WATSONVILLE COMMUNITY HOSPITAL

PVHCDHC

PAJARO VALLEY HEALTH CARE DISTRICT HOSPITAL CORPORATION

BOARD OF DIRECTORS

REGULAR MEETING AGENDA

Virtual/Teleconference

ZOOM LINK https://zoom.us/j/93443061917

TELEPHONE +1 669 900 9128 WEBINAR ID: 934 4306 1917

December 28, 2022
5:00 p.m.

Pursuant to PVHCDHC Resolutions adopted monthly, Assembly Bill 361, and guidance from the Santa Cruz County Health Department in response to concerns regarding COVID-19, Board Members of PVHCDHC are permitted to participate in this duly noticed public meeting via teleconference and certain requirements of The Brown Act are suspended.

TRANSLATION SERVICES/SERVICIOS DE TRADUCCIÓN

Spanish language translation is available on an as needed basis. Please make advance arrangements at least three business days before the meeting at by calling at 831.763.6040 or by emailing at info@pvhcd.org

Las sesiones de la Mesa Directiva pueden ser traducidas del inglés al español y del español al inglés. Por favor llame por lo menos tres días hábiles antes de la junta al 831.763.6040 o envíe un correo electrónico a info@pvhcd.orgpara solicitar interpretación.

ACCOMMODATIONS FOR PERSONS WITH DISABILITIES

The Pajaro Valley Health Care District Hospital Corporation does not discriminate on the basis of disability, and no person shall, by reason of a disability, be denied the benefits of its services, programs, or activities. If you are a person with a disability and wish to participate in the meeting and require special assistance in order to participate, please call 831.763.6040 or email info@pvhcd.org at least three business days in advance of the meeting to make arrangements. Persons with disabilities may request a copy of the agenda in an alternative format.

For Public Participation Guidelines, see last page(s) of the agenda.

1. **CALL TO ORDER/ROLL CALL**

2. **PUBLIC COMMENTS REGARDING THE CLOSED SESSION AGENDA WILL ONLY BE ACCEPTED BY THE BOARD AT THIS TIME.**

3. **CLOSED SESSION**

   The Board will recess to Closed Session to discuss the matters that follow:

   a) Hearings/Reports, Code 1461, 32155
      1. Report of Medical Executive Committee
      2. Report of Medical Staff Credentials Committee
      3. Report of Medical Staff Interdisciplinary Practice Committee
      4. Quality Dashboard – *staff report*

      (Executive Sponsor: Dr. Angel, COS)

5:45 p.m. (Estimated Time)

4. **REPORT OUT OF CLOSED SESSION**

5. **CONSIDERATION OF LATE ADDITIONS TO THE AGENDA**

6. **PUBLIC COMMENT**
   This time is set aside for members of the general public to address the Board on any item not on the Board Agenda (not to exceed two minutes), which is within the subject matter jurisdiction of the Board. No action or discussion shall be taken on any item presented except that any Board Member may respond to statements made or questions asked or may ask questions for clarification. All matters of an administrative nature will be referred to staff. All matters relating to Board will be noted in the minutes and may be scheduled for discussion at a future meeting or referred to staff for clarification and report.

7. **COMMENTS FROM BOARD MEMBERS**

8. **REPORT FROM CHIEF EXECUTIVE OFFICER SALYER**

9. **CONSENT AGENDA**
   Consent items include routine business that does not call for discussion. One roll call vote is taken for all items. Only a Board Member may pull items from Consent to Regular agenda. Members of the public must request that a Board Member pull an item from the Consent Agenda prior to the start of the meeting.

ACTION ON CONSENT AGENDA

a) Board questions to staff
b) Public Comment
c) Motion to approve Consent Agenda
d) Action by Board/Roll Call Vote

A. RESOLUTION MAKING FINDINGS AND ORDERING THE USE OF TELECONFERENCE MEETINGS OF THE BOARD OF DIRECTORS DUE TO COVID-19, PURSUANT TO THE REQUIREMENTS OF ASSEMBLY BILL 361: AND DIRECT STAFF TO RETURN WITHIN 30 DAYS WITH A NEW RESOLUTION ADDRESSING THE NEED TO CONTINUE HOLDING TELECONFERENCE MEETINGS CONSISTENT WITH THE REQUIREMENTS OF ASSEMBLY BILL 361

B. MOTION APPROVING MINUTES OF NOVEMBER 30, 2022

C. RESOLUTION APPROVING RESTATED & AMENDED 401(A) PLAN TO INCLUDE PHARMACISTS AND NURSING SUPERVISORS IN THE EMPLOYER CONTRIBUTION

D. MOTION APPROVING OF QUALITY DASHBOARD – December 2022

E. MOTION APPROVING OF POLICIES – Policy Summary, December 2022

10. REGULAR AGENDA

A. CONSIDERATION OF APPROVAL OF REPORT ON BEHALF OF MEDICAL COMMITTEES ON THE FOLLOWING REPORTS

1) Oral Report
2) Board questions to staff
3) Public Comment
4) Motion approving MEC Report, Credentials Report of December 2022 & Interdisciplinary Practice Credentials Report of December 2022

B. CONSIDERATION OF APPROVAL OF 2023 BUDGET

1) Report by Julie Peterson, CFO
2) Board questions to staff
3) Public Comment
4) Motion to approve 2023 Budget
5) Action by Board/Roll Call Vote

11. ADJOURNMENT

Agenda documents are available for review in person at Watsonville Community Hospital, 75 Nielson Street, Hospital Main Lobby-Visitors Desk; and electronically on the Pajaro Valley Healthcare District's website, at: PVHCHC.ORG

To view online, visit the Board's website at: PVHCHC.ORG and select the meeting date to view the agenda and supporting documents.

This agenda was posted in accordance with the California Brown Act. Any materials related to an item on this Agenda submitted to the Board after distribution of the agenda packet will be made available to the public in accordance with Government Section 54957.5.

RELATED CORRESPONDENCE -

Written comments on agenda items may also be submitted to the Board by email or US

Mail

Email: info@pvhcd.org

- Emailed documents may take up to 24 hours to be posted
- Please include the agenda item number

U.S. Mail:
PVHCD Board of Directors
75 Nielson Street
Watsonville, CA 95076

Comments received after 4 p.m. the day of the meeting and before the end of the meeting will be included with the minutes record.

For additional information, call 831.763.6040 or email info@pvhcd.org

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Public Participation Guidelines

PUBLIC COMMENT

Participating in Person:

The meeting space is open with limited capacity. Face coverings are highly recommended in the meeting space, regardless of vaccination status. To address the Board, please line up at the podium when the Board Chair calls for general public comment or calls for public comment on the regular agenda item to which you would like to speak. Please state your name clearly for the record before making your comment and limit your remarks to the allotted time.

Participating by Phone:

To address the Board, dial the telephone number provided and you will be prompted to enter the meeting ID number. After that, you will be able to listen to the meeting and speak during public comment as announced by the Chair. The Clerk will call on people by the last four digits of their phone number.

The following commands can be entered via DTMF tones using your phone's dial pad while in a Zoom meeting:

- ***6** - Toggle mute/unmute
- ***9** - Raise hand

Participating online via Zoom:

You may download the Zoom client or connect to the meeting in-browser. If using your browser, make sure you are using a current, up-to-date browser: Chrome 30+, Firefox 27+, Microsoft Edge 12+, Safari 7+. Certain functionality may be disabled in older browsers including Internet Explorer.

You will be asked to enter an email address and name. **Please identify yourself by any name** you choose (you are not required to state your real name to participate) as this appears online and is how

we notify you when it is your turn to speak.

When the Board Chair calls for the item on which you wish to speak, click on "raise hand." The Clerk will activate and unmute speakers in turn. Speakers will be notified shortly before they are called to speak.

When called, please limit your remarks to the time allotted.

WATSONVILLE COMMUNITY HOSPITAL

PVHCDHC

Board Memo

Executive Sponsor: Steven Salyer, CEO

Agenda Item: AB 361 Resolution Authorizing Teleconference Meetings

Meeting Date: December 28, 2022

Recommended Actions:
Resolution authorizing making findings and ordering the use of teleconference meetings of the Board of Directors due to COVID-19, pursuant to the requirements of Assembly Bill 361; and Direct Staff to return within 30 days with a new resolution addressing the need to continue holding teleconference meetings consistent with the requirements of Assembly Bill 361.

Executive Summary
As a result of the continuing impacts of the COVID-19 pandemic, many local agencies have been holding teleconference meetings under the modified rules authorized under Assembly Bill 361. This item asks the Board to adopt a resolution ordering the use of teleconference meetings under the modified rules. This will allow Hospital Board members to appear at meetings remotely if they choose to do so.

Background
On March 4, 2020, Governor Newsom issued a Proclamation of State of Emergency in response to the COVID-19 pandemic pursuant to Government Code section 8550 et seq., which remains in effect. Assembly Bill 361 ("AB 361") allows legislative bodies to hold teleconference meetings during declared emergencies as long as they follow designated rules, and the legislative body routinely reviews the need to continue holding such teleconference meetings.

On September 30, 2021, Santa Cruz County Public Health Officer Dr. Gail Newel issued a strong recommendation that legislative bodies in Santa Cruz County continue to engage in physical/social distancing by meeting via teleconference as allowed by AB 361 and confirmed that she will regularly review and reconsider this recommendation and notify the public when it is no longer recommended. Dr. Newel's recommendation remains in effect.

Analysis
Many local legislative bodies have recognized that COVID-19 presents a continuing threat to the Santa Cruz County community and that there is an important governmental interest in protecting the health, safety, and welfare of those who participate in public meetings. Requiring all members of legislative bodies to appear in-person at meetings presents greater risk to the health and safety of meeting participants, including reduced social distancing among people of different communities, increased exposure for those who are immunocompromised or unvaccinated, and challenges associated with fully ascertaining and ensuring compliance with vaccination, face coverings, and other safety measures at such public meetings.

Pursuant to AB 361, a legislative body can hold teleconference meetings under the modified AB 361 teleconferencing rules if a state of emergency remains active, or local officials have recommended measures to promote social distancing, as long as the legislative body reconsiders the circumstances of the state of emergency and determines either that the state of emergency continues to directly impact the ability of the members to meet safely in person or that local officials continue to recommend measures to promote social distancing.

The Governor's emergency proclamation has not been lifted and Dr. Newel's social distancing recommendation remains in effect. The dangers presented by returning to non-emergency meeting protocols remain. Staff recommends that the Board adopt the draft resolution accompanying this item, which contains the findings necessary to hold teleconference meetings under the modified Brown Act rules.

Financial Impact
There is no financial impact associated with this item.

Attachment(s)
1. Resolution AB361

BEFORE THE BOARD OF DIRECTORS
OF THE PAJARO VALLEY HEALTH CARE DISTRICT HOSPITAL CORPORATION

RESOLUTION NO._____

On the motion of Director
Duly seconded by Director
The following resolution is adopted.

RESOLUTION AUTHORIZING TELECONFERENCE MEETINGS UNDER ASSEMBLY BILL 361 AS A RESULT OF THE CONTINUING COVID-19 PANDEMIC STATE OF EMERGENCY AND HEALTH OFFICER RECOMMENDATION FOR SOCIAL DISTANCING

WHEREAS, on March 4, 2020, Governor Newsom issued a Proclamation of State of Emergency in response to the COVID-19 pandemic pursuant to California Government Code section 8550 et seq., which remains in effect; and

WHEREAS, on March 17, 2020, Governor Newsom issued Executive Order N-29-20 that suspended the teleconferencing rules set forth in the California Open Meeting law, known as the Ralph M. Brown Act, and codified in California Government Code section 54950 et seq., provided that certain requirements were met and followed; and

WHEREAS, on June 11, 2021, Governor Newsom issued Executive Order N-08-21 which further extended the suspension of the teleconferencing rules set forth in the Brown Act and clarified that the provisions issued in N-29-20 would remain in effect through September 30, 2021; and

WHEREAS, on September 16, 2021, Governor Newsom signed Assembly Bill 361 (“AB 361”), which amended Government Code section 54953 to permit legislative bodies subject to the Brown Act to continue to meet under modified teleconferencing rules provided that they comply with specific requirements set forth in the statute; and

WHEREAS, pursuant to AB 361, a legislative body may hold an initial teleconference meeting under the modified teleconferencing rules during a proclaimed state of emergency where local officials have imposed or recommended measures to promote social distancing; and

WHEREAS, on September 30, 2021, Santa Cruz County Public Health Officer Dr. Gail Newel strongly recommended that legislative bodies in Santa Cruz County continue to engage in physical/social distancing by meeting via teleconference as allowed by AB 361 and confirmed that she will regularly review and reconsider this recommendation and notify the public when it is no longer recommended; and

WHEREAS, after its initial AB 361 teleconference meeting, a legislative body can continue to hold such teleconference meetings if a state of emergency remains active, or local officials have recommended measures to promote social distancing, if the legislative body has reconsidered the circumstances of the state of emergency and determined either that the state of emergency continues to directly impact the ability of the members to meet safely in person or that local officials continue to recommend measures to promote social distancing; and

WHEREAS, the findings set forth in the paragraph immediately above must be made within 30 days of the date the legislative body first held a teleconferenced meeting pursuant to AB 361, and every 30 days thereafter, for as long as the legislative body wishes to hold such teleconference meetings; and

WHEREAS, the Hospital has an important governmental interest in protecting the health, safety, and welfare of those who participate in meetings of the Hospital Board of Directors; and

WHEREAS, this Board finds that there is a continuing threat of COVID-19 to the community and finds that requiring all Board members to appear in-person at meetings presents greater risk to the health and safety of meeting participants stemming from reduced social distancing among people of different communities, increased exposure for those who are immunocompromised or unvaccinated, and challenges associated with fully ascertaining and ensuring compliance with vaccination, face coverings, and other safety measures at such public meetings; and

WHEREAS, this Board meets in-person in a facility where other functions take place, such that increasing the number of people present may impair the safety of participants and members of the public; and

WHEREAS, as required by AB 361, this Board has considered the circumstances of the current state of emergency and finds that the COVID-19 pandemic continues to directly impact the ability of Board members to meet safely in person and further finds that the Santa Cruz County Public Health Officer continues to recommend measures to promote social distancing; and

WHEREAS, in the interest of public health and safety, due to the emergency caused by the spread of COVID-19 the Board of Directors deems it necessary to utilize the modified teleconferencing rules set forth in AB 361.

NOW, THEREFORE, THE BOARD OF DIRECTORS OF THE PAJARO VALLEY HEALTH CARE DISTRICT HOSPITAL CORPORATION HEREBY RESOLVES AND ORDERS AS FOLLOWS:

Section 1. The foregoing recitals are adopted as findings of the Board of Directors as set forth within the body of this Resolution.

Section 2. Effective immediately, for the next 30 days the Board of Directors will meet using the modified teleconference rules authorized under AB 361 and Government Code section 54953(e)(3).

Section 3. Staff is directed to return no later than thirty (30) days after the adoption of this Resolution with an item requesting the Board to reconsider the circumstances of the COVID-19 state of emergency and, if necessary, consider adoption of a subsequent Resolution to continue using the modified teleconference rules for meetings in accordance with Government Code section 54953(e)(3).

Section 4. Staff is authorized and directed to take all such other necessary or appropriate actions to implement the intent and purposes of this Resolution.

PASSED AND ADOPTED by the Board of Directors of the Pajaro Valley Health Care District Hospital Corporation this _____day of _____, 2022, by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

_____
Chair, Board of Directors

ATTEST:

_____
Clerk of the Board

APPROVED AS TO FORM:

_____
PVHCDHC Counsel

WATSONVILLE COMMUNITY HOSPITAL

PVHCDHC

PAJARO VALLEY HEALTH CARE DISTRICT HOSPITAL CORPORATION

BOARD OF DIRECTORS

REGULAR MEETING MINUTES

November 30, 2022

5:02 p.m.

Meeting was held in virtual format

ZOOM LINK https://zoom.us/j/93443061917

4. CALL TO ORDER/ROLL CALL

Directors Gabriel-Cox, Nájera, Nuñez, Pimentel, and Chair Friel were present.

5. PUBLIC COMMENTS REGARDING THE CLOSED SESSION-None

6. CLOSED SESSION

The Board recessed to Closed Session at 5:05 p.m. to discuss the matters that follow:

a) Report Involving Trade Secret, Code 32106
Discussion will concern: Trade Secret, Strategic Planning, Proposed New Program/Service.
Date of Public Disclosure: Est. November 2022
(Executive Sponsor: Vranjes, COO)

b) Hearings/Reports, Code 1461, 32155
1. Report of Patient Safety and Quality Committee
2. Report of Medical Staff Credentials Committee
3. Report of Medical Staff Interdisciplinary Practice Committee
4. Quality Dashboard – *staff report*

(Executive Sponsor: Dr. Angel, COS)

6:03 p.m.

Director Pimentel was absent.

5. REPORT OUT OF CLOSED SESSION

Chair Friel reported that the Board received reports.

6. CONSIDERATION OF LATE ADDITIONS TO THE AGENDA-None

7. PUBLIC COMMENT-None

8. RECOGNITION TO OUTGOING DIRECTOR NÁJERA
Directors thanked Director Nájera for her work with the Board and the community.

Dr. Joe Gallager thanked Director Nájera for her work.

9. COMMENTS FROM BOARD MEMBERS-None

10. REPORT FROM CHIEF EXECUTIVE OFFICER SALYER
CEO Salyer gave a report.

June Ponce, Dir of Marketing, Growth & Outreach, gave a report on activities and events for Hospital staff.

Cecilia Montalvo, Founderwerk Healthcare Division Managing Director, gave a financial report Cecilia Montalvo

11. INFORMATIONAL ITEMS-None

12. CONSENT AGENDA

ACTION ON CONSENT AGENDA

a) Board questions to staff
b) Public Comment-None
c) **MOTION:** Director Nájera made a motion to approve the Consent Agenda, seconded by Director Gabriel-Cox, and carried by the following vote:
d) **Action by Board/Roll Call Vote**
AYES: Gabriel-Cox, Nájera, Nuñez, Friel
NOES: None
ABSENT: Pimentel

A. RESOLUTION NO. 16-2022
RESOLUTION MAKING FINDINGS AND ORDERING THE USE OF TELECONFERENCE MEETINGS OF THE BOARD OF DIRECTORS DUE TO COVID-19, PURSUANT TO THE REQUIREMENTS OF ASSEMBLY BILL 361: AND DIRECT STAFF TO RETURN WITHIN 30 DAYS WITH A NEW RESOLUTION ADDRESSING THE NEED TO CONTINUE HOLDING TELECONFERENCE MEETINGS CONSISTENT WITH THE REQUIREMENTS OF ASSEMBLY BILL 361

B. MOTION APPROVING MINUTES OF OCTOBER 20, 2022

C. MOTION APPROVING IMAGING EQUIPMENT SERVICE COVERAGE AGREEMENT WITH 626 IN THE AMOUNT OF $292,700 PER YEAR

D. MOTION APPROVING RENTAL AGREEMENT FOR DAVINCI Xi ROBOT

E. MOTION APPROVING POLICIES – Policy Summary, November 2022

13. REGULAR AGENDA

A. REPORT ON BEHALF OF MEDICAL COMMITTEES ON THE FOLLOWING REPORTS

1) Oral Report-None
2) Board questions to staff
3) Public Comment-None
4) Motion approving Interdisciplinary Practice Credentials Report of November 2022
5) Motion approving Credentials Report of November 2022

MOTION: Director Nuñez made a motion to approve the Interdisciplinary Practice Credentials Report and Credentials Report of November 2022. The motion was seconded by Director Gabriel-Cox and carried by the following vote:

AYES: Gabriel-Cox, Nájera, Nuñez, Pimentel, Friel
NOES: None
ABSENT: None

B. CONSIDERATION OF STRATEGIC PLANNING FACILITATOR

1) Report was given by CEO Salyer
   CEO Salyer informed the Board that no action was needed because the Board would be taking action at a future meeting.
2) Board questions to staff-None
3) Public Comment-None
4) No action needed

7. ADJOURNMENT

The meeting was adjourned at 6:46 p.m.

Approved: _____

John Friel, Chair

Attest: _____

Beatriz Vázquez Flores, Clerk of the Board

WATSONVILLE COMMUNITY HOSPITAL

PVHCDHC

Board Memo

Executive Sponsor: Allyson Hauck CHRO

Agenda Item: Approve Resolution to Modify 401(a) Plan to Include Pharmacists and Nursing Supervisors

Meeting Date: December 28, 2022

Summary
Staff requests approval of an amendment to the tax-qualified section 401(a) Plan for eligible employees to include the previously excluded Nursing Supervisors and Pharmacists.

Background/Situation/Rationale
Watsonville Community Hospital ("Hospital") provides a tax-qualified section 401(a) Plan ("Plan") for eligible employees and provides these employees with a 6% annual contribution. Currently, the Plan document excludes from eligibility certain employees, including unrepresented employees who are designated as managers or above, or unrepresented employees designated as "highly compensated" (as defined by the Internal Revenue Service). For 2022, Highly Compensated are those employees making more than $135,000 per year. Except for Nursing Supervisors and Pharmacists, all "highly compensated" employees are salaried overtime exempt employees. There are some Nursing Supervisors and Pharmacists that do not have a full-time schedule, and therefore, based on a pro-rata salary, do not meet the definition of "highly compensated." This creates a situation where employees in a part-time position receive the benefit, while their full-time counterparts do not receive the benefit.

The staff is requesting approval of an amendment to the Plan document to include all Nursing Supervisors and Pharmacists, regardless of whether they are "highly compensated" or not..

The Hospital's special employee benefits counsel, the Plan's recordkeeper and the Plan's investment consultant have worked with staff to develop an amended and restated version of the Plan ("Plan Amendment"), which would make the above-mentioned change and which would simplify and clarify existing provisions of the Plan relating to the exclusion of other "highly compensated" employees.

Timeline/Process to date:
Staff would like to commence providing this benefit to Nursing Supervisors and Pharmacists in the first full pay period of January 2023. Therefore, the effective date of the proposed Plan Amendment is January 1, 2023.

Approved: XYZA 00, 20 xx

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Financial Impact:
Employer contributions are based on gross earnings. The estimated annual financial impact for an employer contribution of 6% for currently ineligible employees in these classifications is $70,000.

Implementation of new agreement will improve creating parity for employees in the same classification. Further, this modification would also assist in the recruitment and retention of these crucial unrepresented positions.

Attachments:
1. Resolution
    Exhibit A to Attachment 1– Adoption Agreement (redlined)

BEFORE THE BOARD OF DIRECTORS
OF THE PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

RESOLUTION NO. **-2022**

On the motion of Director
Duly seconded by Director
The following resolution is adopted.

RESOLUTION APPROVING THE AMENDED AND RESTATED WATSONVILLE COMMUNITY HOSPITAL 401(a) PLAN

WHEREAS, the Pajaro Valley Health Care District Hospital Corporation("Hospital') has established and maintains the Watsonville Community Hospital 401(a) Plan ("Plan") for certain eligible employees of the Hospital; and

WHEREAS, the Hospital has reserved the right to amend the Plan at any time in accordance with section 10.01 of the Plan document; and

WHEREAS, the Hospital's CHRO has identified a provision of the plan that treats employees in the critical classifications of Nurse Supervisors and Pharmacists differently based upon their full-time or part-time status and their relative compensation, creating disparate benefit treatment for employees within the same work classification; and

WHEREAS, the Hospital's CHRO with assistance of special benefits counsel have also identified a Plan provision related to eligibility that requires clarification to facilitate proper administration of the Plan; and

WHEREAS, the Hospital's CHRO is recommending the amendment and restatement of the Plan as of January 1, 2023, in order correct and rectify these plan issues; and

WHEREAS, the board of the Hospital deems it to be the best interests of the Hospital to approve and adopt the proposed amendment of the Plan for the above-mentioned reasons;

NOW, THEREFORE, THE BOARD OF DIRECTORS OF THE PAJARO VALLEY HEALTH CARE DISTRICT HOSPITAL CORPORATION HEREBY RESOLVES AND ORDERS AS FOLLOWS:

Section 1. The foregoing recitals are adopted as findings of the Board of Directors as set forth within the body of this Resolution.

Section 2. Effective January 1, 2023, the Plan shall be amended and restated to effectuate the changes and clarifications mentioned above and recommended by staff in the report accompanying this Resolution;

Section 3. Staff is directed execute an appropriate amendment and restatement of the Plan in accordance with this Resolution.

Section 4. Staff is authorized and directed to take all such other necessary or appropriate actions to implement the intent and purposes of this Resolution.

PASSED AND ADOPTED by the Board of Directors of the Pajaro Valley Health Care District this _ day of _ 2022, by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

_____
Chair, Board of Directors

ATTEST:

_____
Clerk of the Board

APPROVED AS TO FORM:

_____
District Counsel

ADOPTION AGREEMENT

FOR

WATSONVILLE COMMUNITY

HOSPITAL 401(a) PLAN

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C. PLAN NAME AND PLAN NUMBER

D. EFFECTIVE DATE
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F. FISCAL YEAR

G. NAMED FIDUCIARY
H. PLAN ADMINISTRATOR
I PREDECESSOR EMPLOYER AND PRIOR EMPLOYER

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Plan ID No. _____

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ADOPTION AGREEMENT FOR THE WATSONVILLE COMMUNITY

HOSPITAL 401(a) PLAN

INTRODUCTION

The Watsonville Hospital Corporation (the "Predecessor Employer") previously established an Internal Revenue Code ("Code") section 401(k) retirement plan on September 1, 1998 (the "Plan"). The Watsonville Community Hospital Money Purchase Pension Plan was merged into the Plan as of January 1, 2019.

As of December 27, 2021, the Predecessor Employer along with certain related entities involved in the business and operation of the Watsonville Community Hospital ("Hospital") entered into an agreement ("APA") with Pajaro Valley Healthcare District Project ("PVHDP") for PVHDP to purchase the assets, properties, rights, and business operations of the Hospital (collectively, the "Business") and to offer employment to some or all of the Hospital's employees. Effective on or about August 31, 2022, all of PVHDP's rights and obligations under the APA will be assigned and assumed by Pajaro Valley Health Care District Hospital Corporation (the "Employer"). In accordance with the terms of the above-mentioned agreements, the Employer is agreeing to continue the employment of substantially all of the Hospital's employees and to offer these employees, along with any new hires, with retirement benefits that are similar to those previously provided by the Predecessor Employer to the extent possible.

The Employer is considered an instrumentality of local government and any employee benefit plan it sponsors would be considered a "governmental plan" under Code section 414(d) and ERISA section 3(32), such that its retirement plan(s) would be exempt for certain provisions of the Code and ERISA. Furthermore, as a governmental entity, the Employer is not eligible to establish and maintain a Code section 401(k) plan.

The ~~Effective Date of the~~ Plan ~~is~~was previously amended and restated as of September 1, 2022, the ~~anticipated~~ closing date specified under the Asset Purchase Agreement (APA) entered into between the Hospital and the Project on December 27, 2021. ~~In the event that the APA does not close on or about September 1, 2022, the Hospital Corporation (as the Employer) reserves the right to immediately terminate the Plan and rescind any actions previously taken to implement the Plan.~~

The Employer now wishes to further amend and restate the Plan as of January 1, 2023 (the Effective Date) in order to clarify certain provisions of the Plan relating to eligibility and to improve the administration of the Plan.

It is intended that the Plan, as amended, qualify as a profit sharing plan (without a section 401(k) feature) under the Internal Revenue Code of 1986, including any later amendments to the Code that apply to governmental plans. From and after the Effective Date, the Plan will no longer be subject to ERISA to the extent provided in ERISA section 4(b). The Employer agrees to operate the Plan according to the terms, provisions, and conditions set forth in this document.

The amended Plan continues to be for the exclusive benefit of employees of the Employer. All persons covered under the Plan before the effective date of this amendment shall continue to be covered under the amended Plan, if they are still Eligible Employees as of the amendment date, with no loss of benefits.

Any participant under the above-referenced plan(s) who is an Eligible Employee as defined in the DEFINITIONS SECTION of Article I shall continue to be a Participant in this Plan. His entry date under the prior plan shall be deemed to be his Entry Date under this Plan.

(Use black ink to complete the Adoption Agreement.)

Plan ID No. _____

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A. This ADOPTION AGREEMENT together with the attached BASIC DEFINED CONTRIBUTION PLAN FOR THE WATSONVILLE COMMUNITY HOSPITAL 401(a) PLAN constitutes *(Select (1), (2), or (3). Select (4), if applicable.)*

NOTE: The effective date for a new plan cannot be earlier than the first day of the Plan Year in which this Adoption Agreement is signed. The effective date for an amendment or restatement cannot be earlier than the first day of the Plan Year in which the amended or restated Adoption Agreement is signed.

