bad debt is recorded as a direct reduction to patient service revenue instead of being presented as a separate line item on the consolidated statements of operations. The adoption of ASU 2014-09 has no impact on the Group's accounts receivable, as it was historically recorded net of allowance for bad debt and contractual adjustments on the consolidated balance sheets.

4. Investments

The Group's investments as of December 31 by financial statement line item are as follows:

	2018	2017
	(In Thousands)	
Short-term investments	**$ 372,556**	$ 420,533
Investments held in trust for current debt service	**9,561**	6,098
Investments held in trust under bond master indenture	**114,680**	36,313
Investments designated by Board for specific purposes	**62,948**	62,387
Investment restricted by donors for capital expenditures or to provide a permanent source of income	**58,627**	54,811
Receivable from charitable remainder annuity trusts	**10,069**	11,941
	$ 628,441	$ 592,083

Investment income or loss on marketable securities included in donor restricted net assets (including realized and unrealized gains and losses on investments, interest, and dividends) is reported as other income unless the income or loss is restricted by donor or law, in which case the investment income or loss is recorded directly to net assets with donor restrictions.

4. Investments (continued)

Investment income includes the following for the years ended December 31:

	Investment (Loss) Income		
	Without Donor Restrictions	**With Donor Restrictions**	**Total**
	(In Thousands)		
2018			
Interest and dividends	**$ 5,074**	**$ 675**	**$ 5,749**
Net realized gains	**10,482**	**2,595**	**13,077**
Net unrealized losses	**(43,411)**	**(6,648)**	**(50,060)**
	$ (27,855)	**$ (3,378)**	**$ (31,233)**
2017			
Interest and dividends	$ 7,017	$ 733	$ 7,750
Net realized gains	10,017	1,594	11,611
Net unrealized gains	51,243	7,492	58,735
	$ 68,277	$ 9,819	$ 78,096

5. Fair Value Measurements

Fair value is defined as the price that would be received upon sale of an asset or paid upon transfer of a liability in an orderly transaction between market participants. As such, fair value is a market-based measurement that should be determined based on assumptions that market participants would use in pricing an asset or liability.

5. Fair Value Measurements (continued)

As a basis for considering such assumptions, the Group establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value as follows:

Level 1 – Quoted prices are available in active markets for identical assets as of the measurement date.

Level 2 – Assets that are based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Assets whose fair value cannot be determined by using observable measures and can only be calculated using estimates or risk-adjusted value ranges when little or no market data is available. The inputs into the determination of fair value require management's judgment or estimation of assumptions that market participants would use in pricing the assets or liabilities. The fair values are therefore determined using factors that involve considerable judgment and interpretations, including, but not limited to, private and public comparables, third-party appraisals, discounted cash flow models, and fund manager estimates. The Group held no Level 3 financial instruments at December 31, 2018 and 2017.

Financial assets and liabilities measured at fair value are based on one or more of the following three valuation techniques:

(a) Market approach – Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities.

(b) Cost approach – Amount that would be required to replace the service capacity of an asset (replacement cost).

(c) Income approach – Techniques to convert future amounts to a single present amount based on market expectations (including present value techniques, option-pricing, and excess earnings models).

5. Fair Value Measurements (continued)

The Group's assets and liabilities measured at fair value and net asset value on a recurring basis are as follows as of December 31:

	Investments at Fair Value			Valuation technique
	Total	**Level 1**	**Level 2**	
2018	*(In Thousands)*			
Restricted cash and equivalents	**$ 168,475**	**$ 168,475**	**$ -**	**(a)**
Marketable equity securities	**3,364**	**3,364**	**-**	**(a)**
U.S. equity mutual fund	**97,231**	**97,231**	**-**	**(a)**
Global fixed income and equity mutual funds	**211,062**	**211,062**	**-**	**(a)**
Debt securities – corporate and other	**145**	**-**	**145**	**(a)**
Receivable from charitable remainder annuity trusts	**10,069**	**-**	**10,069**	**(c)**
Total	**$ 490,346**	**$ 480,132**	**$ 10,214**	
Investments measured at net asset value:				
U.S. fixed income mutual fund	**21,177**			
Global equity mutual fund	**73,855**			
Pooled hedge funds	**35,783**			
Private equity fund	**7,280**			
Total	**138,095**			
Total investments	**$ 628,441**			
Liabilities				
Gift annuity/CRAT	**$ 1,537**	**$ -**	**$ 1,537**	**(c)**
Total	**$ 1,537**	**$ -**	**$ 1,537**	

5. Fair Value Measurements (continued)

	Investments at Fair Value			
	Total	**Level 1**	**Level 2**	**Valuation technique**
2017	*(In Thousands)*			
Restricted cash and equivalents	$ 64,909	$ 64,909	$ -	(a)
Marketable equity securities	3,843	3,843	-	(a)
U.S. fixed income and equity mutual funds	113,356	113,356	-	(a)
Global fixed income and equity mutual funds	237,987	237,987	-	(a)
Debt securities – corporate and other	138	-	138	(a)
Receivable from charitable remainder annuity trusts	11,941	-	11,941	(c)
Total	$ 432,174	$ 420,095	$ 12,079	
Investments measured at net asset value:				
U.S. fixed income mutual fund	22,383			
Global equity mutual fund	95,682			
Pooled hedge funds	37,205			
Private equity fund	4,639			
Total	159,909			
Total investments	$ 592,083			
Liabilities				
Gift annuity/CRAT	$ 2,165	$ -	$ 2,165	(c)
Total	$ 2,165	$ -	$ 2,165	

5. Fair Value Measurements (continued)

At December 31, 2018 and 2017, the Group's investments of $138.1 million and $159.9 million, respectively, in alternative investment funds, including hedge funds, mutual funds, and private equity funds, are measured using the fund's net asset value per unit as a practical expedient to estimate fair value. For the mutual funds and hedge funds, redemption clauses range between monthly and biannually with various notice requirements between 10 and 95 days. The Group may not withdraw or sell, assign, or transfer its interest in the private equity fund except in certain limited circumstances, subject to consent by the general partners of the fund.