1) ☐ a new plan. *(Cannot select if spin-off of an existing plan. See Item AA(2).)*

2) ☒ a restatement of an existing plan. Such existing plan was qualifiable under Code Section 401(a). Except as provided elsewhere in the Plan, the provisions of this restatement are effective on the effective date described in the Introduction. This is the RESTATEMENT DATE.

3) ☐ Amendment No. _____ to the Plan. It replaces all prior amendments to the Plan and the first Adoption Agreement. Except as provided elsewhere in the Plan, the Provisions of this amendment are effective on _____, _____. (*Month, day and year.*)

4) ☐ The Plan is/was frozen effective _____, _____. (*Month, day and year. The initial amendment to freeze the Plan must be prospective to comply with Code Section 411(d)(6).*

Note: No Contributions will be made to the Plan and no Employee, former Employee, or Inactive Participant will become an Active Participant after such date.

B. The EMPLOYER is Pajaro Valley Healthcare District Hospital Corporation

(*Fill in exact legal name*)

C. The PLAN NAME is Watsonville Community Hospital 401(a) Plan

(*For example: ABC, Inc. Profit Sharing Plan*)

The PLAN NUMBER is 001. (*3-digit number used for Form 5500 reporting*)

D. The Plan's original EFFECTIVE DATE is September 1, 1998. (*Month, day and year*)

E. The YEARLY DATE is the first day of each Plan Year. *(Fill in the Effective Date. If this is not a new plan and the Yearly Date has changed more than once, fill in any Yearly Date that is not later than the Restatement Date or amendment effective date.)*

The Yearly Date is September 1, 1998 *(Month, day and year.)* and *(Select one.)*

1) ☐ the same day of each following year.

2) ☒ each following January 1. *(The first Plan Year is short.)*

3) ☐ each following _____ . *(The first Plan Year is short.)*

4) ☐ (a) each following _____ through

(b) _____, _____ and

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(c) each following _____. *(A later Plan Year is short. Complete (a) using the same month and day as in Yearly Date above, (b) using the same month and day as in (a) and the calendar year in which the short Plan Year begins, and (c) using the first day of the new Plan Year.)*

If the first date in Item E is after the Effective Date, Yearly Dates before the first date in Item E above shall be determined under the provisions of the (Prior) Plan before that date.

F. The FISCAL YEAR is the Employer's taxable year and ends on 12/31.
(Month and day or a specific day of the year such as last Saturday of September.)

G. The Employer is the NAMED FIDUCIARY, unless otherwise specified in (1) below.

1) ☒ The Employer's human resource director is the Named Fiduciary. *(Neither Principal Life Insurance Company nor its affiliates can be named.)*

H. The Employer is the PLAN ADMINISTRATOR, unless otherwise specified in (1) below.

1) ☐ The Employer's human resource director is the Plan Administrator. *(Neither Principal Life Insurance Company nor its affiliates can be named.)*

If (1) is selected, complete the address, phone number, and tax filing number of the Plan Administrator.

Address Allyson Hauck, Chief Human Resource Officer
75 Nielson Street
Watsonville, CA 95076

Phone No. _____ Tax Filing No. _____

I. PREDECESSOR EMPLOYER AND PRIOR EMPLOYER.

1) A PREDECESSOR EMPLOYER is a firm of which the Employer was once a part (e.g., due to a spin-off or a change of corporate status) or a firm absorbed by the Employer because of a merger or acquisition (stock or asset, including a division or an operation of such company). No selections are needed for a Predecessor Employer that maintained this Plan since the Employer is defined as including such Predecessor Employer, and service with the Employer would therefore include service with such Predecessor Employer.

a) ☐ *(Select to count service or compensation with a Predecessor Employer that did not maintain this Plan.)* A Predecessor Employer that did not maintain this Plan is deemed to be the Employer for purposes of determining: *(Select at least one.)*

i) ☐ Entry Service

NOTE: The Entry Date for an employee of such Predecessor Employer shall be the earliest Entry Date on or after he has both met the entry requirements and is an Eligible Employee.

ii) ☐ Vesting Service

iii) ☐ Hours of Service required to be eligible for an Employer Contribution

iv) ☐ Compensation

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NOTE: The crediting of such compensation shall be determined on a reasonably uniform basis for all similarly situated Employees based on all relevant facts and circumstances so as not to discriminate in favor of Highly Compensated Employees.

b) Service with and compensation from such Predecessor Employer shall only be counted if service continued without interruption, unless otherwise specified in (i) below.

i) ☐ Service and compensation is counted even if service did not continue without interruption.

c) ☐ *(Select if not counted for all such Predecessor Employers.)* Service with or compensation from such Predecessor Employer shall be counted only as to a Predecessor Employer that *(Select (i), (ii), or both.)*

i) ☐ maintained a qualified pension or profit sharing plan (or)

ii) ☐ is named below: (Exact Legal Name(s).)

_____

_____

_____

2) A PRIOR EMPLOYER is an Employee's last employer immediately prior to the Employer which is not a Predecessor Employer or a Controlled Group member, but for which service credit is granted under the Plan. Service with such Prior Employer shall be counted only if service continued without interruption.

a) ☐ *(Select to count service with a Prior Employer.)* The following are Prior Employers for which service credit is granted under the Plan: *(Exact legal name(s).)*

_____

_____

_____

b) Service with such Prior Employer shall be counted for purposes of determining: *(If (a) above is selected, select (i), (ii), or both.)*

i) ☐ Entry Service

NOTE: The Entry Date for an employee of such Prior Employer shall be the earliest Entry Date on or after he has both met the entry requirements and is an Eligible Employee.

ii) ☐ Vesting Service

J. ELIGIBLE EMPLOYEE.

An Eligible Employee is any Employee of the Employer or of an Adopting Employer *(See Item Z.)* who is not excluded in (1) or (2) below. Notwithstanding any other provision of this Adoption Agreement or the Basic Plan Document, all employees of WCH, who continue in employment with the Employer on the Effective Date and who have participant accounts under the Plan shall automatically continue their participation in the Plan. Notwithstanding any other provision in this Adoption Agreement, other than

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the provision below regarding the exclusion of per diem Employees, or Basic Plan Document, all employees who are Nurse Supervisors or Pharmacists shall be Eligible Employees.

An independent contractor is not an Employee. If the Internal Revenue Service (or another agency or court) determines that an individual who the Employer considered to be an independent contractor is an Employee, such individual shall become an Eligible Employee as soon as administratively feasible following the reclassification date, unless he is otherwise excluded in this item.

1) ☒ STATUTORY EXCLUSIONS. An Employee will not be an Eligible Employee if he is one of the following: *(These exclusions do not affect coverage testing. Select at least one.)*

   a) ☐ BARGAINING EMPLOYEE. An Employee included in a unit of Employees covered by any collective bargaining agreement between the Employer and employee representatives, if retirement benefits were the subject of good faith bargaining and if two percent or less of the Employees who are covered pursuant to that agreement are professionals as defined in section 1.410(b)-9 of the regulations. For this purpose, the term "employee representatives" does not include any organization more than half of whose members are Employees who are owners, officers, or executives of the Employer.

   b) ☒ NONRESIDENT ALIEN WITH NO U.S. INCOME. An Employee who is a nonresident alien, within the meaning of Code Section 7701(b)(1)(B), who receives no earned income, within the meaning of Code Section 911(d)(2), from the Employer that constitutes income from sources within the United States, within the meaning of Code Section 861(a)(3), or who receives such earned income but it is all exempt from income tax in the United States under the terms of an income tax convention.

2) ☒ NONSTATUTORY EXCLUSIONS. An Employee will not be an Eligible Employee if he is any of the following: *(Select at least one. Selections may affect testing done to determine if the minimum coverage requirement of Code Section 410(b) is met, unless otherwise indicated.)*

   a) ☐ Employed in one of the employment classifications selected below. *(Select at least one.)*

      i) ☐ Paid on a salaried basis

      ii) ☐ Paid on a commission basis

      iii) ☐ Paid on an hourly basis

   b) ☐ Represented for collective bargaining purposes by the specific bargaining unit(s) named below:

      _____

      _____

      (This exclusion does not affect coverage testing if requirements in (1)(a) above are met.)

   c) ☐ A Leased Employee.

   d) ☒ *(Select if continuing to exclude independent contractors who are* reclassified *as Employees.)* An individual considered by the Employer to be an independent contractor who is later determined by the Internal Revenue Service (or another agency or court) to be an Employee. Such individual shall continue to be excluded following the reclassification date.

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e) ☐ A part-time, temporary, or seasonal Employee. A part-time, temporary, or seasonal Employee is an Employee who is regularly scheduled to work less than 1,000 Hours of Service in an Entry Service Period. In the event such an Employee (i) works at least 1,000 Hours of Service during an Entry Service Period based on the Hours of Service credited at the end of the Entry Service Period or (ii) his employment status changes to full-time, he shall become an Eligible Employee, unless he is otherwise excluded in this item.

f) ☐ Covered under any other qualified *(Select (i), (ii), or both.)*

i) ☐ profit sharing plan (or)

ii) ☐ pension plan

to which the Employer contributes.

NOTE: The exclusions entered in (g) and (h) below cannot be structured to result in the group of Nonhighly Compensated Employees participating in the Plan being only those Nonhighly Compensated Employees with the lowest amount of Compensation and/or the shortest service and who represent the minimum number of these Employees necessary to satisfy the minimum coverage requirement of Code Section 410(b).

g) ☐ Employed at one of the following locations(s) or division(s):

_____

_____

h) ☒ Employed in one of the following positions(s) or classification(s): (*Cannot use an exclusion classification that indirectly imposes an impermissible age or service requirement.)*

- Employees designated as per diem Employees;
- ~~Employees less than .5 FTE;~~
- Employees who are covered by the Service and Maintenance Unit collective bargaining agreement by the Employer and SEIU United Healthcare Workers-West;
- An Employee who is ~~employed in a position other than as a pharmacist, who has been~~ a Highly Compensated Employee of the Employer with respect to ~~each~~the Plan Year, and who is not a collectively bargained employee covered by a collective bargaining agreement;
- ~~An Employee who is employed as a pharmacist, who is a Highly Compensated Employee of the Employer with respect to each Plan Year, and who is not a collectively bargained employee covered by a collective bargaining agreement;~~
- An Employee designated in a position of manager or above, and who is not a collectively bargained Employee covered by a collectively bargaining agreement.~~.~~

K. ENTRY REQUIREMENTS AND ENTRY DATE

An Employee is eligible to participate in the Plan in accordance with the provisions specified below. *(Select at least one item for each grouping (service required and service method, age required, and Entry Date). Complete any applicable blanks for items selected. If the hours method for calculating Entry Service is selected in (1) below, (3)(b) below may be used to modify how service is determined.*

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All service selections in the table below are made in the context of Entry Service in (3) below. Select (4) below if waiving age or service requirements for the Employer named in Item B.)

NOTE: If the Plan permits Rollover Contributions in Item R(2), an Eligible Employee can make Rollover Contributions to the Plan without satisfying the entry requirements. See Plan Section 3.04. The vesting must be 100% if over one year is used or if over 6 months and Entry Date is Yearly Date.

1) ENTRY REQUIREMENTS

Entry Requirements	All Contributions
Age Required	
No age	☒
Age _____ (*up to 21*)	☐
Service Required and Service Method	
No Service	☐
1 year (*elapsed time*)	☐
2 years (*elapsed time*)	☐
1 year (*hours*)	☐
2 years (*hours*)	☐
_12__ months (*up to 24, elapsed time*)	☒
_____ days a9*up to 120, elapsed time*)	☐

2) ENTRY DATE

Entry Date	All Contributions
Day the entry requirements are satisfied	☒
Monthly Date	☐
Quarterly Date	☐
Semi-yearly Date	
Yearly Date (*age and service required cannot be over 20 ½ and 18 months,* respectively)	☐

3) ENTRY SERVICE. Subject to the provisions of Plan Section 1.02, Entry Service shall be determined based on the selection(s) made above and in (b) below, if applicable:

a) ELAPSED TIME METHOD. Entry Service is the total of an Employee's Periods of Service without regard to Hours of Service.

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b) HOURS METHOD. A year of Entry Service is an Entry Service Period in which an Employee has at least 1,000 Hours of Service, unless otherwise specified in (i) below.

i) ☐ _____ *(Up to 999.)* Hours of Service.

ii) CREDITING DATE. A year of Entry Service shall be credited at the end of the Entry Service Period, unless otherwise specified in A below.

A. ☐ A year of Entry Service shall be credited when the Employee has reached the specified number of Hours of Service during the Entry Service Period.

iii) ENTRY SERVICE PERIOD is the consecutive 12-month period beginning on an Employee's Hire Date and the consecutive 12-month period ending on the last day of each following Plan Year, unless otherwise specified in A below. Following Plan Years shall include all Plan Years that begin after his Hire Date. *(See Plan Section 1.02 for the crediting of Entry Service during the first two periods.)*

A. ☐ An Entry Service Period is the consecutive 12-month period beginning on an Employee's Hire Date and each following consecutive 12-month period beginning on an anniversary of that Hire Date.

NOTE: The Entry Service Period for a rehired Employee who terminated employment prior to satisfying the entry requirements is based on his original Hire Date. If the Entry Service Period shifts to the Plan Year and such Employee is rehired after the first anniversary of his original Hire Date, his Entry Service Period shall be the Plan Year.

4) ☐ WAIVING ENTRY REQUIREMENTS. The requirements selected below shall be waived on _____, _____. *(Month, day and year.)* This date shall be an Entry Date if the Eligible Employee has met all the other entry requirements.

NOTE: This waiver applies only (i) to the Employer named in Item B and (ii) on the date filled in. Must be the Effective Date or later. See Item Z for the waiver of entry requirements for an Adopting Employer.

	All Contributions
Service requirement	☐
Age requirement	☐

L. HIGHLY COMPENSATED EMPLOYEE AND TESTING METHODS (NOT APPLICABLE)

1) HIGHLY COMPENSATED EMPLOYEE. The definition of Highly Compensated Employee in Plan Section 1.02 is modified below. (*Select any that apply.*)

a) ☐ TOP-PAID GROUP ELECTION. *(Select to limit the number of Highly Compensated Employees to the top 20% of employees based on compensation (top-paid group).)* In determining who is a Highly Compensated Employee, the Employer makes a top-paid group election. The effect of this election is that an Employee (who is not a 5-percent owner at any time during the determination year or the look-back year) with compensation in excess of $120,000 (as adjusted) for the look-back year is a Highly Compensated Employee only if the Employee was in the top-paid group for the look-back year.

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(b) ☐ CALENDAR YEAR DATA ELECTION. *(Select to change the look-back year for compensation determination. This election has no effect if the Plan Year begins on January 1.)* In determining who is a Highly Compensated Employee (other than as a 5-percent owner), the Employer makes a calendar year data election. The effect of this election is that the look-back year is the calendar year beginning with or within the look-back year.

NOTE: These elections must apply consistently to the determination years of all plans of the Employer except as provided in the definition of Highly Compensated Employee in Plan Section 1.02.

2) ~~TESTING METHODS. *(Only applicable if the Plan provides for Matching Contributions or Participant Contributions.)* This Plan shall use the prior year testing method for purposes of the ACP Test, unless otherwise specified in (a) below.~~

~~a) ☐ This Plan shall use the current year testing method for purposes of the ACP Test.~~

~~*NOTE: The testing method cannot be changed from the current year testing method to the prior year testing method for a Plan Year unless (i) the Plan has been using the current year testing method for the preceding five Plan Years or, if less, the number of Plan Years the Plan has been in existence or (ii) if, as a result of a merger or acquisition described in Code Section 410(b)(6)(C)(i), the Employer maintains both a plan using the prior year testing method and a plan using the current year testing method and the change is made within the transition period described in Code Section 410(b)(6)(C)(ii).*~~

~~b) ☐ If this is not a successor plan and the Plan is using the prior year testing method, for the first Plan Year this Plan permits any Participant to make Participant Contributions, provides for Matching Contributions, or both, the prior year's Nonhighly Compensated Employees' ACP, as defined in Plan Section 3.08, shall be three percent, unless otherwise specified in (i) below.~~

~~i) ☐ *(Cannot be used with (a) above.)* The Plan Year's ACP, as defined in Plan Section 3.08, shall be used for the Nonhighly Compensated Employees' ACP.~~

M. COMPENSATION.

NOTE: Compensation, as defined in Plan Section 1.02, is used for contribution determinations other than for top-heavy minimum contributions. Compensation, as defined in Plan Section 3.07, for the Limitation Year is used to determine the limit on Annual Additions. Compensation, as defined in Plan Section 3.07, for the Plan Year is used to determine the amount of top-heavy minimum contributions.

1) Compensation, as defined in Plan Sections 1.02 and 3.07, subject to any modifications set forth in this Item M means the definition under Information Required to be Reported Under Code Sections 6041, 6051, and 6052 ("Wages, Tips and Other Compensation" box on Form W-2) shall apply, unless otherwise specified in (a) or (b) below.

a) ☐ The definition under Code Section 3401(a) Wages shall apply.

b) ☒ The definition under Simplified 415 Compensation shall apply. Simplified 415 Compensation excludes amounts received from a nonqualified unfunded deferred compensation plan, unless otherwise specified in (i) below.

i) ☐ Amounts received from a nonqualified unfunded deferred compensation plan are included, to the extent includible in gross income.

2) POST-SEVERANCE COMPENSATION. Post-severance Compensation shall exclude (i) payments for unused accrued bona fide sick, vacation or other leave that the Employee would have been

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able to use if employment had continued; (ii) payments received by the Employee pursuant to a nonqualified unfunded deferred compensation plan and would have been paid at the same time if employment had continued; and (iii) salary continuation payments made for a Participant who is permanently and totally disabled, as defined in Code Section 22(e)(3), unless otherwise specified in (a) below.

a) ☒ Post-severance Compensation shall include *(Select at least one.)*

i) ☒ Such payments for unused accrued bona fide sick, vacation or other leave.

ii) ☐ Such payments received pursuant to a nonqualified unfunded deferred compensation plan, but only to the extent includible in gross income.

iii) ☐ Such salary continuation payments *(Select A or B.)*

A. ☐ for all Participants who are permanently and totally disabled for a fixed or determinable period.

B. ☐ only for Participants who were Nonhighly Compensated Employees immediately before becoming disabled.

3) ☒ CODE SECTION 414(s) SAFE HARBOR EXCLUSIONS. Compensation, as defined in Plan Section 1.02, shall exclude reimbursements or other expense allowances, fringe benefits (cash and noncash), moving expenses, deferred compensation (other than elective contributions), and welfare benefits.

4) ANNUAL COMPENSATION for an Allocation Year is an Employee's Compensation for the Compensation Year ending with or within the consecutive 12-month period ending on the last day of the Allocation Year. In no event will Annual Compensation exceed the Code Section 401(a)(17) compensation limit. *(Annual Compensation is used for the allocation of Discretionary Contributions.)*

The COMPENSATION YEAR is the consecutive 12-month period ending on the last day of each Allocation Year, unless otherwise specified in (a) below.

a) ☐ *(Only available if the WAVE and comparability allocation formulas are not selected in Items N(1)(c) and (d).)* The Compensation Year is the consecutive 12-month period ending on each _____, _____. *(Month and day.)* If the Allocation Year is not the Plan Year, the Compensation Year for an Employee whose Hire Date is less than 12 months before the end of the consecutive 12-month period designated, Compensation shall be determined over the consecutive 12-month period ending on the last day of the Plan Year.

If (i) the Allocation Year is the Fiscal Year, (ii) the Fiscal Year is a 52-53 week period, and (iii) (a) above is not selected, then the Compensation Year shall be such 52-53 week period.

ANNUAL COMPENSATION MODIFICATIONS: *(Select any that apply.)*

b) ☒ Annual Compensation shall not include Compensation over Section 401(a)(17) limit. *(Up to the Code Section 401(a)(17) compensation limit.)*

c) ☒ *(Cannot use with (a) above.)* Annual Compensation shall exclude Compensation for the portion of the Compensation Year in which an Employee is not an Active Participant.

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NOTE: Excluding Compensation while not an Active Participant may result in additional Contributions needed to satisfy the top-heavy requirements, described in Plan Section 11.04, during any Plan Year in which this Plan is a Top-heavy Plan.

5) ☐ In addition to the Code Section 414(s) safe harbor exclusions in (3) above, if applicable, Compensation for purposes of determining the allocation or amount of Contributions excludes: *(Exclusions are not permitted if integrated allocation formula is used. Select at least one.)*

a) ☐ bonuses

b) ☐ commissions

c) ☐ overtime

d) ☐ other special compensation: *(Specify type of compensation excluded.)* _____

_____

NOTE: Exclusions for purposes of Discretionary Contributions will require Code Section 414(s) nondiscrimination testing.

N. EMPLOYER CONTRIBUTIONS AND FORFEITURES. *(Select (1), (2), or both.)*

1) ☒ DISCRETIONARY CONTRIBUTIONS. *(If (2) below is not selected, Employer Contributions shall be substituted for Discretionary Contributions wherever it appears in this Adoption Agreement.)* Discretionary Contributions may be made for each payroll period in an amount determined by the Employer. Discretionary Contributions shall be allocated as of each payroll period to all Eligible Employees, except for the following:

- Employees designated as per diem Employees;
- Employees less than .5 FTE;
- Employees who are covered by the Service and Maintenance Unit collective bargaining agreement by the Employer and SEIU United Healthcare Workers-West;
- An Employee who is employed in a position other than as a pharmacist, who has been a Highly Compensated Employee of the Employer with respect to each Plan Year, and who is not a collectively bargained employee covered by a collective bargaining agreement;
- An Employee who is employed as a pharmacist, who is a Highly Compensated Employee of the Employer with respect to each Plan Year, and who is not a collectively bargained employee covered by a collective bargaining agreement;
- An Employee designated in a position of manager or above.

The amount allocated shall be equal to the amount determined in (a), (b), (c), or (d) below. *(Select (a), (b), (c), or (d).)*

NOTE: The allocation formulas in (a) and (b) below are design-based safe harbors under Code Section 401(a)(4), unless selections are made in Item M or O that are specifically identified as requiring nondiscrimination testing.

a) ☒ COMPENSATION FORMULA. Discretionary Contributions shall be allocated using Compensation for the current payroll period. The amount allocated shall be equal to the Discretionary Contributions

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multiplied by the ratio of such person's payroll period Compensation to the total payroll period Compensation for all such persons.

b) ☐ INTEGRATED FORMULA. *(Only available if Adopting Employers Separate Plans are not selected in Item Z.)*

i) PROVIDE TOP-HEAVY MINIMUM CONTRIBUTION. Discretionary Contributions shall be allocated to provide the top-heavy minimum contribution under Plan Section 11.04, unless otherwise specified in A below.

Subject to the overall permitted disparity limits, Discretionary Contributions shall be allocated using Annual Compensation for the Allocation Year as follows:

STEP ONE: This step one shall only apply in years in which the Plan is a Top-heavy Plan, as defined in Plan Section 11.02, and the minimum contribution under Plan Section 11.04 is not being provided by other contributions to this Plan or another plan of the Employer.

The allocation in this step one shall be made to each person meeting the requirements in Item O and each person who is entitled to a minimum contribution under Plan Section 11.04. Each such person's allocation shall be an amount equal to the Discretionary Contributions multiplied by the ratio of such person's Annual Compensation to the total Annual Compensation of all such persons. Such amount shall not exceed 3% of such person's Annual Compensation. The allocation for any person who does not meet the requirements in Item O shall be limited to the amount necessary to fund the minimum contribution.

STEP TWO: This step two shall only apply in years in which step one applies. The allocation in this step two shall be made to each person meeting the requirements in Item O. Each such person's allocation shall be equal to any amount remaining after the allocation in step one multiplied by the ratio of such person's Annual Compensation over the Integration Level to the total Annual Compensation over the Integration Level of all such persons. Such amount shall not exceed 3% of such person's Annual Compensation over the Integration Level.

For purposes of this step two, in the case of any person who has exceeded the cumulative permitted disparity limit described below, such person's total Annual Compensation shall be taken into account and the applicable allocation limit for such person shall be 3% of such person's total Annual Compensation.

STEP THREE: The allocation in this step three shall be made to each person meeting the requirements in Item O. Each such person's allocation shall be equal to any amount remaining after the allocation in step two multiplied by the ratio of the sum of such person's total Annual Compensation and his Annual Compensation over the Integration Level to the total of such sums for all such persons. Such amount shall not exceed an amount equal to a percentage (equal to the Maximum Integration Rate) of the sum of such person's total Annual Compensation and his Annual Compensation over the Integration Level.

If steps one and two apply, the Maximum Integration Rate minus 3% shall be substituted for the Maximum Integration Rate wherever it appears in this step three.

For purposes of this step three, in the case of any person who has exceeded the cumulative permitted disparity limit described below, two times such person's total Annual Compensation shall be taken into account and the applicable allocation limit for such person shall be a percentage (equal to the Maximum Integration Rate) of two times such person's total Annual Compensation.

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STEP FOUR: The allocation in this step four shall be made to each person meeting the requirements in Item O. Each such person's allocation shall be equal to any amount remaining after the allocation in step three multiplied by the ratio of such person's Annual Compensation to the total Annual Compensation of all such persons.

A. ☐ DO NOT PROVIDE TOP-HEAVY MINIMUM CONTRIBUTION. Subject to the overall permitted disparity limits, Discretionary Contributions shall be allocated using Annual Compensation for the Allocation Year to each person meeting the requirements in Item O. Each such person's allocation shall be determined as follows:

STEP ONE: An amount equal to the Discretionary Contributions multiplied by the ratio of the sum of such person's total Annual Compensation and his Annual Compensation over the Integration Level to the total of such sums for all such persons. Such amount shall not exceed an amount equal to a percentage (equal to the Maximum Integration Rate) of the sum of such person's total Annual Compensation and his Annual Compensation over the Integration Level.

For purposes of this step one, in the case of any person who has exceeded the cumulative permitted disparity limit described below, two times such person's total Annual Compensation shall be taken into account and the applicable allocation limit for such person shall be a percentage (equal to the Maximum Integration Rate) of two times such person's total Annual Compensation.

STEP TWO: Any amount remaining after the allocation in step one multiplied by the ratio of such person's Annual Compensation to the total Annual Compensation of all such persons.

The INTEGRATION LEVEL is the Taxable Wage Base as in effect on the latest Yearly Date, unless otherwise specified in (ii) or (iii) below.

ii) ☐ $_____. *(Must be less than such Taxable Wage Base.)*

iii) ☐ _____ % of such Taxable Wage Base. *(Must be more than 19% and less than 100%.)*

The MAXIMUM INTEGRATION RATE shall be determined according to the following schedule:

INTEGRATION LEVEL	MAXIMUM INTEGRATION RATE
100% of TWB	5.7%
Less than 100% but more than 80% of TWB	5.4%
More than 20% of TWB but not more than 80% of TWB	4.3%
Not more than 20% of TWB	5.7%

"TWB" means the Taxable Wage Base as in effect on the latest Yearly Date.

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On any date the portion of the rate of tax under Code Section 3111(a) (in effect on the latest Yearly Date) that is attributable to old age insurance exceeds 5.7%, such rate shall be substituted for 5.7%. 5.4% and 4.3% shall be increased proportionately.

OVERALL PERMITTED DISPARITY LIMITS:

ANNUAL OVERALL PERMITTED DISPARITY LIMIT: Notwithstanding the preceding paragraphs, for any Plan Year any person eligible for an allocation under this formula benefits under another qualified plan or simplified employee pension, as defined in Code Section 408(k), maintained by the Employer or any other employer required to be aggregated with the Employer under Code Sections 414(b), (c), (m), or (o) that provides for permitted disparity (or imputes disparity), Discretionary Contributions shall be allocated using (i) only step one, if applicable, and step four under (b)(i) if providing top-heavy minimum contribution and (ii) only step two under (b)(i)A if not providing top-heavy minimum contribution.

CUMULATIVE PERMITTED DISPARITY LIMIT: The cumulative permitted disparity limit for a person is 35 total cumulative permitted disparity years. Total cumulative permitted disparity years means the number of years credited to the person for allocation or accrual purposes under this Plan, any other qualified plan or simplified employee pension plan (whether or not terminated) ever maintained by the Employer or any other employer required to be aggregated with the Employer under Code Sections 414(b), (c), (m), or (o). For purposes of determining the person's cumulative permitted disparity limit, all years ending in the same calendar year are treated as the same year. If the person has not benefited under a defined benefit or target benefit plan maintained for any year beginning on or after January 1, 1994, the person has no cumulative permitted disparity limit.

NOTE: The allocation formulas in (c) and (d) below do not meet the safe harbor requirements of Code Section 401(a)(4).

c) AGE WEIGHTED (WAVE), PROVIDE TOP-HEAVY MINIMUM CONTRIBUTION. Discretionary Contributions shall be allocated to provide the top-heavy minimum contribution under Plan Section 11.04.

Discretionary Contributions shall be allocated using Benefit Factors for the Allocation Year. In years in which the Plan is a Top-heavy Plan, as defined in Plan Section 11.02, and the minimum contribution under Plan Section 11.04 is not being provided by other contributions to this Plan or another plan of the Employer, the allocation shall be made to each person meeting the requirements in Item O and each person entitled to a minimum contribution under Plan Section 11.04. In all other years the allocation shall be made to each person meeting the requirements in Item O. Each such person's allocation shall be an amount equal to Discretionary Contributions multiplied by the ratio of such person's Benefit Factor to the total Benefit Factors for all such persons. The allocation for any person who does not meet the requirements in Item O shall be limited to the amount necessary to fund the minimum contribution.

In years in which the Plan is a Top-heavy Plan, as defined in Plan Section 11.02, the minimum contribution under Plan Section 11.04 is not being provided by other contributions to this Plan or another plan of the Employer, and the allocation described above (or any subsequent allocation described below) would provide an allocation for any person less than the minimum contribution required for such person in Plan Section 11.04, such minimum contribution shall first be allocated to all such persons. Then any amount remaining shall be allocated to the remaining persons sharing in the allocation based on Benefit Factors as described above, as if they were the only persons sharing in the allocation for the Allocation Year.

8.5% INTEREST. The actuarial factor used to determine a person's Benefit Factor shall be the actuarial factor for the Allocation Year determined in Appendix A (based on an interest rate

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assumption of 8.5% and the mortality assumptions in the UP-1984 Table), unless a different appendix is specified in (i) or (ii) below.

i) ☐ 7.5% INTEREST. Appendix B (based on an interest rate assumption of 7.5% and the mortality assumptions in the UP-1984 Table).

ii) ☐ 8.0% INTEREST. Appendix C (based on an interest rate assumption of 8.0% and the mortality assumptions in the UP-1984 Table).

The allocation above meets the requirements in section 1.401(a)(4)-8(b)(1)(i)(B)(2) of the regulations, therefore a minimum gateway contribution is not required.

d) ☐ PARTICIPANT GROUP ALLOCATION (COMPARABILITY), PROVIDE TOP-HEAVY MINIMUM CONTRIBUTION. The Employer shall notify the Plan Administrator in writing, by the due date of the Employer's tax return for the year to which the Discretionary Contribution relates, the portion of such Contribution to be allocated to each Allocation Group. Discretionary Contributions determined for an Allocation Group shall be allocated using Annual Compensation for the Allocation Year to each person in the Allocation Group meeting the requirements in Item O. Each such person's allocation shall be equal to the Discretionary Contribution determined for the Allocation Group multiplied by the ratio of such person's Annual Compensation to the total Annual Compensation of all such person's in the Allocation Group.

MINIMUM ALLOCATION GATEWAY. If the Employer allocates a Discretionary Contribution for any Allocation Year, the Employer shall make an additional Employer Contribution for such Allocation Year for each person who is a Nonhighly Compensated Employee and who had Employer Contributions made for or allocated to him for such Allocation Year if the sum of all Employer Contributions for such Nonhighly Compensated Employee is less than a minimum. The additional Employer Contribution shall be equal to the amount needed, if any, to bring the sum of all Employer Contributions up to the minimum. The amount of the minimum shall be equal to either (i) 5% of his Compensation or (ii) 1/3 of the "highest percentage" of his Compensation. The same minimum shall apply to all such persons and the minimum that applies shall be the minimum resulting in the smallest total additional Employer Contributions.

For purposes of determining the 5% minimum, Compensation means Compensation, as defined in Plan Section 3.07, for the Allocation Year. For purposes of determining the 1/3 of the highest percentage minimum, the highest percentage shall be the highest percentage of Compensation at which Employer Contributions are made for or allocated to any Highly Compensated Employee. The highest percentage shall be determined by dividing the Employer Contributions made for or allocated to each Highly Compensated Employee during the Allocation Year by the amount of his Compensation and selecting the greatest quotient (expressed as a percentage). For purposes of determining the 1/3 of the highest percentage minimum, including the determination of the highest percentage, Compensation means Annual Compensation for purposes of allocating Discretionary Contributions for the Allocation Year.

For purposes of determining the minimum allocation gateway, Employer Contributions shall not include Matching Contributions.

NOTE: In the case of a Self-employed Individual, the requirements of section 1.401(k)-1(a)(6) of the regulations continue to apply, and the allocation above shall not be such that a cash or deferred election is created for a Self-employed Individual.

This additional Employer Contribution shall be credited to the person's Account and shall be deemed to be a Discretionary Contribution.

ALLOCATION GROUPS.

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~~*NOTE: The criteria for determining the make-up of each Allocation Group cannot be subject to Employer discretion, which would cause the Plan to fail to have a definite allocation formula. The Allocation Groups cannot be structured to limit participation to only the shortest service and lowest paid Nonhighly Compensated Employees while excluding all other Nonhighly Compensated Employees.*~~

~~The Allocation Groups shall be: *(Complete (i) and (ii). Complete (iii) and (iv), if applicable. Four is the maximum number of Allocation Groups allowed on this Principal Financial Group Pre-approved Document for Profit Sharing Plans. Complete with titles or classifications.)*~~

~~i) Group 1 _____~~

~~ii) Group 2 _____~~

~~iii) Group 3 _____~~

~~iv) Group 4 _____~~

2) ☐ MATCHING CONTRIBUTIONS. The Employer shall make Matching Contributions for each person meeting the requirements in Item O. *(Select (a), (b), or both.)*

a) ☐ MATCH REQUIRED OR OPTIONAL CONTRIBUTIONS. The amount of such Contributions shall be equal to the sum of (i) and (ii) below. *(Select (i), (ii), or both.)*

i) ☐ % of such person's Required Contributions made for the Allocation Year. *(Item Q(1)(a) must be selected.)*

ii) ☐ % of such person's Optional Contributions made for the Allocation Year. *(Item Q(2) must be selected.)*

NOTE: The selection of (b) below is only available if the Employer is a tax-exempt organization under Code Section 501(c)(3) and maintains a Code Section 403(b) plan separate and apart from this Plan. The election of this option does not establish a 403(b) plan for the Employer. No opinion is expressed as to whether a Code Section 403(b) plan that is maintained by the Employer, in addition to and separate from this Plan, satisfies the requirements of Code Section 403(b).

b) ☐ MATCH 403(b) PLAN ELECTIVE DEFERRAL CONTRIBUTIONS. The amount of such Contributions shall be calculated as of the last day of the Allocation Year using Elective Deferral Contributions and Compensation for the Allocation Year and shall be an amount equal to *(Select (i) or (ii).)*

i) ☐ STATED MATCH. % of such person's Elective Deferral Contributions to the Employer's 403(b) plan.

A. ☐ Elective Deferral Contributions that are over% of such person's Compensation won't be matched.

ii) ☐ STATED TIERED MATCH. *(Complete A through D. For example: 100% of Elective Deferral Contributions that are not over 3% of Compensation, plus 50% of Elective Deferral Contributions that are over 3% but are not over 5% of Compensation.)*

A. _____% of Elective Deferral Contributions that are not over _____% of Compensation, plus *(First limit on Elective Deferral Contributions.)*

B. _____% of Compensation, plus (*First limit on Elective Deferral Contributions.*)

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C. _____% *(Must be less than A.)* of Elective Deferral Contributions that are over the percentage of Compensation specified in B but are not over

D. _____% *(Must be more than B.)* of Compensation. *(Second limit on Elective Deferral Contributions.)*

If Employer Contributions are made from Net Profits (Item O(1)(a) is selected) and Net Profits are not sufficient to provide Matching Contributions, such Contributions shall be proportionately reduced.

3) FORFEITURE APPLICATION.

Forfeitures of Nonvested Accounts when a Participant receives a distribution of his entire Vested Account, as described in Plan Section 3.05, shall occur as of the date the Participant receives, or is deemed to receive, the distribution, unless otherwise specified in (a) below.

a) ☐ Such Forfeitures shall occur on the first day of the Plan Year following the Plan Year in which the Participant receives, or is deemed to receive, the distribution.

O. NET PROFITS AND CONTRIBUTION REQUIREMENTS.

1) Employer Contributions shall be made without regard to current or accumulated NET PROFITS, unless otherwise specified in (a) below.

a) ☐ Employer Contributions shall be made out of current or accumulated Net Profits.

2) REQUIREMENTS FOR CONTRIBUTIONS. Employer Contributions and Forfeitures, if applicable, shall be made for or allocated to each person who was an Active Participant at any time during the Allocation Year, unless otherwise specified in (a), (b), (c), or (d) below.

NOTE: Selections may affect testing done to determine if the minimum coverage requirement of Code Section 410(b) is met, unless otherwise indicated.

a) ☐ Such amounts shall be made for or allocated to each person who was an Active Participant at any time during the Allocation Year and either is an Active Participant on the last day of the Allocation Year or has more than 500 Hours of Service during the latest Accrual Service Period ending on or before the last day of the Allocation Year, unless a lesser number of Hours of Service is specified in (i) below. *(This selection does not affect coverage testing if the Allocation Year and the Accrual Service Period are the Plan Year.)*

i) ☐ Has more than _____ *(Up to 499.)* Hours of Service.

b) ☐ Such amounts shall be made for or allocated to each person who is an Active Participant on the last day of the Allocation Year.

c) ☐ Such amounts shall be made for or allocated to each person who was an Active Participant at any time during the Allocation Year and has at least 1,000 Hours of Service during the latest Accrual Service Period ending on or before the last day of the Allocation Year, unless otherwise specified in (i) below.

i) ☐ Has at least *(Up to 999.)* Hours of Service.

d) ☐ Such amounts shall be made for or allocated to each person who is an Active Participant on the last day of the Allocation Year and has at least 1,000 Hours of Service during the latest

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Accrual Service Period ending on or before the last day of the Allocation Year, unless otherwise specified in (i) below.

i) ☐ Has at least *(Up to 999.)* Hours of Service.

The requirements in (a), (b), (c), or (d) above are modified as follows:

e) ☐ Such amounts shall also be made for or allocated to each person who was an Active Participant at any time during the Allocation Year and (i) dies or (ii) has a Severance from Employment after he reaches his Normal Retirement Date or becomes disabled. Such amounts shall also be made for or allocated to each person who was an Active Participant at any time during the Allocation Year and has died or become disabled while performing Qualified Military Service during the Allocation Year. For purposes of this paragraph, disabled means the disability is subsequently determined to meet the definition of Totally Disabled.

3) The ALLOCATION YEAR is the Plan Year, unless otherwise specified in (a) below.

a) ☐ *(Only available if Items N(1)(c), N(1)(d), and N(2) are not selected.)* The Allocation Year is the Fiscal Year ending in the Plan Year.

NOTE: Selecting (a) above may affect testing done to determine if the minimum coverage requirement of Code Section 410(b) is met. Selecting (a) above will require nondiscrimination testing to determine if the nondiscrimination requirement of Code Section 401(a)(4) is met.

4) The ACCRUAL SERVICE PERIOD is the consecutive 12-month period ending on the last day of each Allocation Year.

P. CONTRIBUTION MODIFICATIONS.

CONTRIBUTION LIMITATIONS. The Annual Additions for a Participant during a Limitation Year shall not be more than the Maximum Annual Addition. *(See Plan Section 3.07.)*

1) The LIMITATION YEAR is the consecutive 12-month period ending on the last day of each Plan Year, unless otherwise specified in (a) below.

a) ☐ The Limitation Year is the consecutive 12-month period ending on each

_____. *(Month and day.)*

NOTE: The same limitation year must be used in all plans maintained by the Employer.

2) MULTIPLE DEFINED CONTRIBUTION PLANS. *(This item applies if the Employer, as defined in Plan Section 1.02, or an Employer, as defined in Plan Section 3.07, maintain another qualified defined contribution plan that is not a Plan in which any Participant in this Plan is or was or could become a participant.)* If the Participant is covered under another qualified defined contribution plan maintained by the Employer, as defined in Plan Section 3.07, the provisions of (c) through (e) of Plan Section 3.07 shall apply, unless otherwise specified in (a) below**.** *(Plan Section 3.07 limits the last Annual Additions.)*

a) ☐ The method described on the attached page(s) shall be used to limit total Annual Additions to the Maximum Annual Addition and shall properly reduce the excess amounts in a manner that precludes Employer discretion. *(If selected, the Employer will provide the method for limiting Annual Additions on the attached page(s).)*

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~~TOP-HEAVY PLAN REQUIREMENTS. The amount and allocation of Contributions shall be subject to the provisions of Article XI of the Basic Plan in Plan Years when this is a Top-heavy Plan, as defined in Plan Section 11.02. Special minimum contribution provisions will apply in such years.~~

~~3) ☐ MULTIPLE PLANS. *(Use this item to specify which plan will provide the minimum contribution or benefit for participants who are covered under this Plan and any other plan or plans of the Employer. If selected, the Employer must provide wording on the attached page(s).)* The method described on the attached page(s) shall be used to meet the minimum contribution and benefit requirements in Plan Years when this is a Top-heavy Plan, in a manner that precludes Employer discretion.~~

Q. REQUIRED CONTRIBUTIONS AND OPTIONAL CONTRIBUTIONS.

1) REQUIRED CONTRIBUTIONS. A Participant is not required to make Contributions in order to participate in the Plan, unless otherwise specified in (a) below.

a) ☐ *(Must select if Item N(2)(a)(i) is selected..)* A Participant is required to make Contributions in order to participate in the Plan. The amount of each Required Contribution made by an Active Participant

shall be _____% of the Participant's Compensation for the payroll period.

2) ☐ OPTIONAL CONTRIBUTIONS. *(Only available if Item N(2)(a)(ii) is selected. Must select if Item N(2)(a)(ii) is selected. If selected, the Plan is subject to an ACP Test.)* A Participant is permitted to make Optional Contributions. The amount of Optional

Contributions for a payroll period may be any amount up to _____% of the Participant's Compensation for the payroll period.

R. VOLUNTARY CONTRIBUTIONS AND ROLLOVER CONTRIBUTIONS.

1) VOLUNTARY CONTRIBUTIONS are not permitted, unless otherwise specified in (a) below.

a) ☐ Voluntary Contributions are permitted. *(Select any that apply.)*

i) ☐ _____% of Compensation is the minimum Voluntary Contribution. *(Must be more than 0% and less than 50%.)*

ii) ☐ Voluntary Contributions must be a whole percentage of Compensation.

iii) ☐ % of Compensation is the maximum Voluntary Contribution. *(Must be more than 0% and less than 100%.)*

2) ROLLOVER CONTRIBUTIONS are permitted, unless otherwise specified in (a) below.

a) ☐ Rollover Contributions are not permitted.

S. INVESTMENTS.

1) The Plan does not have a Trust Agreement in effect, unless otherwise specified in (a) below.

a) ☒ TRUST AGREEMENT. The Plan has at least one Trust Agreement in effect.

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2) INVESTMENT DIRECTION. Subject to the provisions of Article IV of the Basic Plan, the Annuity Contract, and if applicable, the Trust Agreement, the investment of a Participant's Account shall be directed by *(Select one.)*

a) ☒ the Participant for all Contributions.

b) ☐ the Employer for all Contributions.

c) ☐ the Participant for Participant Contributions and Rollover Contributions. The Employer for Employer Contributions.

3) LOANS. Loans to a Participant are not permitted, unless otherwise specified in (a) below.

a) ☒ *(Only available if (1)(a) above is selected and the Trustee agrees to hold the promissory note.)* Loans are available to a Participant subject to the provisions of Plan Section 5.06.

i) The Loan Administrator(s) is/are: *(Fill in the person(s) or position(s) authorized to administer the Participant loan program. Neither Principal Life Insurance Company nor its affiliates can be named.)*

Plan Administrator

ii) The minimum amount of any loan is $1,000, unless otherwise specified in A or B below.

A. ☐ The minimum amount of any loan is $_____ . *(Up to $999.)*

B. ☐ No minimum loan amount applies.

iii) ☒ The maximum amount of any loan is the lesser of 50% of the Participant's Vested Account, reduced by any outstanding loan balance or

$10,000 *(Up to $49,999.),* reduced by the highest outstanding loan balance during the one-year period ending on the day before the loan is made.

NOTE: If not selected, the maximum is the lesser of (i) 50% of the Participant's Vested Account, reduced by any outstanding loan balance or (ii) $50,000, reduced by the highest outstanding loan balance during the one-year period ending on the day before the loan is made.

iv) ☐ SOURCE OF LOAN LIMITED. *(Only available if Item Y(2)(a) is selected.)* Loans shall only be available from the portion of the Participant's Vested Account resulting from all Contributions, excluding any amounts resulting from a direct or indirect transfer after December 31, 1984, of a defined benefit plan, money purchase plan, target benefit plan, stock bonus plan, or profit sharing plan that is subject to the survivor annuity requirements of Code Sections 401(a)(11) and 417.

NOTE: The Participant's Vested Account is used to determine the maximum amount of any loan. The amount a Participant may receive as a loan is limited to the Participant's Vested Account resulting from the Contributions selected above.

v) The number of outstanding loans for a Participant shall be limited to one, unless otherwise specified in A below.

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A. ☒ The number shall be limited to _2_. *(Up to 5.)*

vi) The number of loans approved for a Participant in a rolling 12-month period shall be limited to one, unless a different number or 12-month period is specified in A or B below.

A. ☒ The number shall be limited to _2_. *(Up to 5.)*

B. ☒ The 12-month period shall be the *(Select (1), (2), or (3).)*

1) ☒ Plan Year.

2) ☐ calendar year.

3) ☐ deposit year as defined in the Annuity Contract.

vii) The term of the loan shall be limited to five years, unless otherwise specified in A below.

A. ☒ The term of the loan shall not be limited to five years for the purchase of a Participant's principal residence. Such loan term shall be limited to a period consistent with commercial home loan practices, unless otherwise specified in (1) below.

1) ☐ SPECIFIED LIMIT FOR PRINCIPAL RESIDENCE. The term of the loan shall be limited to the lesser of (i) _10_ *(Up to 25.)* years or (ii) a period of years consistent with commercial home loan practices.

viii) TIMING OF A LOAN DEFAULT. If any payment of principal and interest, or any portion thereof, remains unpaid for more than 90 days after due, the loan shall be in default, unless otherwise specified in A or B below.

A. ☐ The loan shall be in default _____ *(Up to 89.)* days after due.

B. ☐ The loan shall be in default at the end of the calendar-year quarter following the calendar-year quarter in which the missed payment was due.

ix) SEVERANCE FROM EMPLOYMENT. An outstanding loan shall become due and payable in full 60 days after a Participant has a Severance from Employment and ceases to be a party-in-interest as defined in ERISA or after complete termination of the Plan.

However, subject to the provisions of Plan Section 5.06 and in accordance with nondiscriminatory procedures set up by the Loan Administrator, an outstanding loan balance shall not be due and payable at such time as modified in A or B below.

A. An outstanding loan shall not be due and payable at such time if a Participant impacted by a business event, as described in Plan Section 5.06, elects a Direct Rollover to another qualified plan that includes the loan note, unless otherwise specified in (1) or (2) below.

1) ☒ The ability to roll over an outstanding loan note shall not be limited to Participants impacted by a business event.

2) ☐ Rollovers of an outstanding loan note are not permitted.

B. ☐ A Participant may continue to repay an outstanding loan balance after Severance from Employment.

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T. VESTING PERCENTAGE.

Vesting Percentage is used to determine the nonforfeitable percentage of a Participant's Account resulting from Employer Contributions.

The Vesting Percentage for a Participant who is an Employee on or after the date he reaches Normal Retirement Age or Early Retirement Age shall be 100%. The Vesting Percentage for a Participant who is an Employee on the date he dies or the date he becomes disabled shall be 100%. The Vesting Percentage shall also be 100% for a Participant who dies or becomes disabled while performing Qualified Military Service. For purposes of this paragraph, disabled means the disability is subsequently determined to meet the definition of Totally Disabled.

1) VESTING SCHEDULE. A Participant's Account resulting from Employer Contributions is subject to the vesting schedule selected below. *(Select one. If (d) is selected, fill in percentages.)*

VESTING SERVICE *(whole years)*	VESTING PERCENTAGE			
	(a)	(b)	(c)	(d)
	☒	☐	☐	☐
Less than 1	100	0	0	_____
1		0	0	_____
2		0	20	_____
3		100	40	_____
4			60	_____
5			80	_____
6 or more			100	_____

NOTE: The schedule in (d) must provide 100% vesting after 3 years of Vesting Service or must at all times be as great as the Vesting Percentage that the schedule in (c) would provide.

A Participant's Vesting Percentage determined above shall never be reduced in later years.

U. VESTING SERVICE

Vesting Service, subject to the provisions of Plan Section 1.02, shall be the total of an Employee's countable Periods of Service without regard to Hours of Service (elapsed time method), unless otherwise specified in (1) below.

1) ☐ HOURS METHOD. A year of Vesting Service is a Vesting Service Period in which an Employee has at least 1,000 Hours of Service, unless otherwise specified in (a) below.

a) ☐ _____ (Up to 999) Hours of Service.

b) A VESTING SERVICE PERIOD is the consecutive 12-month period ending on the last day of each Plan Year, unless otherwise specified in (i) below.

i) ☐ The consecutive 12-month period ending on each _____. *(Month and day)*

c) A VESTING BREAK, when the hours method is used, is a Vesting Service Period in which an Employee is credited with not more than one-half of the Hours of Service required for a year of Vesting Service, unless otherwise specified in (i) below.

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i) ☐ _____ or fewer Hours of Service. (*Fill in up to 500 hours but less than hours required for a year of Vesting Service)*

NOTE: If the hours method is used, the date completed in (2) below should be the first day of Vesting Service Period. If the first day of such period is not used, service during the period in which the date occurs shall not be excluded because of that modification. If the hours method is used and (3) is selected, service during the period in which the Employee attains the age completed in (3) shall not be excluded because of that modification. If the Employer had a previous plan that terminated within five years of the Effective Date of this Plan, the Employer must treat the effective date of the terminated plan as the Effective Date of this Plan for purposes of the selection in (2) below.

VESTING SERVICE MODIFICATIONS:

2) ☐ Service before _____, _____ (*Month, day and year*)

NOTE: If selected, fill in a date on or before the date the Plan became subject to ERISA. A new plan becomes subject to ERISA on its Effective Date.

3) ☐ Service before an Employee attains age *(Up to 18)* shall not be counted.

4) ☐ *(Select only if Participant Contributions are now or have been required for participation in the (Prior) Plan.)* Service while an Eligible Employee does not make the Contributions required in order to be an Active Participant shall not be counted.

NOTE: If the hours method is used, service during a Vesting Service Period in which the Participant makes any Required Contributions shall not be excluded because of this item

V. EQUIVALENCIES.

Hours of Service shall be determined on the basis of actual Hours of Service that an Employee is paid or entitled to payment if the Employer maintains hourly records for such Employee. If the Employer does not maintain hourly records for an Employee, Hours of Service shall be determined on the basis of months worked and an Employee shall be credited with 190 Hours of Service for each month in which he would otherwise be credited with at least one Hour of Service, unless otherwise specified in (1), (2) or (3) below.

1) ☐ DAYS. On the basis of days worked. An Employee shall be credited with 10 Hours of Service for each day in which he would otherwise be credited with at least one Hour of Service.

2) ☐ WEEKS. On the basis of weeks worked. An Employee shall be credited with 45 Hours of Service for each week in which he would otherwise be credited with at least one Hour of Service.

3) ☐ ALL EMPLOYEES. The equivalency described above shall apply to all Employees.

W. WITHDRAWAL BENEFITS.

1) VOLUNTARY. A Participant may withdraw any part of his Vested Account resulting from Voluntary Contributions, unless such withdrawals are not permitted in (c) below.

A Participant may make two such withdrawals in any 12-month period, unless otherwise specified in (a), (b) or (c) below.

a) ☐ A Participant may make such a withdrawal at any time.

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b) ☐ A Participant may make _____ such withdrawal(s) in any 12-month period.

c) ☐ Withdrawal of Voluntary Contributions is not permitted.

2) ROLLOVER. A Participant may withdraw any part of his Vested Account resulting from Rollover Contributions, unless such withdrawals are not permitted in (c) below.

A Participant may make two such withdrawals in any 12-month period, unless otherwise specified in (a), (b), or (c) below.

a) ☐ A Participant may make such a withdrawal at any time.

b) ☐ A Participant may make _____ such withdrawal(s) in any 12-month period.

c) ☒ Withdrawal of Rollover Contributions is not permitted.

3) ☒ HARDSHIP. A Participant may withdraw any part of his Vested Account resulting from Matching Contributions and Discretionary Contributions in the event of hardship due to financial need. The withdrawal is subject to the provisions of Plan Section 5.05.

4) ☐ AGE 59 1/2. A Participant may withdraw any part of his Vested Account resulting from Matching Contributions and Discretionary Contributions any time after he attains age 59 1/2.

A Participant may make two such withdrawals in any 12-month period, unless otherwise specified in (a) or (b) below.

a) ☐ A Participant may make such a withdrawal at any time.

b) ☐ A Participant may make _____ such withdrawal(s) in any 12-month period.

5) ☐ FIVE YEARS AS AN ACTIVE PARTICIPANT. A Participant may withdraw any part of his Vested Account resulting from Matching Contributions and Discretionary Contributions at any time after he has been an Active Participant for at least five years.

A Participant may make two such withdrawals in any 12-month period, unless otherwise specified in (a) or (b) below.

a) ☐ A Participant may make such a withdrawal at any time.

b) ☐ A Participant may make _____ such withdrawal(s) in any 12-month period.

NOTE: Withdrawals are subject to the distribution of benefits provisions of Article VI or VIA of the Basic Plan, whichever applies.

X. RETIREMENT AND THE START OF BENEFITS.

1) NORMAL RETIREMENT AGE is the age at which the Participant's Account becomes nonforfeitable if he is an Employee. A Participant's Normal Retirement Age is age 65, unless otherwise specified in (a) or (b) below.

a) ☐ Age _____. *(At least 55 and no more than 64.)*

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b) ☐ *(Only available if the WAVE and comparability allocation formulas are not selected in Items N(1)(c) and (d).)* The older of age _____ *(At least 55 and no more than 65.)* or his age on the *(Select (i) or (ii).)*

i) ☐ date _____ *(Up to 5.)* years after the first day of the Plan Year in which his Entry Date occurred.

ii) ☐ earlier of the date *(Up to 5.)* years after his Hire Date or the date 5 years after the first day of the Plan Year in which his Entry Date occurred.

The provisions of (b) are modified as follows:

c) ☐ A Participant's Normal Retirement Age shall not be older than age _____. *(At least the age in (b) and no more than 70.)*

NOTE: If the Plan includes monies from a money purchase plan or another direct or indirect transfer described in Item Y(3), and (a) or (b) is selected, the age entered cannot be less than 62.

2) NORMAL RETIREMENT DATE, DATE REACHES. Normal Retirement Date means the date a Participant reaches his Normal Retirement Age, unless otherwise specified in (a) below.

a) ☐ FIRST OF MONTH ON OR AFTER. Normal Retirement Date means the earliest first day of the month on or after a Participant reaches his Normal Retirement Age.

3) START OF RETIREMENT BENEFITS. A Participant may choose to have retirement benefits begin before he has a Severance from Employment and on or after his Normal Retirement Date, unless otherwise specified in (a) below.

a) ☐ A Participant may not choose to have retirement benefits begin before he has a Severance from Employment.

4) EARLY RETIREMENT DATE. *(Select (a) or (b).)*

a) ☒ PERMITTED. If (2)(a) above is selected, Early Retirement Date is the first day of the month before a Participant's Normal Retirement Date that he selects for receiving a distribution of his Vested Account as an early retirement benefit. If (2)(a) above is not selected, Early Retirement Date is any day before a Participant's Normal Retirement Date that he selects for receiving a distribution of his Vested Account as an early retirement benefit. This day shall be on or after the date the Participant has a Severance from Employment and reaches Early Retirement Age. A Participant reaches Early Retirement Age on the date the following requirement(s) are met: *(Select at least one. A Participant's Account is 100% vested if he is an Employee on or after he reaches this age.)*

i) ☒ He is age 55. (*Less than age in (1) above.*)

ii) ☐ He has _____ (*Up to 6*) years of Vesting Service.

iii) ☐ He is within _____. (*Up to 6*) years of Normal Retirement Date.

iv) ☐ He has been an Active Participant _____ (*Up to 6*) years.

b) ☐ Early retirement is not permitted.