The total unfunded commitments related to private equity funds were $2.3 million at December 31, 2018.

The fair value of the Group's receivable from charitable remainder annuity trusts (CRAT) is based on the Group's percentage of the fair value of the trust's assets adjusted for any outstanding liabilities (discounted using a rate per Internal Revenue Service regulations), based on each trust arrangement.

The fair value of gift annuity/CRAT liabilities was determined using techniques that are consistent with the income approach. The fair value is determined using a net present value approach based on IRS 1457 tables and Applicable Federal Rates. The rates used were 3.6% and 2.6% at December 31, 2018 and 2017, respectively. Mortality tables regularly published by the federal government are utilized to estimate remaining lives of trust donors.

The fair value of the Group's tax-exempt financings at December 31, 2018 and 2017, based on current market rates (Level 2), was $322.9 million and $226.7 million, respectively (carrying value, excluding premium – $298.3 million and $200.7 million, respectively).

6. Availability of Financial Assets

The following reflects the Group's financial assets at December 31, 2018, reduced by amounts not available for general use within one year of the balance sheet date because of contractual or donor-imposed restrictions or internal designations. Amounts not available include amounts set aside for long-term investing in the operating and capital reserves that could be drawn upon if the governing board approves that action.

	2018
Financial assets:	
Cash and cash equivalents	**$ 21,258**
Investments	**372,556**
Accounts receivable	**157,167**
Total financial assets	**$ 550,981**

The Group has certain board designated and donor-restricted assets limited to use which are available for general expenditure within one year in the normal course of operations. Accordingly, these assets have been included in the information above for financial assets to meet general expenditures within one year. The Group has other assets limited to use for donor-restricted purposes and debt service. Additionally, certain other board-designated assets are designated for future capital expenditures. These restricted investments, which are more fully described in Note 9, are not available for general expenditure within the next year. However, the board-designated amounts could be made available, if necessary.

As part of the Group's liquidity management plan, cash in excess of daily requirements are invested in in short-term investments and money market funds. Additionally, the Group maintains a $30.0 million revolving line of credit, as discussed in more detail in Note 8. As of December 31, 2018, $30.0 million remained available on the Group's revolving line of credit.

7. Property, Plant, and Equipment

Property, plant, and equipment consist of the following as of December 31:

	2018	2017
	(In Thousands)	
Land	**$ 21,470**	$ 21,254
Buildings and improvements	**614,558**	607,093
Leasehold improvements	**27,924**	28,063
Equipment	**223,401**	231,656
Equipment - capital leases	**51,464**	52,342
Construction in progress	**84,631**	65,938
	1,023,449	1,006,346
Accumulated depreciation and amortization	**(491,079)**	(499,476)
Accumulated depreciation and amortization - capital leases	**(23,642)**	(23,273)
	$ 508,728	$ 483,597

8. Long-Term Debt and Revolving Line of Credit

Long-term debt consists of the following as of December 31:

	Interest Rate(s)	Final Maturity	2018	2017
			(In Thousands)	
Bonds payable:				
Series 2018 Bonds, including unamortized premiums of $8,842 at December 31, 2018	5%	2048	**$ 108,842**	$ -
Series 2014A Bonds, including unamortized premiums of $1,174 and $1,179 at December 31, 2018 and 2017, respectively	5%	2044	**51,174**	51,179
Series 2014B Bonds, including unamortized premiums of $14,191 and $14,772 at December 31, 2018 and 2017, respectively	3% to 5%	2044	**162,486**	165,517
Obligations under capital leases			**3,368**	1,549
			325,870	218,245
Less current maturities			**(4,734)**	(3,441)
			321,136	214,804
Less debt issuance costs			**(4,599)**	(2,977)
			$ 316,537	$ 211,827

Bond premiums, net of debt discounts, are amortized over the term of the bonds using the effective interest method.

Debt issuance costs are classified as a direct deduction from the carrying amount of the debt liability. Costs incurred in obtaining long-term financing are deferred and amortized over the terms of the related obligations using the effective interest method.

HMH and the Trust are co-obligors on the bonds, comprising the Obligated Group. The Obligated Group members are jointly and severally liable for the debt.

8. Long-Term Debt and Revolving Line of Credit (continued)

The bonds are collateralized by the Gross Receivables of the Obligated Group, and trustee-held funds established in accordance with the bond indenture. Certain receivables are excluded from the Gross Receivables pledge, such as donations or grants restricted for purposes other than debt service, as well as real property held by the Trust. The Obligated Group must comply with certain covenants, including a required minimum debt service coverage ratio, the maintenance of certain required funds, and limitations on the use of bond proceeds. At December 31, 2018 and 2017, the Obligated Group was in compliance with all bond covenants.

On March 30, 2012, the Group executed a promissory note to borrow $13.2 million to finance the upgrade of the Group's information technology (IT) infrastructure, collateralized by IT equipment. The note was fully paid off in March 2017.

On June 22, 2017, the Group entered into a revolving credit agreement with a commitment amount of $30.0 million and a term of three years, with the option to extend in writing, no sooner than 120 days prior to the current maturity date, should both parties desire to continue with the arrangement. The facility is provided by a major bank at 1-month LIBOR +50BPS and contains covenants similar to those associated with the Group's bonds noted above. An advance of $9.7 million was used to refund in advance the Series 2005 Bonds on July 6, 2017, resulting in a gain on extinguishment of the Series 2005 Bonds of $0.1 million. Amounts outstanding under the revolving credit agreement were $0 and $9.7 million as of December 31, 2018 and 2017, respectively.

On May 2, 2018, the Group completed a bond offering resulting in net proceeds of $108.8 million. The proceeds of the bonds are to be used to finance the seismic rehabilitation, construction, improvement, renovation, and equipping of existing health care facilities owned and operated by the Group.

8. Long-Term Debt and Revolving Line of Credit (continued)

The aggregate amounts of annual maturities and sinking fund payments on all long-term debt, including capital leases, for the years subsequent to December 31, 2018, are as follows (in thousands):

2019	**$ 4,381**
2020	**5,338**
2021	**5,593**
2022	**5,866**
2023	**5,961**
Thereafter	**274,524**
Total principal payments	**$ 301,663**
Unamortized bond premiums (including current portion of $353)	**24,207**
	$ 325,870

Interest costs incurred totaled $11.2 million and $10.2 million in 2018 and 2017, respectively, of which $4.4 million and $2.6 million in 2018 and 2017, respectively, was capitalized.

9. Net Assets and Contributions

Net assets with donor restrictions are available for the following purposes as of December 31:

	2018	**2017**
	(In Thousands)	
Patient care services	**$ 53,413**	$ 57,590
Nursing/residency programs	**16,420**	16,100
Building and maintenance	**30,666**	22,610
Research and others	**1,624**	1,568
Time restricted under CRT	**10,247**	12,134
Pledges receivable	**-**	1,300
	$ 112,370	$ 111,302

9. Net Assets and Contributions (continued)

Restricted net assets for building and equipment are included in investments restricted for capital expenditures and other assets on the consolidated balance sheets. Net assets restricted for noncapital purposes are included in short-term investments, other assets, and receivable from charitable remainder annuity trusts.

Net unconditional promises to give, included in current and other non-current assets, consist of the following as of December 31. Promises to give are discounted using approximate 5-year U.S. Treasury rates with active promises currently carrying rates between 2% and 6%.

	2018	2017
	(In Thousands)	
Unconditional promises to give, less:	**$ 13,819**	$ 9,332
Discounts	**(224)**	(114)
Allowance for uncollectibility	**(202)**	(310)
Total unconditional promises to give, net	**$ 13,393**	$ 8,908

As of December 31, 2018, future discounted receipts anticipated from unconditional promises to give, net of an allowance for uncollectibility, are as follows (in thousands):

2019	**$ 7,979**
2020 through 2023	**5,380**
Thereafter	**34**
	$ 13,393

9. Net Assets and Contributions (continued)

Split-interest Agreements

The hospital is party to many gift annuity arrangements. These generally take the form of charitable remainder annuity trusts (CRATs) or charitable remainder unit trusts (CRUTs) where the hospital pays a fixed return to the donor while still living and the remaining undistributed trust assets revert to the hospital upon the donor's passing. The hospital is also a named beneficiary under many legacy and bequest arrangements where it will receive all or a portion of the irrevocable trusts upon the passing of the donors. The fair value of these assets and the associated liabilities for amounts payable under the gift annuities are remeasured at each year-end as outlined in Note 5 Fair Value Measurements. Assets and liabilities recorded in relation to these split-interest agreements as of December 31:

	2018	**2017**
	(In Thousands)	
Gift Annuities and CRTs:		
Assets	**$ 3,545**	$ 4,141
Liabilities	**(1,537)**	(2,165)
Legacies and Bequests:		
Assets	**$ 10,069**	$ 11,941

Contribution revenue recognized in relation to split-interest agreements totaled $0 and $24,000 for the years ended December 31, 2018 and 2017, respectively. Changes in the value of split-interest agreements recognized totaled $(266,000) and $(30,000) for the years ended December 31, 2018 and 2017, respectively.

9. Net Assets and Contributions (continued)

Endowment

The Group's endowment includes all net assets that contain donor restrictions as well as Board-designated funds.

The changes in endowment net assets are as follows:

	Without Donor Restrictions	With Donor Restrictions	Total
		(In Thousands)	
Endowment net assets, January 1, 2017	$ 61,992	$ 83,625	$ 145,617
Investment return	-	697	697
Net appreciation	-	8,681	8,681
Contributions	386	6,937	7,324
Adjustment to CRTs and	-	-	-
legacies and bequests	-	(1,833)	(1,833)
Appropriation of endowment assets	-	-	
for expenditure	(200)	(7,036)	(7,236)
Transfers to create board-designated	-	-	
endowment funds	209	(209)	-
Endowment net assets, December 31, 2017	62,387	90,863	153,250
Investment return	**-**	**640**	**640**
Net depreciation	**-**	**(3,826)**	**(3,826)**
Contributions	**562**	**4,257**	**4,819**
Adjustment to CRTs and			**-**
legacies and bequests	**-**	**(3,588)**	**(3,588)**
Appropriation of endowment assets			**-**
for expenditure	**(200)**	**(4,271)**	**(4,471)**
Transfers to create board-designated			**-**
endowment funds	**199**	**(199)**	**-**
Endowment net assets, December 31, 2018	**$ 62,948**	**$ 83,877**	**$ 146,825**

9. Net Assets and Contributions (continued)

The endowment net asset composition by type of fund as of December 31 consists of the following:

	2018		
	Without Donor Restrictions	**With Donor Restrictions**	**Total**
	(In Thousands)		
Donor-restricted endowment funds	**$ -**	**$ 83,877**	**$ 83,877**
Board-designated endowment funds	**62,948**	**-**	**62,948**
Total funds	**$ 62,948**	**$ 83,877**	**$ 146,825**

	2017		
	Without Donor Restrictions	**With Donor Restrictions**	**Total**
	(In Thousands)		
Donor-restricted endowment funds	$ -	$ 90,863	$ 90,863
Board-designated endowment funds	62,387	-	62,387
Total funds	$ 62,387	$ 90,863	$ 153,250

Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor requires the Group to retain as a fund of perpetual duration. Deficiencies of this nature are reported in net assets without donor restrictions. There were no such deficiencies as of December 31, 2018 or 2017.

9. Net Assets and Contributions (continued)

Return Objectives and Risk Parameters

The Group has investment policies that attempt to provide a predictable stream of funding to programs supported by operations as well as endowment donations. Assets are invested in a manner that is intended to produce results that exceed the respective benchmark while assuming a moderate level of investment risk. Actual returns in any given year may vary from this amount.