5) TOTALLY DISABLED. The definition of Totally Disabled is tied to Social Security disability, unless otherwise specified in (a), (b), or (c) below. (NOT APPLICABLE)

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~~a) ☐ Tied to the Employer's long-term disability plan.~~

~~b) ☐ Determined by a physician chosen by the Plan Administrator and the disability has lasted or can be expected to last for at least 12 months.~~

~~c) ☐ Determined by a physician chosen by the Plan Administrator and the disability has lasted for at least five months.~~

~~*NOTE: The determination of disability shall be applied uniformly to all Participants and may not discriminate in favor of Highly Compensated Employees. If (b) or (c) is selected, any benefit provided to a Participant who is Totally Disabled is a "disability benefit" subject to the special disability claim procedures in Plan Section 9.05(b).*~~

6) VESTED BENEFIT MODIFICATIONS. Plan Section 5.03 permits an Inactive Participant to elect to receive a distribution after he has a Severance from Employment. The ability to receive a distribution is modified as follows*: (Select (a) or (b), if applicable.)*

a) ☐ An Inactive Participant cannot elect to receive a distribution from that part of his Vested Account resulting from

i) ☐ Employer Contributions

ii) ☐ Required and Optional Contributions

before he becomes Totally Disabled (Retirement Date or death, if earlier). A small Vested Account, as defined in Plan Section 10.11, shall be paid earlier.

b) ☐ An Inactive Participant cannot elect to receive a distribution from that part of his Vested Account resulting from Employer Contributions before he has had a Severance from Employment for a period of time (Retirement Date or death, if earlier). Payment of a small Vested Account, as defined in Plan Section 10.11, shall also be delayed.

The period of time is *(Select (i) or (ii).)*

i) ☐ _____ month(s). (Up to 60.)

ii) ☐ _____ year(s). *(Up to 5.)*

Y. FORMS OF DISTRIBUTION FOR RETIREMENT BENEFITS.

NOTE: If this Plan is a direct or indirect transferee after December 31, 1984, of a defined benefit plan, money purchase plan, target benefit plan, stock bonus plan, or profit sharing plan that is subject to the survivor annuity requirements of Code Sections 401(a)(11) and 417, (1)(b) and (1)(c) below cannot be selected.

If the Plan later becomes a direct or indirect transferee of a defined benefit plan, money purchase plan, target benefit plan, stock bonus plan, or profit sharing plan that is subject to the survivor annuity requirements of Code Sections 401(a)(11) and 417, then the options available under the Plan shall be those specified in (1)(a) below and (1)(a)(i), if applicable and the selection of (1)(b) or (1)(c) below cannot be used. The Plan must be amended to reflect the selection of (1)(a) below and (1)(a)(i) below, if applicable.

1) The options available under the Plan shall be: *(Select (a), (b), or (c).)*

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a) ☒ INCLUDE LIFE ANNUITIES. Those specified in Plan Section 6.02 other than the fixed period and fixed payment installments, unless otherwise specified in (i) below.

i) ☒ INSTALLMENTS. The fixed period and fixed payment installment options shall be available.

b) ☐ NO LIFE ANNUITIES. Those specified in subparagraph (a)(2) of Plan Section 6A.02 other than the fixed period and fixed payment installments, unless otherwise specified in (i) below.

i) ☐ INSTALLMENTS. The fixed period and fixed payment installment options shall be available.

c) ☐ SINGLE SUM, PARTIAL PAYMENTS, AND DISTRIBUTIONS IN KIND. Those specified in subparagraph (a)(1) of Plan Section 6A.02 other than the fixed period and fixed payment installments, unless otherwise specified in (i) below.

i) ☐ INSTALLMENTS. The fixed period and fixed payment installment options shall be available.

2) The Plan does not include monies from a money purchase plan or another direct or indirect transfer described in (3) below, unless otherwise specified in (a) below.

a) ☒ Monies from a money purchase plan or another direct or indirect transfer are held under the Plan.

3) SPOUSAL CONSENT FOR DISTRIBUTIONS. If the Plan is not a direct or indirect transferee after December 31, 1984, of a defined benefit plan, money purchase plan, target benefit plan, stock bonus plan, or profit sharing plan that is subject to the survivor annuity requirements of Code Sections 401(a)(11) and (417), spousal consent is not required for electing an optional form of retirement benefit that is not a life annuity.

If the Plan is such direct or indirect transferee, spousal consent shall be required for all Participants electing an optional form of retirement benefit that is not a life annuity, unless otherwise specified in (a) below.

a) ☐ Spousal consent is required for distributions other than a life annuity if any portion of a Participant's Account resulted from such direct or indirect transfer regardless of whether or not the distribution includes the transferred assets, unless otherwise specified in (i) below.

i) ☐ Spousal consent is only required if the distribution includes any transferred assets.

The spousal consent requirements above are modified as follows:

b) ☒ Spousal consent shall be required for all distributions.

Z. ADOPTING EMPLOYERS. *(Identify Adopting Employers below.)*

NOTE: The Plan must meet the minimum coverage requirement of Code Section 410(b) taking into account all employees of Controlled Groups and Affiliated Service Groups. If the Employer is a member of such a group, other employers in the group may need to adopt this Plan in order for the Plan to meet this requirement. Some employers of the group may also choose to adopt this Plan even though not required. Use this item to identify the other employers in the group whose employees may become Participants.

1) There are no Adopting Employers, unless otherwise specified in (a) below.

Plan ID No. _____

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a) ☐ The Adopting Employers listed in (3) below participate with the Employer in a single plan or establish a separate plan for the benefit of their Employees, as specified.

2) Single Plan or Separate Plans

a) SINGLE PLAN. Adopting Employers may participate with the Employer in a single plan. An Adopting Employer's agreement to participate in this Plan shall be evidenced in writing according to the provisions of Plan Section 2.04.

NOTE: The provisions of Plan Section 10.03 shall apply in the case of the merger of this Plan with any Prior Plan of an Adopting Employer participating with the Employer in a single plan.

b) SEPARATE PLANS. Adopting Employers may establish a separate plan for the exclusive benefit of their Employees. The establishment of an Adopting Employer's separate plan shall be evidenced in writing according to the provisions of Plan Section 2.05.

NOTE: A separate plan should not be established unless (i) each plan can meet the minimum coverage requirement of Code Section 410(b) separately or (ii) the combined plans can meet the minimum coverage requirement of Code Section 410(b) and the nondiscrimination requirement of Code Section 401(a)(4). The combined plans may not meet the requirement of Code Section 401(a)(4) if the plans provide for a Discretionary Contribution that is determined separately for each Adopting Employer.

3) The Adopting Employers are:

NOTE: This Item must be completed with at least one Adopting Employer if (1) above is selected.

a) Name _____

Date of Adoption or Participation _____, _____ (*Month, day and year. Must be on or after the Plan's original effective date in Item D.*)

Executed _____, _____
(Month, day and year.)

By _____
(Signature)

Business Title _____

i) Single Plan or Separate Plans

☐ Single Plan ☐ Separate Plans

ii) *Complete A, B, and C below if Separate Plans.*

A. EIN _____

B. Plan No. _____ *(3-digit number used for Form 5500 reporting.)*

C. Fiscal Year End _____
(*Month, day and year*)

iii) *Complete A below if this Adopting Employer had a Prior Plan.*

Plan ID No. _____

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A. Date Prior Plan established _____ , _____
(Month, day and year.)

iv) *Complete A below, if applicable.*

A. This Adopting Employer has waived the entry requirements selected below for its Employees who are Eligible Employees on the date specified. *(The selections in Item K(4) apply only to the Employer named in Item B.)*

Date _____, _____
(*Month, day and year*)

	All Contributions
Service requirement	☐
Age requirement	☐

b) Name _____

Date of Adoption or Participation _____, _____ (*Month, day and year. Must be on or after the Plan's original effective date in Item D.*)

Executed _____, _____
(Month, day and year.)

By _____
(Signature)

Business Title _____

i) Single Plan or Separate Plans

☐ Single Plan ☐ Separate Plans

ii) *Complete A, B, and C below if Separate Plans.*

A. EIN _____

B. Plan No. _____ *(3-digit number used for Form 5500 reporting.)*

C. Fiscal Year End _____
(*Month, day and year*)

iii) *Complete A below if this Adopting Employer had a Prior Plan.*

A. Date Prior Plan established _____ , _____
(Month, day and year.)

iv) *Complete A below, if applicable.*

A. This Adopting Employer has waived the entry requirements selected below for its Employees who are Eligible Employees on the date specified. *(The selections in Item K(4) apply only to the Employer named in Item B.)*

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Date _____, _____
(*Month, day and year*)

	All Contributions
Service requirement	☐
Age requirement	☐

c) Name _____

Date of Adoption or Participation _____, _____ (*Month, day and year. Must be on or after the Plan's original effective date in Item D.*)

Executed _____, _____
(Month, day and year.)

By _____
(Signature)

Business Title _____

i) Single Plan or Separate Plans

☐ Single Plan ☐ Separate Plans

ii) *Complete A, B, and C below if Separate Plans.*

A. EIN _____

B. Plan No. _____ *(3-digit number used for Form 5500 reporting.)*

C. Fiscal Year End _____
(*Month, day and year*)

iii) *Complete A below if this Adopting Employer had a Prior Plan.*

A. Date Prior Plan established _____ , _____
(Month, day and year.)

iv) *Complete A below, if applicable.*

A. This Adopting Employer has waived the entry requirements selected below for its Employees who are Eligible Employees on the date specified. *(The selections in Item K(4) apply only to the Employer named in Item B.)*

Date _____, _____
(*Month, day and year*)

	All Contributions
Service requirement	☐

Plan ID No. _____

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Age requirement	☐

d) Name _____

Date of Adoption or Participation _____, _____ (*Month, day and year. Must be on or after the Plan's original effective date in Item D.*)

Executed _____, _____
(Month, day and year.)

By _____
(Signature)

Business Title _____

i) Single Plan or Separate Plans

☐ Single Plan ☐ Separate Plans

ii) *Complete A, B, and C below if Separate Plans.*

A. EIN _____

B. Plan No. _____ *(3-digit number used for Form 5500 reporting.)*

C. Fiscal Year End _____
(*Month, day and year*)

iii) *Complete A below if this Adopting Employer had a Prior Plan.*

A. Date Prior Plan established _____ , _____
(Month, day and year.)

iv) *Complete A below, if applicable.*

A. This Adopting Employer has waived the entry requirements selected below for its Employees who are Eligible Employees on the date specified. *(The selections in Item K(4) apply only to the Employer named in Item B.)*

Date _____, _____
(*Month, day and year*)

	All Contributions
Service requirement	☐
Age requirement	☐

e) Name _____

Plan ID No. _____

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Date of Adoption or Participation _____, _____ (*Month, day and year. Must be on or after the Plan's original effective date in Item D.*)

Executed _____, _____
(Month, day and year.)

By _____
(Signature)

Business Title _____

i) Single Plan or Separate Plans

☐ Single Plan ☐ Separate Plans

ii) *Complete A, B, and C below if Separate Plans.*

A. EIN _____

B. Plan No. _____ *(3-digit number used for Form 5500 reporting.)*

C. Fiscal Year End _____
(*Month, day and year*)

iii) *Complete A below if this Adopting Employer had a Prior Plan.*

A. Date Prior Plan established _____ , _____
(Month, day and year.)

iv) *Complete A below, if applicable.*

A. This Adopting Employer has waived the entry requirements selected below for its Employees who are Eligible Employees on the date specified. *(The selections in Item K(4) apply only to the Employer named in Item B.)*

Date _____, _____
(*Month, day and year*)

	All Contributions
Service requirement	☐
Age requirement	☐

f) Name _____

Date of Adoption or Participation _____, _____ (*Month, day and year. Must be on or after the Plan's original effective date in Item D.*)

Executed _____, _____
(Month, day and year.)

By _____

Plan ID No. _____

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(Signature)

Business Title _____

i) Single Plan or Separate Plans

☐ Single Plan ☐ Separate Plans

ii) *Complete A, B, and C below if Separate Plans.*

A. EIN _____

B. Plan No. _____ *(3-digit number used for Form 5500 reporting.)*

C. Fiscal Year End _____
(*Month, day and year*)

iii) *Complete A below if this Adopting Employer had a Prior Plan.*

A. Date Prior Plan established _____ , _____
(Month, day and year.)

iv) *Complete A below, if applicable.*

A. This Adopting Employer has waived the entry requirements selected below for its Employees who are Eligible Employees on the date specified. *(The selections in Item K(4) apply only to the Employer named in Item B.)*

Date _____, _____
(*Month, day and year*)

	All Contributions
Service requirement	☐
Age requirement	☐

g) Name _____

Date of Adoption or Participation _____, _____ (*Month, day and year. Must be on or after the Plan's original effective date in Item D.*)

Executed _____, _____
(Month, day and year.)

By _____
(Signature)

Business Title _____

i) Single Plan or Separate Plans

☐ Single Plan ☐ Separate Plans

Plan ID No. _____

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ii) *Complete A, B, and C below if Separate Plans.*

A. EIN _____

B. Plan No. _____ *(3-digit number used for Form 5500 reporting.)*

C. Fiscal Year End _____
(*Month, day and year*)

iii) *Complete A below if this Adopting Employer had a Prior Plan.*

A. Date Prior Plan established _____ , _____
(Month, day and year.)

iv) *Complete A below, if applicable.*

A. This Adopting Employer has waived the entry requirements selected below for its Employees who are Eligible Employees on the date specified. *(The selections in Item K(4) apply only to the Employer named in Item B.)*

Date _____, _____
(*Month, day and year*)

	All Contributions
Service requirement	☐
Age requirement	☐

h) Name _____

Date of Adoption or Participation _____, _____ (*Month, day and year. Must be on or after the Plan's original effective date in Item D.*)

Executed _____, _____
(Month, day and year.)

By _____
(Signature)

Business Title _____

i) Single Plan or Separate Plans

☐ Single Plan ☐ Separate Plans

ii) *Complete A, B, and C below if Separate Plans.*

A. EIN _____

B. Plan No. _____ *(3-digit number used for Form 5500 reporting.)*

C. Fiscal Year End _____
(*Month, day and year*)

Plan ID No. _____

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iii) *Complete A below if this Adopting Employer had a Prior Plan.*

A. Date Prior Plan established _____ , _____
(Month, day and year.)

iv) *Complete A below, if applicable.*

A. This Adopting Employer has waived the entry requirements selected below for its Employees who are Eligible Employees on the date specified. *(The selections in Item K(4) apply only to the Employer named in Item B.)*

Date _____, _____
(*Month, day and year*)

	All Contributions
Service requirement	☐
Age requirement	☐

AA. MERGER OR SPIN-OFF.

1) ☐ MERGER. The following plan(s) merged into this Plan:

a) Name _____

_____

Effective date of merger _____ , _____
(Month, day and year.)

b) Name _____

_____

Effective date of merger _____ , _____

c) Name _____

_____

Effective date of merger _____ , _____

d) Name _____

_____

Effective date of merger _____ , _____

2) ☐ SPIN-OFF. This Plan was a restatement due to a spin-off from the following plan:

a) Name _____

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Effective date of merger _____ , _____
(Month, day and year.)

Plan ID No. _____

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By executing this Adoption Agreement, the Employer, adopts the Plan for the exclusive benefit of its Employees. The selections and specifications contained in this Adoption Agreement and the terms, provisions, and conditions provided in the Basic Defined Contribution Document for the Watsonville Community Hospital 401(a) Plan constitute the Employer's PLAN. No other basic plan may be used with this Adoption Agreement.

It is understood that Principal Life Insurance Company is not a party to the Employer's Plan and shall not be responsible for any tax or legal aspects of the Employer's Plan. The Employer assumes responsibility for these matters. The Employer acknowledges that it has counseled, to the extent necessary, with selected legal and tax advisors. The obligations of Principal Life Insurance Company shall be governed solely by the provisions of its contracts and policies. Principal Life Insurance Company shall not be required to look into any action taken by the Plan Administrator, Named Fiduciary, Trustee, Investment Manager, or the Employer and shall be fully protected in taking, permitting, or omitting any action on the basis of the Employer's actions. Principal Life Insurance Company shall incur no liability or responsibility for carrying out actions as directed by the Plan Administrator, Named Fiduciary, Trustee, Investment Manager, or the Employer.

Note: The Employer must sign the Adoption Agreement when it first adopts the Plan; and must complete and sign a new Adoption Agreement if the Plan has been restated, or if the Plan has been amended to change any prior elections or make new elections.

(Complete in black ink.)

This Adoption Agreement is executed _____, 2022_____.
(Date Signed. Month, day and year.)

FOR THE EMPLOYER

By my signature, I certify that I have reviewed the terms of and the Items selected within this Adoption Agreement. If the Plan has a Trust Agreement in effect, I hereby certify that a copy of this Plan document shall be provided to each Trustee.

By _____
(Signature)

Print Name Monica Morales

Business Title _____

Plan ID No. _____

Watsonville Community Hospital Monthly Quality Report December 2022

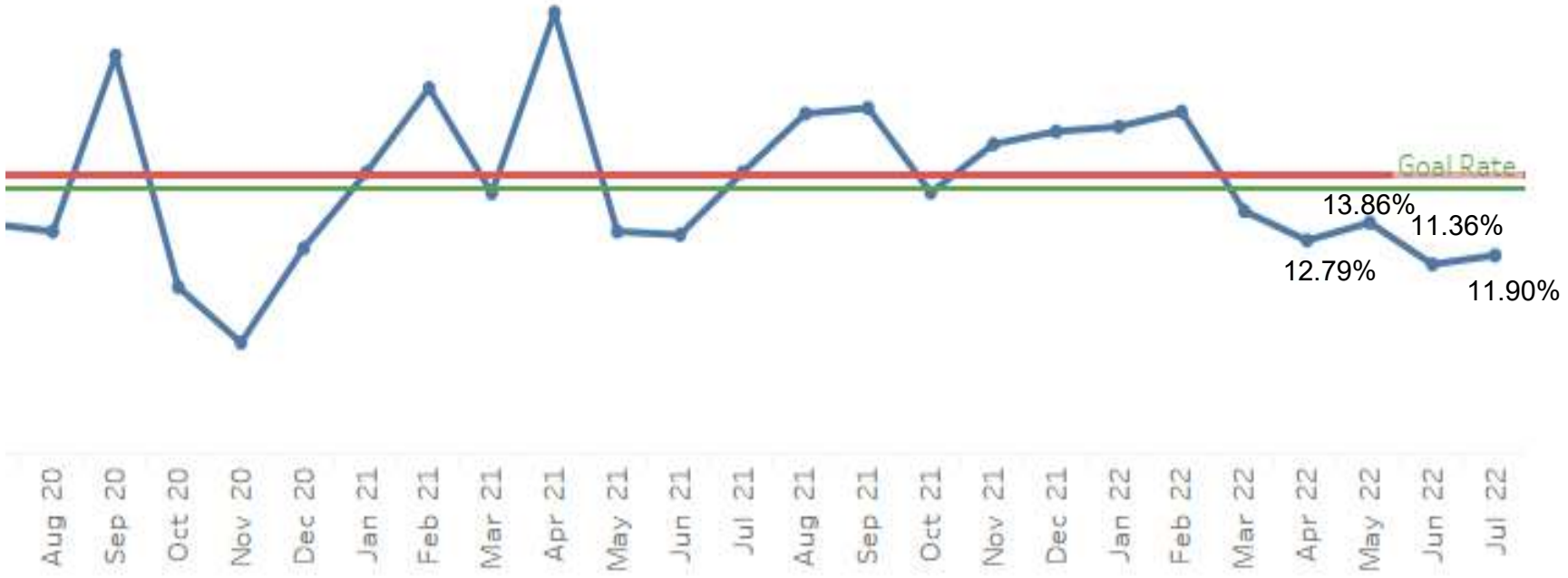
Tracy Trail-Mahan MS RN PMGT-BC CPHQ
Director of Quality, Risk and Patient safety

WATSONVILLE COMMUNITY HOSPITAL

30-day All Cause Readmit

HRRP: Hospital Readmission Reduction Program

Baseline(2019)=16.73%
Goal=15.89%
Latest Current month=11.90%



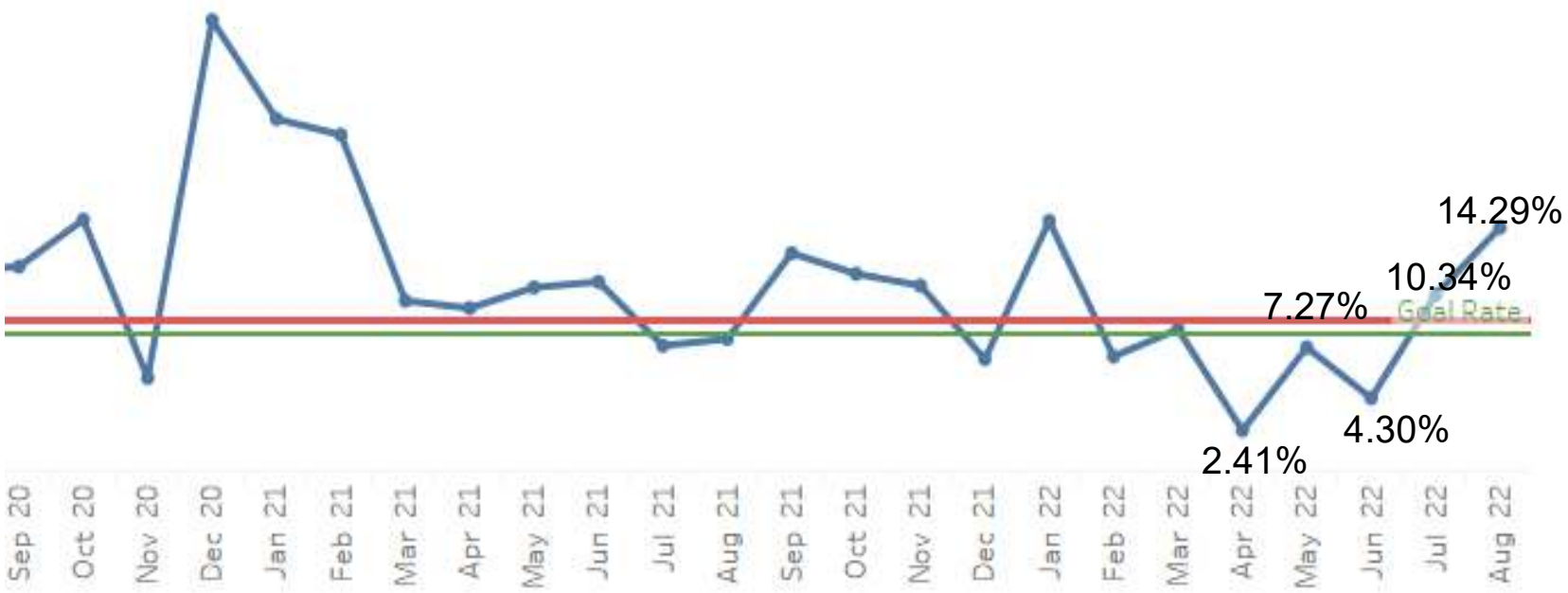
Source: CMS claims data for Medicare and Medi-Cal patients

HSAG HEALTH SERVICES ADVISORY GROUP

WATSONVILLE COMMUNITY HOSPITAL

30-day All Cause Mortality

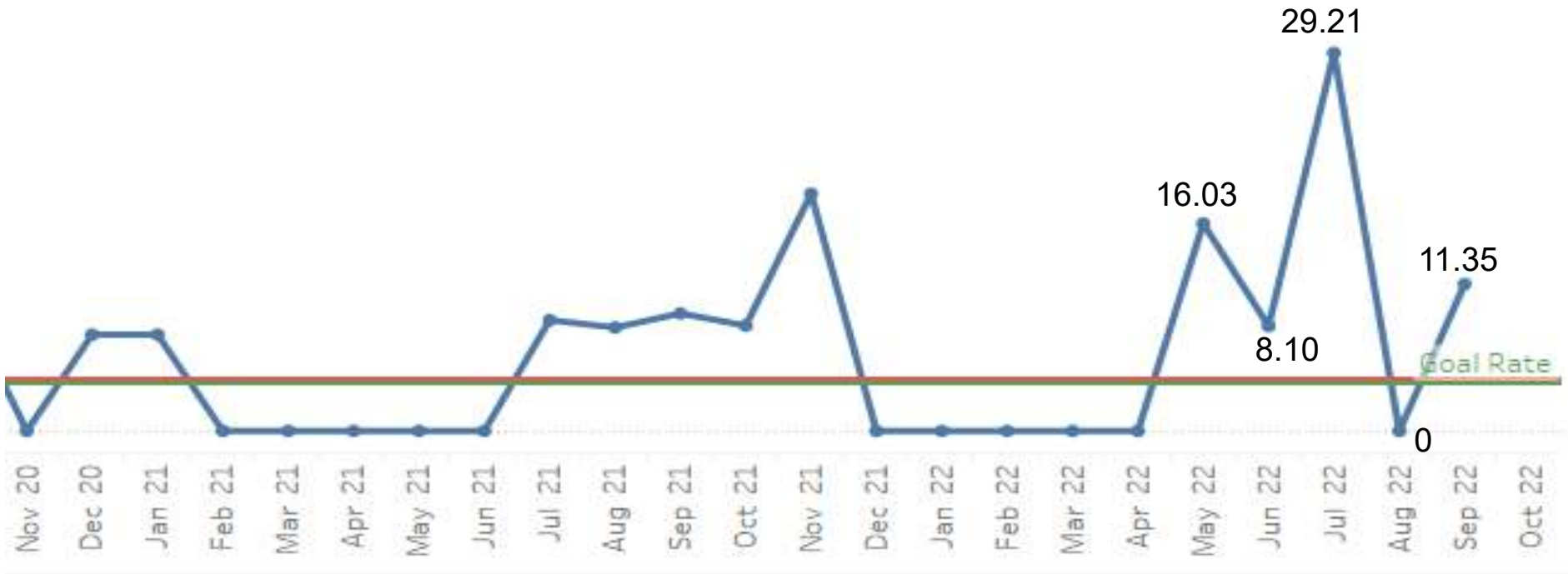
Baseline(2019)=8.83%
Goal=8.03%
Latest Current month=14.29%



Source: CMS claims data for Medicare and Medi-Cal patients

C. Diff Infection Rate

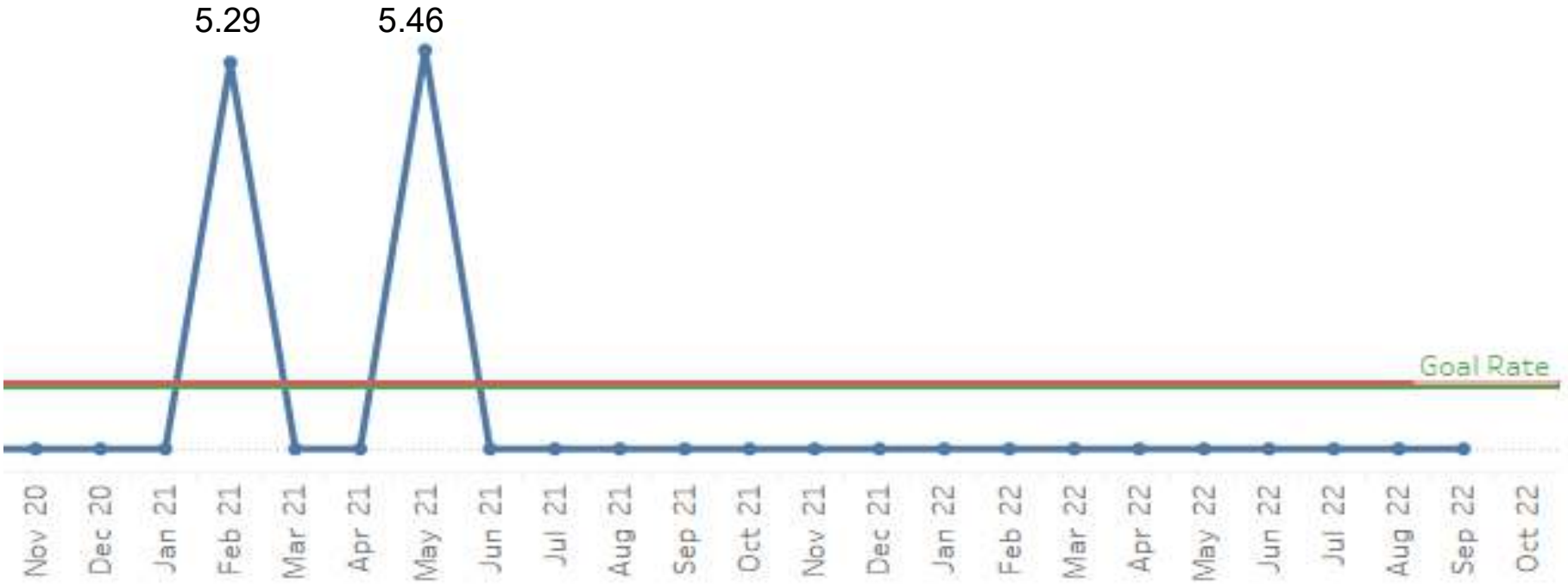
Baseline(2019)=3.96
Goal=3.60
Latest Current month=11.35