Strategies Employed for Achieving Objectives

To satisfy its long-term rate-of-return objectives, the Group relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Group targets a diversified asset allocation to achieve its long-term return objectives within prudent risk constraints.

Interpretation of Relevant Law

In 2009, the Uniform Prudent Management of Institutional Funds Act (UPMIFA) was enacted to update and replace Ohio's previous law, the Uniform Management of Institutional Funds Act. The Group has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds, absent explicit donor stipulations to the contrary. As a result of this interpretation, the Group classifies as net assets with donor restrictions (1) the original value of gifts donated to the permanent endowment, (2) the original value of subsequent gifts to the permanent endowment, and (3) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in the permanent endowment is available for appropriation for expenditure by the Group in a manner consistent with the standard for expenditure prescribed by UPMIFA. In accordance with UPMIFA, the Group considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

(1) The duration and preservation of the fund

(2) The purposes of the Group and the donor-restricted endowment fund

(3) General economic conditions

(4) The possible effect of inflation and deflation

9. Net Assets and Contributions (continued)

(5) The expected total return from income and the appreciation of investments

(6) Other resources of the Group

(7) The investment policies of the Group

A description of endowment assets is as follows as of December 31:

	2018	2017
	(In Thousands)	
Net Assets with Donor Restrictions		
(1) Term endowment funds	**$ 41,647**	$ 49,045
(2) The portion of perpetual endowment funds subject to a time restriction under UPMIFA:		
Without purpose restrictions	**161**	161
With purpose restrictions	**42,069**	41,657
Total endowment funds classified as net assets with donor restrictions	**$ 83,877**	$ 90,863

Fundraising & Contributed Services

Fundraising costs consist solely of direct costs associated with philanthropic activities, such as salaries and benefits of individuals pursuing donations, costs of fundraising events, and the like. No allocations of general expense are made.

Contributed services consist of volunteer hours worked through the hospital's volunteer program. The Group does not recognize these donated service hours as revenue. 126,353 and 108,461 volunteer hours (unaudited) were donated to the hospital in 2018 and 2017, respectively. These services represent an approximate value (unaudited) of $3.1 million and $2.6 million for 2018 and 2017, utilizing hourly rates of $24.69 and $24.14 in 2018 and 2017, respectively.

10. Commitments and Contingencies

Commitments

The Group leases office space and facilities under leases ranging from 5 to 20 years. Building rent expense totaled approximately $10.3 million and $9.7 million in 2018 and 2017, respectively. The Group leases the Pavilion Medical Building under three master lease agreements. The rental agreements commenced on June 1, 2009, and have 20-year terms plus two consecutive options to extend the terms of the leases for ten years each. The leases also include annual CPI escalation clauses (with a 3% floor and 6% cap). The Group subleases certain portions of the Pavilion Medical Building to an unconsolidated equity method investee. The Group's portion of rental income and rental expense related to this unconsolidated equity method investee is eliminated in consolidation.

Huntington Medical Foundation has eight building leases with 3–10 year terms, with short-term renewal options and annual escalation clauses from 0% to 3%.

The Group leases equipment under leases ranging from one to seven years. Equipment rent expense totaled approximately $3.1 million for both 2018 and 2017.

As of December 31, 2018, payments relating to future operating leases are as follows (in thousands):

2019	**$ 9,121**
2020	**8,729**
2021	**8,658**
2022	**8,798**
2023	**8,706**
Thereafter	**49,622**
	$ 93,634
Less: Sublease rental income	**1,618**
Total	**$ 92,016**

10. Commitments and Contingencies (continued)

Contingencies

The Group records accruals for loss contingencies to the extent it is probable that a liability has been incurred and the amount of the related loss can be reasonably estimated. Certain legal actions arising in the ordinary course of business are pending against the Group. Management believes that the ultimate resolution of the various proceedings will not have a material adverse effect upon the consolidated financial position, results of operations, or cash flows of the Group.

Recently, the Hospital has been named in several lawsuits related to the treatment of patients in an inappropriate manner by an affiliated (not employed) private practice physician at his medical office and the Hospital. Litigation in this matter involves numerous complex issues and discovery is still in the very early states. Additional litigation could be filed or the cases could be dismissed. Accordingly, based upon information currently available, it is not possible to predict the final resolution of these matters and their impact on the future consolidated financial position and results of operations of the Group.

11. Retirement Plans

HMH has a defined benefit retirement plan. This plan was contributory through June 30, 2005, and became noncontributory on July 1, 2005. Effective July 1, 2013, the plan was closed to new participants and all benefit accruals under the plan were frozen. Additionally, HMH adopted a 457(f) defined benefit retirement plan, effective December 31, 2005, covering key executives.

In 2018, the plans had a net actuarial gain of $15.5 million, resulting in an increase in the plans' projected benefit obligation that was primarily driven by an increase in the discount rate from 3.75% at December 31, 2017, to 4.35% at December 31, 2018. Plan related cost components are presented in salaries and benefits expense.

11. Retirement Plans (continued)

The changes in benefit obligation and plan assets of the plans are as follows for the years ended December 31:

	2018	2017
	(In Thousands)	
Projected benefit obligation at beginning of year	**$ 239,868**	$ 227,769
Service cost	**2,439**	2,531
Interest cost	**8,720**	9,613
Benefits paid	**(4,663)**	(11,992)
Actuarial (gain) loss	**(15,541)**	11,947
Settlement	**(12,331)**	-
Projected benefit obligation at end of year	**$ 218,492**	$ 239,868
Fair value of plan assets at beginning of year	**$ 173,027**	$ 161,702
Actual return on plan assets	**(11,482)**	23,317
Employer contributions	**7,905**	-
Benefits paid	**(16,980)**	(11,992)
Fair value of plan assets at end of year	**$ 152,470**	$ 173,027
Funded status (long-term accrued pension liability)	**$ (66,022)**	$ (66,841)

Lump sum settlements in 2018 reached a level requiring the current year recognition of $3.1 million in losses from changes in net assets without restrictions arising from a defined benefit plan but not yet included in net periodic benefit cost, representing the settlement of 0.14% of the plan's obligations.