Source: CMS claims data for Medicare and Medi-Cal patients

CAUTI Infection Rate

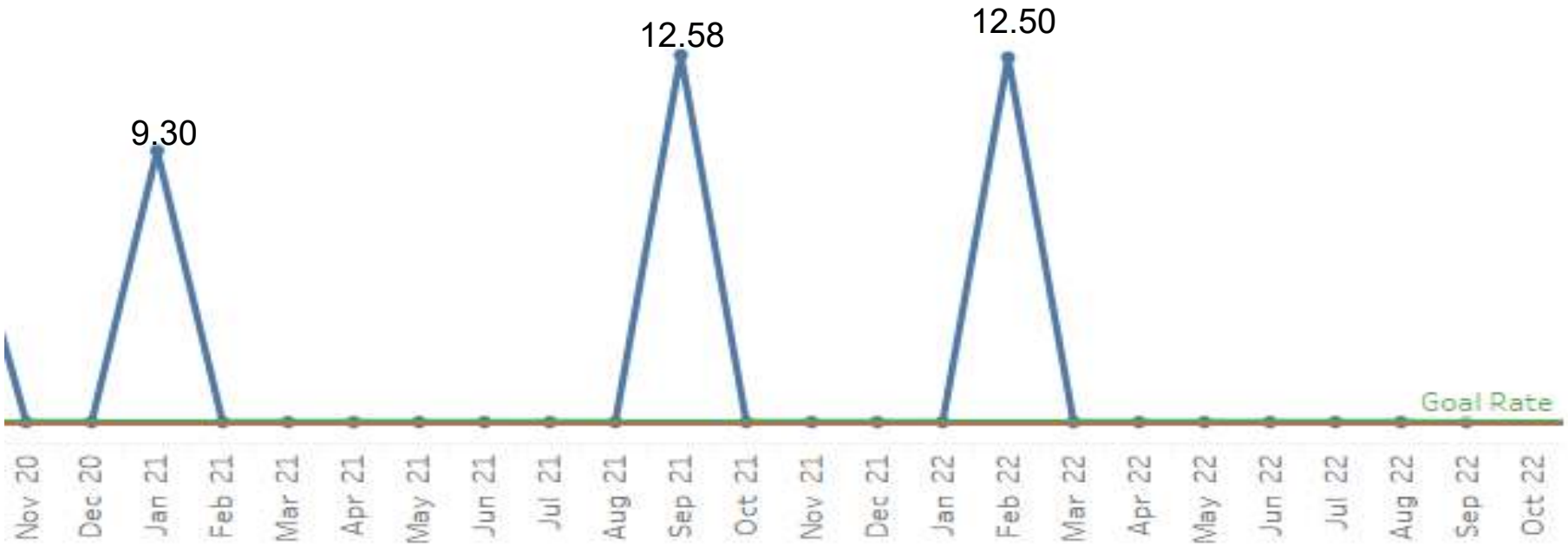
Baseline(2019)=0.90
Goal=0.82
Latest Current month=0



Source: CMS claims data for Medicare and Medi-Cal patients

CLABSI Infection Rate

Baseline(2019)=0
Goal=0
Latest Current month=0



Source: CMS claims data for Medicare and Medi-Cal patients

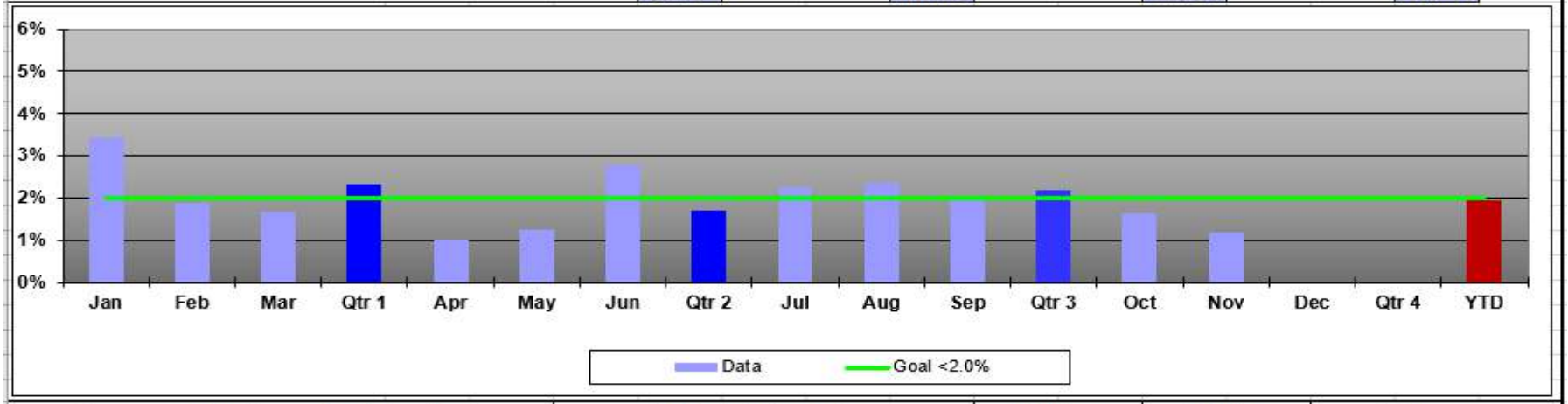
Emergency Dept Quarterly Report

Robert Schambach Director
Left Without Being Seen

WATSONVILLE COMMUNITY HOSPITAL

Watsonville Community Hospital - 2022 PI

Emergency Department	PI Description: Reduce patient dissatisfaction													
	Goal	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
N: Patients that left without being seen (LWBS only)		85	37	40	23	35	78	62	67	57	46	38		568
D: Number of patient seen		2,464	1,980	2,400	2,305	2,769	2,800	2,766	2,826	2,889	2,803	3,180		29182
	< 2.0%	3.4%	1.9%	1.7%	1.0%	1.3%	2.8%	2.2%	2.4%	2.0%	1.6%	1.2%	#DIV/0!	1.9%
				2.3%			1.7%			2.2%			#DIV/0!	
				Qtr 1			Qtr 2			Qtr 3			Qtr 4	



Summary of Findings - Analysis of Data	Action(s) to be Taken	By Whom	By When	Follow-up
Quarter 1: 2.3% Goal is less than 2%,				
Quarter 2: 1.7%, met goal for month	working to increase PA staff and working on			

In 2007, the most recent year for which data are available, 1.9 million people—representing 2 percent of all ED visits—left the ED before being seen. AHRQ [Section 1. The Need to Address Emergency Department Crowding | Agency for Healthcare Research and Quality (ahrq.gov)]

WATSONVILLE COMMUNITY HOSPITAL

Watsonville Community Hospital
POLICY APPROVAL SUMMARY REPORT

Committee: Board of Directors
Reporting Period: December 28 2022

As required under Title, 22, CMS and The Joint Commission (TJC), please find below a list of regulatory required policies with summary of changes that request your approval.

Policy Title	Policy Number	Summary of Changes	Rationale for Change	Approvals & Dates
Nursing (NUR)				
Restraint and Seclusion	NUR0243	Removed the language below that listed mittens(hand mitts) as NO restraint: -mittens applied to hands for scratching or pulling that are NOT secured to the bed or frame and follow freedom of hand finger movement.	Hand mitts whether secured to bedframe or not ARE considered a restraint as they restrict independent use of hands and fingers. This was noted during our July 2022 Joint Commission survey. The staff were educated to this clarification.	Author: Nursing Director CNO/QCC: 9/22*10/222 VP/Sr. Leader/CEO: 10/22 MEC: 10/2022 BOT:
Patient Access/Registration/Bussiness Sevices				
Charity Care-Financial Assistance Policy		California's Hospital Fair Pricing Policies law requires all hospitals to provide medical care for free or at a reduced cost if a qualifying patient cannot afford to pay for that medical treatment, and to provide a written notice to patients of the availability of such "charity care."	WCH prior policy outdated. Revised policy ensures that WCH fulfills charitable obligation to address community needs.	Author: Patient Access/Registration Director Counsel:12/10/2022 CFO: 12/20/2022 VP/Sr. Leader/CEO: 12/20/2022 MEC: N/A BOT:

WATSONVILLE COMMUNITY HOSPITAL

Policy Title	Restraint and Seclusion	Policy #	NUR0243
Responsible	Nursing Administration	Revised/Reviewed	07/28/22

I. PURPOSE

This facility creates an environment that helps hospital staff focus on the patient's well being. This requires planning, thoughtful education, quality improvement, and possibly new or reallocated resources. Our goal is an organization-wide approach to restraints that protects the patient's health and safety and preserves his or her dignity, rights, and well-being.

This facility ensures that restraint and seclusion interventions are safely and appropriately used. Because of the associated risks and consequences of use, this facility is continually exploring ways to decrease restraint use through effective preventative strategies or the use of alternatives.

Policies and procedures for the use of restraint and seclusion are developed through an interdisciplinary process and approved by medical staff and administration. Staff roles and responsibilities in the use of restraints and seclusion are identified for all appropriate disciplines. Requirements for documenting the justification and use of these interventions are defined.

II. POLICY

A. It is the policy of this facility to:

1. Protect the patient and preserve the patient's rights, dignity, and well-being during restraint use by:
   a) Respecting the patient as an individual.
   b) Maintaining a clean and safe environment.
   c) Encouraging the patient to continue to participate in own care.
   d) Maintaining the patient's modesty, preventing inappropriate visibility to others and maintaining comfortable body temperature.
   e) Implementing the policy that convenience is not an acceptable reason to restrain a patient nor can restraint use serve as a substitute for adequate staffing to monitor a patient.
2. Prevent, reduce, and eliminate the use of restraints by basing use on the patient's assessed needs:
   a) Preventing emergencies that have the potential to lead to use of restraint.
   b) The rationale that the patient should be restrained because he/she "might" fall does not constitute an adequate basis for using a restraint
   c) Limiting the use of restraints and seclusion to emergencies where there is a risk to the patient harming himself / herself or others. Though patients have the right to refuse treatment, under certain circumstances, if serious bodily harm is judged to be imminent, (e.g. violent patient) an R.N., after assessment of the patient, should institute the use of restraint, which he/she believes will protect the patient and/or others effectively, but alternatives must be considered.
   d) Using the least restrictive method. Restraint use shall not be the first choice solution. The choice of device shall be the least restrictive restraint needed to accomplish this purpose and in consideration of the patients condition when a restraint is used.

e) All efforts should be made to avoid restraints if patient safety may be maintained without the use of restraints. The nurse who is caring for a patient who is at high risk for confusion/possible use of restraints should concentrate on attempts at preventing the need for restraint by initiating the items listed in Limiting the Use of Restraint or Seclusion in this policy.
f) The intervention should not cause or inflict harm to the patient. The more restrictive the restraint, the more diligent the monitoring should be.
g) Use of restraints shall be added to the patient's plan of care.

B. Provide for safe application and removal of the restraint by qualified staff. All staff providing direct patient care will receive education and training in the proper and safe use of seclusion and restraint application and alternative methods of handling behavior that have traditionally been treated by restraint.
C. Monitor and meet the patient's needs while in restraints.
D. Reassess and encourage the release of restraints as soon as possible.
E. If a hospital suspects a death or permanent injury has occurred due to restraint or seclusion, notify the CEO and Risk Manager (RM) immediately. The event will be reported by the Risk Manager to the CMS/state regional office (RO) CMS Region IX, San Francisco, CA (415) 744-3735 Fax (443) 380-8909.

When the circumstances of the patient's death involve only the use of soft two point wrist restraints and no use of seclusion the hospital is required to report these deaths by recording the information about the death into a log or other system. The information must be entered into the log no later than seven days after the death. Information to be recorded on the log includes: the patient's name, date of birth, date of death, attending physician, primary diagnose(s), and medical record number. The date and time of entry into the log must be recorded in the medical record. The hospital must make this information available to CMS in either written or electronic form immediately upon request. When restraints other than 2 point soft wrist restraints are used, those deaths must be reported to the CMS Regional Office using form CMS10455

Further, the hospital must also report to CMS/state regional office (RO) all other deaths that occurs while a patient is restrained or in seclusion, within the close of the next business day following the knowledge of death, even if the death was not as a result of the restraint or seclusion. This includes death that occurs while in restraint or seclusion, death that occurs within 24 hours after the restraint or seclusion has been removed and a death known to the hospital that occurs within one week after restraint or seclusion where it is "reasonable to assume" that the use of restraint or seclusion contributed to the patient's death. Document on the medical record the date and time any restraint or seclusion associated death is reported to CMS.

F. Restraints are not to be used for punishment, coercion, discipline, or retaliation of the patient, or for staff convenience.
G. When the patient is awaiting transfer to a psychiatric unit, the transfer is accomplished as rapidly as possible. If the patient is in restraint or seclusion, emergency department staff or medical or surgical services staff collaborate with psychiatric staff to ensure appropriate evaluation of the patient, until the transfer occurs.

III. DEFINITIONS

Restraint: is any physical or mechanical device, material, medication, or equipment that

immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. A restraint can be a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is NOT a standard treatment or dosage for the patient's condition. The application of force to physically hold a patient, in order to administer a medication against the patient's wishes, is considered a restraint. A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Seclusion: Involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

Seclusion is just not confining a patient to an area, but involuntarily confining a patient alone in a room or an area where the patient is prevented from leaving. If a patient is restricted to a room alone and staff are physically intervening to prevent the patient from leaving the room or giving the perception that threatens the patient with physical intervention if the patient attempts to leave the room, the room is considered locked, whether the room is locked or not. In this situation the patient is being secluded.

A patient physically alone in an unlocked room does not constitute seclusion.

Confinement on a locked unit or ward where the patient is with others does not constitute seclusion.

IV. PROCEDURE

Instances Where Restraint and Seclusion Standards DO NOT Apply:

A. Standard practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes. These include but are not limited to:
-surgical positioning
-arm-board during intravenous administration
-radiotherapy procedures
-post-op / post-anesthetic care.
-protection of surgical and treatment sites in pediatric patients

B. Adaptive support in response to assessed patient need. A voluntary mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support. These include, but are not limited to:
-orthopedic appliances, dressings, bandages, braces
-wheelchairs
-table top chairs
-enclosed framed wheeled walker (with or without a seat) Merry-Walkers when used to permit the patient to participate in activities without the risk of harm, and they can easily open the front gate and exit the device.

C. If bed-rails or side-rails are raised that restrict the patient's freedom to exit the bed, but the patient is not physically able to get out of bed, then bed-rails or side-rails are not considered

a restraint. If in the case of four segmented side rails, and all but one side rail is raised to allow the patient to freely exit the bed, the side rails would not be considered a restraint. Stretcher side-rails and seat belts applied during transport, because they are a prudent safety intervention, are not considered a restraint. Side rails raised as a seizure precaution are not a restraint.

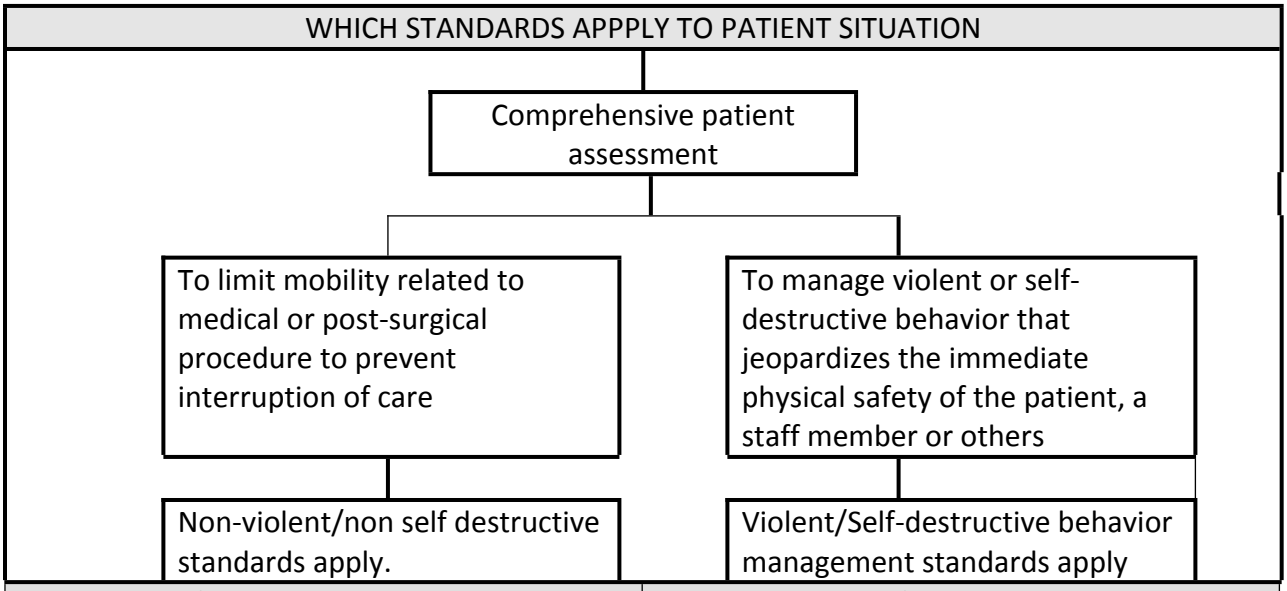
D. Temporary holding for a procedure or test is not considered a restraint as long as the patient's right to refuse the treatment is being honored. Physical escort holding with a "light grasp" where the patient can easily escape the grasp.
E. Protective devices or mechanisms intended to compensate for a specific physical deficit or prevent safety incidents not related to cognitive dysfunction. These include but are not limited to:
    -helmets
    -Geri-chairs (the patient has the skill / ability to easily remove)
    -side-rails
F. Therapeutic holding or comforting of children.
G. Forensic or correctional restrictions for security purposes. The use of handcuffs or other restrictive devices applied by law enforcement officials is for custody, detention, and public safety reasons, and is not involved in the provision of health care. Therefore, the use of restrictive devices applied and monitored by law enforcement is not considered a restraint.
H. Drugs/medications used as a standard of treatment are not considered a restraint if the medication is used within FDA guidelines (including dosing), follows national practice standards and is based on the patient's symptoms and overall condition. Medications used to enable (improve the patient's ability to effectively or appropriately interact with the world) and not disable the patient are not considered a restraint.
I. For patients on a respirator or ventilator and drugs/medications are used as part of the Ventilator Management Protocol to reduce anxiety and agitation and to decrease cardiac and respiratory workload.
J. Staff (security, sitters, etc.) watching a patient and the patient are allowed to leave the room if physically able with or without an escort.
K. Confinement on a licensed locked unit.
L. Age appropriate cribs, "bubbles", or canopies are not considered a restraint.
M. **Timeout** is not considered seclusion. Timeout is an intervention in which the patient consents to being alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving.

TYPE OF RESTRAINT

There are two types of restraints. A restraint is either a *Non-violent, Non-self-destructive (formerly Medical/Surgical) or Violent/Self-Destructive Behavior* restraint. It is important to note that the requirements for each type of restraint is not specific to any treatment setting, but to the situation why the restraint is being used. Further, the decision to use a restraint is driven not by diagnosis, but by comprehensive individual assessment that concludes for this patient and at this time, that the use of less intrusive measures poses a greater risk than the risk of using a restraint.

Violent/Self-Destructive Behavioral reasons for the use of restraint are primarily to protect the patient against injury to self or others because of an emotional or behavioral disorder with violent or self-destructive behavior. Seclusion can only be used to manage Violent/Self-Destructive

Behavior. Restraint AND Seclusion used at the same time is only permitted if the patient is continually monitored by trained staff via audio AND video monitoring equipment or face-to-face by competent staff.



VIOLENT/SELF-DESTRUCTIVE BEHAVIOR	NON-VIOLENT/NON-SELF DESTRUCTIVE
In the case of a patient with cognitive impairment, such as Alzheimer's Disease, which restraint standard (Violent/Self-Destructive Behavior Standards) or (Non-violent/Non-self destructive) would apply? Two examples are offered for the sake of clarification.	
Example 1: A patient with Alzheimer's Disease has a catastrophic reaction where he/she becomes so agitated and aggressive that he/she physically attacks a staff member. He/she cannot be calmed by other mechanisms, and his/her behavior presents a danger to himself, and to staff and other patients. The use of restraint or seclusion in this situation is governed by the Violent/Self-Destructive Behavior Standard.	Example 2: A patient diagnosed with Alzheimer's Disease has surgery for a fractured hip. Staff determines that it is necessary to immobilize the hip to prevent re-injury. The use of less restrictive alternatives has been evaluated or were unsuccessful. The use of restraint or seclusion in this situation is governed by the Non-violent/Non Self Destructive Care Standard.

STAFF TRAINING AND COMPETENCE

Our facility ensures staff which have direct patient care responsibilities, including contract or agency personnel, receive training and are competent to minimize the use of restraint and seclusion, and to use them safely when their use is indicated. Our facility assures the staff

providing training is qualified as evidenced by education, training, and experience in techniques to address patients' behaviors.

Our facility educates and assesses the competence of staff in minimizing the use of restraint and seclusion prior to participation in any use of restraint or seclusion, as part of orientation and on a periodic basis in order to use them safely, including:

1. the basic underlying causes of threatening behaviors exhibited by the patients they serve;
2. aggressive behavior that is related to a patient's medical condition and not related to his / her emotional condition, for example threatening behavior that may result from delirium in fevers or from hypoglycemia;
3. how staff behavior can affect the behavior of the patients they serve;
4. the use of alternative and/or nonphysical interventions;
5. the use of the least restrictive intervention based on the assessment of the patient;
6. the initiation, safe application, and removal of restraints to include monitoring and reassessment;
7. recognizing signs of physical and psychological distress in patients who are restrained or secluded and application of first aid techniques;
8. clinical identification of behavioral changes that indicate restraint or seclusion is no longer necessary
9. monitoring of the physical and psychological well-being of a patient in restraint or seclusion including respiratory and circulatory status, skin integrity, vital signs and special requirements for the face-to-face evaluation
10. documentation requirements
11. Physicians and LIP's authorized to order restraint and seclusion must have working knowledge of hospital policy regarding restraint and seclusion as evidenced by documented review and education on the hospitals restraint policy.

ASSESSMENT OF RISK FACTORS

A comprehensive assessment of the patient must determine that the risks associated with the use of restraint outweigh the risk of not using it. The use of an anatomical, physiological and psychological assessment for risk factors by the RN and / or physician LIP facilitates the limited, justified use of restraints / seclusion. Planning for being proactive rather than reacting to the patient's behavior, protects the patient's health and safety and allows for the implementation of preventative strategies that would be of the greatest benefit to the patient.

Factors to consider as part of the assessment include, but are not limited to:

-degree of orientation to person, time and place
-memory disturbances
-fluctuating levels of awareness
-alteration in sleep / wake cycle
-perceptual disturbance
-pain or other discomfort
-victims of sexual, physical, or emotional abuse
-types and / or combination of medications which may be contributing to the behavior
-types and /or combination of treatment modalities
-physiological changes, such as oxygen perfusion, blood glucose changes, blood

chemistry, etc., which may be causing or contributing to the altered behavior patterns
-techniques, methods, or tools that would assist the patient control his / her behavior
-risks associated with vulnerable patient populations, such as emergency, pediatric, pregnant and cognitively or physically limited patients, or patients with certain pre-existing medical conditions.

Restraint or seclusion use is limited to situations in which there is imminent risk of a patient physically harming himself or herself, staff, or others, and nonphysical interventions would not be effective.

Situations in which restraints / seclusion are clinically justified include:

1. harmful to self or others and alternative measures have been attempted;
2. threatens placement and / or patency of necessary therapeutic lines / tubes, interfering with necessary medical treatment and alternative measures have been attempted; and
3. patient is unable to follow directions to avoid self-injury and protective, alternative measures have been attempted.

LIMITING THE USE OF RESTRAINT OR SECLUSION

Our facility believes nonphysical techniques are the preferred intervention in the management of behavior.

Attempts should be made to evaluate and use interventions / alternatives when possible and in response to the patient's assessed needs:

1. Monitoring
2. companionship; staff or family to stay with patient
3. room near to or visible from the nursing station
4. close, frequent observation, one-to-one when necessary
5. Environmental Measures
    a. decrease stimulation; quiet surroundings, appropriate lighting, relaxing music
    b. call bell accessible at all times
    c. orientation / reorientation of patient to surroundings
    d. bed in low position with brakes locked
    e. rooms / halls clear of obstacles and excess equipment
    f. use of bed alarm system
    g. availability of bedside commode
    h. familiar possessions / photographs
    i. briefs over indwelling catheter
6. Comfort Measures
    a. address pain management or other source of discomfort
    b. comfortable positioning and clothing, keeping patient clean and dry
    c. reduce noise; avoid waking up patient during periods of sleep, if possible
    d. gentle touch, soothing voice
7. Interpersonal Skills
    a. pleasant, consistent interaction with patient and family
    b. actively listening to patient; calm reassurance
8. Staffing

   a. consider assessed patient needs / behavior as well as patient / staff safety when making assignments
   b. flexibility to allow for assignment changes as per patient needs / behavior
   c. consistency in staffing, i.e., assigning staff familiar to patient as often as possible
9. Regular Toileting
   a. establish consistent toileting schedule; every two hours while awake, one to two times at night
   b. encourage patient to ask for assistance at first feeling of toileting need; respond to patient's needs promptly and positively
   c. check for constipation / full bladder as indicated
10. Education
   a. educate patient / family / significant other to patient deficits and have a consistent plan of approach; re-educate / remind them of goals / potentials on an ongoing basis
   b. solicit patient / family / significant other for alternative measures
   c. provide patient / family / significant other with opportunities for control; other choices
11. Diversion Activities
   a. distract patient with videos, TV, reading materials; engage in conversation
   b. purposeful activities such as puzzles
   c. provide alternative activity for hands, i.e., rubber ball, squeezing devices
   d. sensory aids
   e. listening to music
   f. be sure patient has and is using eyeglasses, hearing aids, as appropriate
   g. provide alternative system for sensory deficits if needed
12. Medication / Nutrition
   a. assist in adjustment of treatment to stabilize physiological changes by notifying physician
   b. discontinue all lines that may be no longer medically necessary and initiate oral as appropriate from I.V. or N. G.
13. Reality Orientation and Psychological Intervention
   a. involve the patient in conversation. Do not talk over him / her.
   b. explain procedures to reduce fear and convey a sense of calm
   c. provide reality links when appropriate (calendar, clock, etc.)
   d. use relaxation techniques (warm bath, warm drink, etc.)
   e. attempt to verbally redirect behavior
14. Interdepartmental Communication / Consultation
   a. Occupation / Physical / Activities Therapy may be consulted by staff to assist with activities planning to redirect behavior.
   b. b. Pharmacy may be consulted to review medication regimen.
   c. Respiratory Therapist may be consulted to review oxygenation.

SAMPLE OF ASSESSMENT OF RISK AND APPROPRIATE INTERVENTIONS

Comprehensive assessment is critical in coming to an effective intervention decision of what would be the greater benefit to a patient. In the case of a patient with dementia who wanders and there is concern about the patient falling, part of the hospital's assessment process should address these questions:

-Is there a way to enable the patient to ambulate safely?

-Is there some assistive device that will improve the patient's ability to safely self ambulate?

-Is a medication or a reversible condition causing a problem with safe self-ambulating?

-Would the patient be content to walk with a staff person for a while?

-Could he/she be brought closer to the nurses' station where he/she could be supervised?

-Does he/she have a history of falling that indicates that for him/her, a fall is likely if he/she is allowed to walk about?

-Could the patient's environment be altered to improve the patient's ability to self ambulate and reduce the risk of falling/injury?

NOTIFICATION OF THE PATIENT'S FAMILY

Efforts are made to discuss the issue of restraint, when practical, with the patient and family around the time of restraint or seclusion is applied.

In cases in which the patient, or surrogate decision maker, has consented to have the family kept informed regarding his or her care and the family has agreed to be notified, staff attempts to contact the family promptly to inform them of the restraint or seclusion episode and document in the medical record of the notification.

ORDERS FOR RESTRAINT

1. The physician or other authorized Licensed Practitioners {LP} responsible for the care of the patient is authorized to order a restraint. Physicians and LIPs authorized to order restraint and seclusion must have a working knowledge of hospital policy regarding restraint and seclusion. Orders should:
2. Be for each use of the restraints and related to a specific episode of the patient's behavior and not for an unspecified future time or episode.
3. All verbal or telephone orders must be countersigned with 24 hours.
4. At Watsonville Community Hospital (WCH) the following categories of LPs are allowed to order restraint or seclusion:
    a. Physicians
    b. Physician's Assistant (PA)/Nurse Practitioner (NP)
5. In an emergency application situation, a RN who has documented Restraint and Seclusion competency may initiate the application of restraint or seclusion prior to obtaining an order from a LP. In this event the order must be obtained either during the emergency application of the restraint or seclusion or immediately (within a few minutes) after the restraint or seclusion has been applied.
6. Orders for restraints may never been written as standing orders or PRN orders. Each episode of restraint or seclusion must be initiated in accordance with an order by a physician or other LP. If a patient was recently released from restraint or

seclusion, and exhibits behavior that can only be handled through the reapplication of restraint or seclusion, a new order is required. Staff can not discontinue restraint or seclusion as a trial and then re-start it under the same order.