11. Retirement Plans (continued)

	2018	2017
	(In Thousands)	
Pension liability recorded as changes in net assets without donor restrictions:		
Unrecognized prior actuarial loss	**$ 54,476**	$ 51,175
	54,476	51,175
Pension liability recorded through earnings	**11,546**	15,666
Total pension liability recorded	**$ 66,022**	$ 66,841
Accumulated benefit obligation	**$ 218,492**	$ 239,868

	2018	2017
	(In Thousands)	
Net periodic benefit cost recognized:		
Service cost	**$ 2,439**	$ 2,531
Interest cost	**8,719**	9,613
Expected return on plan assets	**(11,327)**	(10,656)
Net actuarial loss amortization	**895**	844
Net periodic benefit cost	**$ 726**	$ 2,332

11. Retirement Plans (continued)

The actuarial assumptions as of December 31 are as follows:

	2018	2017
Weighted-average assumptions:		
Discount rate (used for funded status)	**4.35%**	3.75%
Discount rate (used for pension cost)	**3.75%**	4.29%
Expected return on plan assets (based on historical investment returns)	**6.75%**	6.75%

The following benefit payments are expected to be paid during the years ending December 31 (in thousands):

2019	**$ 21,870**
2020	**11,719**
2021	**12,408**
2022	**14,553**
2023	**12,685**
Years 2024– 2028	**67,444**

Employer contributions for fiscal 2019 are expected to be $6.5 million.

The pension plan's weighted-average asset allocation as of December 31, by asset category, is as follows:

	2018	2017
Asset categories:		
Equity securities	**55%**	60%
Debt securities	**44%**	39%
Other	**1%**	1%
Total	**100%**	100%

11. Retirement Plans (continued)

The pension plans' asset allocation and investment strategies are designed to earn returns on plan assets consistent with a reasonable and prudent level of risk. Investments are diversified across classes, sectors, and manager style to minimize the risk of large losses. The Group uses investment managers specializing in each asset category and, where appropriate, provides the investment manager with specific guidelines, which include allowable and/or prohibited investment types. The Group regularly monitors manager performance and compliance with investment guidelines.

The target allocations for plan assets are 50%-80% equity fund, 25%-45% fixed income fund. The equity fund includes U.S. and international investments and range from large-cap to small-cap companies. The fixed income fund includes bonds and cash equivalents. The plan has also entered into an annuity contract in which the funds are held in an insurance company general account that is reported at fair value which approximates the contract value. The expected rate of return actuarial assumption considers the historical long-term rate of return of assets across these asset classes.

Fair Value Measurement

A fair value hierarchy has been established with three levels that prioritize the valuation inputs into each level (see Note 5).

11. Retirement Plans (continued)

The plans' assets measured at fair value and net asset value on a recurring basis as of December 31 were as follows:

	Investments at Fair Value				
	Total	Level 1	Level 2	Level 3	Valuation technique
	(In Thousands)				
2018					
Cash and equivalents	**$ 2,505**	**$ 2,505**	**$ -**	**$ -**	**(a)**
Corporate bond mutual fund	**39,574**	**39,574**	**-**	**-**	**(a)**
Funds held in insurance company general account	**1,001**	**-**	**-**	**1,001**	**(b)**
Total	**$ 43,080**	**$ 42,079**	**$ -**	**$ 1,001**	
Investments measured at net asset value:					
Commingled global equity fund	**40,237**				
U.S. equity securities and fixed income mutual funds	**69,153**				
Total investments	**$ 152,470**				

11. Retirement Plans (continued)

	Investments at Fair Value				Valuation technique
	Total	Level 1	Level 2	Level 3	
	(In Thousands)				
2017					
Cash and equivalents	$ 2,443	$ 2,443	**$ -**	**$ -**	(a)
Corporate bond mutual fund	40,477	40,477	-	-	(a)
Funds held in insurance company general account	809	–	–	809	(b)
Total	$ 43,729	$ 42,920	**$ -**	$ 809	
Investments measured at net asset value:					
Commingled global equity fund	50,043				
U.S. equity securities and fixed income mutual funds	79,255				
Total investments	$ 173,027				

There were no transfers to or from Level 1 or 2 during the years presented. The changes in fair value of the Plans' Level 3 assets are as follows for the year ended December 31:

	2018	2017
	(In Thousands)	
Beginning balance	**$ 809**	$ 541
Contributions	**15,527**	12,279
Distributions	**(15,562)**	(11,992)
Deposit in transit	**250**	0
Administrative charges	**(22)**	(19)
Ending balance	**$ 1,001**	$ 809

11. Retirement Plans (continued)

At December 31, 2018 and 2017, the Group's investments of $109.4 million and $129.3 million, respectively, in alternative investment funds, including hedge funds, mutual funds, and private equity funds, are measured using the fund's net asset value per unit as a practical expedient to estimate fair value. For the mutual funds and hedge funds, redemption clauses range between monthly and biannually with various notice requirements between 10 and 95 days. The Group may not withdraw or sell, assign, or transfer its interest in the private equity fund except in certain limited circumstances, subject to consent by the general partners of the fund.

Defined Contribution Plan

The Group sponsors a defined contribution benefit plan for its employees. For the years ended December 31, 2018 and 2017, employer contributions of $14.1 million and $14.9 million, respectively, were recorded in salaries and benefits expense.

12. Functional Expenses

The Group provides general health care services to residents within its geographic location. The following table presents the Group's expenses by function for the years 2018 and 2017.

	Healthcare Services		Support Services		
December 31, 2018	**Hospital**	**Physician**	**Management, General and Administration**	**Fundraising**	**Total**
			(in Thousands)		
Salaries and benefits	**$ 270,311**	**$ 10,976**	**$ 99,371**	**$ 1,207**	**$381,865**
Supplies and purchased services	**154,985**	**9,421**	**44,331**	**917**	**209,653**
Provider fee expense	**43,701**	**-**	**-**	**-**	**43,701**
Depreciation and amortization	**7,571**	**999**	**25,694**	**8**	**34,272**
Interest	**-**	**-**	**6,758**	**-**	**6,758**
Other	**6,669**	**5,952**	**27,301**	**883**	**40,804**
	$ 483,236	**$ 27,348**	**$ 203,455**	**$ 3,014**	**$717,053**

12. Functional Expenses (continued)

	Healthcare Services		Support Services		
December 31, 2017	**Hospital**	**Physician**	**Management, General and Administration**	**Fundraising**	**Total**
			(in Thousands)		
Salaries and benefits	$ 273,416	$ 9,262	$ 105,060	$ 1,162	$388,899
Supplies and purchased services	150,136	11,755	47,377	702	209,970
Provider fee expense	55,656	-	-	-	55,656
Depreciation and amortization	10,353	1,014	30,452	11	41,829
Interest	-	-	7,585	-	7,585
Other	5,770	5,897	23,222	885	35,774
	$ 495,331	$ 27,927	$ 213,695	$ 2,760	$739,713

The consolidated financial statements report certain expense categories that are attributable to more than one health care service or support function. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Costs not directly attributable to a function, including depreciation, amortization, interest, and other occupancy costs, are allocated to a function based on a square footage or units of service basis. Allocated health care services cost not allocated on a units-of-service basis are otherwise allocated on revenue.

Supplementary Information

Collis P. and Howard Huntington Memorial Hospital Trust, Pasadena Hospital Association, Ltd. and Affiliates

Consolidating Balance Sheets

(In Thousands)

	As of December 31, 2018					As of December 31, 2017				
	Trust	**HMH**	**Foundation**	**Eliminations**	**Consolidated**	**Trust**	**HMH**	**Foundation**	**Eliminations**	**Consolidated**
Assets										
Current assets:										
Cash and cash equivalents	**$ 2,969**	**$ 17,386**	**$ 903**	**$ –**	**$ 21,258**	$ 5,153	$ 14,445	$ (28)	$ –	$ 19,570
Investments:										
Short-term investments	**221,458**	**151,098**	**–**	**–**	**372,556**	238,708	181,825	–	–	420,533
Held in Trust for current debt service	**–**	**9,561**	**–**	**–**	**9,561**	–	6,098	–	–	6,098
Total investments	**221,458**	**160,659**	**–**	**–**	**382,117**	238,708	187,923	–	–	426,631
Accounts receivable:										
Patient accounts receivable, net	**–**	**104,790**	**3,397**	**–**	**108,187**	–	95,371	3,285	–	98,656
Provider fee receivable	**–**	**42,349**	**–**	**–**	**42,349**	–	57,491	–	–	57,491
Estimated settlements from third-party payors	**–**	**6,631**	**–**	**–**	**6,631**	–	5,886	–	–	5,886
Total accounts receivable	**–**	**153,770**	**3,397**	**–**	**157,167**	–	158,748	3,285	–	162,033
Inventories	**–**	**15,194**	**43**	**–**	**15,237**	–	13,627	33	–	13,660
Prepaid expenses and other	**1,158**	**47,887**	**1,470**	**(24,746)**	**25,769**	1,640	45,193	1,693	(24,457)	24,069
Total current assets	**225,585**	**394,896**	**5,813**	**(24,746)**	**601,548**	245,501	419,936	4,983	(24,457)	645,963
Investments restricted or designated for specific purposes:										
Held in Trust under bond master indenture	**–**	**114,680**	**–**	**–**	**114,680**	–	36,313	–	–	36,313
Designated by Board for specific purposes	**–**	**62,948**	**–**	**–**	**62,948**	–	62,387	–	–	62,387
Donor restricted for capital expenditures or to provide a permanent source of income	**2,034**	**56,593**	**–**	**–**	**58,627**	2,034	52,777	–	–	54,811
Receivable from charitable remainder annuity trusts	**–**	**10,069**	**–**	**–**	**10,069**	–	11,941	–	–	11,941
Total investments restricted or designated for specific purposes	**2,034**	**244,290**	**–**	**–**	**246,324**	2,034	163,418	–	–	165,452
Property, plant, and equipment, net	**50,068**	**453,698**	**4,962**	**–**	**508,728**	50,420	427,942	5,234	–	483,597
Other assets:										
Due from affiliates	**7,266**	**–**	**–**	**(7,266)**	**–**	9,090	–	–	(9,090)	–
Goodwill	**–**	**10,006**	**–**	**–**	**10,006**	–	10,006	–	–	10,006
Other noncurrent assets	**3**	**12,308**	**–**	**–**	**12,311**	3	10,405	–	–	10,408
Total assets	**$ 284,956**	**$ 1,115,198**	**$ 10,775**	**$ (32,012)**	**$ 1,378,917**	$ 307,049	$ 1,031,707	$ 10,217	$ (33,547)	$ 1,315,426

Collis P. and Howard Huntington Memorial Hospital Trust, Pasadena Hospital Association, Ltd. and Affiliates

Consolidating Balance Sheets (continued)

(In Thousands)