Note: A temporary, directly supervised release for the purpose of caring for a patient's needs (e.g. toileting, range of motion) is not considered a discontinuation of restraint or seclusion as long as a staff member is continuously present.

Exceptions:

- Geri Chair: Given that a patient may be out of bed in a Geri chair several times a day, it is not necessary to obtain a new order each time.
- Raised Side Rails: It is not necessary to obtain a new order every time the patient is returned to bed after being out of bed.
- Repetitive self mutilating behavior: If a patient is diagnosed with a chronic medical or psychiatric condition, such as Lesch-Nyham Syndrome, and the patient engages in repetitive self-mutilating behavior, a standing or PRN order for restraint to be applied in accordance with specific parameters established in the care plan is permitted. Since the use of restraint to prevent self injury is needed for these types of rare, severe, medical and psychiatric conditions, the specific requirements (1 hour face-to-face, time limited orders, and evaluation every 24 hours before renewal of the order) for the management of violent or self destructive behavior do not apply.

7. The attending physician (or covering physician) must be consulted as soon as possible if the attending physician did not order the restrain or seclusion. The intent of this requirement is to ensure that the physician who has the overall responsibility and authority for the management and care of the patient is aware of the patient's condition and is aware of the restraint or seclusion intervention
8. Staff is expected to continually assess and monitor the patient to ensure the patient is released from restraint or seclusion at the earliest possible time. A RN with documented restraint and seclusion competency may discontinue restraint or seclusion.
    a. The individual order is consistent with this policy. The LIP issuing the order identifies a rational for any variation from hospital policies and procedures for monitoring of the patient and for release from restraint before the order expires.

NON-VIOLENT/NON SELF-DESTRUCTIVE RESTRAINT/SECLUSION - RENEWAL ORDERS

Each order for restraint to ensure the physical safety of non-violent or non-self-destructive patient must be renewed:

E.g. – Once every calendar day

VIOLENT OR SELF-DESTRUCTIVE RESTRAINT OR SECLUSION ORDERS

Orders for restraint or seclusion used for the management of violent or self destructive behavior that jeopardizes the immediate physical safety of the patient or staff member may be renewed in accordance with the following limits for up to a total of 24 hours:

- 4 hours for adults 18 years or older

- 2 hours for children and adolescents 9-17 years old

- 1 hour for children under 9 years old

24 hours is the maximum time limit for each order for restraints or seclusion. The LIP may order for a shorter length of time.

As the time frame is about to expire (4 hours, 2 hours, 1 hour as appropriate for the age of the patient) the RN must contact the LIP as soon as possible, report the results of the latest assessment and request that the order be renewed, not to exceed the required timeframe limits. The LIP may determine if an onsite assessment is required in conjunction with the RN who is over-seeing the care of the patient. Another 1 hour face-to-face evaluation is not required when the order is renewed.

The original order may only be renewed within the required timeframe limits for a total of 24 hours. After the original order expires, a LIP must see and assess the patient in person before issuing a new order.

1. Restraint AND Seclusion used at the same time is only permitted if the patient is continually monitored by trained staff in person or via audio AND video monitoring equipment.

PERIODICALLY ASSESSING, ASSISTING AND MONITORING THE PATIENT IN RESTRAINT OR SECLUSION

When restraints or seclusion is used there is an increased need for patient monitoring and assessment to assure patient safety that least restrictive methods are used when possible, and use is discontinued as soon as possible.

1. The LIP responsible for the patient in person within one hour of the initiation of restraint or seclusion used for violent or self destructive behavior. <<Facility Specific if State allows >> A RN or Physician Assistant with a documented competency may perform the in person evaluation within one hour.
2. When the in person evaluation in person is performed by the RN or Physician Assistant he / she consults with the LIP responsible for the patient as soon as possible.
3. The in person evaluation must include:
   -an evaluation of the patient's immediate situation
   -the patient's reaction to the intervention
   -the patient's mental and behavioral condition
   -the need to continue or terminate the restraint or seclusion
4. Immediately after restraints are applied, a qualified Registered Nurse makes an assessment to ensure restraints were:
   -properly and safely applied
   -applied so as not to cause patient harm or pain.
5. A qualified Registered Nurse must assess the patient at established timeframes.
6. Assessment, as appropriate to the type or restraint or seclusion, includes:
   -signs of injury associated with the application of restraints or seclusion

-nutrition / hydration
-circulation and range of motion in the extremities
-vital signs
-hygiene and elimination
-physical and psychological status and comfort
-cognitive functioning
-readiness for discontinuation of restraint or seclusion.
-Ongoing monitoring is performed. Monitoring includes, but is not limited to: the physical and emotional well being of the patient
-that the patient's rights, dignity and safety are maintained
-whether less restrictive methods are possible
-changes in the patient's behavior or clinical condition needed to initiate the removal of restraints
-whether the restraint has been appropriately applied, removed, or reapplied.

7. Care is provided at least every 2 hours to include:
   -offer of fluids / nourishment
   -hygiene care as required
   -toileting as required
   -release of extremities and range of motion exercises provided.
8. A physician or other LIP responsible for the patient must see and re-assess the patient face-to-face every 24 hours if the restraint or seclusion is used for a violent and/or self-destructive behavior. Note: If by hospital policy and if allowed by state practice act, a PA or RN with specialized training may evaluate the patient's immediate situation, reaction, medical and behavioral conditions, and need to continue or terminate the behavioral restraint or seclusion in consult with the LIP as soon as possible after completing the evaluation.
9. When a drug or medication is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement, monitoring may be more frequent after administration such as every 15 minutes for first 2 hours, depending on the dose and type of drug or medication ordered.

DOCUMENTATION

Each episode of restraint is documented in the patient's medical record, consistent with policies and procedures.

1. Circumstances and patient's condition or symptoms that led to restraint use, description of patient's behavior.
2. Consideration or failure of alternative interventions.
3. Rational for the type of interventions selected.
4. Notification of the patient's family, when appropriate.
5. Written orders for use.
6. Notification of the LIP responsible for the patient if he / she is not the ordering LIP.
7. Consultations.
8. Any in-person medical and behavioral evaluation of the patient in restraint or seclusion for violent or self destructive behavior.
9. Revisions to the plan of care.

All assessments and monitoring of the patient.

10. Patient's response to the intervention, including the rationale for continued use of the intervention
11. Document the time the restraint is released and response of patient to release of restraint and any action taken.
12. Document significant changes in the patient's condition.
13. Any injury to the patient
14. Death associated with the use of restraint or seclusion.
15. Document on the medical record the date and time any restraint or seclusion associated death is reported to CMS.

QUALITY IMPROVEMENT PROCESS

Leadership determines our facility's approach to the use of restraint and seclusion, which limits its use to those situations where there is appropriate clinical justification by:

1. Development of supportive policies, plans and priorities.
2. Understanding of the staffing needs associated with alternatives to restraint and seclusion.
3. Ongoing staff orientation and training.
4. Patient and family education, as appropriate.
5. Refining medical, surgical, and diagnostic patient assessment processes to identify earlier the potential risk of dangerous patient behavior.
6. Development and promotion of patient safety and restraint alternative strategies.
7. Development and promotion of safe and effective alternatives including human resources.
8. Development and promotion of policies and procedures regarding the proper use of restraints.
9. Reviewing and, when necessary, redesigning patient care processes associated with restraint and seclusion use.
10. The integration of restraint / seclusion into the Quality Improvement (QI) activities of the hospital, for the purpose of reducing / eliminating restraint or seclusion use. This is accomplished by assessment of aggregate data and targeted monitoring.

Our facility collects data on the use of restraints and seclusion in order to monitor and improve its performance of processes that involve risks and may result in sentinel events.

1. ensure that restraint and seclusion are used only when clinically indicated;
2. identify opportunities for incrementally improving the rate of restraint and seclusion use; and
3. identify any need to redesign care processes.

We analyze data by:

1. Aggregating data at least quarterly.
2. Collecting data on all restraint episodes.
3. Collecting data from all settings (in-patient units, emergency room, and ambulatory areas where restraints are applied).
4. Data may be classified by:
   -shift

-staff who initiated the process
-the length of each episode
-date and time each episode was initiated
-day of the week each episode was initiated
-type of restraint used
-any injuries sustained by patient or staff
-age of patient
-gender of patient
-multiple episodes of restraint for the patient

Our facility, as part of our commitment to reduce / eliminate restraint use, will complete the following:

1. In this revised policy and procedure communicate to all staff our commitment to the reduction of restraints.
2. Identify and select interdisciplinary members for the Quality Coordinating Counsel.
3. This committee will continue the restraint reduction process by:
   -Re-evaluating the patients for the least restrictive restraint necessary to ensure their safety, but at the same time give them more freedom.
   -Enlisting the help of rehabilitation staff, such as occupational therapists to evaluate these patients and determine the use of less restrictive restraints.
   -Educate nursing staff on the alternatives to physical restraints they would be asked to employ.
   -Providing education on the effects of restraint.

II. REFERENCES

The Joint Commission PC.03.05.05

The Joint Commission Standards and FAQ's
March 4, 2021

III. STAKEHOLDERS

N/A

WATSONVILLE
COMMUNITY HOSPITAL

WATSONVILLE COMMUNITY HOSPITAL
FINANCIAL ASSISTANCE – BILLING AND COLLECTIONS POLICY

I. PURPOSE

The purpose of this policy is to comply with and provide information regarding the billing and collection of patient debt, pursuant to the Internal Revenue Code 501(r), California Health and Safety Code 127400-127449, and the policies and practices of Pajaro Valley Health Care District Hospital Corporation dba Watsonville Community Hospital (WCH), a nonprofit hospital.

II. POLICY

It is the policy of WCH to state clear guidelines for staff to commence appropriate collections actions on delinquent patient accounts that have qualified for the financial assistance policy. WCH does turn over patient accounts to a collection agency that have not responded to WCH's collection efforts. WCH does not sell debt to a debt buyer or other parties or assignees.

III. DEFINITIONS

Application Period: The period of time set for patients to complete the financial assistance application process. The period expires 270 days from the patient's admission or service date, or 150 days from the initial post-discharge bill, for the emergency or medically necessary care received at WCH.

Emergency and Medically Necessary Care: Any hospital emergency, inpatient, outpatient, or emergency medical care that is not entirely elective for patient comfort and/or convenience. (Typical non-medically necessary services would be cosmetic surgery, infertility treatments, and alternative therapies.)

Emergency Medical Treatment & Labor Act (EMTALA): In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with emergency medical conditions. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented. See WCH's EMTALA policy for further guidance.

Essential Living Expenses: Expenses for 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 childcare; child or spousal support; transportation and auto expenses, including insurance, gas, and repairs; installment payments; laundry and cleaning; and other extraordinary expenses.

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Extraordinary Collection Actions (ECAs): Extraordinary collection actions (ECAs) are actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the financial assistance policy that:

- Involve selling an individual's debt to another party
- Involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus
- Involve deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's non-payment of one or more bills for previously provided care covered under the WCH's financial assistance policy
- Require a legal or judicial process

Examples of actions that may require a legal or judicial process include, but are not limited to:

- Placing a lien on an individual's property
- Foreclosing on an individual's real property
- Attaching or seizing an individual's bank account or any other personal property
- Commencing a civil action against an individual
- Causing an individual's arrest
- Causing an individual to be subject to a writ of body attachment
- Garnishing an individual's wages

A claim filed by a hospital facility in any bankruptcy proceeding is not an ECA. Also, a lien placed on the proceeds of a judgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries caused by a third party for which the hospital facility provided care is not an ECA.

Financial Assistance: Assistance provided to patients and their families that qualify for financial help to fully or partially pay their portion of emergency and medically necessary care received at WCH as defined in WCH's financial assistance policy.

Financial Assistance Policy: WCH's financial assistance policy describes the eligibility criteria, application process to apply for financial assistance, and the charity care (free care) and discounted care (partially free care). It further describes where applications are located and how they can be obtained free of charge.

Guarantor: An individual other than the patient who is responsible for payment of the bill.

Presumptive Eligibility: A hospital facility may presumptively determine that an individual is eligible for financial assistance based on information other than that provided by the individual (e.g., socio-economic information specific to the patient that is gathered from market sources) or based on a prior financial assistance eligibility determination.

A presumptive determination that an individual is eligible for less than the most generous assistance available under a financial assistance policy constitutes "reasonable efforts" to determine financial assistance eligibility if a hospital facility:

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- Notifies the individual regarding the basis for the presumptive eligibility determination and how he or she may apply for more generous assistance available under the financial assistance policy;
- Gives the individual a reasonable period of time to apply for more generous assistance before initiating ECAs to obtain the discounted amount owed for the care; and
- Processes any complete financial assistance application the individual submits by the end of the application period or, if later, by the end of the reasonable time period given to apply for more generous assistance.

WCH uses a third-party vendor to assist in determining presumptive eligibility.

Reasonable Payment Plan: A payment plan where the monthly payments are not more than ten percent (10%) of a patient's family income for a month, excluding deductions for essential living expenses.

IV. REASONABLE EFFORTS, MULTIPLE EPISODES OF CARE AND NOTIFICATIONS

WCH will make every reasonable effort not to enter into any ECA's for emergency and medically necessary care prior to determining whether a patient is eligible for financial assistance. ECA's will not be initiated prior to 180 days of the initial post-discharge billing statement.

Reasonable efforts for incomplete financial assistance applications – When WCH receives an incomplete financial assistance application during the application period, it will suspend any ECA's and refrain from initiating any ECA's for at least 180 from the date WCH provided the first post-discharge billing statement, and it will notify the patient or guarantor of the incomplete application. WCH will also provide the patient with a list of the required documents needed to satisfy the application.

Reasonable efforts for completed FAA – When WCH receives a completed financial assistance application during the application period, it will do the following:

- Suspend any ECA's that may exist until financial eligibility is determined.
- Determine if the patient is eligible for financial assistance.
- Notify the patient or guarantor in writing of the financial assistance eligibility determination and the basis for such determination.

If the patient is determined to be eligible for financial assistance, WCH will:

- Provide a billing statement of the amount owed, if any, along with the determination letter.
- Refund any amounts the patient or guarantor paid that exceed what is owed. The refund will include interest accrued from the date the payment is received by WCH by the patient or guarantor, at a rate of ten percent (10%) per annum on the refunded amount. The refund will be issued within thirty (30) days from the later of the date the excess amount is paid or the date WCH determines the amount for which the

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patient is personally liable for paying (as a patient or guarantor eligible for financial assistance) after receiving the excess payment.

- WCH will take all reasonably available measures to reverse any ECA's, including any judgements or liens, and remove the any adverse information reported on the patient or guarantor's credit history.

If WCH believes a patient or guarantor who has submitted a complete financial assistance application may qualify for Medi-Cal, WCH will postpone making a financial assistance eligibility determination until after the patient's Medi-Cal application has been submitted and a determination as to Medi-Cal eligibility has been made. Under these circumstances, WCH will not initiate or resume any ECA's to obtain payment for the care at issue until a financial assistance eligibility determination has been made.

Notification Letter – No less than thirty (30) days prior to an ECA for any emergency or medically necessary care, a notification letter of WCH's intent will be sent to the patient or guarantor that will contain the following information:

a. A copy of the plain language summary of the financial assistance policy.

b. A copy of the financial assistance application, if one is not already on file.

c. The date of service for the ECA, and the name of entity the bill is being sold to.

d. Any insurance coverage on file or whether WCH has the patient listed as uninsured.

e. The documentation noted in the system, if any, of when the patient or guarantor was notified of WCH's financial assistance policy.

f. The timing of the application period.

Oral Notification – WCH staff will make every reasonable effort during the registration process for medically necessary care and at a time appropriate after the medical screening examination for emergency care to notify patients and guarantors about the financial assistance policy and the plain language summary thereof. These efforts will be documented in the patients account notes.

Multiple Episodes of Care – If WCH aggregates the outstanding bills for multiple episodes of care, it will not initiate an ECA until 180 days after it provided the first post-discharge bill for the most recent episode of care included in the aggregation.

V. PROCESSES FOR PAYMENT PLANS AND ADVANCING PATIENT DEBT TO COLLECTIONS

If a patient is applying for eligibility under the financial assistance policy and is attempting, in good faith, to settle an outstanding bill with WCH by negotiating a reasonable payment plan or by making regular reasonable payments, WCH will not send the bill to a collection agency until a final determination of the patient's application has been made.

A. In cases where the patient or guarantor is approved for discounted care and still owes a bill:

1. WCH does not require any patient or guarantor eligible for financial assistance to undergo an independent dispute resolution process if a discrepancy exists between a good faith estimate and the final bill.

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2. WCH will negotiate a reasonable payment plan (or an extended payment plan) when requested by the patient or guarantor.

3. WCH will not send unpaid bills to outside collection agencies and will stop any ECA's, if any exist.

4. Any extended payment plan agreed to will be interest free.

B. With respect to an extended payment plan where the patient, or guarantor, fails to make all consecutive payments due during a 90-day period:

1. Before declaring an extended payment plan in default, WCH or the collection agency must make a reasonable attempt to contact the patient or guarantor by phone and give written notice that the extended payment plan may default.

2. Before declaring an extended payment plan in default, WCH or the collection agency must attempt to renegotiate the extended payment plan with the patient or guarantor, if requested.

3. WCH or collection agency will not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or guarantor for nonpayment prior to the time the extended payment plan is declared to be in default.

4. WCH will not report adverse information for any credit bureau until at least 180 days from the date the patient or guarantor was initially billed for the patient's emergency or medically necessary care.

5. For purposes of this section, the notice and telephone call to the patient may be made to the last known telephone number and address of the patient and documented in the patient account notes.

C. All circumstances for adverse information reporting to credit bureaus must wait a minimum of 180 days from the initial bill date to the patient or guarantor.

D. The contractual agreement between WCH and any collection agency will comply with all IRC 501(r) and California Health and Safety Code 127400-127449 regulations.

E. WCH will not advance patient or guarantor debt to the collection agency unless an extended payment plan is declared to be in default and is not re-negotiated with the patient or guarantor or the patient is unresponsive for at least 180 days from the initial bill date to attempts to bill or offer financial assistance.

F. All patient or guarantor debt advanced to a collection agency will be reviewed by the Chief Financial Officer of WCH.

1. WCH's financial counselors will provide the Chief Financial Officer with a monthly list of the patient account, name, total, dates of service, initial billed date, and account notes.

2. The list will be initialed and dated by the Chief Financial Officer and WCH's financial counselors will scan the lists to the WCH server.

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G. Prior to assigning a patient's or guarantor's account to a collection agency, WCH will send the patient a notice with the following information:

1. The date(s) of service of the account being assigned to collections.
2. The name of the entity the bill is being assigned to.
3. A statement informing the patient how to obtain an itemized hospital bill from WCH.
4. The name and plan type of the health coverage for the patient on record with WCH at the time of services or a statement that WCH does not have that information.
5. A financial assistance application.
6. The date or dates the patient was originally sent a notice about applying for financial assistance, the date or dates the patient was sent a financial assistance application, and, if applicable, the date a decision on the application was made.

H. WCH will not, in dealing with patients eligible under WCH's financial assistance policy, use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills.

I. The collection agency will not, in dealing with any patient eligible under WCH's financial assistance policy, use as a means of collecting unpaid hospital bills any of the following:

1. A wage garnishment, except by order of the court upon noticed motion, supported by a declaration filed by the movant identifying the basis for which it believes that the patient has the ability to make payments on the judgment under the wage garnishment, which the court will consider in light of the size of the judgment and additional information provided by the patient prior to, or at, the hearing concerning the patient's ability to pay, including information about probable future medical expenses based on the current condition of the patient and other obligations of the patient.
2. Notice or conduct a sale of the patient's primary residence during the life of the patient or the patient's spouse, or during the period a child of the patient is a minor, or a child of the patient who has attained the age of majority is unable to take care of themselves and resides in the dwelling as their primary residence. In the event a person protected by this paragraph owns more than one dwelling, the primary residence will be the dwelling that is the patient's current homestead, as defined in Section 704.710 of the California Code of Civil Procedure, or was the patient's homestead at the time of the death of a person other than the patient who is asserting the protections of this paragraph.

J. This requirement does not preclude a hospital, collection agency, debt buyer, or other assignee from pursuing reimbursement and any enforcement remedy or

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remedies from third-party liability settlements, tortfeasors, or other legally responsible parties.

VI. AUTHORIZED BODY AND REPORTING REQUIREMENTS

The WCH executive team will review and update this policy and make recommendations to the WCH Board of Directors on a biennual basis (i.e., every other year) unless there are changes in the California Health and Welfare Code section 127400-127449, Internal Revenue Code 501(r), or any other regulations deemed to impact this policy.

WCH is required to upload this policy to the California Department of Health Care Access and Information at least biennually on January 1, or when a significant change is made.

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SUMMARY OF FINANCIAL ASSISTANCE

Thank you for choosing Pajaro Valley Health Care District Hospital Corporation dba Watsonville Community Hospital (WCH). WCH is committed to serving the health care needs of the community by providing financial assistance to patients and their families that qualify. WCH's financial assistance policy describes the financial assistance programs available to uninsured or underinsured. This summary is designed to help assist patients in understanding the policy.

Uninsured Patient

An uninsured patient is someone who does not have any healthcare coverage or has exceeded the benefit cap for coverage prior to the service or cannot be reimbursed by anyone else for their health care bills.

Underinsured Patient

An underinsured patient is someone who has healthcare coverage but is left with high medical costs.

100% Discounted Charity Care (Free Care)

If you are uninsured or underinsured with a family income of up to 250% of the federal poverty level, you may be eligible to receive medically necessary hospital services at no cost to you.

Discounted Care

If you are uninsured or underinsured with an annual family income between 250%-400% of the federal poverty level, you may be eligible to reduce your balance owed to no more than the than the average of what Medicare and commercial payers pay for the same services. This is referred to as the "amounts generally billed."

Patients and their families who qualify for WCH's financial assistance will never pay more than the amounts generally billed.

Application Assistance

You can ask for help with your bill at any time during your visit or billing process. Our financial counselors are available to answer questions, provide information about our financial assistance policy and help guide patients through the application process. During the application process, will you be asked for the number of people in your family, your monthly income, and other financial information that will assist WCH in determining whether you and your family qualify for assistance.

Payment Plans

If you qualify, you may also request an interest-free extended payment plan.

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Where to Get a Copy of the Financial Assistance Policy

Free copies of WCH's financial assistance policy and financial assistance application forms are available online, at the registration desk areas, at the Emergency Department, and at WCH's financial counseling office. You can also call and request that a copy be mailed to you. Please see the information below.

Online at www.watsonvillehospital.com

Telephone: (831) 761-5689, Financial Counseling Office

Mail a request to: Financial Counseling Office, 75 Nielson Street, Watsonville, CA 95076

Translations

WCH's financial assistance policy and application forms will be translated to Spanish and any other language deemed necessary to address the need of our community.

Other Organizations That Can Assist

There are other independent organizations that can help you understand the billing and payment process and provide you with information regarding Covered California and Medi-Cal presumptive eligibility. Please visit the Health Consumer Alliance at https://healthconsumer.org for more information.

Collections

WCH will make reasonable collection efforts to obtain payment from patients. General collection activities may include issuing patient statements, phone calls, and referral of statements that have been sent to the patient or guarantor. Bills that are not paid 180 days after the first billing date may be placed with a collection agency. WCH or collection agencies will not engage in any extraordinary collection actions, as defined in WCH's financial assistance billing and collections policy.

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FINANCIAL ASSISTANCE POLICY

I. PURPOSE

Pajaro Valley Health Care District Hospital Corporation dba Watsonville Community Hospital (WCH), a nonprofit hospital, offers a financial assistance policy for its patients. The financial assistance policy describes WCH's policy for both charity care (free care) and discounted care, and the process for patients who need help paying for their emergency and medically necessary care.

The intent of this policy is to satisfy the requirements of Section 501(r) of the Internal Revenue Code and California Health and Safety Code sections 127400 to 127446.

II. POLICY

A. WCH's financial assistance policy is designed to support patients who financially qualify and is not intended to replace any third-party coverage. WCH will make reasonable efforts to assist patients with their financial obligation to pay for hospital services, including emergency and medically necessary hospital care. Circumstances requiring assistance may include:

1. Patients with no insurance and/or not eligible for any third-party coverage;
2. Patients with third-party coverage which does not cover/reimburse all charges; and
3. Patients with who have high medical costs as defined by state and federal law, whose incomes are at or below 400% of the federal poverty level.

B. WCH's financial assistance policy applies to emergency and medically necessary care, as described in the definitions below. The policy does not extend to physician services, which are billed separately.

III. DEFINITIONS

Amounts Generally Billed: The amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. WCH uses the "look-back" method for establishing amounts generally billed using Medicare allowable charges.

Charity Care (Free Care): Hospital services that are offered at a 100% discount of the patient financial obligation for emergency and medically necessary care (e.g., eligible patients and families who earn up to 250% of the federal poverty level).

Discounted Care (Partially Free Care): A partial discount of the patient financial obligation for emergency and medically necessary care for patients who qualify (e.g., eligible patients and families who earn between 250% and 400% of the federal poverty level).

Eligibility Determination Period: Patients determined to be eligible are granted financial assistance for a period of twelve (12) months. Financial assistance will become effective on the admission or service date of the emergency or medically necessary care for which the assistance is being sought.

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Emergency and Medically Necessary Care: Any hospital emergency, inpatient, outpatient, or emergency medical care that is not entirely elective for patient comfort and/or convenience. (Typical non-medically necessary services would be cosmetic surgery, infertility treatments, and alternative therapies.)

Emergency Medical Treatment & Labor Act (EMTALA): In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with emergency medical conditions. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented. See WCH's EMTALA policy for further guidance.

Essential Living Expenses: Expenses for 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 childcare; child or spousal support; transportation and auto expenses, including insurance, gas, and repairs; installment payments; laundry and cleaning; and other extraordinary expenses.

Extraordinary Collection Actions (ECAs): Extraordinary collection actions (ECAs) are actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the financial assistance policy that:

- Involve selling an individual's debt to another party
- Involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus
- Involve deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's non-payment of one or more bills for previously provided care covered under the WCH's financial assistance policy
- Require a legal or judicial process

Examples of actions that may require a legal or judicial process include, but are not limited to:

- Placing a lien on an individual's property
- Foreclosing on an individual's real property
- Attaching or seizing an individual's bank account or any other personal property
- Commencing a civil action against an individual
- Causing an individual's arrest
- Causing an individual to be subject to a writ of body attachment
- Garnishing an individual's wages

A claim filed by a hospital facility in any bankruptcy proceeding is not an ECA. Also, a lien placed on the proceeds of a judgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries caused by a third party for which the hospital facility provided care is not an ECA.

Family: For patients 18 years or older, family includes the patient's spouse, domestic partner, and dependent children under 21. For patients under 18 years of age, family includes patient's parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker. If a patient claims a dependent on their income tax return, according to the Internal Revenue Service rules, that individual may be considered a dependent for the purposes of determining financial assistance eligibility. All financial resources of the household are considered together to determine eligibility under WCH's financial assistance policy.

Family Income: Family income includes the following types of income:

- Earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, disability payments, pension or retirement income, interest, dividends, rents, royalties, income from estates and trusts, educational assistance, alimony, child support, financial assistance from outside the household, and other miscellaneous sources
- Capital gains or losses
- A person's family income includes the income of all adult family members. For patients under 18 years of age, family income includes that of the parents and/or caretaker relatives.
- Fifty percent (50%) of the family's monetary assets above $10,000. The first $10,000 is not counted in the income calculation.

Assets that will not be considered as income are qualified retirement or deferred compensation plans under the Internal Revenue Code, or nonqualified deferred compensation plans.

Federal Poverty Level / Federal Policy Guidelines: A measure of income issued every year and updated annually in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current guidelines can be referenced https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.

Financial Assistance: Assistance provided to patients and their families that qualify for financial help to fully or partially pay their portion of emergency and medically necessary care received at WCH, as defined in this policy.

Guarantor: An individual other than the patient who is responsible for payment of the bill.

High Medical Costs: Financial assistance that provides a discount to eligible patients with annualized family income in excess of 400% of the federal poverty guidelines and financial obligations resulting from emergency or medically necessary services that exceed 10% of annualized family income.

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Presumptive Eligibility: A hospital facility may presumptively determine that an individual is eligible for financial assistance based on information other than that provided by the individual (e.g., socio-economic information specific to the patient that is gathered from market sources) or based on a prior financial assistance eligibility determination.