	As of December 31, 2018					As of December 31, 2017				
	Trust	**HMH**	**Foundation**	**Eliminations**	**Consolidated**	**Trust**	**HMH**	**Foundation**	**Eliminations**	**Consolidated**
Liabilities and net assets										
Current liabilities:										
Accounts payable	**$ 671**	**$ 37,055**	**$ 5,962**	**$ (3,781)**	**$ 39,907**	$ 762	$ 26,222	$ 5,075	$ (2,732)	$ 29,327
Current maturities of long-term debt	**–**	**5,247**	**–**	**(513)**	**4,734**	–	4,629	–	(1,188)	3,441
Current portion of accrued self-insurance claims	**–**	**8,720**	**–**	**–**	**8,720**	–	7,881	–	–	7,881
Accrued payroll and employee benefits	**–**	**34,324**	**1,040**	**–**	**35,364**	–	31,817	1,165	–	32,982
Current maturities of notes payable to affiliate	**–**	**–**	**18,285**	**(18,285)**	**–**	–	–	14,147	(14,147)	–
Accrued provider fee	**–**	**31,675**	**–**	**–**	**31,675**	–	45,826	–	–	45,826
Other accrued liabilities	**1,050**	**17,961**	**3**	**(1,182)**	**17,832**	6,104	13,647	64	(6,084)	13,731
Revolving credit line	**–**	**–**	**–**	**–**	**–**	–	9,664	–	–	9,664
Total current liabilities	**1,721**	**134,982**	**25,290**	**(23,761)**	**138,232**	6,866	139,686	20,451	(24,151)	142,852
Long-term debt, less current maturities	**–**	**316,537**	**–**	**–**	**316,537**	–	211,827	–	–	211,827
Accrued pension liability	**–**	**66,022**	**–**	**–**	**66,022**	–	66,841	–	–	66,841
Accrued self-insurance claims, less current portion	**–**	**18,474**	**–**	**–**	**18,474**	–	19,605	–	–	19,605
Long-term due to affiliates	**–**	**6,751**	**–**	**(6,751)**	**–**	–	7,896	–	(7,896)	–
Other	**4,080**	**950**	**–**	**–**	**5,030**	4,434	1,453	–	–	5,887
Total liabilities	**5,801**	**543,716**	**25,290**	**(30,512)**	**544,295**	11,300	447,308	20,451	(32,047)	447,012
Net assets:										
Without donor restrictions	**277,033**	**461,234**	**(14,515)**	**(1,500)**	**722,252**	293,193	475,653	(10,234)	(1,500)	757,112
With donor restrictions	**2,122**	**110,248**	**–**	**–**	**112,370**	2,556	108,746	–	–	111,302
Total net assets (deficit)	**279,155**	**571,482**	**(14,515)**	**(1,500)**	**834,622**	295,749	584,399	(10,234)	(1,500)	868,414
Total liabilities and net assets	**$ 284,956**	**$ 1,115,198**	**$ 10,775**	**$ (32,012)**	**$ 1,378,917**	$ 307,049	$ 1,031,707	$ 10,217	$ (33,547)	$ 1,315,426

Collis P. and Howard Huntington Memorial Hospital Trust, Pasadena Hospital Association, Ltd. and Affiliates

Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions

(In Thousands)

	Year Ended December 31, 2018					Year Ended December 31, 2017				
	Trust	**HMH**	**Foundation**	**Eliminations**	**Consolidated**	**Trust**	**HMH**	**Foundation**	**Eliminations**	**Consolidated**
Revenues without donor restrictions:										
Patient service revenue	**$ –**	**$ 658,228**	**$ –**	**$ –**	**$ 658,228**	$ –	$ 668,120	$ –	$ –	$ 668,120
Contributions	**–**	**8,839**	**–**	**–**	**8,839**	–	5,615	–	–	5,615
Other	**10,826**	**9,940**	**22,415**	**(1,549)**	**41,632**	10,696	10,248	22,895	(1,559)	42,280
Net assets released from restrictions	**241**	**4,941**	**–**	**–**	**5,182**	150	7,245	–	–	7,395
Total revenues without donor restrictions	**11,067**	**681,948**	**22,415**	**(1,549)**	**713,881**	10,846	691,228	22,895	(1,559)	723,410
Expenses:										
Salaries and benefits	**–**	**370,889**	**10,976**	**–**	**381,865**	–	379,640	9,262	–	388,902
Supplies and purchased services	**3,236**	**196,996**	**9,421**	**–**	**209,653**	2,619	195,596	11,754	–	209,969
Provider fee expense	**–**	**43,701**	**–**	**–**	**43,701**	–	55,656	–	–	55,656
Depreciation and amortization	**1,925**	**31,348**	**999**	**–**	**34,272**	3,743	37,072	1,014	–	41,829
Interest	**(452)**	**7,210**	**–**	**–**	**6,758**	(523)	8,109	–	–	7,586
Other expenses	**832**	**35,569**	**5,952**	**(1,549)**	**40,804**	1,052	30,382	5,896	(1,559)	35,771
Total expenses	**5,541**	**685,713**	**27,348**	**(1,549)**	**717,053**	6,891	706,455	27,926	(1,559)	739,713
Excess (deficiency) of revenues over expenses before other income and expense	**5,526**	**(3,765)**	**(4,933)**	**–**	**(3,172)**	3,955	(15,227)	(5,031)	–	(16,303)
Other income and expense:										
Investment (loss) income	**(16,714)**	**(11,141)**	**–**	**–**	**(27,855)**	36,724	31,553	–	–	68,277
Other	**–**	**(2,539)**	**91**	**–**	**(2,448)**	–	(1,099)	18	–	(1,081)
(Deficiency) excess of revenues over expenses	**(11,188)**	**(17,445)**	**(4,842)**	**–**	**(33,475)**	40,679	15,227	(5,013)	–	50,893
Change in pension liability	**–**	**(3,261)**	**–**	**–**	**(3,261)**	–	1,609	–	–	1,609
Assets released from restrictions used for capital purposes	**–**	**1,903**	**–**	**–**	**1,903**	–	1,866	–	–	1,866
Transactions with related parties	**–**	**(587)**	**560**	**–**	**(27)**	–	(569)	569	–	–
Other changes in unrestricted net assets	**(4,973)**	**4,973**	**–**	**–**	**–**	(4,579)	4,775	–	–	196
Change in net assets without donor restrictions	**$ (16,161)**	**$ (14,417)**	**$ (4,282)**	**$ –**	**$ (34,860)**	$ 36,100	$ 22,908	$ (4,444)	$ –	$ 54,564

EY | Assurance | Tax | Transactions | Advisory

About EY

EY is a global leader in assurance, tax, transaction and advisory services. The insights and quality services we deliver help build trust and confidence in the capital markets and in economies the world over. We develop outstanding leaders who team to deliver on our promises to all of our stakeholders. In so doing, we play a critical role in building a better working world for our people, for our clients and for our communities.