A presumptive determination that an individual is eligible for less than the most generous assistance available under a financial assistance policy constitutes "reasonable efforts" to determine financial assistance eligibility if a hospital facility:

- Notifies the individual regarding the basis for the presumptive eligibility determination and how he or she may apply for more generous assistance available under the financial assistance policy;
- Gives the individual a reasonable period of time to apply for more generous assistance before initiating ECAs to obtain the discounted amount owed for the care; and
- Processes any complete financial assistance application the individual submits by the end of the application period or, if later, by the end of the reasonable time period given to apply for more generous assistance.

WCH uses a third-party vendor to assist in determining presumptive eligibility.

Proof of Income: For purposes of determining financial assistance eligibility, WCH will review annual family income from ninety (90) days prior to the service date, and/or the prior tax year using tax return information.

Reasonable Payment Plan: An extended interest-free payment plan that is negotiated between and the patient for any patient out-of-pocket fees. A reasonable payment plan is based on monthly payments that are not more than ten percent (10%) of a patient's family income for a month, excluding deductions for essential living expenses.

Share of Cost: For an individual on Medi-Cal, the amount the individual agrees to pay for health care before Medi-Cal starts to pay.

Uninsured Patient: An individual having no third-party coverage by a commercial third-party insurer, an ERISA plan, a government program or other third-party assistance to assist with meeting their payment obligations. It also includes patients that have third-party coverage, but have either exceeded their benefit cap, have been denied coverage, or have insurance that does not provide coverage for the emergency or medically necessary care for which the patient is seeking treatment from WCH.

Underinsured Patient: An individual, with third-party insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medical services provided by WCH.

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IV. PHYSICIAN SERVICES

A. The physicians working at WCH are independent contractors and bill separately for their services.

B. A list of physicians that care for patients at WCH is available at https://watsonvillehospital.com/. Hardcopies of the physician list can be obtained in the admission or registration areas.

C. An emergency physician who provides emergency medical services is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400% of the federal poverty level.

V. COMMUNICATION REGARDING FINANCIAL ASSISTANCE

Notification regarding WCH's financial assistance policy is attained by:

A. Posters regarding the availability of financial assistance are posted in the following areas:

1. Financial Counseling Office
2. Emergency Department
3. Business Office
4. Patient Access Department
5. All admitting and registration desks
6. Other places within the community served by WCH as it chooses
7. WCH's internet website with a link to the policy

B. Paper copies of WCH's financial assistance policy, financial assistance application and a plain language summary of the policy are available upon request and without charge in WCH's Financial Counseling Office, Emergency Department, Business Office, Patient Access Department, and admitting and registration areas. Patients may also request that copies of these documents be sent to them electronically or mailed.

C. A written notice about WCH's financial assistance is provided to the patient either at the time of admission or discharge depending on the patient's condition on admission.

D. A plain language summary of the financial assistance policy that includes the information listed below:

1. The contact information, including telephone number and physical location WCH office or department that can provide information about the policy
2. The office or department at WCH that can provide assistance with the application process
3. Instructions on how the individual can obtain a free copy of the policy and application form by mail

4. The direct website address (URL) and physical locations where the individual can obtain copies of the policy and application form

5. A statement that an individual eligible for financial assistance may not be charged more than amounts generally billed for emergency or other medically necessary care

E. The financial assistance policy, plain language summary of the financial assistance policy, notices, posted signs and other communication related to the financial assistance policy will be printed in the appropriate languages and provided to patients as required.

F. WCH's website: The following resources are on WCH's website at https://watsonvillehospital.com/ free of charge. They are available in the primary languages of significant patient populations with limited English proficiency:

1. Financial assistance policy

2. Plain language summary of the financial assistance policy

3. Financial assistance billing and collections policy

4. Financial assistance applications

G. WCH's billing statements include:

1. A statement on the availability of financial assistance

2. The telephone number for WCH staff that provides help with the application process, and the website address where the financial assistance policy, plain language summary of the financial assistance policy, and financial assistance application can be found.

H. The plain language summary of the financial assistance policy will be available at community events and will be provided to local agencies that offer consumer assistance.

VI. INSURANCE PROGRAM ELIGIBILITY SCREENING PROCESS

All patients are screened for the ability to pay and/or to determine eligibility for payment programs including financial assistance. Emergency patients are not screened until after the EMTALA-required medical screening exam. Once a patient is eligible for screening, the WCH staff will:

A. Make reasonable efforts to obtain information from the patient about whether private or public health insurance may fully or partially cover the charges for emergency and medically necessary care.

B. Provide help in assessing the patient's eligibility for Medi-Cal, Medicare, the California Health Benefit Exchange, or any other third-party coverage as part of the application process for financial assistance.

C. Patients or patient's guarantors who do not cooperate in applying for programs that may pay in full or in part for their emergency for medically necessary services may be denied financial assistance.

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VII. FINANCIAL ASSISTANCE GENERAL GUIDELINES

A. All patients applying for financial assistance are required to follow the procedures in Section VIII below (Financial Assistance Application Process).

B. WCH will determine eligibility for financial assistance based on an individual's determination of financial need in accordance with this policy, without regards to an applicant's age, gender, race, immigrant status, sexual orientation, or religious affiliation.

C. In accordance with EMTALA regulations, no patient will be screened for financial assistance or payment information prior to the rendering of services in emergency situations.

D. The Internal Revenue Service requires WCH to establish a methodology by which patients eligible for financial assistance will not be charged more than the amounts generally billed for emergency and medically necessary services to individuals who have insurance covering such care. For purposes of this requirement, WCH will use the prior year's Medicare allowable charges.

E. The patient or guarantor is responsible for meeting the conditions of coverage of their health plan, if they have a health plan or other third-party coverage.

F. The federal poverty guidelines will be used for determining a patient's eligibility for financial assistance. Eligibility for financial assistance will be based on family income.

G. WCH will use reasonable collection efforts to obtain payment from patients. General collection activities may include issuing patient statements, phone calls, and referral of statements that have been sent to the patient or guarantor. WCH or collection agencies will not engage in any extraordinary collection actions.

H. Presumptive financial assistance occurs when WCH staff may assume that a patient will qualify for financial assistance based on information received by the hospital (i.e., homelessness, etc.).

1. A financial counselor will complete a financial assistance application for the patient, to include:

   a. The reason the patient, or patient's guarantor, cannot apply on his/her own behalf; and

   b. The patient's documented medical or socio-economic reasons that stop the patient, or patient's guarantor, from completing the application.

2. WCH may also assign patient accounts to be evaluated for presumptive eligibility for charity care or discounted care, if they think that the patient may need financial help paying the bill. This may occur if:

   a. The patient's medical record documents that they are homeless or currently in jail or prison.

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b. It is verified that the patient expired with no known estate.

c. The patient qualifies for a public benefit program including Social Security Disability Insurance (SSDI), Unemployment Insurance Benefits, Medi-Cal, County Indigent Health, Aid to Families with Dependent Children (AFDC), Food Stamps, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), etc.

d. The patient has not completed a financial assistance application or responded to requests for documentation.

3. If the patient does not or cannot respond to the application process, then the patient's account will be screened using the presumptive eligibility information outlined above to make an individual assessment of financial need.

4. WCH uses a third-party to conduct electronic reviews of patient information to assess financial need. These reviews use a healthcare industry-recognized model that is based on public record databases. This predictive model uses public record data to calculate a socio-economic and financial capacity score. It includes estimates of income, assets, and liquidity.

5. Electronic technology will be used after all other eligibility and payment sources have been tried before a patient account is considered bad debt and turned over to a collection agency. This ensures that WCH screens all patients for financial assistance before taking any collection actions.

6. Patient accounts granted presumptive eligibility will be reclassified under the financial assistance policy. WCH will not:

a. Send them to collection agencies, debt buyers, or other assignees; or

b. Subject them to further collection actions.

I. Charity care (free care) is granted to eligible patients and families who earn 250% or less of the federal poverty level. 100% of their emergency and medically necessary services will be discounted for the eligibility qualification period of one year. This type of care applies to uninsured and underinsured patients.

J. Discounted care (partially free care) is granted to eligible patient and families who earn between 250% and 400% of the federal poverty level. 50% of their emergency and medically necessary services will be discounted for the eligibility qualification period of one year. This type of care applies to uninsured and underinsured patients.

VIII. FINANCIAL ASSISTANCE APPLICATION PROCESS

A. Required Documentation

To qualify for financial assistance, an application must be filled out. The financial assistance application and the required supporting documents are used by WCH to

determine eligibility. In addition to filling out the application, the patient must provide the following documentation:

1. A copy of the patient's or guarantor's proof of income for the prior three (3) months (for all types of income listed in the application).
2. A copy of the patient's or guarantor's most recent tax return with all accompanying schedules.
3. A copy of the patient's or the guarantor's bank statements for prior three (3) months.
4. If no proof of income is evidenced in a completed application, a written affidavit is required.
5. Information obtained while determining income and/or charity care eligibility for financial assistance under this policy will not be used in collection efforts.

B. Eligibility Criteria for Financial Assistance

1. Patients are uninsured or underinsured or have high medical costs and are unable to pay for their care may be eligible for financial assistance.
2. An initial financial assistance determination will be based on the patient's individual or family income and family size, as determined by tax returns or recent pay stubs. The following additional information may also be required:
    a. Information on all monetary assets, both liquid and non-liquid, except statements on retirement or deferred-compensation plans (as such plans will not be considered as "income").
    b. Waivers or releases from the patient or family, authorizing WCH to obtain account information from financial or commercial institutions that hold monetary assets to verify their value.
    c. The first $10,000 of a patient's monetary assets are not counted in determining eligibility and 50% of the monetary assets in excess of $10,000 may not be counted in determining eligibility.
    d. Does not include retirement or delayed compensation plans (as such plans will not be considered as "income").
    e. Family size (includes legally qualified dependents) is also used to help determine the appropriate benchmark for assistance type (i.e., charity care or discounted care) if income is at or below the established income levels.
3. For patients on Medi-Cal with a Share of Cost, these amounts are not eligible for financial assistance.

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4. A patient may qualify for financial assistance if they meet one of the following:

   a. Family income is at or below 400% of the federal poverty level.

   b. Family income does meet the federal poverty limit of 400%, but allowable charges for emergency and medically necessary care exceed 10% of the family income (i.e., the patient has high medical costs).

C. Financial Assistance Levels

1. Patients who qualify for financial assistance cannot be charged more than the amounts generally billed for emergency and medically necessary care.

2. Charity care and discounted care are based on family income.

3. Patients earning less than 250% of the federal poverty level will be eligible for charity care (free care). Patients earning between 250% and 400% of the federal poverty level will be responsible for 50% of amounts generally billed.

4. Reasonable efforts will be made to make a determination of eligibility within fifteen (15) business days of receipt of all requested documentation. Details of the charity care or discounted care will be provided to the patient or the patient's representative.

5. The eligibility determination period will be valid for a period of twelve (12) months (one year) from the date of determination unless the patient's circumstances have changed.

6. At the time of the evaluation, should it be determined that the patient has paid more than required, a refund of the overpayment will be made.

D. Approvals and Appeals

1. Once a completed application has been reviewed and deemed complete by the financial counselor, the application will proceed to the director or officer set forth below for final approval based on the dollar value of the write off:

   a. Patient Financial Director approves <$10,000

   b. Chief Financial Officer approves $10,000-$75,000

   c. Chief Executive Officer approves >$75,000

2. Patients can submit a written request for reconsideration to the Chief Financial Officer of WCH if they believe the application was not approved according to the policy or disagree with how the policy has applied.

3. The Chief Financial Officer will have final level of approval.

4. Appeals dated more than ninety (90) days after application approval date will not be considered.

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IX. AUTHORIZED BODY AND REPORTING REQUIREMENTS

The WCH executive team will review and update this policy and make recommendations to the WCH Board of Directors on a biennual basis (i.e., every other year) unless there are changes in the California Health and Welfare Code section 127400-127449, Internal Revenue Code 501(r), or any other regulations deemed to impact this policy.

WCH is required to upload this policy to the California Department of Health Care Access and Information at least biennually on January 1, or when a significant change is made.

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Instructions for the Charity Application

The following information and supporting documents must be provided to evaluate this application for a possible reduction of hospital expenses provided by Watsonville Community Hospital.

Please complete all section of the application and provide applicable documents. Return the application to the Admitting Department or to the Business Office at the address below:

Attn: Financial Counselors
75 Nielson St
Watsonville, CA. 95076

Should you need assistance or have any questions regarding the Charity Application, please call 831-761-5689 or 831-761-5690.

List of documents required to complete the Charity Application:

- Copy of ID and Social Security Card
- Homeless Affidavit

Proof of Gross Income

- Check Stubs (last 3 Months)
- Employers Statement
- W-2 Form
- Complete Tax Return
- Profit/loss Statement from accountant (if self-employed)
- Bank Statements (3 months, all pages, for all accounts)
- Unemployment Benefits/EDD (3 months paystubs)
- Social Security/Disability
- Worker's Compensation
- Strike Benefits
- Welfare/AFDC/General Relief
- Veteran's Benefits
- Stipends
- Alimony
- Child Support
- Military Family Allotments
- Private or Government Pensions
- Proceeds from Insurance or Annuity Payments
- Income from Dividends
- Interest Income
- Rental Income
- Royalties
- Farm Income
- Other Assets

WATSONVILLE
COMMUNITY HOSPITAL

Charity Care and Low-Income Financial Assistance Application

To be completed by financially responsible party. Please complete this application in its entirety.

Date: _____

Patient Information

Patient's Name: _____ Patient's Employer: _____

Spouse's Name: _____ Spouse's Employer: _____

Patient's Address: _____

City: _____ State: _____ ZIP: _____

Patient's Phone #: _____

Patient's Date of Birth: _____ Spouse's Date of Birth: _____

Social Security Number: _____Spouse's Social Security Number: _____

Guarantor Information

Guarantor's Name: _____ Guarantor's Employer: _____

Guarantor's Address: _____

City: _____ State: _____ ZIP: _____

Patient's Phone #: _____ Guarantor's Social Security Number: _____

Please fill out the following:	Total for past 12 months	
	Patient	Spouse
Wages	$ _____	$ _____
Social Security	$ _____	$ _____
Strike Benefits	$ _____	$ _____
Alimony or Child Support	$ _____	$ _____
Military Allotment	$ _____	$ _____

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Dividends/Interest	$ _____	$ _____
Pensions	$ _____	$ _____
Unemployment	$ _____	$ _____
Disability	$ _____	$ _____
IRA	$ _____	$ _____
Trust Account	$ _____	$ _____
Interest Income	$ _____	$ _____
Other	$ _____	$ _____

Check the appropriate boxes below as you compile to submit:

Proof of Income for Patient & Spouse ( ) Pay Check Stubs for Patient & Spouse ( )

Current W-2 Form ( ) All Pages of Tax Return for Previous Year ( )

Expenses: *Submit last month's expense receipts*

House / Rent Payment: $ _____ Food: $ _____ Insurance: $ _____

Gas & Electricity: $ _____ Water: $ _____ Trash: $ _____

Child Support: $ _____ Auto Expenses: $ _____

Credit Cards: *Submit last statements*

Company: _____

Balance Owing: $_____ Amount Available: $_____

Company: _____

Balance Owing: $ _____ Amount Available: $_____

Company: _____

Balance Owing: $ _____ Amount Available: $_____

WATSONVILLE
COMMUNITY HOSPITAL

Medical Bills: ***Submit last statement***

Hospital: _____ Doctor Names _____

Amount Owed $ _____

Number of dependents in my household: _____

Name: _____ Relationship: _____ Age: ____

Name: _____ Relationship: _____ Age: ____

Name: _____ Relationship: _____ Age: ____

Name: _____ Relationship: _____ Age: ____

Name: _____ Relationship: _____ Age: ____

Name: _____ Relationship: _____ Age: ____

Bank References: ***Submit all pages of past 3 statements***

Checking: Bank Name: _____ Account# _____

Savings: Bank Name: _____ Account# _____

Assets:

Do you own your own Home?	Yes ( ) or No ( )	Value: $ _____
Is your home a Duplex / Triplex?	Yes ( ) or No ( )	
Do you own other Property?	Yes ( ) or No ( )	Value: $ _____
How many automobiles do you own? __	Yes ( ) or No ( )	Value: $ _____

WATSONVILLE
COMMUNITY HOSPITAL

STATEMENT

I certify the information provided is true and accurate to the best of my knowledge. Further, I have or will apply for any assistance (Medical, Medicare, insurance, etc.) that may be available for payment of medical services, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for medical services.

I understand this application is for the hospital to evaluate eligibility for Charity Services. I also understand the hospital will verify the information, which may include obtaining a credit report. If the information I have given proves to be untrue, or if I fail to comply with the referral process for Medical, Medicare, California Children's Services, or other identified programs this will result in forfeiture of the right to be considered for Charity Care.

I affirm the statements made herein are true and correct to the best of my knowledge.

Signature of the applicant: _____ Date: _____

Witness: _____ Date: _____

HOMELESS AFFIDAVIT

I, _____, I hereby certify I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others and or General Relief.

I also acknowledge all of the information provided herein is true and correct. I understand that providing false information will result in denial of this application. Additionally, depending upon local or state statutes, providing false information to defraud a hospital for obtaining goods or services may be considered an unlawful act. I also acknowledge and consent that a credit report may be obtained, or other such measure may be taken to verify the information provided herein. I fully understand that Watsonville Community Hospital Charity Care program is a "Payer of Last Resort" and herby confirm all prior assignments of benefits and rights, which may include liability actions, personal injury claims, settlements, and any and all insurance benefits that may become payable, for fitness or injury, for which Watsonville Community Hospital provided care.

WATSONVILLE
COMMUNITY HOSPITAL

_____ _____

Patient/Guarantor Signature Date

WATSONVILLE
COMMUNITY HOSPITAL

Instrucciones Para la aplicación del Programa de Caridad

La información siguiente y los documentos requeridos se deben entregar para evaluar esta aplicación para una reducción posible de gastos de hospital proporcionados por Watsonville Community Hospital.

Complete por favor todas secciones de la aplicación e incluye copias de los documentos aplicables **Regrese la aplicación al departamento de admisiones o a la Oficina de Negocios en la dirección listó abajo:**

Attn: Financial Counselors
75 Nielson St
Watsonville, CA. 95076

Si usted tiene alguna pregunta sobre su aplicación, por favor comuníquese al (831)761-5689 o (831)761-5690.

Lista de documentos requerido a completar la Aplicación de la Caridad:

- Copia de su identificación/ licencia de manejo
- Declaración jurada sin hogar

Prueba de Ingresos:

- Talón de Cheque (últimos 3 meses)
- Estado de cuentas bancarias todas las paginas (últimos 3 meses)
- Declaración de empleadores de ganancias
- Forma W-2
- Declaraciones de Impuestos (todas las páginas)
- Declaración de la gana/pérdida del contable (propio empleador)
- Seguro Social/Incapacidad
- Compensación de Trabajadores
- Huelga Beneficia
- Bienestar/AFDC/GR
- Beneficios de Veterano
- Remuneraciones
- Pensión
- Sostenimiento de Niño
- Lotes Militares de Familia
- Pensión Privado o Gobierno
- Avanza de Pagos de Seguro o Anualidad
- Ingresos de Dividendos
- Ingresos de Interés
- Alquileres
- Realezas
- Los Recibos Periodo de Propiedades o Fondos Financieros
- Ingresos de Agricultura (después de gastos)
- Sostenga de miembros de la familia o de alguien no viviendo en casa (no serán responsables de su cuenta)
- Beneficios de Desempleo (EDD) (los últimos 3 meses)
- Ventajas

WATSONVILLE
COMMUNITY HOSPITAL

Aplicación para el programa de caridad / cuidado indigente

La aplicación debe ser completada por la persona responsable para la cuenta. Complete la aplicación en su totalidad.

Fecha: _____

Información de paciente

Nombre de paciente: _____ Empleador del paciente: _____

Nombre del esposo/a: _____ Empleador del esposo/a: _____

Domicilió del paciente: _____

Ciudad: _____ Estado: _____ Código: _____

Número de teléfono: _____

Fecha de Nacimiento: _____ Fecha de nacimiento del esposo/a: _____

Número de Seguro Social: _____

Número de Seguro Social del esposo/a: _____

Información de guardián

Nombre del guardián: _____ Empleador del guardián: _____

Domicilió del guardián: _____

Ciudad: _____ Estado: _____ Código: _____

Número de teléfono: _____

Número de Seguro Social del guardián: _____

WATSONVILLE COMMUNITY HOSPITAL

Complete por favor el siguiente: Salarios de los últimos 12 meses

	Paciente	Esposo/a
Salarios	$ _____	$ _____
Seguro Social	$ _____	$ _____
Ventajas de huelga	$ _____	$ _____
Sostenimiento de niños	$ _____	$ _____
Asignación Militar	$ _____	$ _____
Dividendos / Interés	$ _____	$ _____
Pensiones	$ _____	$ _____
Desempleo	$ _____	$ _____
Incapacidad	$ _____	$ _____
IRA	$ _____	$ _____
Cuenta de fideicomiso	$ _____	$ _____
Ingreso de interés	$ _____	$ _____
Otro ingreso	$ _____	$ _____

Marque la casilla apropiada en cuanto junte la información pare someter.

Comprobante de Ingresos para Paciente y Cónyuge ( )

Talones de Cheque para Paciente y Cónyuge( )

Formulario W-2 ( )

Todas las Páginas de la Declaración de Impuestos del año Anterior ( )

Gastos: ***Someta los recibos del mes pasado***

Renta / Pago de casa $ _____ Alimento $ _____ Agua $ _____

Gas & Electricidad $ _____ Basura $ _____

Sostenimiento de niños $ _____ Pago de auto $ _____

Sostenimiento de auto $ _____ Seguro de Auto, Vida o medica $_____

WATSONVILLE COMMUNITY HOSPITAL

Tarjetas de crédito: ***Someta la ultima declaración***

Compañía: _____

Balance que debe $_____ Cantidad disponible $ _____

Compañía: _____

Balance que debe $_____ Cantidad disponible $ _____

Compañía: _____

Balance que debe $_____ Cantidad disponible $ _____

Cuentas medicas: ***Someta la ultima declaración***

Hospital / Nombre del Doctor: _____

Cantidad que debe $ _____

Número de mis dependientes en mi familia: _____

Nombre: _____ Relación: _____Edad: _____

Nombre: _____ Relación: _____Edad: _____

Nombre: _____ Relación: _____Edad: _____

Nombre: _____ Relación: _____Edad: _____

Nombre: _____ Relación: _____Edad: _____

Nombre: _____ Relación: _____Edad: _____

Referencias de Banco: ***Someta todas las páginas de los últimos 3 meses***

Cuenta de Cheques: Nombre del Banco: _____ Número de Cuenta# _____

Cuenta de Ahorros: Nombre del Banco: _____ Número de Cuenta# _____

Activos:

¿Es usted dueño de su propio hogar? Sí ( ) o No ( ) Valor $_____

¿Su casa es Dúplex/Triple? Sí ( ) o No ( )

¿Es usted dueño de otra propiedad? Sí ( ) o No ( ) Valor $_____

¿De cuántos automóviles es dueño/a? ___ Sí ( ) o No ( ) Valor $_____

WATSONVILLE
COMMUNITY HOSPITAL

Declaración

Certifico que la información proporcionada es verdadera y precisa a mi leal saber y entender. Además, tengo o solicitaré cualquier asistencia (médica, Medicare, seguro, etc.) que pueda estar disponible para el pago de servicios médicos, y tomaré cualquier acción razonablemente necesaria para obtener dicha asistencia y asignaré o pagaré al hospital la cantidad recuperada por servicios médicos. Entiendo que esta solicitud es para que el hospital evalúe la elegibilidad para los servicios de caridad.

También entiendo que el hospital verificará la información, lo que puede incluir la obtención de un informe de crédito. Si la información que he proporcionado resulta ser falsa, o si no cumplo con el proceso de referencia para Medical, Medicare, California Children's Services u otros programas identificados, esto resultara en la pérdida del derecho a ser considerado para el programa de Cuidado de Caridad. Afirmo que las declaraciones hechas en este documento son verdaderas y correctas a mi leal saber y entender.

Firma del solicitante: _____ Fecha: _____

Testigo: _____ Fecha: _____

DECLARACIÓN JURADA SIN HOGAR

Yo, _____, Certifico que no tengo hogar, no tengo dirección permanente, ni trabajo, ni ahorros, ni cuentas bancarias o propiedades de bienes y raíces, ni ingresos que no sean posibles donaciones de otros o de Ayuda General.

También reconozca que toda la información proporcionada en este documento es verdadera y correcta. Entiendo que proporcionar información falsa resultará en la denegación de esta solicitud. Además, dependiendo de los estatutos locales o estatales, proporcionar información falsa para defraudar a un hospital por obtener bienes o servicios puede considerarse un acto ilegal. También reconozco y doy mi consentimiento de que se puede obtener un informe de crédito o se pueden tomar otras medidas similares para verificar la información proporcionada en este documento.

Entiendo completamente que el programa de Cuidado de Caridad de Watsonville Community Hospital es un "Pagador de último recurso" y confirmo todas las asignaciones anteriores de beneficios y derechos, que pueden incluir acciones de responsabilidad, reclamos por lesiones personales, acuerdos y todos y cada uno de los beneficios de seguro que puedan ser pagaderos, por aptitud física o lesión, para los cuales Watsonville Community Hospital brindó atención.