EY refers to the global organization, and may refer to one or more, of the member firms of Ernst & Young Global Limited, each of which is a separate legal entity. Ernst & Young Global Limited, a UK company limited by guarantee, does not provide services to clients. For more information about our organization, please visit ey.com.

© 2019 Ernst & Young LLP.
All Rights Reserved.

ey.com

Exhibit 37-C

PHA's Unaudited Consolidated Financial Statements for First Quarter of 2020

UNAUDITED CONSOLIDATED FINANCIAL STATEMENTS

Pasadena Hospital Association, Ltd.

Three months ended March 31, 2020 and 2019

Colis P. and Howard Huntington Memorial Hospital Trust,
Pasadena Hospital Association, Ltd. and Affiliates
Consolidated Balance Sheets
(In Thousands)

	Mar-20	Dec-19
Assets		
Current assets:		
Cash and cash equivalents	$ 55,927	$ 46,791
Investments:		
Short-term investments	325,716	416,915
Held in trust for current debt service	7,089	9,435
Total investments	332,805	426,350
Accounts receivable:		
Patient accounts receivable	96,780	102,972
Provider fee receivable	46,914	52,791
Estimated settlements from third-party payors	7,643	5,344
Total accounts receivable	151,337	161,107
Inventories	15,334	14,184
Prepaid expenses and other	28,132	28,362
Total current assets	583,535	676,394
Investments restricted or designated for specific purposes:		
Held in Trust under bond master indenture	46,885	66,179
Designated by Board for specific purposes	63,656	63,530
Donor restricted for capital expenditures or to provide a permanent source of income	61,765	57,211
Interest in charitable remainder annuity trusts	11,163	11,163
Total investments restricted or designated for specific purposes	183,639	198,033
Property, plant, and equipment, net	594,879	587,749
Operating lease right-of-use assets	57,849	59,990
Other assets:		
Goodwill	10,806	10,006
Other noncurrent assets	23,849	21,201
Total assets	$ 1,452,747	$ 1,553,373
Liabilities and net assets		
Current liabilities:		
Accounts payable	$ 37,107	$ 51,640
Accrued payroll and employee benefits	37,210	36,781
Current portion of accrued self-insurance claims	7,235	6,898
Current maturities of long-term debt	7,579	7,780
Current maturities of operating lease liability	7,242	7,417
Accrued provider fee	37,485	45,379
Other accrued liabilities	9,730	14,117
Revolving credit line	38,000	18,000
Total current liabilities	171,588	188,012
Long-term debt, less current maturities	317,811	318,564
Accrued pension liability	74,410	75,292
Accrued self-insurance claims, less current portion	20,036	20,036
Long-term operating lease liability	50,687	52,573
Other	4,025	4,002
Total liabilities	640,477	658,479
Net assets:		
Without donor restrictions	694,764	771,259
With donor restrictions	117,506	123,635
Total net assets	812,270	894,894
Total liabilities and net assets	$ 1,452,747	$ 1,553,373

Collis P. and Howard Huntington Memorial Hospital Trust,
Pasadena Hospital Association, Ltd. and Affiliates
Consolidated Statements of Operations
(in Thousands)

	Quarters Ended March 31,	
	2020	2019
Revenues without donor restrictions:		
Patient service revenues	$ 153,072	$ 156,364
Contributions	621	601
Other	9,899	10,013
Net assets released from restrictions	1,308	1,077
Total revenue without donor restrictions	164,600	168,055
Expenses:		
Salaries and benefits	100,076	96,064
Supplies and purchased services	55,602	54,163
Depreciation and amortization	9,205	8,704
Interest	1,864	1,690
Other expenses	9,007	9,016
Total expenses	175,754	169,637
Deficiency of revenues over expenses before other income and expenses	(11,154)	(1,582)
Other income and expense:		
Investment (loss) income	(65,222)	31,534
Other	(518)	(366)
(Deficiency) excess of revenues over expenses	(76,894)	29,586

Collis P. and Howard Huntington Memorial Hospital Trust, Pasadena Hospital Association, Ltd. and Affiliates

UTILIZATION AND SOURCES OF REVENUE OF HMH

Utilization

The table below summarizes utilization at the Hospital for the years ended December 31, 2019 and 2018, and interim year-to-date for the quarter ended March 31, 2020.

Utilization

	FY 2018	FY 2019	Year-to-date Mar 31, 2020
Licensed and Available Beds	578	578	573
Observation visits	2,689	3,390	602
Discharges	28,635	28,152	6,971
Births	3,475	3,348	754
Patient Days	121,897	118,833	29,669
Occupancy	58%	56%	57%
Average Daily Census	334	326	326
Average Length of Stay	4.26	4.22	4.26
Inpatient Surgical Procedures	8,182	7,831	1,769
Outpatient Surgeries	8,185	8,221	1,765

Source: HMH records

#38

Title 11, California Code of Regulations, § 999.5(d)(11)(G)

Copies of any requests for opinions to the Internal Revenue Service for rulings attendant to this transaction and any Internal Revenue Service responses thereto

There have not been any requests for opinions to the Internal Revenue Service for rulings in connection with the proposed Affiliation.

#39

Title 11, California Code of Regulations, § 999.5(d)(11)(H)

Pro forma post-transaction balance sheet for the surviving or successor nonprofit corporation

The Affiliation provides for Cedars-Sinai to become the sole member of PHA, and does not involve the sale, transfer, merger or other disposition of any assets of PHA. Therefore, there is no anticipated change to the pro forma balance sheet of PHA as a result of the Affiliation.

For information regarding PHA and Cedars-Sinai's assets, liabilities, and other financial matters, see the response to Section 999.5(d)(11)(F) and Section 999.5(d)(9), respectively.