_____ _____

Firma del Paciente Fecha

WATSONVILLE COMMUNITY HOSPITAL

PVHCDHC

Board Memo

Executive Sponsor: Clay Angel, M.D., Chief of Staff
Chair, Medical Executive Committee

Agenda Item: Chief of Staff Report – December 13, 2022, MEC

Meeting Date: December 28, 2022

ACTION ITEMS FOR APPROVAL

1. Credentialing Actions:

1.1 Credentials Report: December 2022
1.2 Interdisciplinary Practice Credentials Report: December 2022

2. Policies & Procedures:

2.1 Update to Orthopedic Privilege Delineation List
2.2 Adoption of Initial Application Evaluation Form
2.3 Removal of Background Investigation at Reappointment
2.4 Order Sets (informational)

3. Quality Report: (Presented by Tracy Trail-Mahan)

WATSONVILLE COMMUNITY HOSPITAL

Medical Executive Committee Summary – December 13, 2022
ITEMS FOR BOARD APPROVAL

Credentials Committee

INITIAL APPOINTMENTS: (19)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
Almidani, Mazen, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	12/28/2022 – 11/30/2024
Grewal, Santinder, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	12/28/2022 – 10/31/2024
Hossain, Nagma, MD	Tele-Infectious Disease / Provisional	Medicine	Telemedicine Infectious Disease	12/28/2022 – 10/31/2024
Kanter, Jenna, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	12/28/2022 – 10/31/2024
Kapuria, Abhi, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	12/28/2022 – 10/31/2024
McDonald, Mark, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	12/28/2022 – 11/30/2024
Myers, Robert, DO	Teleneurology / Provisional	Medicine	Telemedicine Neurology	12/28/2022 – 11/30/2024
Noya Santana, Monica, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	12/28/2022 – 11/30/2024
Patel, Birenkumar, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	12/28/2022 – 10/31/2024
Patrylo, Morgan, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	12/28/2022 – 10/31/2024
Ressa, Nicholas, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	12/28/2022 – 10/31/2024
Riordan, Katherine, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	12/28/2022 – 10/31/2024
Shenoy, Anant, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	12/28/2022 – 11/30/2024
Sombutmai, Chut, DO	Teleneurology / Provisional	Medicine	Telemedicine Neurology	12/28/2022 – 11/30/2024
Then, Ryna, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	12/28/2022 – 10/31/2024
Tong, Tao, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	12/28/2022 – 11/30/2024
Vajapey, Geetanjali, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	12/28/2022 – 10/31/2024
Vidgop, Yelena, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	12/28/2022 – 10/31/2024
Knight, Justin, MD	Emergency Medicine / Provisional	Medicine	Emergency Medicine Moderate Sedation	12/28/2022 – 11/30/2024

REAPPOINTMENTS: (9)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
Averill, Kenneth, MD	Radiology / Active	Medicine	Radiology	01/01/2023-12/31/2024
Granthom, Maria, MD	OBGYN / Active	OBGYN	OBGYN	01/01/2023-12/31/2024
Higashigawa, Kevin, MD	Orthopedic Surgery / Active	Surgery	Orthopedic Surgery	01/01/2023-12/31/2024
Knorr, Phillip, MD	Urology / Active	Surgery	Urology	01/01/2023-12/31/2024
Magana, Hector, MD	OBGYN / Active	OBGYN	OBGYN	01/01/2023-12/31/2024
McNamara, Edward, MD	Neonatology / Active	Pediatric	Neonatal - Perinatal	01/01/2023-12/31/2024
Potkin, Benjamin, MD	Cardiology / Active	Medicine	Cardiovascular Disease; Internal Medicine; Moderate Sedation; Fluoroscopy	01/01/2023-12/31/2024
Rasi, Leroy, MD	Orthopedic Surgery / Active	Surgery	Orthopedic Surgery	01/01/2023-12/31/2024
Walther, John, MD	Emergency Medicine /	Emergency Medicine	Emergency Medicine Moderate Sedation	01/01/2023-12/31/2024

MODIFICATION / ADDITION OF PRIVILEGES:

NAME	SPECIALTY	Privileges
None		

STAFF STATUS MODIFICATIONS:

NAME	SPECIALTY / DEPARTMENT	RECOMMENDATION
Edwards, Teresa, MD	Anesthesia	Resignation, effective 12/06/2022
Gleghorn, Janie, MD	Hospice and Palliative Care	Resignation, effective 12/17/2022
Medawar, Chad, DO	Critical Care Telemedicine	Resignation, effective 12/02/2022
Prasad, Ganesh, MD	Anesthesia	Resignation, effective 12/06/2022

TEMPORARY PRIVILEGES:

NAME	SPECIALTY / DEPARTMENT	DATES
Almidani, Mazen, MD	Teleneurology / Medicine	12/09/2022 – 1/31/2023
Grewal, Santinder, MD	Telemedicine Infectious Disease	11/30/2022 – 1/31/2023
Hossain, Nagma, MD	Tele-Infectious Disease / Medicine	12/16/2022 – 12/27/2022
Kanter, Jenna, MD	Teleneurology / Medicine	11/30/2022 – 1/31/2023
Kapuria, Abhi, MD	Teleneurology / Medicine	11/30/2022 – 1/31/2023
McDonald, Mark, MD	Teleneurology / Medicine	12/09/2022 – 1/31/2023
Myers, Robert, DO	Teleneurology / Medicine	12/12/2022 – 1/31/2023
Noya Santana, Monica, MD	Teleneurology / Medicine	12/12/2022 – 1/31/2023
Patel, Birenkumar, MD	Teleneurology / Medicine	11/30/2022 – 1/31/2023
Patrylo, Morgan, MD	Teleneurology / Medicine	12/09/2022 – 1/31/2023
Ressa, Nicholas, MD	Teleneurology / Medicine	12/09/2022 – 1/31/2023
Riordan, Katherine, MD	Teleneurology / Medicine	11/30/2022 – 1/31/2023

Shenoy, Anant, MD	Teleneurology / Medicine	12/12/2022 – 1/31/2023
Sombutmai, Chut, DO	Teleneurology / Medicine	12/12/2022 – 1/31/2023
Then, Ryna, MD	Teleneurology / Medicine	11/30/2022 – 1/31/2023
Tong, Tao, MD	Teleneurology / Medicine	12/09/2022 – 1/31/2023
Vajapey, Geetanjali, MD	Teleneurology / Medicine	11/30/2022 – 1/31/2023
Vidgop, Yelena, MD	Teleneurology / Medicine	11/30/2022 – 1/31/2023
Yousefi, Arian, MD	Internal Medicine Hospitalist / Medicine	12/22/2022 – 01/31/2023

INTERDISCIPLINARY PRACTICE COMMITTEE

Initial Appointment: (0)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
None				

REAPPOINTMENT: (0)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
None				

MEDICAL EXECUTIVE COMMITTEE, December 13, 2022, ACTION ITEMS FOR APPROVAL

1. **Credentialing Actions:**

1.1 Credentials Report: December 2022
1.2 Interdisciplinary Practice Credentials Report: November 2022

2. **Policies & Procedures:**

2.1 Update to Orthopedic Privilege Delineation List,
Criteria for Total Hip and Total Knee Surgery
2.2 Adoption of Initial Application Evaluation Form
2.3 Removal of Background Investigation at Reappointment
2.4 Order Sets (informational)

3. Quality Report: (Presented by Tracy Trail-Mahan, RN, Quality Director)

Watsonville Community Hospital

DEPARTMENT OF SURGERY
ORTHOPEDIC Clinical Privileges

ORTHOPEDIC	PRIVILEGES REQUESTED			
CLINICAL PRIVILEGES Privileges in Orthopedic Surgery are awarded to those who have completed postgraduate training in an Accreditation Council of Medical Education (ACGME) approved program in Orthopedic Surgery, and who are eligible for certification by the American Board of Orthopedic Surgery, and who maintain the standards and proficiency set by the American Board of Orthopedic Surgery. Place an "X" in the appropriate column	**Requested**	**Approved**	**Addition**	**Deletion**
Perform History & Physical				
Moderate Sedation of Patients (**Must take exam - refer to policy & procedure)**				
Surgical assisting (Documentation to be provided showing prior surgical assisting experience)				
Fluoroscopy Privileges: Criteria: Documentation of California State Fluoroscopy X-Ray Supervisor and Operator Permit				
CATEGORY II: Applicants must have completed an approved residency training program in Orthopedics and/or met board certification qualification requirements for the American Board of Orthopedic Surgery. The Category II physician may treat patients whose illness or problem requires skills usually acquired during specialty training or as a consequence of experience.				
Critical Care privilege (Refer to separate sheet)				
Repair and reconstruction of acute and chronic deformities and injuries of the adult musculoskeletal system including but not limited to bones, joints, ligaments, muscle tendons, nerves and arteries.				
Joint Replacement Surgery: Total Hip Replacement • Must provide documentation of cases, in the last 2 years, of ~~at least 25~~ **at least 5** cases for THR (total hip replacement)				
Joint Replacement Surgery: Total Knee Replacement • Must provide documentation of cases, in the last 2 years, of ~~at least 25~~ **at least 5** cases for TKR (total knee replacement)				
Repair and reconstruction of acute and chronic deformities and injuries of the pediatric musculoskeletal system including but not limited to bones, joints, ligaments, muscle tendons, nerves and arteries.				
Basic spine surgery including fusions, laminectomy, disc excisions, intra distal injections for chemonucleolysis.				
Surgery for repair of acute and chronic hand disorders and injuries.				
Closed or open treatment of open or complex closed fractures, including internal fixation.				

Watsonville Community Hospital
Medical Staff Initial Appointment Summary Report
To be Completed by Clinical Service Director

Practitioner Name: **Specialty**:

QUALIFICATIONS FOR MEMBERSHIP	Yes	No*	Comments
Application is Complete: No gaps noted; Attachments are signed.			
All Disclosure Questions were answered; explanations provided when required			
CA State License is Current & without Limitations, Conditions or Exceptions.			
DEA Certificate is Current and without Limitations, Conditions and/or Exceptions.			
Radiology/Fluoroscopy License is Current and without Limitations, Conditions or Exceptions			Not Applicable to Privileges
Professional Liability Insurance is Current, Meets Minimum Requirements and Coverage has no Conditions, Limitations or Exceptions. **Insurance covers the requested privileges.**			
Physician is Board Certified or is in the 5-YEAR interim time frame to obtain board certification			
Health Requirements (COVID, TB, Flu, e.g.) are current and documented with no questions or concerns.			
All gaps in training and concerns are accounted for			

Practitioner meets the minimum qualifications for Medical Staff Membership in Staff Status (choose one):
Provisional Staff **Refer and Follow Staff** **Allied Health Provider**

COMPETENCIES FOR PRIVILEGES	Yes	No	Comments
Practitioner's **Education and Training** met the requirements for privileges requested			
Practitioner's **practice experience** met all **volume, training, competency requirements** or other criteria for privileges (e.g. Sedation Test)			
Previous and Current Healthcare Affiliations were verified with no questions or concerns.			
Peer and Other References stated without exception, limitation or condition, good or better medical and clinical knowledge, competency, judgment, cognitive and technical skills, interpersonal and communication skills, professionalism, practice-based learning and improvement and systems-based practice to perform privileges requested.			
Any **Professional Liability Claims** were reviewed and determined to have no bearing / impact on privileges requested by this practitioner.			
National Practitioner Data Bank was verified with no current or previous issues noted or determined to have no impact / bearing on privileges requested by this practitioner			
Practitioner's **Background Report** was reviewed and determined to have no bearing / impact on privileges requested by this practitioner.			
OIG, EPLS, and other required sanctions and checks were verified with no current or previous issues determined to have an impact on privileges requested.			
Report of Providers CME Credits reflects medical staff requirements for ongoing education and training.			
To the best of your knowledge, is this practitioner mentally and physically able to perform the requested privileges?			

Practitioner meets the minimum competencies for Medical Staff Privileges

☐ **Yes**

☐ **Yes with the following conditions, exceptions or limitations:** _____

☐ **No for the following reasons:** _____

My signature affirms that I have reviewed this practitioner's initial appointment credentialing file.

Clinical Department Chair SIGNATURE: _____ ***Date:*** _____
NAME

Dates Recommended: by Credentials: _____ ***by MEC:*** _____**; Date Approved by Board of Directors:** _____

"CODE STROKE" (Inpatient) ORDER SET

(Mock-up/Draft)

√ = preselected

GENERAL:

□ Transfer patient to ICU, ONCE, Stat

Reminder text: *If candidate for thrombolytic therapy*

PRECAUTIONS:

√□ PLACE ON ASPIRATION PRECAUTIONS, ONCE, Routine

√□ PLACE ON FALL PRECAUTIONS, ONCE, Routine

√□ PLACE ON SEIZURE PRECATUIONS, ONCE, Routine

NURSING/PATIENT CARE:

√□ Obtain and document accurate patient weight, ONCE, Stat

√□ Measure vital signs per unit standards

√□ Notify provider if MAP <65 mmHg or SBP <90mmHg

√□ Notify provider if SBP >185 mmHg or DBP >110 mmHg pre-thrombolytic administration (mmHg needs to be added to all BP "Notify" orders)

√□ Notify provider if SBP >180mmHg or DBP >105mmHg post-thrombolytic administration

√□ Insert 2 large-bore IVs

√□ NIHSS score on arrival, then mini-NIHSS Q1H until thrombolytic given

√□ Notify tele neurology, ONCE, Stat

√□ Finger stick blood glucose, ONCE, Stat

□ Administer O2 via nasal cannula, titrate to maintain sats >94%

□ POC Urine pregnancy test

DIET:

√□ NPO until swallow eval by RN

DIAGNOSTICS:

√□ CT-head w/o contrast Code Stroke, ONCE, Stat

√□ Perform 12-lead EKG, ONCE, Stat

√□ Cardiac monitoring**,** ONCE, Stat

√□ Chest X-Ray 1V portable, ONCE, Stat

□ CT Angiogram head & neck w/contrast, ONCE, Stat

RESPIRATORY THERAPY:

√□ RT to assess and treat, ONCE, Stat, per protocol

IV FLUIDS:

□ NS, 100ml/hr., IV, continuous

LABORATORY:

√□ CBC w/Auto Diff, ONCE, Stat

√□ CMP, ONCE, Stat

√□ PT/INR, ONCE, Stat

√□ PTT, ONCE, Stat

□ POC, Hcg, ONCE, Stat

□ Urine drug screen**,** ONCE, Stat

□ ABG, puncture, ONCE, Stat

□ Alcohol, blood, ONCE, Stat

□ Troponin, ONCE, Stat

MEDICATIONS:

□ Labetalol 10mg, IV, every 10 minutes as needed for 2 doses *for* SBP >185mmHg or DBP>110 mmHg

Reminder text: *Administer over 1-2 minutes*

□ Nicardipine (Cardene), 5 mg/hr., IV, CONTINUOUS **(Pharmacy to add concentration)**

note: Embedded here: Thrombolytic Order Set into this order set to be enabled if need be.

Begin at 5mg/hr if labetalol doses are ineffective for systolic blood pressure greater than or equal to 185mmHg OR diastolic blood pressure greater than or equal to 110mmHg.

Titrate by 2.5 mg/hr, every 5 minutes to keep SBP less than 185mmHg and diastolic blood pressure less than 110mmHg.

Maximum dose is 15mg/h

Notify physician if maximum dose is reached.

CONSULTS:

√□ Consult to Neurology, ONCE, Stat

√□ Consult Hospital Medicine, ONCE, Stat

THROMBOLYTIC ORDER SET (Inpatient)

√ = preselected

MEDICATIONS:

√□ Tenecteplase 0.25mg/kg IV bolus over 5-10 sec (Max of 25 mg)

1 dose

Bolus

Give only under specific direction of treating physician

TNKase is incompatible with D5W; Do NOT administer in the same line as dextrose.

Normal saline 10 mL flush before IV Tenecteplase if dextrose containing solution is currently infusing.

Inject bolus dose over 5 seconds.

Dose not to exceed 25 mg (Maximum TOTAL TNKase dose is 25mg)

Flush IV line with 10mL normal saline after bolus.

No heparin, warfarin, aspirin, dabigatran, rivaroxaban, apixaban, or clopidogrel for 24 hours from start of TNKase administration.

Chart EXACT time when TNKase was administered.

Notify physician for acute deterioration in neurological status or worsening stroke to get STAT CT scan of head.

√□ Normal saline 0.9% inj syringe 10mL, IV

For 1 dose

Normal saline 10mL IV flush BEFORE IV Tenecteplase if dextrose containing solution is currently infusing

√□ Normal saline 0.9% inj syringe 10mL, IV

For 1 dose

Flush line with 10mL Normal saline AFTER Tenecteplase administration.

NURSING ORDERS:

During IV Tenecteplase administration, if symptoms such as neurological deterioration (i.e., NIHSS increase > 4 points), new headache, acute hypertension, nausea, or vomiting:

□ Hold Tenecteplase infusion

□ Notify Tele-neurologist STAT

□ Head CT w/o contrast STAT (Reason for exam: Stroke patient s/p IV thrombolytic, evaluate for ICH)

□ Dysphagia screen, Once

VITAL SIGNS:

- Q 15 minutes VS (BP, HR) x 1 hour during infusion, then
- Q 15 minutes VS (BP, HR) x 1 hour after infusion completed, then
- Q 30 minutes VS (BP, HR) x 6 hours, then
- Q 1hour VS (BP, HR) x 16 hours

NEUROLOGICAL CHECKS:

- Q 15 minutes neuro checks x 1 hour during infusion, then
- Q 15 minutes neuro checks x 1 hour after infusion completed, then
- Q 30 minutes neuro checks x 6 hours then
- Q 1hour neuro checks x 16 hours

MEDICATION WARNING:

Hold all anti-thrombotic (anti-platelet and anti-coagulant medications such as Aspirin, Clopidogrel, Aggrenox, heparin, lovenox, apixaban, dabigatran, rivaroxaban) for 24 hours after Tenecteplase infusion

POST-THROMBOLYTIC ORDER SET (Inpatient)

(MOCK-UP/Draft)

(Reference: Kaiser Epic Post Thrombolytic Order Set)

√ = preselected

NURSING:

√□ Vital signs

Perform BP every 15 minutes for 2 hours, every 30 minutes for 6 hours, and every 1 hour for the remainder of the first 24 hours from the initiation of the thrombolytic administration. Then per unit standards. All other vital signs per unit standard.

Call for temp >100.4F or <95F

Call for heart rate >120 BPM or <50 BPM

Call for SBP >180 mmHg DBP >105 mmHg

Call for SBP < 105 mmHg or DBP < 50 mmHg

Call for respiratory rate >26 or < 8

√□ NIHSS

Record NIHSS a minimum every 4 hours x 24 hours, then every 8 hours

Notify provider of deterioration in neurological condition (NIHSS increases by 2 or more points)

√□ Neuro checks

Record mini-NIHSS and presenting deficit (LOC, motor, language, and dysarthria) every 15 minutes for 2 hours, every 30 minutes for 6 hours, and every 1 hour for the remainder of the first 24 hours from the initiation of thrombolytic bolus.

If there is an increase in mini-NIHSS, perform full NIHSS and notify provider if the NIHSS increases by 2 or more points.

√○ Oxygen 2L via nasal cannula to maintain O2 sats 94% or greater

√□ Cardiac monitoring

Follow ACLS protocol

Call if chest pain, symptomatic arrhythmias, and any sustained VT, pacemaker malfunction (failure to sense or capture), non-sustained VT or greater than 7 beats, pause greater than 3 seconds

SWALLOW ASSESSMENT: (Subset under 'Nursing)

√○ Nurse to perform swallow screen

Reminder text: Patient to remain NPO including medications until swallow screen is performed and documented.

If patient fails, keep patient NPO and refer to Speech/Occupational therapy for dysphagia evaluation.

○ Swallow function evaluation by speech therapy

○ Insert Nasogastric (NG) feeding tube

Order instructions: *Insert small bore feeding tube*

Obtain portable chest X-ray after placement to confirm tube placement

Clamp tube between feedings

Flush with 10mL water to establish patency as needed

Teach feeding tube care to family

○ Swallow screen performed and passed

Reminder test: Do not change diet from NPO until it is documented and confirmed that the patient has passed a swallow evaluation.

√□ Give Stroke education packet to patient/family

DIAGNOSTICS:

√□ Perform 12-lead EKG, ONCE, Stat

□ X-ray Chest, portable, 1 view, ONCE, STAT

Order comments: To confirm feeding tube placement

√□ CT Head w/o contrast, ROUTINE

Order comments: *24 hours after thrombolytic infusion is completed*

□ CT Angiogram Head & Neck W (with contrast), ROUTINE

□ Ultrasound carotid vascular, STAT

- MRI BRAIN W, ONCE, Routine

  Diffusion weighted imaging

- MRI BRAIN WO, ONCE, Routine

  Diffusion weighted imaging

- MRI BRAIN WWO, ONCE, Routine

  MRV

- MRA HEAD WWO, ONCE, Routine
- MRA NECK WWO, ONCE, Routine

□ US Echo Complete

DIET:

√○ NPO, Once, STAT

MEDICATIONS:

ANTIPLATELETS

Reminder text (for this sub-section): Anti-platelets to start in 24 hours after thrombolytic given, NO heparin, warfarin, enoxaparin, aspirin, NSAIDs, Aggrenox, clopidogrel (Plavix), dipyridamole (Persantine), or TSOAs: Target specific anticoagulants for 24 hours from the start of thrombolytic bolus.

○ Aspirin chew tab, 81 mg, PO, Daily

Reminder text: Give first dose at least 24 hours after the start of thrombolytic administration. Use NG order if unable to give orally.

○ Aspirin chew tab, 81 mg, via NG, Daily

Reminder text: Give first dose at least 24 hours after the start of thrombolytic administration. Use NGT route if unable to take orally.

Call provider if patient does not have an order for NGT

○ Aspirin, 300 mg, SUPP, PR, Daily

Reminder text: Give first dose at least 24 hours after the start of thrombolytic administration. Administer PR if unable to give orally and patient unable to tolerate feeding tube.

○ Aspirin 325 mg, PO, Daily

Reminder text: Give first dose at least 24 hours after the start of thrombolytic administration. Use NG order if unable to give orally.

○ Aspirin, 325 mg, NG, Daily

Reminder text: Give first dose at least 24 hours after the start of thrombolytic administration. Use NGT route if unable to take orally.

○ Clopidogrel (Plavix), 75 mg, Orally, Daily

Reminder text: Reminder text: Use in patients allergic to or cannot tolerate aspirin. Give first dose at least 24 hours after the start of thrombolytic administration. Use NGT route if unable to take orally.

○ Clopidogrel (Plavix), 75 mg, NG, Daily

Reminder text: Use in patients allergic to or cannot tolerate aspirin. Give first dose at least 24 hours after the start of thrombolytic administration. Use NGT route if unable to take orally.

Call provider if patient does not have an order for NGT

○ Reason antithrombotic not ordered

□ Already given

□ Ordered outside of order set

□ High bleeding risk

□ Other (Specify in comments)

ANTIHYPERTENSIVES

√□ Labetalol (Normodyne/Trandate), 5 mg, IV

Every 10 minutes as needed, for 2 doses. See administration instructions

Give over 1-2 minutes if SBP > 180 mmHg or DBP > 105 mmHg after treatment with thrombolytic.

Prepare nicardipine drip if blood pressure still above parameters after first dose of labetalol. HOLD for heart rate equal to or less than 50 beats per minute. Repeat blood pressure 5 minutes after each administration.

√□ Nicardipine (Cardene), 5 mg/hr, IV **(Pharmacy to add concentration)**

Begin at 5mg/hr if labetalol doses are ineffective for systolic blood pressure greater than or equal to 180 mmHg OR diastolic blood pressure greater than or equal to 105 mmHg.

Titrate by 2.5 mg/hr every 5 minutes to keep SBP less than 180 mmHg or diastolic blood pressure less than 105 mmHg.

Maximum dose is 15mg/hr

Notify physician if maximum dose is reached.

PHARMACIST: Ensure this is mixed in Normal Saline

STATIN THERAPY

Reminder text for this sub-section: Atorvastatin (Lipitor) 80 mg daily is now the preferred statin for patients with Acute Ischemic Stroke.

If patient is already on a statin with LDL less than or equal to 70 mg/dl, continue current statin.

A lower dose of 40 mg a day Atorvastatin may be considered in patients with baseline LDL less than 70 mg/dl, liver disease, alcoholism, eGFR less than 30 mL/min, eGFR greater than 75 years, or certain drugs (e.g., azole antifungals, cyclosporine, danazol, HIV medications, clarithromycin, etc.) due to drug interaction.

○ Atorvastatin (Lipitor) 80 mg, Oral, Daily

First dose now as soon as patient has been cleared to take PO.

Use NG order if unable to give orally

○ Atorvastatin (Lipitor) 80 mg, NG, Daily

RN check first dose.

Use NG route if patient unable to take orally.

Call provider if patient does not have an order for an NG tube.

First dose NOW.

○ Atorvastatin (Lipitor) 40 mg, Oral, Daily

RN check first dose.

First dose now as soon as patient has been cleared to take PO.

Use NG order if unable to give orally

○ Atorvastatin (Lipitor) 40 mg, NG, Daily

RN check first dose.

Use NG route if patient unable to take orally.

Call provider if patient does not have an order for an NG tube.

First dose NOW.

○ Reason Statin not ordered

□ Allergy to statin medication

□ Myositis/myalgias currently or in the past

□ Liver dysfunction/hepatitis currently or in the past with statin use

□ Pregnancy

□ Other (Specify in comments)

□ Ordered outside of order set

DVT PROPHYLAXIS

√□ DVT prophylaxis for stroke post-thrombolytic

Reminder text:

Do not give pharmacologic VTE prophylaxis for the first 24 hours after IV thrombolytics.

24 hours post-thrombolytic, consideration can be given to pharmacologic VTE prophylaxis if the 24-hour head CT shows no evidence of hemorrhage.

□ Heparin, porcine injection, 5,000 units, SubQ, Q12H

Every 12 hours

First dose 24 hours after thrombolytic

□ Heparin, porcine injection, 5,000 units, SubQ, Q8H

Every 8 hours

First dose 24 hours after thrombolytic

MECHANICAL DVT PROPHYLAXIS

□ VTE Prophylaxis already ordered

Reminder text: VTE prophylaxis already ordered or already on anticoagulation for another indication.

√□ Apply sequential compression device (SCDs), ONCE

SCD while in bed

LABORATORY:

√□ Lipid Panel, Next A.M., x 1 occurrence

√□ Hemoglobin A1C, Next A.M, x 1 occurrence

□ POC finger stick blood glucose, NOW, Starting today x 1 occurrence

- ☐ CARDIOLIPN AB IGG IGM IGA, ONCE, Routine
- ☐ FACTOR VIII ACTIVITY, CLOTTING, ONCE, Routine
- ☐ PROTIME FOR STROKE, ONCE, Routine
- ☐ PROTEIN C ACTIVITY, ONCE, Routine
- ☐ PROTEIN S ACTIVITY, ONCE, Routine
- ☐ LUPUS ANTICOAGULANT EVAL W/RFL, ONCE, Routine
- ☐ FACTOR V (LEIDEN) MUT ANAL, ONCE, Routine

☐ ANA SCREEN W/RFL PATTERN/TITER, ONCE, Routine
☐ HOMOCYSTEINE CARDIOVASCULAR, ONCE, Routine

ANTITHROMBIN III AG	$ANTTHR3

□ Urine Drug Screen, ONCE, Routine

Send-out Misc.:

Beta 2 glycoprotein

Activated protein C resistance

Hemoglobin electrophoresis

CONSULTS:

√□ Neurology consult, ROUTINE, Once

√□ Inpatient Dietary consult

Reminder text: Nutrition consult for stroke education

√□ PT Eval and treat stroke patient, ROUTINE, Once

√□ Occupational therapy, Eval and treat, ROUTINE, Once

√□ Speech therapy, ROUTINE, Once

□ Social Services, ROUTINE, Once

WATSONVILLE COMMUNITY HOSPITAL

PVHCDHC

Board Memo

Executive Sponsor: Julie Peterson, CFO

Agenda Item: Approval of 2023 Budget Approval

Meeting Date: December 27, 2022

Recommended Actions:
Approval of the 2023 Budget to the Pajaro Valley Health Care District Hospital Corporation Board of Directors.

Executive Summary
The Pajaro Valley Health Care District Hospital Corporation has created an Operating Budget for the 2023 calendar year. This item asks the Board to approve the 2023 Budget with a provision that the Hospital staff will present quarterly revisions as necessary.

Background
Each year the Hospital creates an annual budget. After concluding with the Bankruptcy proceedings and the sale of the hospital to new ownership as of September 1, 2022, the hospital is preparing a summary level budget for the calendar year 2023. There are many initiatives in the plan and hospital leadership feels it is in the best interest of the corporation to prepare quarterly updates of the budget during the calendar year 2023. The District is the legal provider of care provided by Coastal Health Partners. The Hospital performance is combined with the District performance, which includes the Coastal Health Partners medical group.

Analysis
A summary level budget was prepared using calendar year 2022 October YTD actuals and key performance metrics to build a base budget for 2023. Volume assumptions and inflationary factors were layered onto the base budget. Initiatives were created to quantify the improvement actions at the Hospital as well as incremental expenses being added.

The District budget was prepared using the calendar year 2022 October YTD actuals for Coastal Health Partners and four months of District expenses. Volumes are assumed flat and inflationary factors were layered onto the base budget. Payer contracting estimates were added in for 2023.

For 2023, the MPT lease payments of $3,000,000 and $859,056 for property insurance are included in the District budget. Prior to Sept 1, 2022 these amounts were captured in the Hospital performance.

Financial Impact

The Hospital's projected EBITDA loss for 2022 is ($21,153,446). The initiatives provide for $29,820,655 improvement. The projected EBITDA for 2023 is $3,378,979.

The District projected EBITDA loss for 2023 is ($6,659,983). The combined EBITDA loss is budgeted at ($3,432,498).

Attachment(s)

1. Pajaro Valley Healthcare District Hospital Corporation 2023 Budget

Pajaro Valley Healthcare District Hospital Corporation
(Watsonville Community Hospital)
2023 Budget
As of December 2022

	ACTUAL 2021	PROJECTED 2022	BUDGET 2023
Inpatient Revenue	405,742,348	387,548,801	412,974,509
Outpatient Revenue	541,964,278	578,779,155	609,993,782
Total Revenue	**947,706,626**	**966,327,956**	**1,022,968,291**
Deductions From Revenue:	818,735,235	836,830,518	867,147,926
Net Revenue	**128,971,391**	**129,497,438**	**155,820,365**
Provision for Bad Debts	9,350,298	1,630,432	1,321,461
Collectible Patient Revenue	**119,621,093**	**127,867,005**	**154,498,903**
Other Revenue	2,618,989	1,921,071	1,375,126
Total Net Operational Revenue	**122,240,082**	**129,788,077**	**155,874,030**
Salaries & Wages	58,412,216	60,215,217	67,559,594
Employee Benefits	17,896,224	22,666,621	23,987,044
Registry	7,973,372	8,758,750	6,206,003
Labor Subtotal	**84,281,812**	**91,640,588**	**97,752,641**
Professional Fees Medical	7,071,885	8,934,968	9,937,220
Supplies	12,472,144	10,165,687	11,050,258
Repairs & Maintenance	1,521,417	1,167,148	1,226,746
Utilities	1,571,936	1,856,658	1,951,465
Purchased Services	17,885,312	23,349,140	13,951,993
Lease Cost and Rent	1,623,919	1,386,912	2,311,227
Property Taxes & Insurance	5,553,664	3,050,676	3,206,454
Grant Expenses	-	-	-
Other Expenses	10,081,798	9,239,746	10,957,045
Management Fees	-	150,000	150,000
Total Operating Exp	**142,063,887**	**150,941,523**	**152,495,051**
EBITDA	**(19,823,805)**	**(21,153,446)**	**3,378,979**
Depreciation & Amortization	2,791,075	2,197,388	-
MPT Lease & Other Finance Leases	7,251,732	7,390,741	151,494
Net Income/Loss from Operations	**(29,866,612)**	**(30,741,575)**	**3,227,485**
Non-Operating Expense/Income	-	30,698,034	
Net Income / (Loss)	**(29,866,612)**	**(43,541)**	**3,227,485**